



# NATIONAL AND STATE HEALTHCARE ASSOCIATED INFECTIONS

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# PROGRESS REPORT



THIS REPORT IS BASED ON 2013 DATA, PUBLISHED JANUARY 2015



**Centers for Disease  
Control and Prevention**  
National Center for Emerging and  
Zoonotic Infectious Diseases

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| <br>  |               |               |                |               |
| Alabama   | Hawaii        | Michigan      | North Carolina | Texas         |
| Alaska  | Idaho         | Minnesota     | North Dakota   | Utah          |
| Arizona   | Illinois      | Mississippi   | Ohio           | Vermont       |
| Arkansas  | Indiana       | Missouri      | Oklahoma       | Virginia      |
| California  | Iowa          | Montana       | Oregon         | Washington    |
| Colorado  | Kansas        | Nebraska      | Pennsylvania   | West Virginia |
| Connecticut   | Kentucky      | Nevada        | Puerto Rico    | Wisconsin     |
| Delaware  | Louisiana     | New Hampshire | Rhode Island   | Wyoming       |
| District of Columbia  | Maine         | New Jersey    | South Carolina |               |
| Florida   | Maryland      | New Mexico    | South Dakota   |               |
| Georgia   | Massachusetts | New York      | Tennessee      |               |
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**H**ealthcare-associated infections (HAIs) are a major, yet often preventable, threat to patient safety. The Centers for Disease Control and Prevention (CDC) is committed to helping all Americans receive the best and safest care. The *National and State Healthcare-Associated Infections Progress Report* (HAI Progress Report) expands and provides an update on the previous reports detailing progress toward the ultimate goal of eliminating healthcare-associated infections. The Report can serve as a reference for anyone looking for information about national and state HAI prevention progress. It is specifically designed to be accessible to many audiences. For detailed methods and references, please refer to the Technical Appendix within this report. For complete data tables and a glossary of terms, please visit CDC's HAI Progress Report website at [www.cdc.gov/hai/progress-report](http://www.cdc.gov/hai/progress-report).

To help improve patient safety, CDC tracks infections, responds to outbreaks, provides infection prevention expertise and guidelines, spearheads prevention research, and serves as the nation's gold-standard laboratory. CDC's National Healthcare Safety Network (NHSN), the nation's healthcare-associated infection tracking system, is critical in this work. More than 13,000 hospitals and other healthcare facilities provide data to NHSN. This vital information is then used for reporting, including in this HAI

Progress Report, and for care improvement by facilities, states, regions, quality groups, and national public health agencies including CDC.

This HAI Progress Report includes national and state-by-state summaries of six HAI types based on 2013 data. The Report helps measure progress toward the HAI prevention goals outlined in the *National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination* ([HAI Action Plan](#)) set by the U.S. Department of Health and Human Services (HHS). Progress is measured using the standardized infection ratio (SIR), a summary statistic that can be used to track HAI prevention progress over time. The individual state progress reports include infection-specific SIRs, progress in reducing HAIs, and state prevention efforts. These customized reports can aid in identifying areas in need of improvement from a national level and within specific states.

Data in this report are from acute care hospitals only. National and state-level data include: central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), hospital-onset *Clostridium difficile* infections (*C. difficile*), and hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia (bloodstream infections). This is the first report that includes state-specific

information about MRSA bacteremia and *C. difficile* infections. State-specific SSI data are presented for colon surgery and abdominal hysterectomy surgery, two of the most commonly reported surgeries.

The Report describes significant reductions reported at the national level in 2013 for nearly all infections. Despite this progress, the nation did not reach the 2013 goals established by the HAI Action Plan in 2009. More action is needed at every level of public health and health care to improve patient safety and eliminate infections that commonly threaten hospital patients. CLABSI and SSI show the greatest reduction as they closely approached the set goals. Some progress is shown in reducing both hospital-onset MRSA bacteremia and hospital-onset *C. difficile* infections. The Report shows an increase in CAUTI, similar to last year's report, signaling a strong need for additional prevention efforts.

**On the national level, the report found:**

46 percent decrease in CLABSI between 2008 and 2013

19 percent decrease in SSI related to the 10 select procedures tracked in the report between 2008 and 2013

6 percent increase in CAUTI between 2009 and 2013

8 percent decrease in MRSA bacteremia between 2011 and 2013

10 percent decrease in *C. difficile* infections between 2011 and 2013

**On the state level:**

26 states performed better than the national SIR on at least two infection types

16 states performed better than the national SIR on at least three infection types

6 states performed better than the national SIR on at least four infection types

19 states performed worse than the national SIR on at least two infection types

8 states performed worse than the national SIR on at least three infection types

**The number of states performing better than the nation by infection type:**

CLABSI – 16 states

SSI, colon surgery – 9 states

SSI, abdominal hysterectomy – 8 states

CAUTI – 19 states

MRSA bacteremia – 19 states

*C. difficile* infections – 21 states

**The number of states performing worse than the nation by infection type:**

CLABSI – 14 states

SSI, colon surgery – 13 states

SSI, abdominal hysterectomy – 3 states

CAUTI – 17 states

MRSA bacteremia – 12 states

*C. difficile* infections – 18 states

This report shows that although significant progress was made in some infection types, there is much more work to be done. On any given day, approximately one in 25 U.S. patients has at least one infection contracted during the course of their hospital care,

demonstrating the need for improved infection control in U.S. healthcare facilities. Steps can be taken to control and prevent healthcare-associated infections in a variety of settings. Research shows that when healthcare facilities, care teams, and individual doctors and nurses are aware of infection problems and take specific steps to prevent them, rates of some targeted HAIs (e.g., CLABSI) can decrease by more than **70 percent**. Full engagement between local, state and federal public health agencies and their partners in the healthcare sector will be vital to sustaining and extending HAI surveillance and prevention progress. CDC will continue its prevention, tracking, lab, and guideline work to push the country further toward the goal of eliminating HAIs.

Any comments and suggestions that would improve the usefulness of future publications are appreciated and should be sent to the Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road, Mailstop A-07; Atlanta, Georgia, 30333. E-mail can also be used: [patientsafety@cdc.gov](mailto:patientsafety@cdc.gov).

# STATE PROGRESS LANDSCAPE



# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | CLABSI: CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS |                         |  |                                       |  |                       |                    |                         |
|---------------|--|-------------------------|--|---------------------------------------|--|-----------------------|--------------------|-------------------------|
|               | 2013 Reporting and Validation                          |                         |  |                                       |  | 2013 State CLABSI SIR |                    |                         |
|               | # Hospitals Reporting to NHSN                          | State Reporting Mandate | State HD <sup>†</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR    | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Alabama       | 75   |                         |  |                                       |  |                       |                    |                         |
| Alaska        | 10   |                         |  |                                       |  |                       |                    |                         |
| Arizona       | 56   |                         |  |                                       |  |                       |                    |                         |
| Arkansas      | 48   |                         |  |                                       |  |                       |                    |                         |
| California    | 350  |                         |  |                                       |  |                       |                    |                         |
| Colorado      | 52   |                         |  |                                       |  |                       |                    |                         |
| Connecticut   | 30   |                         |  |                                       |  |                       |                    |                         |
| D.C.          | 8  |                         |  |                                       |  |                       |                    |                         |
| Delaware      | 8  |                         |  |                                       |  |                       |                    |                         |
| Florida       | 191  |                         |  |                                       |  |                       |                    |                         |
| Georgia       | 102  |                         |  |                                       |  |                       |                    |                         |
| Hawaii        | 15   |                         |  |                                       |  |                       |                    |                         |
| Idaho         | 16   |                         |  |                                       |  |                       |                    |                         |
| Illinois      | 148  |                         |  |                                       |  |                       |                    |                         |
| Indiana       | 104  |                         |  |                                       |  |                       |                    |                         |
| Iowa          | 50   |                         |  |                                       |  |                       |                    |                         |
| Kansas        | 49   |                         |  |                                       |  |                       |                    |                         |
| Kentucky      | 72   |                         |  |                                       |  |                       |                    |                         |
| Louisiana     | 79   |                         |  |                                       |  |                       |                    |                         |
| Maine         | 21   |                         |  |                                       |  |                       |                    |                         |
| Maryland      | 47   |                         |  |                                       |  |                       |                    |                         |
| Massachusetts | 69   |                         |  |                                       |  |                       |                    |                         |
| Michigan      | 97   |                         |  |                                       |  |                       |                    |                         |
| Minnesota     | 47   |                         |  |                                       |  |                       |                    |                         |
| Mississippi   | 47   |                         |  |                                       |  |                       |                    |                         |
| Missouri      | 74   |                         |  |                                       |  |                       |                    |                         |

HD<sup>†</sup>: State Health Department

Data Checked for Quality<sup>‡</sup>: State analyzed 2013 data for quality and completeness.

Additional In-Depth Data Review<sup>‡</sup>: State reviewed medical records to determine 2013 data accuracy.

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# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | CLABSI: CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS |                         |  |                                       |  |                       |                    |                         |
|----------------|--|-------------------------|--|---------------------------------------|--|-----------------------|--------------------|-------------------------|
|                | 2013 Reporting and Validation                          |                         |  |                                       |  | 2013 State CLABSI SIR |                    |                         |
|                | # Hospitals Reporting to NHSN                          | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR    | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Montana        | 14   |                         |  |                                       | ✓  | ↑                     | ↑                  | ↓                       |
| Nebraska       | 20   |                         |  |                                       |  | ↓                     | ↑                  | ↓                       |
| Nevada         | 23   | ✓                       | ✓  |                                       |  | ↑                     | ↑                  | ↓                       |
| New Hampshire  | 24   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| New Jersey     | 72   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↑                  | ↓                       |
| New Mexico     | 36   | ✓                       | ✓  | ✓                                     | ✓  | ↓                     | ↓                  | ↓                       |
| New York       | 172  | ✓                       | ✓  | ✓                                     | ✓  | ↓                     | ↑                  | ↓                       |
| North Carolina | 98   | ✓                       | ✓  | ✓                                     |  | ↑                     | ↓                  | ↓                       |
| North Dakota   | 6  |                         |  |                                       |  | ↑                     | ↓                  | ↓                       |
| Ohio           | 137  |                         |  |                                       |  | ↓                     | ↓                  | ↓                       |
| Oklahoma       | 53   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Oregon         | 49   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Pennsylvania   | 172  | ✓                       | ✓  | ✓                                     |  | ↑                     | ↓                  | ↓                       |
| Puerto Rico    | 18   |                         | ✓  |                                       |  | ↓                     | ↑                  | ↓                       |
| Rhode Island   | 11   | ✓                       | ✓  |                                       |  | ↑                     | ↑                  | ↓                       |
| South Carolina | 65   | ✓                       | ✓  | ✓                                     | ✓  | ↓                     | ↑                  | ↓                       |
| South Dakota   | 16   |                         | ✓  | ✓                                     | ✓  | ↓                     | ↓                  | ↓                       |
| Tennessee      | 95   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Texas          | 281  | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Utah           | 26   | ✓                       | ✓  | ✓                                     |  | ↑                     | ↑                  | ↓                       |
| Vermont        | 7  | ✓                       | ✓  | ✓                                     |  | ↑                     | ↓                  | ↓                       |
| Virginia       | 81   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Washington     | 83   | ✓                       | ✓  | ✓                                     | ✓  | ↓                     | ↓                  | ↓                       |
| West Virginia  | 43   | ✓                       | ✓  | ✓                                     |  | ↓                     | ↓                  | ↓                       |
| Wisconsin      | 90   |                         | ✓  | ✓                                     |  | ↑                     | ↓                  | ↓                       |
| Wyoming        | 21   |                         |  |                                       |  | ↑                     | ↓                  | ↓                       |

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# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

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2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | CAUTIS: CATHETER-ASSOCIATED URINARY TRACT INFECTIONS |                         |  |                                       |  |                      |                    |                         |
|---------------|--|-------------------------|--|---------------------------------------|--|----------------------|--------------------|-------------------------|
|               | 2013 Reporting and Validation                        |                         |  |                                       |  | 2013 State CAUTI SIR |                    |                         |
|               | # Hospitals Reporting to NHSN                        | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR   | vs. 2013 Nat'l SIR | vs. 2009 Nat'l Baseline |
| Alabama       | 86   | ✓                       | ✓  | ✓                                     | ✓  | ↑                    | ↓                  | ↓                       |
| Alaska        | 10   |                         |  |                                       |  | ↓                    | ↓                  | ↑                       |
| Arizona       | 55   |                         |  |                                       |  | ↓                    | ↓                  | ↑                       |
| Arkansas      | 49   | ✓                       | ✓  | ✓                                     |  | ↓                    | ↓                  | ↑                       |
| California    | 341  |                         |  |                                       |  | ↑                    | ↓                  | ↓                       |
| Colorado      | 52   |                         |  |                                       |  | ↓                    | ↓                  | ↓                       |
| Connecticut   | 31   | ✓                       | ✓  | ✓                                     |  | ↓                    | ↑                  | ↑                       |
| D.C.          | 7  |                         | ✓  | ✓                                     |  | ↓                    | ↑                  | ↑                       |
| Delaware      | 8  | ✓                       | ✓  | ✓                                     |  | ↑                    | ↑                  | ↑                       |
| Florida       | 190  |                         |  |                                       |  | ↑                    | ↓                  | ↓                       |
| Georgia       | 105  | ✓                       | ✓  |                                       |  | ↑                    | ↑                  | ↑                       |
| Hawaii        | 15   | ✓                       | ✓  | ✓                                     |  | ↓                    | ↓                  | ↓                       |
| Idaho         | 17   |                         |  |                                       | ✓  | ↓                    | ↓                  | ↑                       |
| Illinois      | 148  |                         |  |                                       |  | ↓                    | ↓                  | ↓                       |
| Indiana       | 110  | ✓                       | ✓  |                                       |  | ↑                    | ↑                  | ↑                       |
| Iowa          | 68   |                         | ✓  | ✓                                     |  | ↓                    | ↓                  | ↓                       |
| Kansas        | 53   |                         | ✓  | ✓                                     |  | ↑                    | ↑                  | ↑                       |
| Kentucky      | 73   |                         | ✓  |                                       |  | ↑                    | ↑                  | ↑                       |
| Louisiana     | 81   |                         | ✓  | ✓                                     |  | ↓                    | ↓                  | ↓                       |
| Maine         | 21   |                         | ✓  | ✓                                     |  | ↓                    | ↑                  | ↑                       |
| Maryland      | 39   |                         |  |                                       |  | ↓                    | ↑                  | ↑                       |
| Massachusetts | 69   |                         |  |                                       |  | ↑                    | ↑                  | ↑                       |
| Michigan      | 98   |                         | ✓  | ✓                                     |  | ↑                    | ↑                  | ↑                       |
| Minnesota     | 51   | ✓                       |  |                                       |  | ↓                    | ↑                  | ↑                       |
| Mississippi   | 48   |                         | ✓  |                                       |  | ↓                    | ↑                  | ↑                       |
| Missouri      | 76   |                         |  |                                       |  | ↑                    | ↑                  | ↑                       |

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# STATE HAI PROGRESS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | CAUTIS: CATHETER-ASSOCIATED URINARY TRACT INFECTIONS |                         |  |                                       |  |                      |                    |                         |
|----------------|--|-------------------------|--|---------------------------------------|--|----------------------|--------------------|-------------------------|
|                | 2013 Reporting and Validation                        |                         |  |                                       |  | 2013 State CAUTI SIR |                    |                         |
|                | # Hospitals Reporting to NHSN                        | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR   | vs. 2013 Nat'l SIR | vs. 2009 Nat'l Baseline |
| Montana        | 14   |                         |  |                                       | ✓  | ⬇                    | ⬇                  | ⬇                       |
| Nebraska       | 20   |                         |  |                                       |  | ⬇                    | ⬇                  | ⬇                       |
| Nevada         | 24   |                         |  |                                       |  | ⬆                    | ⬆                  | ⬆                       |
| New Hampshire  | 23   | ✓                       | ✓  | ✓                                     |  | ⬇                    | ⬇                  | ⬇                       |
| New Jersey     | 72   | ✓                       | ✓  | ✓                                     |  | ⬇                    | ⬇                  | ⬆                       |
| New Mexico     | 35   |                         |  |                                       |  | ⬇                    | ⬇                  | ⬇                       |
| New York       | 172  |                         | ✓  |                                       |  | ⬇                    | ⬆                  | ⬆                       |
| North Carolina | 98   | ✓                       | ✓  | ✓                                     |  | ⬆                    | ⬆                  | ⬆                       |
| North Dakota   | 6  |                         |  |                                       |  | ⬆                    | ⬇                  | ⬇                       |
| Ohio           | 136  |                         |  |                                       |  | ⬆                    | ⬇                  | ⬇                       |
| Oklahoma       | 58   |                         |  |                                       |  | ⬆                    | ⬇                  | ⬇                       |
| Oregon         | 50   |                         | ✓  |                                       |  | ⬇                    | ⬆                  | ⬆                       |
| Pennsylvania   | 184  | ✓                       | ✓  | ✓                                     |  | ⬆                    | ⬇                  | ⬆                       |
| Puerto Rico    | 18   |                         | ✓  |                                       |  | ⬇                    | ⬇                  | ⬇                       |
| Rhode Island   | 10   |                         |  |                                       |  | ⬇                    | ⬆                  | ⬆                       |
| South Carolina | 64   |                         |  |                                       |  | ⬇                    | ⬆                  | ⬆                       |
| South Dakota   | 18   |                         | ✓  |                                       |  | ⬆                    | ⬇                  | ⬇                       |
| Tennessee      | 94   | ✓                       | ✓  | ✓                                     |  | ⬇                    | ⬆                  | ⬆                       |
| Texas          | 289  |                         | ✓  | ✓                                     |  | ⬆                    | ⬇                  | ⬆                       |
| Utah           | 26   | ✓                       | ✓  | ✓                                     | ✓  | ⬇                    | ⬆                  | ⬆                       |
| Vermont        | 5  |                         |  |                                       |  | ⬇                    | ⬇                  | ⬇                       |
| Virginia       | 81   |                         |  |                                       |  | ⬆                    | ⬇                  | ⬆                       |
| Washington     | 69   |                         |  |                                       |  | ⬇                    | ⬇                  | ⬆                       |
| West Virginia  | 47   | ✓                       | ✓  | ✓                                     |  | ⬇                    | ⬇                  | ⬇                       |
| Wisconsin      | 102  |                         | ✓  | ✓                                     |  | ⬆                    | ⬇                  | ⬇                       |
| Wyoming        | 24   |                         |  |                                       |  | ⬇                    | ⬇                  | ⬇                       |

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# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | SSIs: SURGICAL SITE INFECTIONS, ABDOMINAL HYSTERECTOMY |                         |  |                                       |  |                          |                    |                         |
|---------------|--|-------------------------|--|---------------------------------------|--|--------------------------|--------------------|-------------------------|
|               | 2013 Reporting and Validation                          |                         |  |                                       |  | 2013 State SSI: HYST SIR |                    |                         |
|               | # Hospitals Reporting to NHSN                          | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR       | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Alabama       | 60   | ✓                       | ✓  | ✓                                     |  | ↑                        | ↓                  | ↓                       |
| Alaska        | 8  |                         |  |                                       |  | ↑                        | ↓                  | ↓                       |
| Arizona       | 52   |                         |  |                                       |  | ↓                        | ↑                  | ↑                       |
| Arkansas      | 39   | ✓                       | ✓  | ✓                                     |  | ↑                        | ↑                  | ↓                       |
| California    | 303  | ✓                       | ✓  | ✓                                     | ✓  | ↓                        | ↓                  | ↓                       |
| Colorado      | 56   | ✓                       | ✓  | ✓                                     |  | ↑                        | ↑                  | ↓                       |
| Connecticut   | 29   | ✓                       | ✓  | ✓                                     |  | ↑                        | ↑                  | ↑                       |
| D.C.          | 7  |                         | ✓  |                                       |  | ↓                        | ↑                  | ↑                       |
| Delaware      | 7  | ✓                       | ✓  | ✓                                     |  | ↑                        | ↑                  | ↑                       |
| Florida       | 172  |                         |  |                                       |  | ↓                        | ↑                  | ↓                       |
| Georgia       | 90   | ✓                       | ✓  |                                       |  | ↑                        | ↑                  | ↓                       |
| Hawaii        | 13   | ✓                       | ✓  | ✓                                     |  | ↓                        | ↓                  | ↓                       |
| Idaho         | 17   |                         |  |                                       | ✓  | ↑                        | ↑                  | ↑                       |
| Illinois      | 135  |                         |  |                                       |  | ↓                        | ↓                  | ↓                       |
| Indiana       | 98   | ✓                       | ✓  |                                       |  | ↑                        | ↓                  | ↓                       |
| Iowa          | 33   |                         |  |                                       |  | ↓                        | ↑                  | ↓                       |
| Kansas        | 41   |                         | ✓  | ✓                                     |  | ↓                        | ↓                  | ↓                       |
| Kentucky      | 60   |                         | ✓  |                                       |  | ↑                        | ↑                  | ↓                       |
| Louisiana     | 79   |                         | ✓  | ✓                                     |  | ↓                        | ↑                  | ↓                       |
| Maine         | 19   |                         | ✓  | ✓                                     |  | ↑                        | ↑                  | ↓                       |
| Maryland      | 12   |                         |  |                                       |  | ↓                        | ↑                  | ↑                       |
| Massachusetts | 57   | ✓                       | ✓  | ✓                                     |  | ↑                        | ↑                  | ↑                       |
| Michigan      | 88   |                         | ✓  | ✓                                     |  | ↑                        | ↑                  | ↑                       |
| Minnesota     | 50   | ✓                       |  |                                       |  | ↓                        | ↑                  | ↑                       |
| Mississippi   | 42   |                         | ✓  |                                       |  | ↓                        | ↓                  | ↓                       |
| Missouri      | 67   |                         | ✓  |                                       |  | ↓                        | ↓                  | ↓                       |

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2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | SSIs: SURGICAL SITE INFECTIONS, ABDOMINAL HYSTERECTOMY |                         |  |                                       |  |                          |                    |                         |
|----------------|--|-------------------------|--|---------------------------------------|--|--------------------------|--------------------|-------------------------|
|                | 2013 Reporting and Validation                          |                         |  |                                       |  | 2013 State SSI: HYST SIR |                    |                         |
|                | # Hospitals Reporting to NHSN                          | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2012 State SIR       | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Montana        | 14   |                         |  |                                       |  |                          |                    |                         |
| Nebraska       | 19   |                         |  |                                       |  |                          |                    |                         |
| Nevada         | 20   |                         |  |                                       |  |                          |                    |                         |
| New Hampshire  | 22   |                         |  |                                       |  |                          |                    |                         |
| New Jersey     | 66   |                         |  |                                       |  |                          |                    |                         |
| New Mexico     | 26   |                         |  |                                       |  |                          |                    |                         |
| New York       | 158  |                         |  |                                       |  |                          |                    |                         |
| North Carolina | 89   |                         |  |                                       |  |                          |                    |                         |
| North Dakota   | 6  |                         |  |                                       |  |                          |                    |                         |
| Ohio           | 128  |                         |  |                                       |  |                          |                    |                         |
| Oklahoma       | 62   |                         |  |                                       |  |                          |                    |                         |
| Oregon         | 46   |                         |  |                                       |  |                          |                    |                         |
| Pennsylvania   | 146  |                         |  |                                       |  |                          |                    |                         |
| Puerto Rico    | 0  |                         |  |                                       |  |                          |                    |                         |
| Rhode Island   | 11   |                         |  |                                       |  |                          |                    |                         |
| South Carolina | 51   |                         |  |                                       |  |                          |                    |                         |
| South Dakota   | 14   |                         |  |                                       |  |                          |                    |                         |
| Tennessee      | 87   |                         |  |                                       |  |                          |                    |                         |
| Texas          | 290  |                         |  |                                       |  |                          |                    |                         |
| Utah           | 29   |                         |  |                                       |  |                          |                    |                         |
| Vermont        | 12   |                         |  |                                       |  |                          |                    |                         |
| Virginia       | 66   |                         |  |                                       |  |                          |                    |                         |
| Washington     | 64   |                         |  |                                       |  |                          |                    |                         |
| West Virginia  | 34   |                         |  |                                       |  |                          |                    |                         |
| Wisconsin      | 75   |                         |  |                                       |  |                          |                    |                         |
| Wyoming        | 13   |                         |  |                                       |  |                          |                    |                         |

HD<sup>+</sup>: State Health Department

Data Checked for Quality<sup>‡</sup>: State analyzed 2013 data for quality and completeness.

Additional In-Depth Data Review<sup>‡</sup>: State reviewed medical records to determine 2013 data accuracy.

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# STATE HAI PROGRESS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | SSIs: SURGICAL SITE INFECTIONS, COLON SURGERY |                         |  |                                       |  |                           |                    |                         |
|---------------|---|-------------------------|--|---------------------------------------|--|---------------------------|--------------------|-------------------------|
|               | 2013 Reporting and Validation                 |                         |  |                                       |  | 2013 State SSI: COLON SIR |                    |                         |
|               | # Hospitals Reporting to NHSN                 | State Reporting Mandate | State HD <sup>†</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>§</sup> | vs. 2012 State SIR*       | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Alabama       | 72  | ✓                       | ✓  | ✓                                     |  | ⬇                         | ⬇                  | ⬇                       |
| Alaska        | 9   |                         |  |                                       |  | ⬇                         | ⬇                  | ⬇                       |
| Arizona       | 51  |                         |  |                                       |  | ⬇                         | ⬆                  | ⬆                       |
| Arkansas      | 39  | ✓                       | ✓  | ✓                                     |  | ⬇                         | ⬇                  | ⬇                       |
| California    | 318   | ✓                       | ✓  | ✓                                     | ✓  | ⬆                         | ⬇                  | ⬇                       |
| Colorado      | 57  | ✓                       | ✓  | ✓                                     |  | ⬇                         | ⬇                  | ⬇                       |
| Connecticut   | 30  | ✓                       | ✓  | ✓                                     |  | ⬆                         | ⬆                  | ⬆                       |
| D.C.          | 7   |                         | ✓  |                                       |  | ⬆                         | ⬇                  | ⬇                       |
| Delaware      | 7   | ✓                       | ✓  | ✓                                     |  | ⬆                         | ⬇                  | ⬇                       |
| Florida       | 183   |                         |  |                                       |  | ⬆                         | ⬇                  | ⬇                       |
| Georgia       | 96  | ✓                       | ✓  |                                       |  | ⬆                         | ⬇                  | ⬇                       |
| Hawaii        | 13  | ✓                       | ✓  | ✓                                     |  | ⬆                         | ⬆                  | ⬆                       |
| Idaho         | 18  |                         |  |                                       | ✓  | ⬆                         | ⬇                  | ⬇                       |
| Illinois      | 138   |                         |  |                                       |  | ⬆                         | ⬇                  | ⬇                       |
| Indiana       | 101   | ✓                       | ✓  |                                       |  | ⬆                         | ⬆                  | ⬆                       |
| Iowa          | 36  |                         |  |                                       |  | ⬆                         | ⬆                  | ⬆                       |
| Kansas        | 43  |                         | ✓  | ✓                                     |  | ⬆                         | ⬆                  | ⬆                       |
| Kentucky      | 66  |                         | ✓  |                                       |  | ⬇                         | ⬇                  | ⬇                       |
| Louisiana     | 78  |                         | ✓  | ✓                                     |  | ⬆                         | ⬆                  | ⬆                       |
| Maine         | 21  |                         | ✓  | ✓                                     |  | ⬇                         | ⬆                  | ⬆                       |
| Maryland      | 22  |                         |  |                                       |  | ⬇                         | ⬇                  | ⬇                       |
| Massachusetts | 62  |                         |  |                                       |  | ⬆                         | ⬆                  | ⬆                       |
| Michigan      | 92  |                         | ✓  | ✓                                     |  | ⬆                         | ⬆                  | ⬆                       |
| Minnesota     | 51  | ✓                       |  |                                       |  | ⬆                         | ⬆                  | ⬇                       |
| Mississippi   | 43  |                         | ✓  |                                       |  | ⬇                         | ⬇                  | ⬇                       |
| Missouri      | 74  |                         |  |                                       |  | ⬆                         | ⬇                  | ⬇                       |

HD<sup>†</sup>: State Health Department

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\*Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

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# STATE HAI PROGRESS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

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2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | SSIs: SURGICAL SITE INFECTIONS, COLON SURGERY |                         |  |                                       |  |                           |                    |                         |
|----------------|---|-------------------------|--|---------------------------------------|--|---------------------------|--------------------|-------------------------|
|                | 2013 Reporting and Validation                 |                         |  |                                       |  | 2013 State SSI: COLON SIR |                    |                         |
|                | # Hospitals Reporting to NHSN                 | State Reporting Mandate | State HD <sup>†</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>§</sup> | vs. 2012 State SIR*       | vs. 2013 Nat'l SIR | vs. 2008 Nat'l Baseline |
| Montana        | 14  |                         |  |                                       |  |                           |                    |                         |
| Nebraska       | 19  |                         |  |                                       |  |                           |                    |                         |
| Nevada         | 22  |                         |  |                                       |  |                           |                    |                         |
| New Hampshire  | 25  |                         |  |                                       |  |                           |                    |                         |
| New Jersey     | 72  |                         |  |                                       |  |                           |                    |                         |
| New Mexico     | 27  |                         |  |                                       |  |                           |                    |                         |
| New York       | 171   |                         |  |                                       |  |                           |                    |                         |
| North Carolina | 93  |                         |  |                                       |  |                           |                    |                         |
| North Dakota   | 6   |                         |  |                                       |  |                           |                    |                         |
| Ohio           | 131   |                         |  |                                       |  |                           |                    |                         |
| Oklahoma       | 56  |                         |  |                                       |  |                           |                    |                         |
| Oregon         | 50  |                         |  |                                       |  |                           |                    |                         |
| Pennsylvania   | 160   |                         |  |                                       |  |                           |                    |                         |
| Puerto Rico    | 0   |                         |  |                                       |  |                           |                    |                         |
| Rhode Island   | 11  |                         |  |                                       |  |                           |                    |                         |
| South Carolina | 57  |                         |  |                                       |  |                           |                    |                         |
| South Dakota   | 14  |                         |  |                                       |  |                           |                    |                         |
| Tennessee      | 95  |                         |  |                                       |  |                           |                    |                         |
| Texas          | 285   |                         |  |                                       |  |                           |                    |                         |
| Utah           | 30  |                         |  |                                       |  |                           |                    |                         |
| Vermont        | 6   |                         |  |                                       |  |                           |                    |                         |
| Virginia       | 75  |                         |  |                                       |  |                           |                    |                         |
| Washington     | 70  |                         |  |                                       |  |                           |                    |                         |
| West Virginia  | 36  |                         |  |                                       |  |                           |                    |                         |
| Wisconsin      | 84  |                         |  |                                       |  |                           |                    |                         |
| Wyoming        | 12  |                         |  |                                       |  |                           |                    |                         |

HD<sup>†</sup>: State Health Department

Data Checked for Quality<sup>‡</sup>: State analyzed 2013 data for quality and completeness.

Additional In-Depth Data Review<sup>§</sup>: State reviewed medical records to determine 2013 data accuracy.

\*Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

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# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | MRSA Bacteremia: LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS |                         |  |                                       |  |                                |                         |
|---------------|--|-------------------------|--|---------------------------------------|--|--------------------------------|-------------------------|
|               | 2013 Reporting and Validation  |                         |  |                                       |  | 2013 State MRSA Bacteremia SIR |                         |
|               | # Hospitals Reporting to NHSN  | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2013 Nat'l SIR             | vs. 2011 Nat'l Baseline |
| Alabama       | 93   |                         |  |                                       |  |                                |                         |
| Alaska        | 11   |                         |  |                                       |  |                                |                         |
| Arizona       | 63   |                         |  |                                       |  |                                |                         |
| Arkansas      | 47   |                         |  |                                       |  |                                |                         |
| California    | 359  |                         |  |                                       |  |                                |                         |
| Colorado      | 56   |                         |  |                                       |  |                                |                         |
| Connecticut   | 32   |                         |  |                                       |  |                                |                         |
| D.C.          | 9  |                         |  |                                       |  |                                |                         |
| Delaware      | 8  |                         |  |                                       |  |                                |                         |
| Florida       | 190  |                         |  |                                       |  |                                |                         |
| Georgia       | 111  |                         |  |                                       |  |                                |                         |
| Hawaii        | 13   |                         |  |                                       |  |                                |                         |
| Idaho         | 21   |                         |  |                                       |  |                                |                         |
| Illinois      | 183  |                         |  |                                       |  |                                |                         |
| Indiana       | 102  |                         |  |                                       |  |                                |                         |
| Iowa          | 41   |                         |  |                                       |  |                                |                         |
| Kansas        | 59   |                         |  |                                       |  |                                |                         |
| Kentucky      | 71   |                         |  |                                       |  |                                |                         |
| Louisiana     | 101  |                         |  |                                       |  |                                |                         |
| Maine         | 25   |                         |  |                                       |  |                                |                         |
| Maryland      | 13   |                         |  |                                       |  |                                |                         |
| Massachusetts | 71   |                         |  |                                       |  |                                |                         |
| Michigan      | 104  |                         |  |                                       |  |                                |                         |
| Minnesota     | 53   |                         |  |                                       |  |                                |                         |
| Mississippi   | 64   |                         |  |                                       |  |                                |                         |
| Missouri      | 82   |                         |  |                                       |  |                                |                         |

HD<sup>+</sup>: State Health Department

Data Checked for Quality<sup>‡</sup>: State analyzed 2013 data for quality and completeness.

Additional In-Depth Data Review<sup>‡</sup>: State reviewed medical records to determine 2013 data accuracy.

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# STATE HAI PROGRESS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | MRSA Bacteremia: LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS |                         |  |                                       |  |                                |                         |
|----------------|--|-------------------------|--|---------------------------------------|--|--------------------------------|-------------------------|
|                | 2013 Reporting and Validation  |                         |  |                                       |  | 2013 State MRSA Bacteremia SIR |                         |
|                | # Hospitals Reporting to NHSN  | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2013 Nat'l SIR             | vs. 2011 Nat'l Baseline |
| Montana        | 15   |                         |  |                                       |  |                                |                         |
| Nebraska       | 24   |                         |  |                                       |  |                                |                         |
| Nevada         | 23   |                         |  |                                       |  |                                |                         |
| New Hampshire  | 21   |                         |  |                                       |  |                                |                         |
| New Jersey     | 72   |                         |  |                                       |  |                                |                         |
| New Mexico     | 37   |                         |  |                                       |  |                                |                         |
| New York       | 179  |                         |  |                                       |  |                                |                         |
| North Carolina | 100  |                         |  |                                       |  |                                |                         |
| North Dakota   | 11   |                         |  |                                       |  |                                |                         |
| Ohio           | 144  |                         |  |                                       |  |                                |                         |
| Oklahoma       | 91   |                         |  |                                       |  |                                |                         |
| Oregon         | 49   |                         |  |                                       |  |                                |                         |
| Pennsylvania   | 168  |                         |  |                                       |  |                                |                         |
| Puerto Rico    | 3  |                         |  |                                       |  |                                |                         |
| Rhode Island   | 11   |                         |  |                                       |  |                                |                         |
| South Carolina | 66   |                         |  |                                       |  |                                |                         |
| South Dakota   | 23   |                         |  |                                       |  |                                |                         |
| Tennessee      | 115  |                         |  |                                       |  |                                |                         |
| Texas          | 359  |                         |  |                                       |  |                                |                         |
| Utah           | 37   |                         |  |                                       |  |                                |                         |
| Vermont        | 13   |                         |  |                                       |  |                                |                         |
| Virginia       | 84   |                         |  |                                       |  |                                |                         |
| Washington     | 59   |                         |  |                                       |  |                                |                         |
| West Virginia  | 39   |                         |  |                                       |  |                                |                         |
| Wisconsin      | 88   |                         |  |                                       |  |                                |                         |
| Wyoming        | 14   |                         |  |                                       |  |                                |                         |

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Data Checked for Quality<sup>‡</sup>: State analyzed 2013 data for quality and completeness.

Additional In-Depth Data Review<sup>‡</sup>: State reviewed medical records to determine 2013 data accuracy.

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# STATE HAI PROGRESS

## LEGEND

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or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE         | C. difficile Infections: LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS |                         |  |                                       |  |                                  |                         |
|---------------|---|-------------------------|--|---------------------------------------|--|----------------------------------|-------------------------|
|               | 2013 Reporting and Validation   |                         |  |                                       |  | 2013 State C. diff Infection SIR |                         |
|               | # Hospitals Reporting to NHSN   | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2013 Nat'l SIR               | vs. 2011 Nat'l Baseline |
| Alabama       | 93  |                         |  |                                       |  |                                  |                         |
| Alaska        | 11  |                         |  |                                       |  |                                  |                         |
| Arizona       | 62  |                         |  |                                       |  |                                  |                         |
| Arkansas      | 47  |                         |  |                                       |  |                                  |                         |
| California    | 359   |                         |  |                                       |  |                                  |                         |
| Colorado      | 55  |                         |  |                                       |  |                                  |                         |
| Connecticut   | 32  |                         |  |                                       |  |                                  |                         |
| D.C.          | 7   |                         |  |                                       |  |                                  |                         |
| Delaware      | 8   |                         |  |                                       |  |                                  |                         |
| Florida       | 190   |                         |  |                                       |  |                                  |                         |
| Georgia       | 111   |                         |  |                                       |  |                                  |                         |
| Hawaii        | 13  |                         |  |                                       |  |                                  |                         |
| Idaho         | 20  |                         |  |                                       |  |                                  |                         |
| Illinois      | 183   |                         |  |                                       |  |                                  |                         |
| Indiana       | 102   |                         |  |                                       |  |                                  |                         |
| Iowa          | 57  |                         |  |                                       |  |                                  |                         |
| Kansas        | 64  |                         |  |                                       |  |                                  |                         |
| Kentucky      | 71  |                         |  |                                       |  |                                  |                         |
| Louisiana     | 101   |                         |  |                                       |  |                                  |                         |
| Maine         | 36  |                         |  |                                       |  |                                  |                         |
| Maryland      | 46  |                         |  |                                       |  |                                  |                         |
| Massachusetts | 71  |                         |  |                                       |  |                                  |                         |
| Michigan      | 104   |                         |  |                                       |  |                                  |                         |
| Minnesota     | 55  |                         |  |                                       |  |                                  |                         |
| Mississippi   | 65  |                         |  |                                       |  |                                  |                         |
| Missouri      | 82  |                         |  |                                       |  |                                  |                         |

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# STATE HAI PROGRESS

## LEGEND

2013 state SIR is significantly lower (better) than comparison group in column header

or Change in 2013 state SIR compared to group in column header is not statistically significant

2013 state SIR is significantly higher (worse) than comparison group in column header

2013 state SIR cannot be calculated

Yes

| STATE          | C. difficile Infections: LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS |                         |  |                                       |  |                                  |                         |
|----------------|---|-------------------------|--|---------------------------------------|--|----------------------------------|-------------------------|
|                | 2013 Reporting and Validation   |                         |  |                                       |  | 2013 State C. diff Infection SIR |                         |
|                | # Hospitals Reporting to NHSN   | State Reporting Mandate | State HD <sup>+</sup> has Access to Data | Data Checked for Quality <sup>‡</sup> | Additional In-Depth Data Review <sup>‡</sup> | vs. 2013 Nat'l SIR               | vs. 2011 Nat'l Baseline |
| Montana        | 16  |                         |  |                                       |  |                                  |                         |
| Nebraska       | 24  |                         |  |                                       |  |                                  |                         |
| Nevada         | 22  |                         |  |                                       |  |                                  |                         |
| New Hampshire  | 22  |                         |  |                                       |  |                                  |                         |
| New Jersey     | 72  |                         |  |                                       |  |                                  |                         |
| New Mexico     | 39  |                         |  |                                       |  |                                  |                         |
| New York       | 180   |                         |  |                                       |  |                                  |                         |
| North Carolina | 100   |                         |  |                                       |  |                                  |                         |
| North Dakota   | 11  |                         |  |                                       |  |                                  |                         |
| Ohio           | 144   |                         |  |                                       |  |                                  |                         |
| Oklahoma       | 91  |                         |  |                                       |  |                                  |                         |
| Oregon         | 59  |                         |  |                                       |  |                                  |                         |
| Pennsylvania   | 167   |                         |  |                                       |  |                                  |                         |
| Puerto Rico    | 4   |                         |  |                                       |  |                                  |                         |
| Rhode Island   | 11  |                         |  |                                       |  |                                  |                         |
| South Carolina | 64  |                         |  |                                       |  |                                  |                         |
| South Dakota   | 23  |                         |  |                                       |  |                                  |                         |
| Tennessee      | 115   |                         |  |                                       |  |                                  |                         |
| Texas          | 359   |                         |  |                                       |  |                                  |                         |
| Utah           | 35  |                         |  |                                       |  |                                  |                         |
| Vermont        | 13  |                         |  |                                       |  |                                  |                         |
| Virginia       | 84  |                         |  |                                       |  |                                  |                         |
| Washington     | 61  |                         |  |                                       |  |                                  |                         |
| West Virginia  | 41  |                         |  |                                       |  |                                  |                         |
| Wisconsin      | 95  |                         |  |                                       |  |                                  |                         |
| Wyoming        | 27  |                         |  |                                       |  |                                  |                         |

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## NATIONAL FACTSHEETS



## HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

# NATIONAL

**Healthcare-associated infections (HAIs)** are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## CLABSIs

↓ 46% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

■ U.S. hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

■ Among the 2,389 hospitals in U.S. with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

↑ 6% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

■ U.S. hospitals reported a significant increase in CAUTIs between 2012 and 2013.

■ Among the 2,781 U.S. hospitals with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

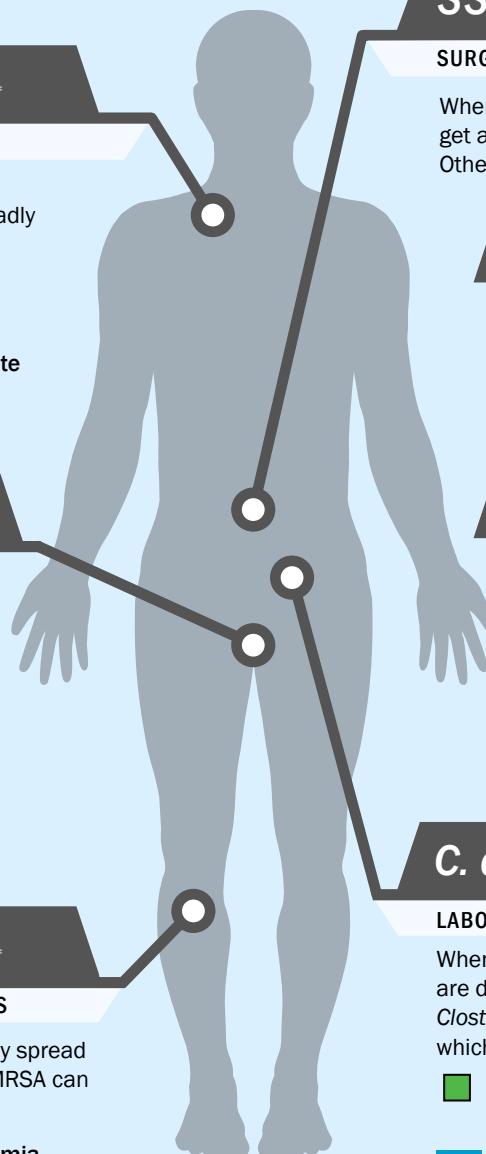
↓ 8% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

■ U.S. hospitals reported a significant decrease in MRSA Bacteremia between 2012 and 2013.

■ Among the 2,002 U.S. hospitals with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

See page 3 for additional procedures

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

↓ 14% LOWER COMPARED TO NAT'L BASELINE\*

□ U.S. hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

■ Among the 765 U.S. hospitals with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

↓ 8% LOWER COMPARED TO NAT'L BASELINE\*

■ U.S. hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

■ Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

■ Among the 2,030 U.S. hospitals with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

↓ 10% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

■ U.S. hospitals reported a significant decrease in *C. difficile* infections between 2012 and 2013.

■ Among the 3,557 U.S. hospitals with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



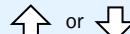
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



#### LEGEND



2013 Nat'l SIR is significantly lower (better) than comparison group



Change in 2013 Nat'l SIR compared to group in column header is not statistically significant



2013 Nat'l SIR is significantly higher (worse) than comparison group in

| HAI TYPE   | # OF U.S. HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013+ | 2013 NAT'L SIR VS.<br>2012 NAT'L SIR‡ | 2013 NAT'L SIR VS.<br>NAT'L BASELINE‡ | 2013 NAT'L SIR |
|--|---|---------------------------------------|---------------------------------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 3,578   | ⬇️ 4%                                 | ⬇️ 46%                                | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 3,640   | ⬆️ 3%                                 | ⬆️ 6%                                 | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 3,182   | ⬇️ 4%                                 | ⬇️ 14%                                | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 3,348   | ⬆️ 14%                                | ⬇️ 8%                                 | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 3,827   | ⬇️ 5%                                 | ⬇️ 8%                                 | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 3,924   | ⬇️ 6%                                 | ⬇️ 10%                                | 0.90           |

+The number of hospitals reporting for each HAI type may differ because some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

‡The 2012 Nat'l SIRs can be found in the data tables of this report.

§Nat'l baseline time period varies by infection type. See first column of this table for specifics.

#### WHAT DOES THE STANDARDIZED INFECTION RATIO (SIR) MEAN?

##### IF THE NATIONAL SIR IS:

MORE THAN 1

There was an increase in the number of infections reported in the nation in 2013 compared to the national baseline.

1

There were about the same number of infections reported in the nation in 2013 compared to the national baseline.

LESS THAN 1

There was a decrease in the number of infections reported in the nation in 2013 compared to the national baseline.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)





HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



# NATIONAL SSIs BY PROCEDURE TYPE

SURGICAL SITE INFECTIONS

SSIs: 10 SELECT PROCEDURES

19% LOWER COMPARED TO NAT'L BASELINE\*

U.S. hospitals reported no significant change in SSIs from 10 select procedures between 2012 and 2013.

9% Among the 2,543 U.S. hospitals with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.81.

Almost all U.S. hospitals report SSI data following colon surgeries and abdominal hysterectomies to NHSN.

| PROCEDURE CATEGORY                 | # FACILITIES REPORTING | # PROCEDURES REPORTED | 2013 NAT'L SIR VS. NAT'L BASELINE | 2013 NAT'L SIR |
|------------------------------------|------------------------|-----------------------|-----------------------------------|----------------|
| Hip arthroplasty                   | 1,761                  | 261,809               | 27%                               | 0.73           |
| Knee arthroplasty                  | 1,750                  | 378,846               | 40%                               | 0.60           |
| Colon surgery                      | 3,348                  | 296,623               | 8%                                | 0.92           |
| Rectal surgery                     | 322                    | 6,633                 | 21%                               | 0.79           |
| Abdominal hysterectomy             | 3,182                  | 302,250               | 14%                               | 0.86           |
| Vaginal hysterectomy               | 826                    | 35,488                | 19%                               | 0.81           |
| Coronary artery bypass graft       | 742                    | 116,105               | 40%                               | 0.60           |
| Other cardiac surgery              | 371                    | 43,409                | 44%                               | 0.56           |
| Peripheral vascular bypass surgery | 288                    | 8,856                 | 43%                               | 0.57           |
| Abdominal aortic aneurysm repair   | 302                    | 2,462                 | 70%                               | 0.30           |
| These 10 procedures combined       | 3,581                  | 1,452,481             | 19%                               | 0.81           |

LEGEND

2013 national SIR is significantly lower (better) than the 2008 SSI national baseline

or Change in 2013 national SIR compared to the 2008 SSI national baseline is not statistically significant

2013 national SIR is significantly higher (worse) than 2008 SSI national baseline



\* Statistically significant.

THIS REPORT IS BASED ON 2013 DATA, PUBLISHED JANUARY 2015

## **STATE FACTSHEETS**



# ALABAMA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

33% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Alabama hospitals reported no significant change in CLABSIs between 2012 and 2013.

13% Among the 39 hospitals in Alabama with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

7% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Alabama hospitals reported a significant increase in CAUTIs between 2012 and 2013.

6% Among the 70 hospitals in Alabama with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

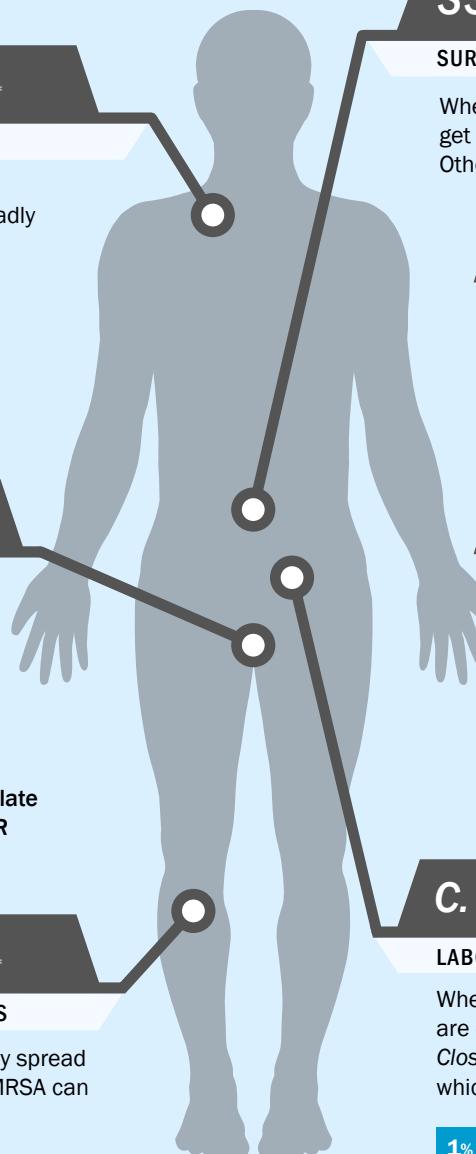
42%

HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

26% Among the 38 hospitals in Alabama with enough data to calculate an SIR, 26% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

39% LOWER COMPARED TO NAT'L BASELINE\*

Alabama hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

7% Among the 14 hospitals in Alabama with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

53% LOWER COMPARED TO NAT'L BASELINE\*

Alabama hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

0% Among the 35 hospitals in Alabama with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

37% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

1% Among the 83 hospitals in Alabama with enough data to calculate an SIR, 1% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# ALABAMA

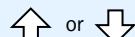
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Alabama: [www.adph.org/hai/](http://www.adph.org/hai/)
- Alabama validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF ALABAMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 118 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 75  | ↑ 2%  | ↑ 25%                                | ↓ 33%   | 0.67           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 86  | ↑ 25%   | ↓ 12%                                | ↓ 7%  | 0.93           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 60  | ↑ 20%   | ↓ 30%                                | ↓ 39%   | 0.61           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 72  | ↓ 20%   | ↓ 49%                                | ↓ 53%   | 0.47           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 93  | 2012 SIR not available                            | ↑ 56%                                | ↑ 42%   | 1.42           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 93  | 2012 SIR not available                            | ↓ 30%                                | ↓ 37%   | 0.63           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS ALABAMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Alabama has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (MRSA)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship



# ALASKA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

72% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Alaska hospitals reported a significant decrease in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

2% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Alaska hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

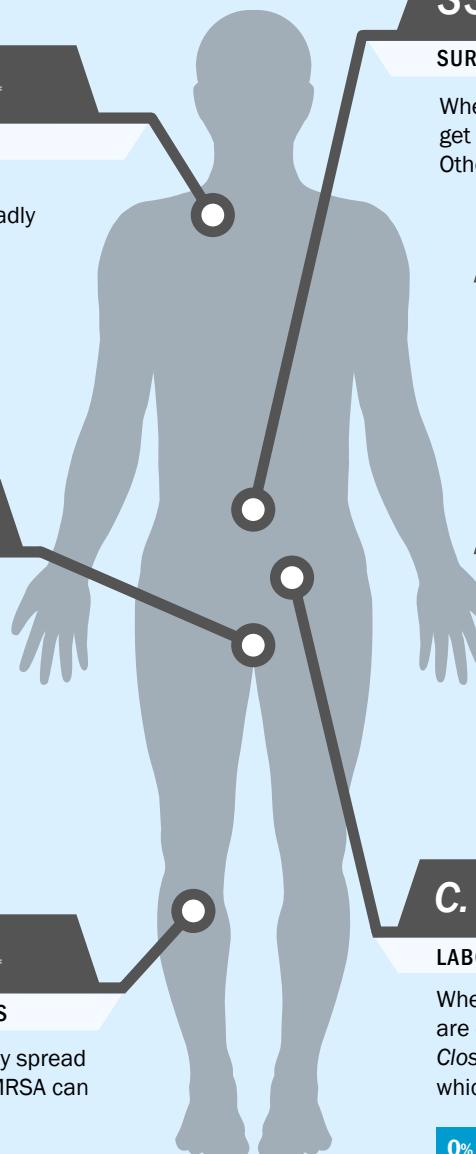
## MRSA Bacteremia

80% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

55% LOWER COMPARED TO NAT'L BASELINE

- Alaska hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

16% LOWER COMPARED TO NAT'L BASELINE

- Alaska hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

27% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 11 hospitals in Alaska with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# ALASKA

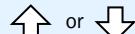
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

**HEALTHCARE-ASSOCIATED INFECTION (HAI)**  
DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Alaska: [www.epi.hss.state.ak.us/id/hai/default.htm](http://www.epi.hss.state.ak.us/id/hai/default.htm)
- Alaska validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF ALASKA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 26 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 10  | ⬇️ 75%  | ⬇️ 48%                               | ⬇️ 72%  | 0.28           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 10  | ⬇️ 23%  | ⬇️ 4%                                | ⬆️ 2%   | 1.02           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 8   | ⬆️ 20%  | ⬇️ 48%                               | ⬇️ 55%  | 0.45           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 9   | ⬇️ 47%  | ⬇️ 9%                                | ⬇️ 16%  | 0.84           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 11  | 2012 SIR not available                            | ⬇️ 78%                               | ⬇️ 80%  | 0.20           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 11  | 2012 SIR not available                            | ⬇️ 19%                               | ⬇️ 27%  | 0.74           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS ALASKA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile*, CRE)
- Healthcare personnel influenza vaccination



# ARIZONA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**36%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Arizona hospitals reported no significant change in CLABSIs between 2012 and 2013.

**7%** Among the 43 hospitals in Arizona with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**2%** HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Arizona hospitals reported no significant change in CAUTIs between 2012 and 2013.

**11%** Among the 45 hospitals in Arizona with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

**3%**

LOWER COMPARED TO NAT'L BASELINE

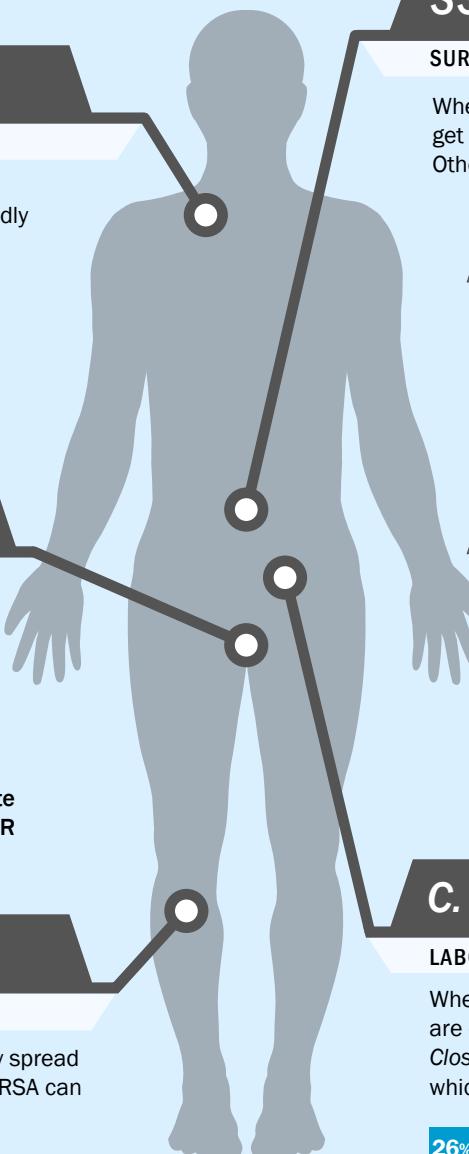
### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**9%** Among the 35 hospitals in Arizona with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**19%** HIGHER COMPARED TO NAT'L BASELINE

Arizona hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**6%** Among the 17 hospitals in Arizona with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**11%** HIGHER COMPARED TO NAT'L BASELINE

Arizona hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**13%** Among the 39 hospitals in Arizona with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**LESS THAN 1%** HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**26%** Among the 54 hospitals in Arizona with enough data to calculate an SIR, 26% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# ARIZONA

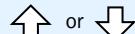
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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- Arizona validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF ARIZONA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 97 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 56   | ↑ 1%  | ↑ 19%                                | ↓ 36%   | 0.64           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 55   | ↓ 6%  | ↓ 3%                                 | ↑ 2%  | 1.02           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 52   | ↓ 3%  | ↑ 38%                                | ↑ 19%   | 1.19           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 51   | ↓ 1%  | ↑ 22%                                | ↑ 11%   | 1.11           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 63   | 2012 SIR not available                            | ↑ 6%                                 | ↓ 3%  | 0.97           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 62   | 2012 SIR not available                            | ↑ 11%                                | ↑ < 1%  | 1.00           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS ARIZONA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# ARKANSAS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

45% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Arkansas hospitals reported no significant change in CLABSIs between 2012 and 2013.

13% Among the 24 hospitals in Arkansas with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

4% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Arkansas hospitals reported no significant change in CAUTIs between 2012 and 2013.

12% Among the 33 hospitals in Arkansas with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

16% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

5% Among the 21 hospitals in Arkansas with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

6% LOWER COMPARED TO NAT'L BASELINE

Arkansas hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

23% LOWER COMPARED TO NAT'L BASELINE\*

Arkansas hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

0% Among the 25 hospitals in Arkansas with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

37% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

0% Among the 46 hospitals in Arkansas with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# ARKANSAS

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

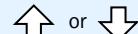
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Arkansas: [www.healthy.arkansas.gov/programsServices/epidemiology/Pages/HAI.aspx](http://www.healthy.arkansas.gov/programsServices/epidemiology/Pages/HAI.aspx)
- Arkansas validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF ARKANSAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 87 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 48  | ⬇ 2%  | ⬆ 2%                                 | ⬇ 45%   | 0.55           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 49  | ⬇ 5%  | ⬇ 2%                                 | ⬆ 4%  | 1.04           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 39  | ⬆ 16%   | ⬆ 9%                                 | ⬇ 6%  | 0.94           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 39  | ⬇ 21%   | ⬇ 16%                                | ⬇ 23%   | 0.77           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 47  | 2012 SIR not available                            | ⬆ 27%                                | ⬆ 16%   | 1.16           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 47  | 2012 SIR not available                            | ⬇ 31%                                | ⬇ 37%   | 0.63           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS ARKANSAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Arkansas has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (*C. difficile*)
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# CALIFORNIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

48% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

California hospitals reported no significant change in CLABSIs between 2012 and 2013.

**12%** Among the 290 hospitals in California with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

10% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

California hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**11%** Among the 296 hospitals in California with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.06.

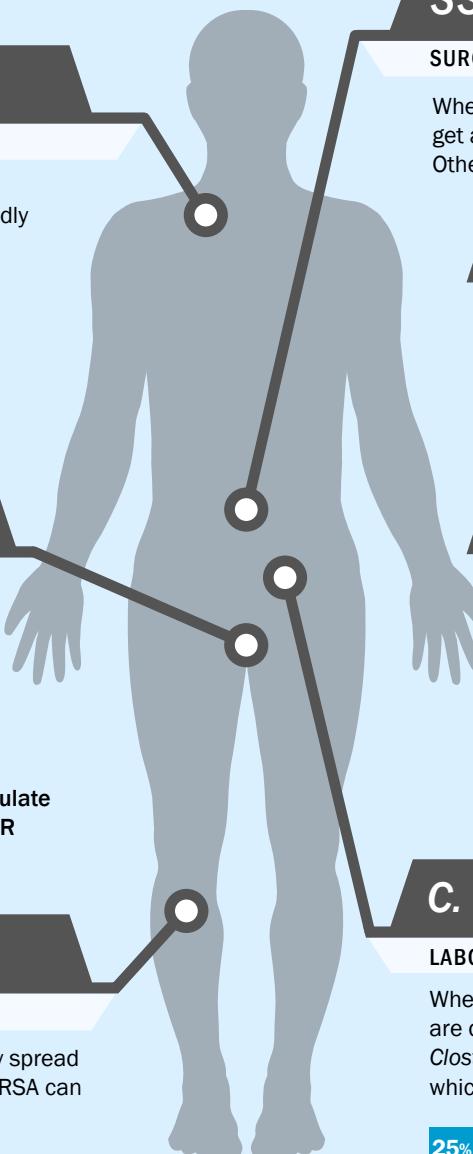
## MRSA Bacteremia

27% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**2%** Among the 225 hospitals in California with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

28% LOWER COMPARED TO NAT'L BASELINE\*

California hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**1%** Among the 77 hospitals in California with enough data to calculate an SIR, 1% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

18% LOWER COMPARED TO NAT'L BASELINE\*

California hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**5%** Among the 204 hospitals in California with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

5% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**25%** Among the 325 hospitals in California with enough data to calculate an SIR, 25% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# CALIFORNIA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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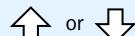
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in California: [www.cdph.ca.gov/programs/hai/Pages/default.aspx](http://www.cdph.ca.gov/programs/hai/Pages/default.aspx)
- California validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF CALIFORNIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 417 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 350  | ⬇ 3%  | ⬇ 4%                                 | ⬇ 48%   | 0.52           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 341  | ⬆ 7%  | ⬇ 16%                                | ⬇ 10%   | 0.90           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 303  | ⬇ 7%  | ⬇ 18%                                | ⬇ 28%   | 0.72           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 318  | ⬆ 16%   | ⬇ 12%                                | ⬇ 18%   | 0.82           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 359  | 2012 SIR not available                            | ⬇ 21%                                | ⬇ 27%   | 0.74           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 359  | 2012 SIR not available                            | ⬆ 18%                                | ⬆ 5%  | 1.05           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS CALIFORNIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

California has a state mandate to publicly report at least one HAI to NHSN. California is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# COLORADO

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**51%** LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Colorado hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 3%** Among the 32 hospitals in Colorado with enough data to calculate an SIR, 3% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**21%** LOWER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Colorado hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 3%** Among the 33 hospitals in Colorado with enough data to calculate an SIR, 3% had an SIR significantly worse than the national SIR of 1.06.

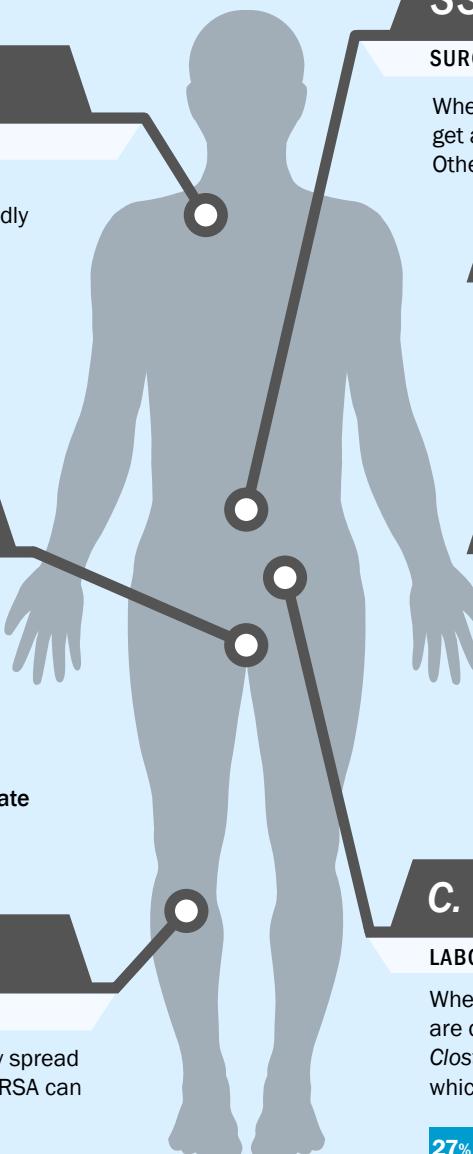
## MRSA Bacteremia

**26%** LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 0%** Among the 27 hospitals in Colorado with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**11%** LOWER COMPARED  
TO NAT'L BASELINE

- Colorado hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 0%** Among the 10 hospitals in Colorado with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**29%** LOWER COMPARED  
TO NAT'L BASELINE\*

- Colorado hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- 6%** Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 6%** Among the 31 hospitals in Colorado with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**5%** HIGHER COMPARED  
TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 27%** Among the 48 hospitals in Colorado with enough data to calculate an SIR, 27% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# COLORADO

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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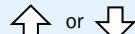
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### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF COLORADO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 94 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 52  | ↑ 5%  | ↓ 8%                                 | ↓ 51%   | 0.49           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 52  | ↓ 13%   | ↓ 25%                                | ↓ 21%   | 0.79           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 56  | ↑ 9%  | ↑ 3%                                 | ↓ 11%   | 0.89           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 57  | ↓ 3%  | ↓ 23%                                | ↓ 29%   | 0.71           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 56  | 2012 SIR not available                            | ↓ 19%                                | ↓ 26%   | 0.74           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 55  | 2012 SIR not available                            | ↑ 16%                                | ↑ 5%  | 1.05           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS COLORADO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Colorado has a state mandate to publicly report at least one HAI to NHSN. Colorado is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.



# CONNECTICUT

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

44% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Connecticut hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 25 hospitals in Connecticut with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

65% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Connecticut hospitals reported no significant change in CAUTIs between 2012 and 2013.

Among the 26 hospitals in Connecticut with enough data to calculate an SIR, 35% had an SIR significantly worse than the national SIR of 1.06.

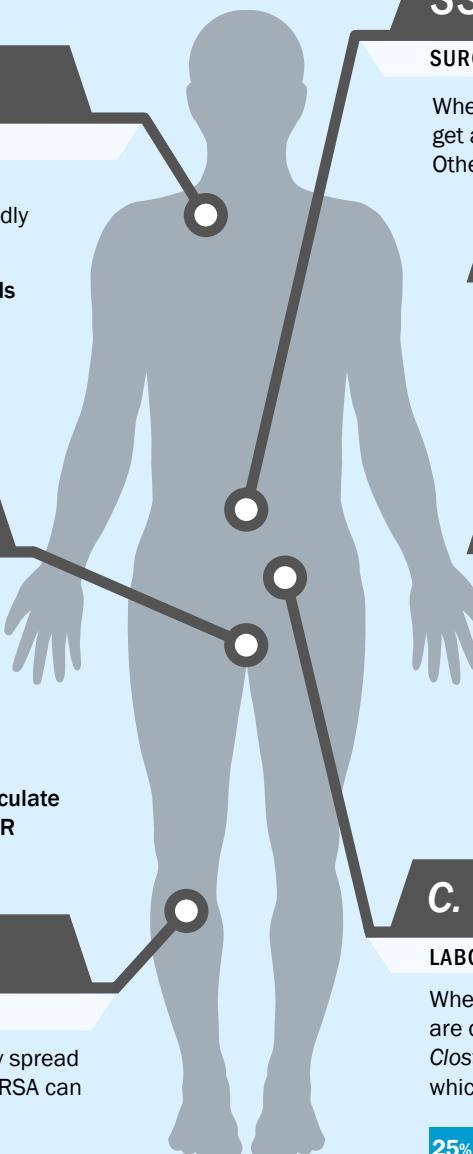
## MRSA Bacteremia

26% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 23 hospitals in Connecticut with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

6%

HIGHER COMPARED TO NAT'L BASELINE

- Connecticut hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

13%

HIGHER COMPARED TO NAT'L BASELINE

- Connecticut hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 24 hospitals in Connecticut with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

1%

HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 32 hospitals in Connecticut with enough data to calculate an SIR, 25% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# CONNECTICUT

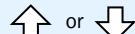
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Connecticut: [www.ct.gov/dph/cwp/view.asp?a=3136&q=417318](http://www.ct.gov/dph/cwp/view.asp?a=3136&q=417318)
- Connecticut validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF CONNECTICUT HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 41 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 30   | ⬇️ 22%  | ⬆️ 4%                                | ⬇️ 44%  | 0.56           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 31   | ⬇️ 11%  | ⬆️ 57%                               | ⬆️ 65%  | 1.65           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 29   | ⬆️ 2%   | ⬆️ 23%                               | ⬆️ 6%   | 1.06           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 30   | ⬆️ 7%   | ⬆️ 23%                               | ⬆️ 13%  | 1.13           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 32   | 2012 SIR not available                            | ⬇️ 19%                               | ⬇️ 26%  | 0.74           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 32   | 2012 SIR not available                            | ⬆️ 12%                               | ⬆️ 1%   | 1.01           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS CONNECTICUT DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Connecticut has a state mandate to publicly report at least one HAI to NHSN. Connecticut is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# DELAWARE

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

29% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Delaware hospitals reported a significant increase in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

30% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Delaware hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

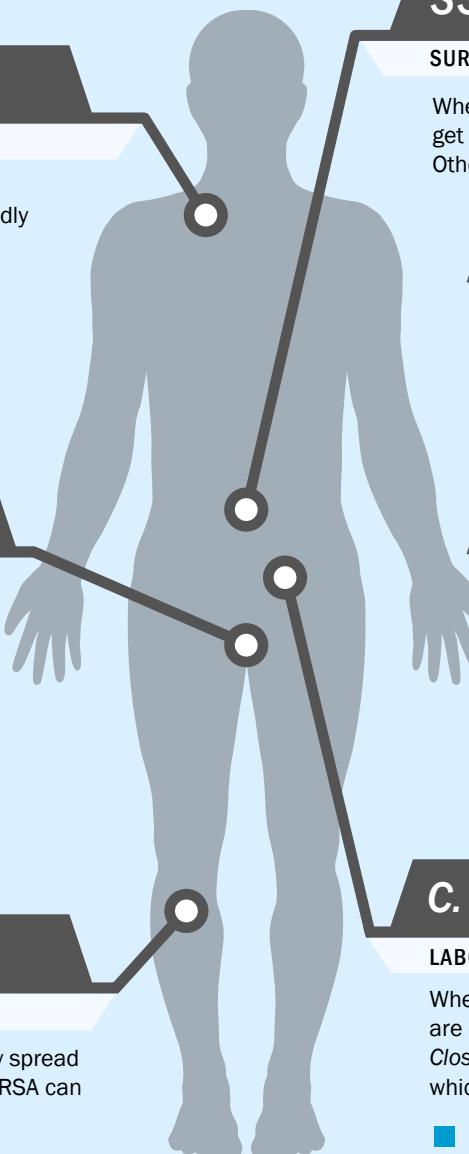
## MRSA Bacteremia

20% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

15% HIGHER COMPARED TO NAT'L BASELINE

- Delaware hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

19% LOWER COMPARED TO NAT'L BASELINE

- Delaware hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

5% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



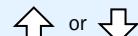
**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



**LEGEND**



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

# DELAWARE

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Delaware: [dhss.delaware.gov/dph/epi/haihomepage.html](http://dhss.delaware.gov/dph/epi/haihomepage.html)
- Delaware validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF DELAWARE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 13 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 8   | ▲ 65%   | ▲ 32%                                | ▼ 29%   | 0.71           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 8   | ▲ 24%   | ▲ 23%                                | ▲ 30%   | 1.30           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 7   | ▲ 9%  | ▲ 34%                                | ▲ 15%   | 1.15           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 7   | ▲ 20%   | ▼ 12%                                | ▼ 19%   | 0.81           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 8   | 2012 SIR not available                            | ▲ 31%                                | ▲ 20%   | 1.20           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 8   | 2012 SIR not available                            | ▲ 16%                                | ▲ 5%  | 1.05           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS DELAWARE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Delaware has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# DISTRICT OF COLUMBIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

30%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- District of Columbia hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

30%

HIGHER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- District of Columbia hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

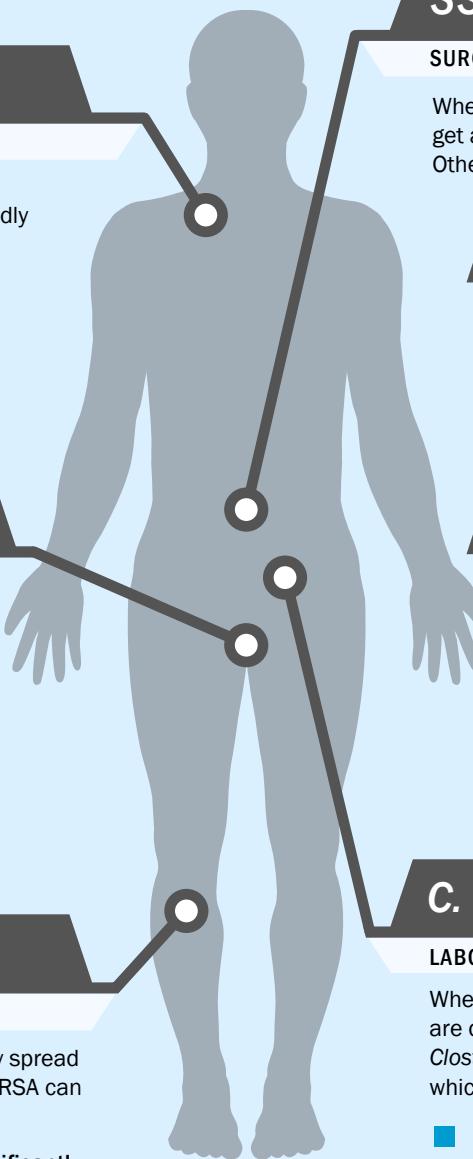
58%

HIGHER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

15%

HIGHER COMPARED  
TO NAT'L BASELINE

- District of Columbia hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

30%

LOWER COMPARED  
TO NAT'L BASELINE

- District of Columbia hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

12%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



## HEALTHCARE ASSOCIATED INFECTIONS PROGRESS



# DISTRICT OF COLUMBIA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

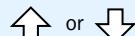
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in District of Columbia: [doh.dc.gov/page/healthcare-associated-infections](http://doh.dc.gov/page/healthcare-associated-infections)
- District of Columbia validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF DISTRICT OF COLUMBIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 12 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 8   | ⬇ 9%  | ⬆ 30%                                | ⬇ 30%   | 0.70           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 7   | ⬇ 1%  | ⬆ 23%                                | ⬆ 30%   | 1.30           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 7   | ⬇ 17%   | ⬆ 34%                                | ⬆ 15%   | 1.15           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 7   | ⬆ 47%   | ⬇ 24%                                | ⬇ 30%   | 0.71           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 9   | 2012 SIR not available                            | ⬆ 73%                                | ⬆ 58%   | 1.58           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 7   | 2012 SIR not available                            | ⬇ 3%                                 | ⬇ 12%   | 0.88           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>\*</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS DISTRICT OF COLUMBIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

District of Columbia has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (MRSA, *C. difficile*, CRE)

- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# FLORIDA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**41%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Florida hospitals reported no significant change in CLABSIs between 2012 and 2013.

**8%** Among the 170 hospitals in Florida with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**6%** LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Florida hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**9%** Among the 180 hospitals in Florida with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 1.06.

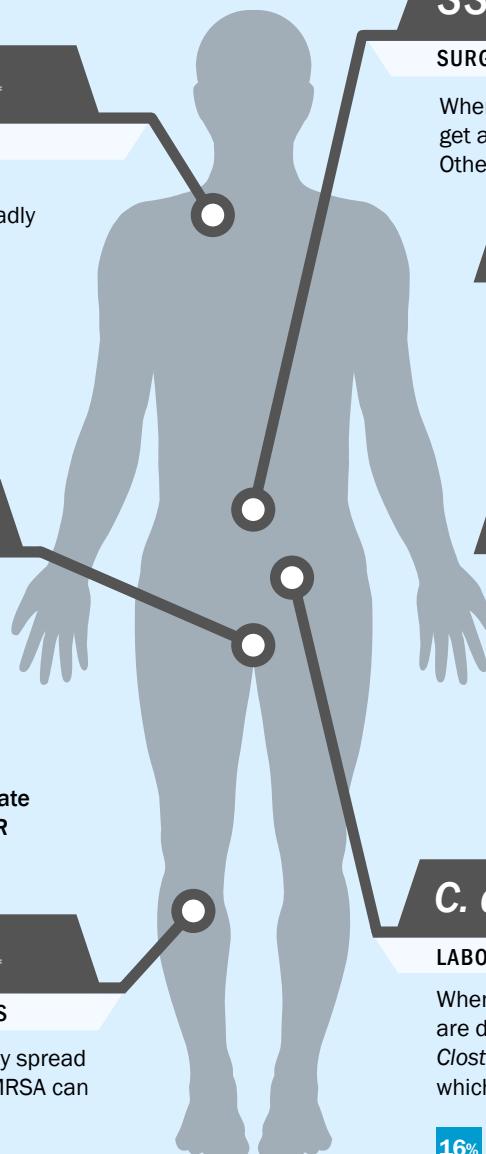
## MRSA Bacteremia

**11%** HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**11%** Among the 150 hospitals in Florida with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**10%** LOWER COMPARED TO NAT'L BASELINE

Florida hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**6%** Among the 47 hospitals in Florida with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**21%** LOWER COMPARED TO NAT'L BASELINE\*

Florida hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**5%** Among the 150 hospitals in Florida with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**11%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**16%** Among the 184 hospitals in Florida with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# FLORIDA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

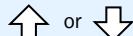
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Florida: [www.floridahealth.gov/diseases-and-conditions/health-care-associated-infections/index.html](http://www.floridahealth.gov/diseases-and-conditions/health-care-associated-infections/index.html)
- Florida validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF FLORIDA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 237 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 191   | ↑ 6%  | ↑ 11%                                | ↓ 41%   | 0.59           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 190   | ↑ 11%   | ↓ 12%                                | ↓ 6%  | 0.94           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 172   | ↓ 7%  | ↑ 5%                                 | ↓ 10%   | 0.90           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 183   | ↑ 9%  | ↓ 15%                                | ↓ 21%   | 0.79           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 190   | 2012 SIR not available                            | ↑ 23%                                | ↑ 11%   | 1.11           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 190   | 2012 SIR not available                            | ↓ 2%                                 | ↓ 11%   | 0.89           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS FLORIDA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities
- Antibiotic stewardship



# GEORGIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

28% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Georgia hospitals reported no significant change in CLABSIs between 2012 and 2013.

**15%** Among the 65 hospitals in Georgia with enough data to calculate an SIR, 15% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

36% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Georgia hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**24%** Among the 75 hospitals in Georgia with enough data to calculate an SIR, 24% had an SIR significantly worse than the national SIR of 1.06.

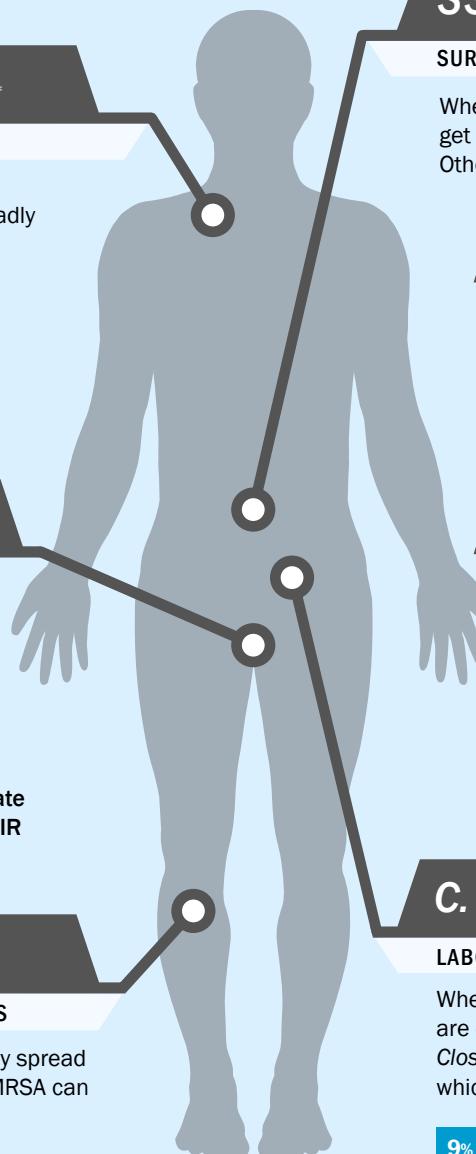
## MRSA Bacteremia

6% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**11%** Among the 57 hospitals in Georgia with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

1% LOWER COMPARED TO NAT'L BASELINE

Georgia hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**19%** Among the 32 hospitals in Georgia with enough data to calculate an SIR, 19% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

14% LOWER COMPARED TO NAT'L BASELINE\*

Georgia hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**11%** Among the 55 hospitals in Georgia with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

17% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**9%** Among the 105 hospitals in Georgia with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# GEORGIA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

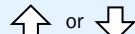
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Georgia: [dph.georgia.gov/healthcare-associated-infections](http://dph.georgia.gov/healthcare-associated-infections)
- Georgia validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF GEORGIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 166 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 102   | ↑ 7%  | ↑ 35%                                | ↓ 28%   | 0.72           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 105   | ↑ 32%   | ↑ 30%                                | ↑ 36%   | 1.36           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 90  | ↑ 13%   | ↑ 15%                                | ↓ 1%  | 0.99           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 96  | ↑ 5%  | ↓ 7%                                 | ↓ 14%   | 0.87           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 111   | 2012 SIR not available                            | ↑ 16%                                | ↑ 6%  | 1.06           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 111   | 2012 SIR not available                            | ↓ 9%                                 | ↓ 17%   | 0.83           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS GEORGIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Georgia has a state mandate to publicly report at least one HAI to NHSN. Georgia is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Antibiotic stewardship



# HAWAII

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

75% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Hawaii hospitals reported no significant change in CLABSIs between 2012 and 2013.

0% Among the 13 hospitals in Hawaii with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

38% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Hawaii hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

0% Among the 13 hospitals in Hawaii with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

43% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

100% LOWER COMPARED TO NAT'L BASELINE\*

Hawaii hospitals reported a significant decrease in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

3% HIGHER COMPARED TO NAT'L BASELINE

Hawaii hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

36% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 13 hospitals in Hawaii with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# HAWAII

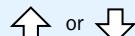
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF HAWAII HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 27 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 15  | ↑ 27%   | ↓ 54%                                | ↓ 75%   | 0.25           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 15  | ↓ 37%   | ↓ 41%                                | ↓ 38%   | 0.62           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 13  | ↓ 100%  | ↓ 100%                               | ↓ 100%  | 0.00           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 13  | ↑ 6%  | ↑ 12%                                | ↑ 3%  | 1.03           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 13  | 2012 SIR not available                            | ↓ 38%                                | ↓ 43%   | 0.57           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 13  | 2012 SIR not available                            | ↓ 29%                                | ↓ 36%   | 0.65           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS HAWAII DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Hawaii has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Surgical site infections
- Hand hygiene
- Antibiotic stewardship



# IDAHO

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

71% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Idaho hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

LESS THAN 1% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Idaho hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 10 hospitals in Idaho with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 1.06.

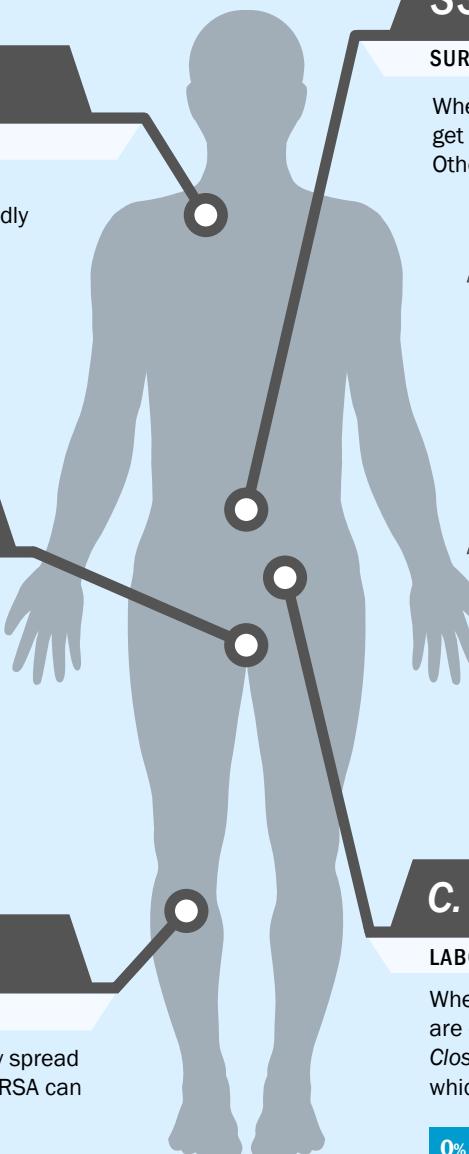
## MRSA Bacteremia

55% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

28% HIGHER COMPARED TO NAT'L BASELINE

- Idaho hospitals reported a significant increase in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

20% LOWER COMPARED TO NAT'L BASELINE

- Idaho hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

33% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 15 hospitals in Idaho with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# IDAHo

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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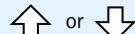
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Idaho: [healthandwelfare.idaho.gov/Health/DiseasesConditions/MethicillinresistantStaphylococcusAureus\(MRSA\)/tabid/203/Default.aspx](http://healthandwelfare.idaho.gov/Health/DiseasesConditions/MethicillinresistantStaphylococcusAureus(MRSA)/tabid/203/Default.aspx)
- Idaho validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF IDAHO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 47 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 16   | ⬇ 11%   | ⬇ 47%                                | ⬇ 71%   | 0.29           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 17   | ⬇ 12%   | ⬇ 5%                                 | ⬆ < 1%  | 1.00           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 17   | ⬆ > 100%  | ⬆ 49%                                | ⬆ 28%   | 1.28           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 18   | ⬆ 11%   | ⬇ 13%                                | ⬇ 20%   | 0.80           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 21   | 2012 SIR not available                            | ⬇ 51%                                | ⬇ 55%   | 0.45           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 20   | 2012 SIR not available                            | ⬇ 26%                                | ⬇ 33%   | 0.67           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS IDAHO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile*)
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# ILLINOIS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

53% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Illinois hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 106 hospitals in Illinois with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

3% LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Illinois hospitals reported no significant change in CAUTIs between 2012 and 2013.

Among the 114 hospitals in Illinois with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

29% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 95 hospitals in Illinois with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

42% LOWER COMPARED TO NAT'L BASELINE\*

Illinois hospitals reported a significant decrease in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Among the 38 hospitals in Illinois with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

19% LOWER COMPARED TO NAT'L BASELINE\*

Illinois hospitals reported significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 90 hospitals in Illinois with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

9% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 163 hospitals in Illinois with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# ILLINOIS

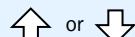
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Illinois: [www.idph.state.il.us/patientsafety/index.htm#hai](http://www.idph.state.il.us/patientsafety/index.htm#hai)
- Illinois validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF ILLINOIS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 207 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 148  | ⬇️ 17%  | ⬇️ 13%                               | ⬇️ 53%  | 0.47           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 148  | ⬇️ 7%   | ⬇️ 9%                                | ⬇️ 3%   | 0.97           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 135  | ⬇️ 36%  | ⬇️ 33%                               | ⬇️ 42%  | 0.58           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 138  | ⬆️ 32%  | ⬇️ 12%                               | ⬇️ 19%  | 0.81           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 183  | 2012 SIR not available                            | ⬇️ 23%                               | ⬇️ 29%  | 0.72           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 183  | 2012 SIR not available                            | ⬆️ < 1%                              | ⬇️ 9%   | 0.91           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS ILLINOIS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Illinois has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile*, CRE)

- Long-term care facilities
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# INDIANA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

31% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Indiana hospitals reported no significant change in CLABSIs between 2012 and 2013.

12% Among the 58 hospitals in Indiana with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

23% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Indiana hospitals reported a significant increase in CAUTIs between 2012 and 2013.

9% Among the 70 hospitals in Indiana with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 1.06.

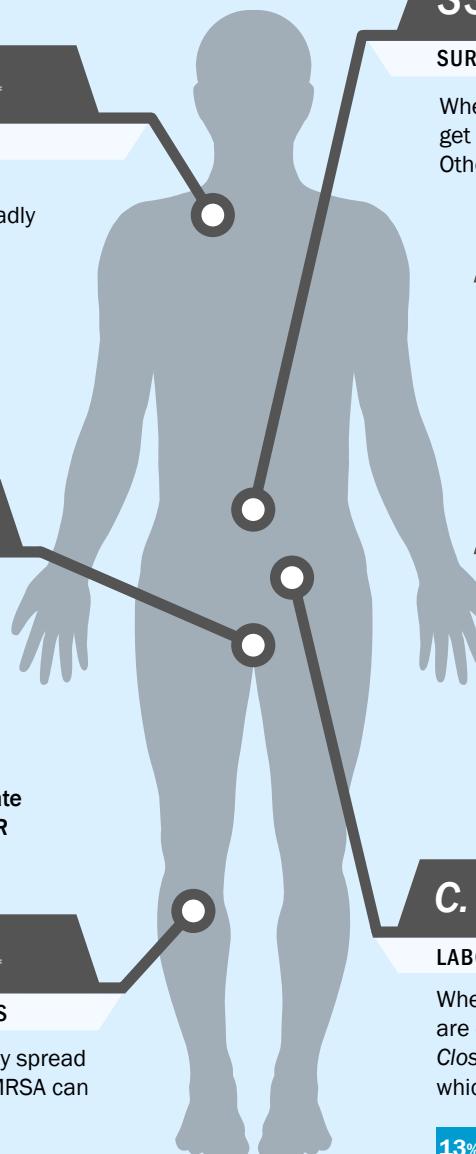
## MRSA Bacteremia

19% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

5% Among the 43 hospitals in Indiana with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

16% LOWER COMPARED TO NAT'L BASELINE

Indiana hospitals reported a significant increase in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

0% Among the 17 hospitals in Indiana with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

7% HIGHER COMPARED TO NAT'L BASELINE

Indiana hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

9% Among the 53 hospitals in Indiana with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

9% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

13% Among the 94 hospitals in Indiana with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# INDIANA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

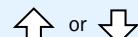
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Indiana: [www.in.gov/isdh/25479.htm](http://www.in.gov/isdh/25479.htm)
- Indiana validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF INDIANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 148 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 104   | ↑ 5%  | ↑ 30%                                | ↓ 31%   | 0.69           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 110   | ↑ 16%   | ↑ 16%                                | ↑ 23%   | 1.23           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 98  | ↑ 61%   | ↓ 2%                                 | ↓ 16%   | 0.84           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 101   | ↑ 2%  | ↑ 16%                                | ↑ 7%  | 1.07           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 102   | 2012 SIR not available                            | ↓ 12%                                | ↓ 19%   | 0.81           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 102   | 2012 SIR not available                            | ↑ 1%                                 | ↓ 9%  | 0.92           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS INDIANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Indiana has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Long-term care facilities
- Antibiotic stewardship



# IOWA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

46% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Iowa hospitals reported no significant change in CLABSIs between 2012 and 2013.

- Among the 18 hospitals in Iowa with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

12% LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Iowa hospitals reported no significant change in CAUTIs between 2012 and 2013.

- Among the 34 hospitals in Iowa with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

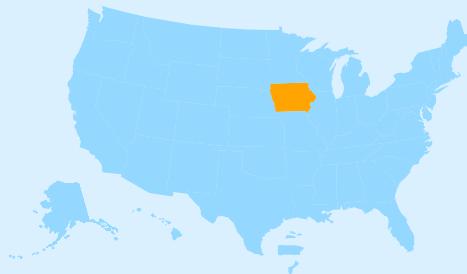
56% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Among the 21 hospitals in Iowa with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

6% LOWER COMPARED TO NAT'L BASELINE

- Iowa hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

13% HIGHER COMPARED TO NAT'L BASELINE

- Iowa hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

- Among the 22 hospitals in Iowa with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

22% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 45 hospitals in Iowa with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# IOWA

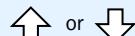
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Iowa: [www.idph.state.ia.us/hai\\_prevention/default.asp](http://www.idph.state.ia.us/hai_prevention/default.asp)
- Iowa validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF IOWA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 122 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 50   | ↑ 17%   | ↓ < 1%                               | ↓ 46%   | 0.54           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 68   | ↓ 6%  | ↓ 16%                                | ↓ 12%   | 0.88           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 33   | ↓ 22%   | ↑ 9%                                 | ↓ 6%  | 0.94           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 36   | ↑ 12%   | ↑ 23%                                | ↑ 13%   | 1.13           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 41   | 2012 SIR not available                            | ↓ 52%                                | ↓ 56%   | 0.44           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 57   | 2012 SIR not available                            | ↓ 14%                                | ↓ 22%   | 0.78           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS IOWA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (*C. difficile*)
- Long-term care facilities
- Healthcare personnel influenza vaccination



# KANSAS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

42% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Kansas hospitals reported no significant change in CLABSIs between 2012 and 2013.

**10%** Among the 20 hospitals in Kansas with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

12% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Kansas hospitals reported no significant change in CAUTIs between 2012 and 2013.

**14%** Among the 28 hospitals in Kansas with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

52% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**0%** Among the 14 hospitals in Kansas with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

58% LOWER COMPARED TO NAT'L BASELINE\*

Kansas hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

38% HIGHER COMPARED TO NAT'L BASELINE\*

Kansas hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**31%** Among the 16 hospitals in Kansas with enough data to calculate an SIR, 31% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

8% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**8%** Among the 51 hospitals in Kansas with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



## HEALTHCARE ASSOCIATED INFECTIONS PROGRESS



# KANSAS

### HEALTHCARE-ASSOCIATED INFECTION (HAI)

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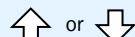
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#### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF KANSAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 149 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 49   | ↑ 14%   | ↑ 7%                                 | ↓ 42%   | 0.58           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 53   | ↑ 17%   | ↑ 6%                                 | ↑ 12%   | 1.12           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 41   | ↓ 36%   | ↓ 52%                                | ↓ 58%   | 0.42           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 43   | ↑ 47%   | ↑ 52%                                | ↑ 38%   | 1.38           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 59   | 2012 SIR not available                            | ↓ 48%                                | ↓ 52%   | 0.48           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 64   | 2012 SIR not available                            | ↑ 2%                                 | ↓ 8%  | 0.92           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS KANSAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile*)
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# KENTUCKY

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

34% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Kentucky hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 38 hospitals in Kentucky with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

21% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Kentucky hospitals reported no significant change in CAUTIs between 2012 and 2013.

Among the 54 hospitals in Kentucky with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.06.

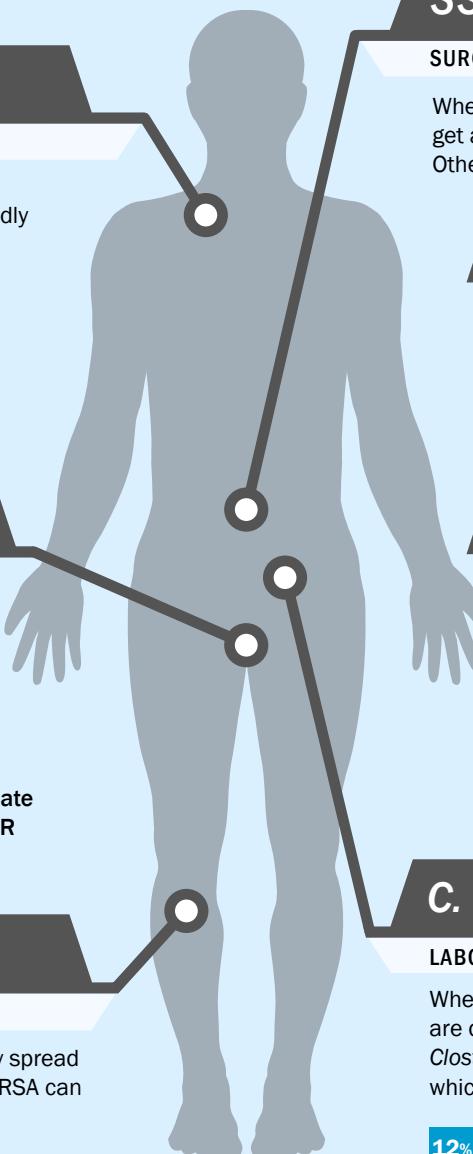
## MRSA Bacteremia

27% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 33 hospitals in Kentucky with enough data to calculate an SIR, 18% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

11% LOWER COMPARED TO NAT'L BASELINE

Kentucky hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Among the 13 hospitals in Kentucky with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

24% LOWER COMPARED TO NAT'L BASELINE\*

Kentucky hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 36 hospitals in Kentucky with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

3% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 69 hospitals in Kentucky with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# KENTUCKY

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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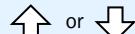
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Kentucky: [chfs.ky.gov/dph/epi/hai](http://chfs.ky.gov/dph/epi/hai)
- Kentucky validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF KENTUCKY HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 116 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 72   | 26%   | 24%                                  | 34%   | 0.67           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 73   | 3%  | 15%                                  | 21%   | 1.21           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 60   | 12%   | 5%                                   | 11%   | 0.90           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 66   | 4%  | 17%                                  | 24%   | 0.76           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 71   | 2012 SIR not available                            | 40%                                  | 27%   | 1.27           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 71   | 2012 SIR not available                            | 7%                                   | 3%  | 0.97           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS KENTUCKY DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities



# LOUISIANA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

31%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Louisiana hospitals reported no significant change in CLABSIs between 2012 and 2013.

**15%** Among the 47 hospitals in Louisiana with enough data to calculate an SIR, 15% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

19%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Louisiana hospitals reported no significant change in CAUTIs between 2012 and 2013.

**8%** Among the 60 hospitals in Louisiana with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

22%

HIGHER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**17%** Among the 35 hospitals in Louisiana with enough data to calculate an SIR, 17% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

12%

LOWER COMPARED  
TO NAT'L BASELINE

Louisiana hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**8%** Among the 12 hospitals in Louisiana with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

9%

HIGHER COMPARED  
TO NAT'L BASELINE

Louisiana hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

**Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.**

**6%** Among the 33 hospitals in Louisiana with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

37%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**4%** Among the 83 hospitals in Louisiana with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# LOUISIANA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

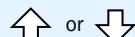
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Louisiana: [new.dhh.louisiana.gov/index.cfm/page/824](http://new.dhh.louisiana.gov/index.cfm/page/824)
- Louisiana validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF LOUISIANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 172 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 79  | ⬇ < 1%  | ⬆ 28%                                | ⬇ 31%   | 0.69           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 81  | ⬇ 1%  | ⬇ 24%                                | ⬇ 19%   | 0.81           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 79  | ⬇ 20%   | ⬆ 2%                                 | ⬇ 12%   | 0.88           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 78  | ⬆ 10%   | ⬆ 18%                                | ⬆ 9%  | 1.09           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 101   | 2012 SIR not available                            | ⬆ 34%                                | ⬆ 22%   | 1.22           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 101   | 2012 SIR not available                            | ⬇ 31%                                | ⬇ 37%   | 0.63           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS LOUISIANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections



# MAINE

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

34% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Maine hospitals reported a significant decrease in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

72% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Maine hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 13 hospitals in Maine with enough data to calculate an SIR, 23% had an SIR significantly worse than the national SIR of 1.06.

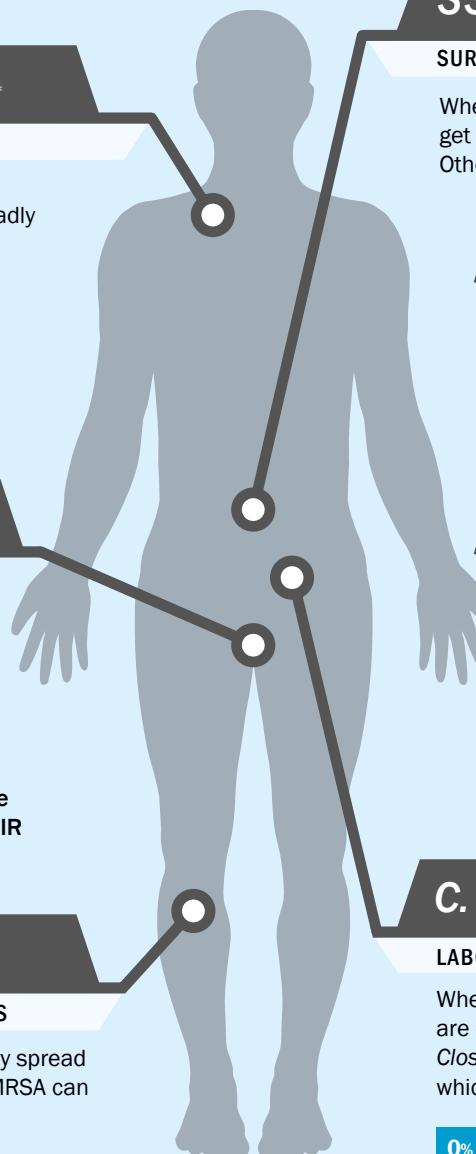
## MRSA Bacteremia

28% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

13% LOWER COMPARED TO NAT'L BASELINE

- Maine hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

20% HIGHER COMPARED TO NAT'L BASELINE

- Maine hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Among the 10 hospitals in Maine with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

47% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 36 hospitals in Maine with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# MAINE

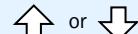
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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- Maine validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF MAINE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 41 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 21   | ⬇️ 30%  | ⬆️ 24%                               | ⬇️ 34%  | 0.66           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 21   | ⬇️ 10%  | ⬆️ 63%                               | ⬆️ 72%  | 1.72           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 19   | ⬆️ 15%  | ⬆️ 1%                                | ⬇️ 13%  | 0.87           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 21   | ⬇️ 9%   | ⬆️ 30%                               | ⬆️ 20%  | 1.20           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 25   | 2012 SIR not available                            | ⬇️ 22%                               | ⬇️ 28%  | 0.72           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 36   | 2012 SIR not available                            | ⬇️ 41%                               | ⬇️ 47%  | 0.53           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MAINE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Maine has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship



# MARYLAND

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

49% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Maryland hospitals reported no significant change in CLABSIs between 2012 and 2013.

5% Among the 39 hospitals in Maryland with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

38% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Maryland hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

19% Among the 36 hospitals in Maryland with enough data to calculate an SIR, 19% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

18% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

0% Among the 10 hospitals in Maryland with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

29% HIGHER COMPARED TO NAT'L BASELINE

Maryland hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.  
 Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

15% LOWER COMPARED TO NAT'L BASELINE

Maryland hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.  
 Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

13% Among the 15 hospitals in Maryland with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

16% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

39% Among the 44 hospitals in Maryland with enough data to calculate an SIR, 39% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# MARYLAND

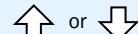
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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| HAI TYPE   | # OF MARYLAND HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 59 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 47  | ⬇ 6%  | ⬇ 4%                                 | ⬇ 49%   | 0.51           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 39  | ⬇ 26%   | ⬆ 31%                                | ⬆ 38%   | 1.38           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 12  | ⬇ 40%   | ⬆ 50%                                | ⬆ 29%   | 1.29           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 22  | ⬇ 2%  | ⬇ 8%                                 | ⬇ 15%   | 0.85           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 13  | 2012 SIR not available                            | ⬇ 10%                                | ⬇ 18%   | 0.82           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 46  | 2012 SIR not available                            | ⬆ 28%                                | ⬆ 16%   | 1.16           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

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## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MARYLAND DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Maryland has a state mandate to publicly report at least one HAI to NHSN. Maryland is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Multidrug-resistant infections (*C. difficile*, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship



# MASSACHUSETTS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

49% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Massachusetts hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 2%** Among the 48 hospitals in Massachusetts with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

58% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Massachusetts hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 20%** Among the 55 hospitals in Massachusetts with enough data to calculate an SIR, 20% had an SIR significantly worse than the national SIR of 1.06.

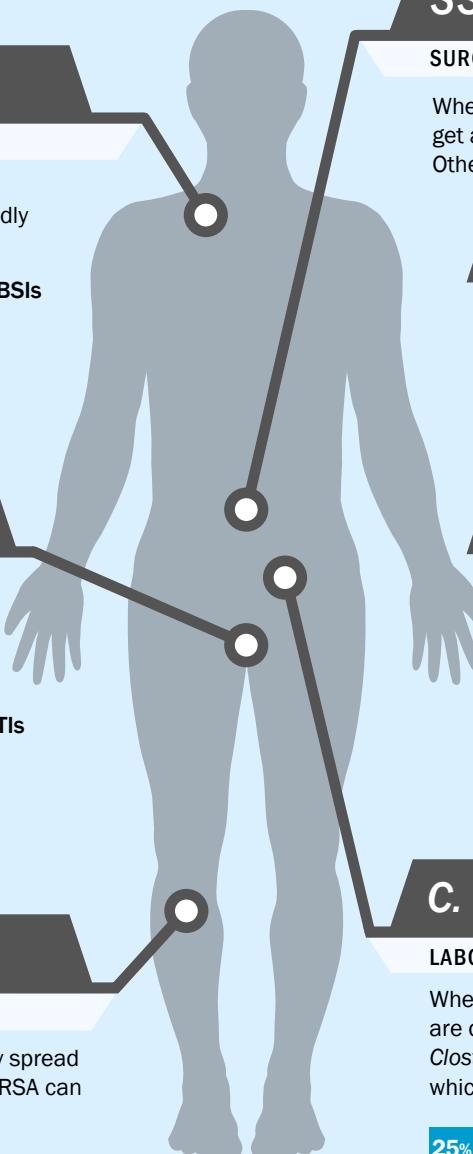
## MRSA Bacteremia

40% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 2%** Among the 50 hospitals in Massachusetts with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

11% HIGHER COMPARED TO NAT'L BASELINE

- Massachusetts hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 18%** Among the 11 hospitals in Massachusetts with enough data to calculate an SIR, 18% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

22% HIGHER COMPARED TO NAT'L BASELINE\*

- Massachusetts hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 19%** Among the 42 hospitals in Massachusetts with enough data to calculate an SIR, 19% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

1% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 25%** Among the 68 hospitals in Massachusetts with enough data to calculate an SIR, 25% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# MASSACHUSETTS

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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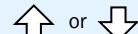
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### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF MASSACHUSETTS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 95 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 69   | ⬇ 4%  | ⬇ 5%                                 | ⬇ 49%   | 0.51           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 69   | ⬆ 9%  | ⬆ 51%                                | ⬆ 58%   | 1.58           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 57   | ⬆ 45%   | ⬆ 29%                                | ⬆ 11%   | 1.11           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 62   | ⬆ 49%   | ⬆ 34%                                | ⬆ 22%   | 1.22           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 71   | 2012 SIR not available                            | ⬇ 35%                                | ⬇ 40%   | 0.60           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 71   | 2012 SIR not available                            | ⬆ 12%                                | ⬆ 1%  | 1.01           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MASSACHUSETTS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Massachusetts has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, *C. difficile*)

- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# MICHIGAN

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**56%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Michigan hospitals reported no significant change in CLABSIs between 2012 and 2013.

**5%** Among the 59 hospitals in Michigan with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**25%** HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Michigan hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**20%** Among the 75 hospitals in Michigan with enough data to calculate an SIR, 20% had an SIR significantly worse than the national SIR of 1.06.

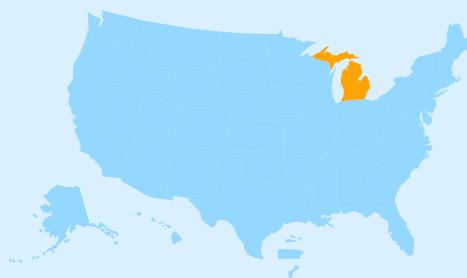
## MRSA Bacteremia

**1%** LOWER COMPARED TO NAT'L BASELINE

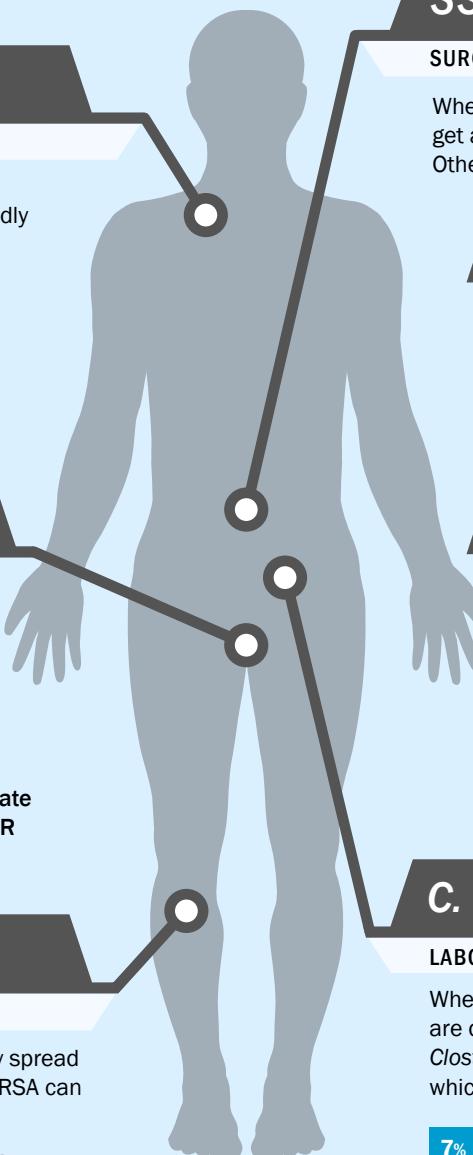
### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**14%** Among the 57 hospitals in Michigan with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 0.92.



**Healthcare-associated infections (HAIs)** are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**24%** HIGHER COMPARED TO NAT'L BASELINE

Michigan hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**21%** Among the 24 hospitals in Michigan with enough data to calculate an SIR, 21% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**5%** HIGHER COMPARED TO NAT'L BASELINE

Michigan hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**14%** Among the 57 hospitals in Michigan with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**9%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**7%** Among the 100 hospitals in Michigan with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



## HEALTHCARE ASSOCIATED INFECTIONS PROGRESS



# MICHIGAN

### HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

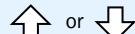
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Michigan: [www.michigan.gov/mdch/0,4612,7-132-2945\\_5104\\_55205--,00.html](http://www.michigan.gov/mdch/0,4612,7-132-2945_5104_55205--,00.html)
- Michigan validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



#### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF MICHIGAN HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 157 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 97   | ▲ 3%  | ▼ 19%                                | ▼ 56%   | 0.44           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 98   | ▲ 25%   | ▲ 19%                                | ▲ 25%   | 1.25           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 88   | ▲ 15%   | ▲ 46%                                | ▲ 24%   | 1.24           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 92   | ▲ 21%   | ▲ 15%                                | ▲ 5%  | 1.05           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 104  | 2012 SIR not available                            | ▲ 8%                                 | ▼ 1%  | 0.99           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 104  | 2012 SIR not available                            | ▲ 1%                                 | ▼ 9%  | 0.91           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MICHIGAN DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship



# MINNESOTA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

56% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Minnesota hospitals reported no significant change in CLABSIs between 2012 and 2013.

**0%** Among the 19 hospitals in Minnesota with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

26% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Minnesota hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

**19%** Among the 26 hospitals in Minnesota with enough data to calculate an SIR, 19% had an SIR significantly worse than the national SIR of 1.06.

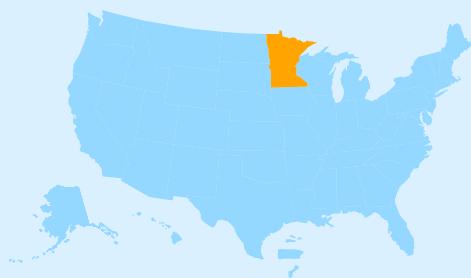
## MRSA Bacteremia

55% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**0%** Among the 23 hospitals in Minnesota with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

2%

HIGHER COMPARED TO NAT'L BASELINE

Minnesota hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**10%** Among the 10 hospitals in Minnesota with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

2%

LOWER COMPARED TO NAT'L BASELINE

Minnesota hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**7%** Among the 28 hospitals in Minnesota with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

17%

LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**13%** Among the 53 hospitals in Minnesota with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# MINNESOTA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

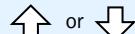
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Minnesota: [www.health.state.mn.us/divs/idepc/dtopics/hai/index.html](http://www.health.state.mn.us/divs/idepc/dtopics/hai/index.html)
- Minnesota validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF MINNESOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 144 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 47  | ⬇ 7%  | ⬇ 18%                                | ⬇ 56%   | 0.44           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 51  | ⬇ 14%   | ⬆ 19%                                | ⬆ 26%   | 1.26           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 50  | ⬇ 5%  | ⬆ 19%                                | ⬆ 2%  | 1.02           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 51  | ⬆ 44%   | ⬆ 7%                                 | ⬇ 2%  | 0.98           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 53  | 2012 SIR not available                            | ⬇ 51%                                | ⬇ 55%   | 0.45           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 55  | 2012 SIR not available                            | ⬇ 8%                                 | ⬇ 17%   | 0.83           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MINNESOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Minnesota has a state mandate to publicly report at least one HAI to NHSN. Minnesota is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (*C. difficile*)
- Long-term care facilities
- Antibiotic stewardship



# MISSISSIPPI

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

23%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Mississippi hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 26 hospitals in Mississippi with enough data to calculate an SIR, 35% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

8%

HIGHER COMPARED  
TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Mississippi hospitals reported no significant change in CAUTIs between 2012 and 2013.

Among the 33 hospitals in Mississippi with enough data to calculate an SIR, 15% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

13%

HIGHER COMPARED  
TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 23 hospitals in Mississippi with enough data to calculate an SIR, 22% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

16%

LOWER COMPARED  
TO NAT'L BASELINE

Mississippi hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Among the 11 hospitals in Mississippi with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

19%

LOWER COMPARED  
TO NAT'L BASELINE

Mississippi hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 22 hospitals in Mississippi with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

40%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 56 hospitals in Mississippi with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# MISSISSIPPI

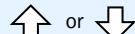
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Mississippi: [www.msdh.ms.gov/msdhsite/\\_static/14,0,194.html](http://www.msdh.ms.gov/msdhsite/_static/14,0,194.html)
- Mississippi validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF MISSISSIPPI HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 111 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 47  | ⬇️ 18%  | ⬆️ 44%                               | ⬇️ 23%  | 0.77           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 48  | ⬇️ 10%  | ⬆️ 2%                                | ⬆️ 8%   | 1.08           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 42  | ⬇️ 36%  | ⬇️ 2%                                | ⬇️ 16%  | 0.84           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 43  | ⬇️ 1%   | ⬇️ 12%                               | ⬇️ 19%  | 0.81           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 64  | 2012 SIR not available                            | ⬆️ 23%                               | ⬆️ 13%  | 1.13           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 65  | 2012 SIR not available                            | ⬇️ 34%                               | ⬇️ 40%  | 0.60           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MISSISSIPPI DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Multidrug-resistant infections



# MISSOURI

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

58% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Missouri hospitals reported no significant change in CLABSIs between 2012 and 2013.

9% Among the 47 hospitals in Missouri with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

6% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Missouri hospitals reported no significant change in CAUTIs between 2012 and 2013.

17% Among the 54 hospitals in Missouri with enough data to calculate an SIR, 17% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

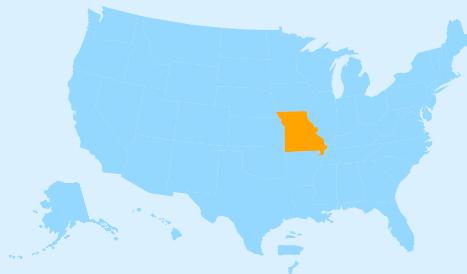
20% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

5% Among the 43 hospitals in Missouri with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

**Healthcare-associated infections (HAIs)** are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

32% LOWER COMPARED TO NAT'L BASELINE\*

Missouri hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

0% Among the 18 hospitals in Missouri with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

31% LOWER COMPARED TO NAT'L BASELINE\*

Missouri hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

4% Among the 47 hospitals in Missouri with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

14% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

8% Among the 78 hospitals in Missouri with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# MISSOURI

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

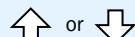
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Missouri: [health.mo.gov/data/hai/](http://health.mo.gov/data/hai/)
- Missouri validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF MISSOURI HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 135 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 74   | ⬇ 9%  | ⬇ 22%                                | ⬇ 58%   | 0.42           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 76   | ⬆ 10%   | ⬆ <1 %                               | ⬆ 6%  | 1.06           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 67   | ⬇ 5%  | ⬇ 22%                                | ⬇ 32%   | 0.68           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 74   | ⬆ 6%  | ⬇ 25%                                | ⬇ 31%   | 0.69           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 82   | 2012 SIR not available                            | ⬇ 14%                                | ⬇ 20%   | 0.80           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 82   | 2012 SIR not available                            | ⬇ 5%                                 | ⬇ 14%   | 0.86           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MISSOURI DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Antibiotic stewardship



# MONTANA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

37%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Montana hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

32%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Montana hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 10 hospitals in Montana with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

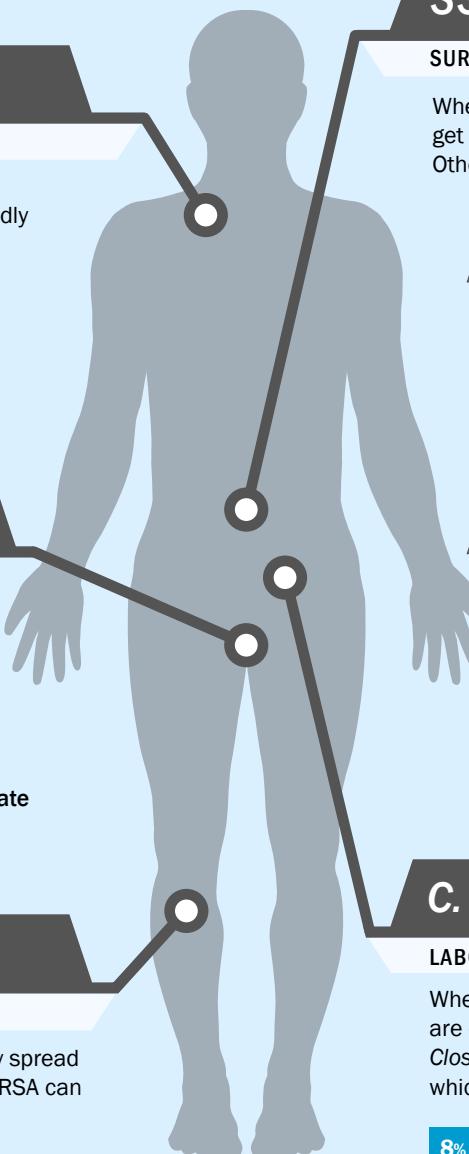
50%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

LESS THAN 1% HIGHER COMPARED  
TO NAT'L BASELINE

- Montana hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

16% LOWER COMPARED  
TO NAT'L BASELINE

- Montana hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

18%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 13 hospitals in Montana with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# MONTANA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

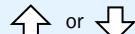
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Montana: [dphhs.mt.gov/publichealth/cdepi/haiprevention](http://dphhs.mt.gov/publichealth/cdepi/haiprevention)
- Montana validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF MONTANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 64 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 14   | ↑ 30%   | ↑ 18%                                | ↓ 37%   | 0.63           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 14   | ↓ 21%   | ↓ 35%                                | ↓ 32%   | 0.68           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 14   | ↑ 24%   | ↑ 16%                                | ↑ < 1%  | 1.00           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 14   | ↑ 83%   | ↓ 9%                                 | ↓ 16%   | 0.84           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 15   | 2012 SIR not available                            | ↓ 45%                                | ↓ 50%   | 0.50           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 16   | 2012 SIR not available                            | ↓ 9%                                 | ↓ 18%   | 0.83           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS MONTANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Hand hygiene
- Antibiotic stewardship



# NEBRASKA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**29%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Nebraska hospitals reported no significant change in CLABSIs between 2012 and 2013.

**13%** Among the 16 hospitals in Nebraska with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**8%** LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Nebraska hospitals reported no significant change in CAUTIs between 2012 and 2013.

**11%** Among the 19 hospitals in Nebraska with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.06.

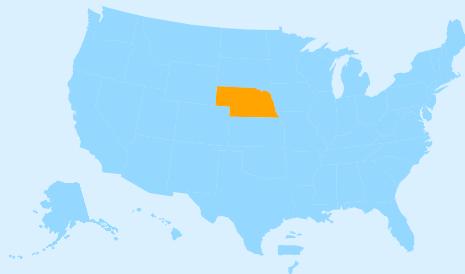
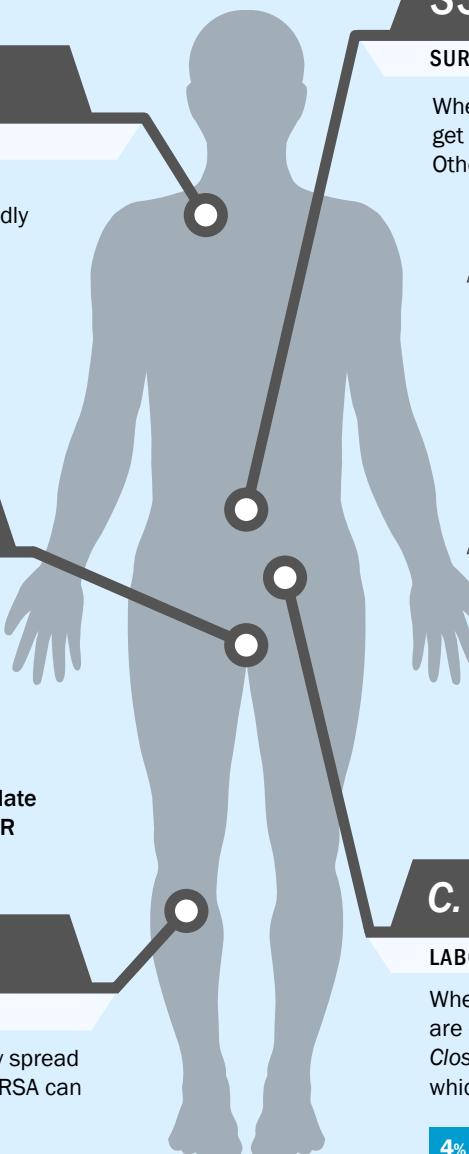
## MRSA Bacteremia

**38%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**0%** Among the 10 hospitals in Nebraska with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**37%** LOWER COMPARED TO NAT'L BASELINE

Nebraska hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**30%** HIGHER COMPARED TO NAT'L BASELINE\*

Nebraska hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**25%** Among the 12 hospitals in Nebraska with enough data to calculate an SIR, 25% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**39%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**4%** Among the 24 hospitals in Nebraska with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# NEBRASKA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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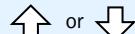
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Nebraska: [dhhs.ne.gov/Pages/default.aspx](http://dhhs.ne.gov/Pages/default.aspx)
- Nebraska validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



**LEGEND**



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF NEBRASKA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 95+ | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|--------------------------------------|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 20  | ⬇ 4%  | ⬆ 32%                                | ⬇ 29%                                | 0.71           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 20  | ⬇ 5%  | ⬇ 12%                                | ⬇ 8%                                 | 0.93           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 19  | ⬇ 39%   | ⬇ 27%                                | ⬇ 37%                                | 0.63           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 19  | ⬆ 6%  | ⬆ 41%                                | ⬆ 30%                                | 1.30           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 24  | 2012 SIR not available                            | ⬇ 32%                                | ⬇ 38%                                | 0.62           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 24  | 2012 SIR not available                            | ⬇ 32%                                | ⬇ 39%                                | 0.61           | 0.90           |

<sup>†</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

\*Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEBRASKA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# NEVADA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

37% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Nevada hospitals reported no significant change in CLABSIs between 2012 and 2013.

**26%** Among the 19 hospitals in Nevada with enough data to calculate an SIR, 26% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

8% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Nevada hospitals reported no significant change in CAUTIs between 2012 and 2013.

**15%** Among the 20 hospitals in Nevada with enough data to calculate an SIR, 15% had an SIR significantly worse than the national SIR of 1.06.

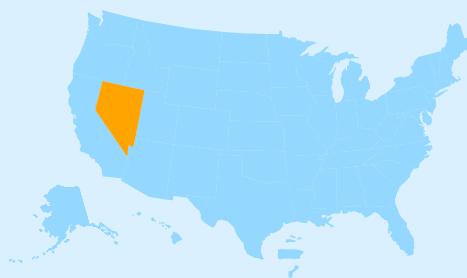
## MRSA Bacteremia

21% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**6%** Among the 16 hospitals in Nevada with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

22% LOWER COMPARED TO NAT'L BASELINE

Nevada hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

7% HIGHER COMPARED TO NAT'L BASELINE

Nevada hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**14%** Among the 14 hospitals in Nevada with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

17% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**38%** Among the 21 hospitals in Nevada with enough data to calculate an SIR, 38% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# NEVADA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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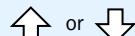
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### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF NEVADA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 46 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 23  | ↑ 6%  | ↑ 18%                                | ↓ 37%   | 0.63           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 24  | ↑ 9%  | ↑ 2%                                 | ↑ 8%  | 1.08           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 20  | ↑ 23%   | ↓ 9%                                 | ↓ 22%   | 0.78           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 22  | ↓ 4%  | ↑ 16%                                | ↑ 7%  | 1.07           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 23  | 2012 SIR not available                            | ↓ 14%                                | ↓ 21%   | 0.79           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 22  | 2012 SIR not available                            | ↑ 30%                                | ↑ 17%   | 1.17           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEVADA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Nevada has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile* and others)
- Hand hygiene
- Antibiotic stewardship



# NEW HAMPSHIRE

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**66%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- New Hampshire hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**8%** LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- New Hampshire hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 16 hospitals in New Hampshire with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

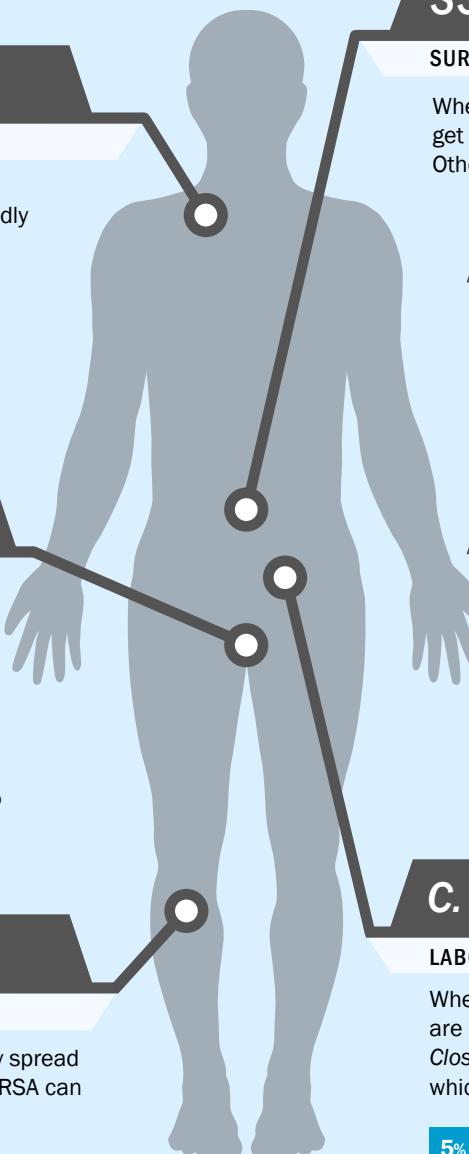
## MRSA Bacteremia

**50%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**24%** LOWER COMPARED TO NAT'L BASELINE

- New Hampshire hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**31%** LOWER COMPARED TO NAT'L BASELINE\*

- New Hampshire hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**0%** Among the 12 hospitals in New Hampshire with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**15%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 21 hospitals in New Hampshire with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# NEW HAMPSHIRE

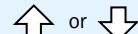
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/ai/progress-report/](http://www.cdc.gov/ai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in New Hampshire: [www.dhhs.nh.gov/dphs/cdcs/hai/index.htm](http://www.dhhs.nh.gov/dphs/cdcs/hai/index.htm)
- New Hampshire validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF NEW HAMPSHIRE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 29 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 24   | ⬇ 20%   | ⬇ 36%                                | ⬇ 66%   | 0.35           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 23   | ⬇ 4%  | ⬇ 13%                                | ⬇ 8%  | 0.92           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 22   | ⬆ 40%   | ⬇ 12%                                | ⬇ 24%   | 0.76           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 25   | ⬆ 13%   | ⬇ 25%                                | ⬇ 31%   | 0.69           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 21   | 2012 SIR not available                            | ⬇ 45%                                | ⬇ 50%   | 0.50           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 22   | 2012 SIR not available                            | ⬇ 6%                                 | ⬇ 15%   | 0.85           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEW HAMPSHIRE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

New Hampshire has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (*C. difficile*)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# NEW JERSEY

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**39%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

New Jersey hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

**18%** Among the 68 hospitals in New Jersey with enough data to calculate an SIR, 18% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**2%** HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

New Jersey hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**13%** Among the 71 hospitals in New Jersey with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 1.06.

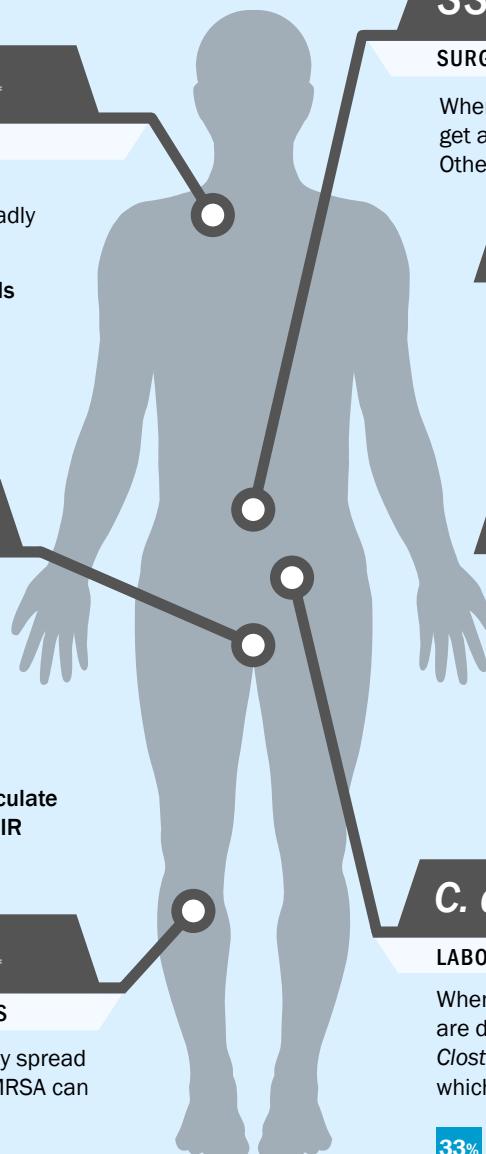
## MRSA Bacteremia

**14%** HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**20%** Among the 65 hospitals in New Jersey with enough data to calculate an SIR, 20% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**17%** LOWER COMPARED TO NAT'L BASELINE

New Jersey hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**5%** Among the 21 hospitals in New Jersey with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**14%** LOWER COMPARED TO NAT'L BASELINE\*

New Jersey hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**5%** Among the 57 hospitals in New Jersey with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**2%** HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**33%** Among the 72 hospitals in New Jersey with enough data to calculate an SIR, 33% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# NEW JERSEY

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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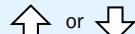
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in New Jersey: [www.state.nj.us/health/hais/index.shtml](http://www.state.nj.us/health/hais/index.shtml)
- New Jersey validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF NEW JERSEY HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 94 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 72  | 13%   | 14%                                  | 39%   | 0.61           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 72  | 16%   | 4%                                   | 2%  | 1.02           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 66  | 18%   | 3%                                   | 17%   | 0.83           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 72  | 37%   | 7%                                   | 14%   | 0.86           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 72  | 2012 SIR not available                            | 25%                                  | 14%   | 1.14           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 72  | 2012 SIR not available                            | 14%                                  | 2%  | 1.02           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEW JERSEY DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

New Jersey has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# NEW MEXICO

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**51%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- New Mexico hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 0%** Among the 14 hospitals in New Mexico with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**17%** LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- New Mexico hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 0%** Among the 19 hospitals in New Mexico with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

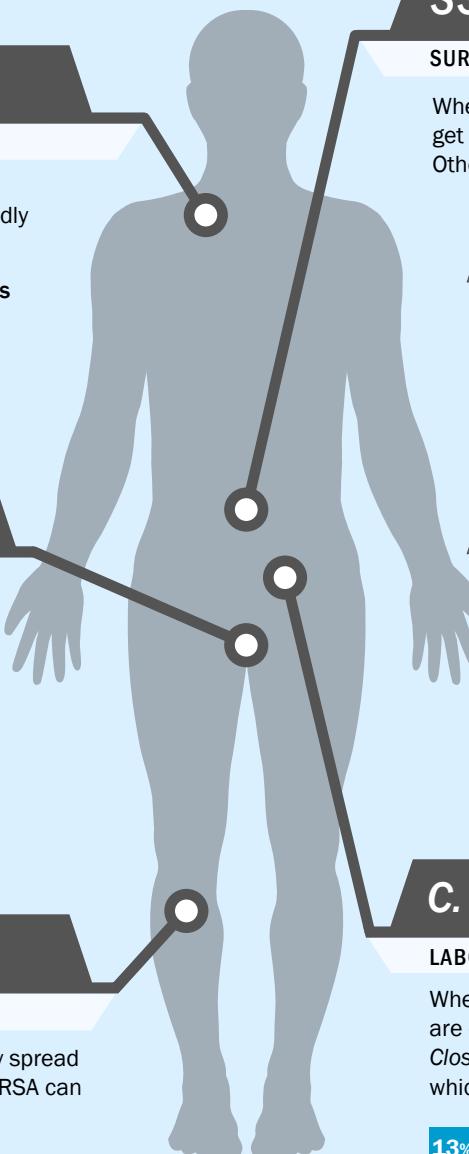
## MRSA Bacteremia

**69%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.**



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**24%** LOWER COMPARED TO NAT'L BASELINE

- New Mexico hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.**

#### SSI: Colon Surgery

**27%** LOWER COMPARED TO NAT'L BASELINE

- New Mexico hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.**
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.**

## *C. difficile* Infections

**4%** HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 13%** Among the 31 hospitals in New Mexico with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# NEW MEXICO

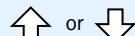
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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- HAIs and prevention activities in New Mexico: [nmhealth.org/about/erd/ideb/hai/](http://nmhealth.org/about/erd/ideb/hai/)
- New Mexico validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF NEW MEXICO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 48 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 36  | ⬇ 21%   | ⬇ 10%                                | ⬇ 51%   | 0.49           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 35  | ⬇ 14%   | ⬇ 21%                                | ⬇ 17%   | 0.83           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 26  | ⬆ 7%  | ⬇ 12%                                | ⬇ 24%   | 0.76           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 27  | ⬆ 26%   | ⬇ 20%                                | ⬇ 27%   | 0.74           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 37  | 2012 SIR not available                            | ⬇ 67%                                | ⬇ 69%   | 0.31           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 39  | 2012 SIR not available                            | ⬆ 15%                                | ⬆ 4%  | 1.04           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEW MEXICO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

New Mexico has a state mandate to publicly report at least one HAI to NHSN. New Mexico is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# NEW YORK

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

44% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

New York hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

13% Among the 141 hospitals in New York with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

26% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

New York hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

20% Among the 153 hospitals in New York with enough data to calculate an SIR, 20% had an SIR significantly worse than the national SIR of 1.06.

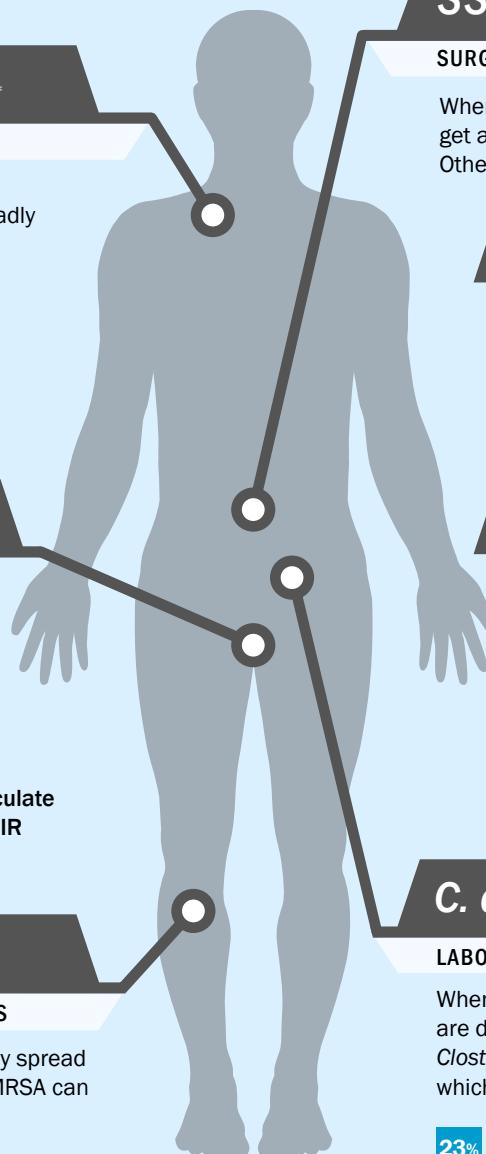
## MRSA Bacteremia

1% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

11% Among the 133 hospitals in New York with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

22% HIGHER COMPARED TO NAT'L BASELINE\*

New York hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

10% Among the 51 hospitals in New York with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

31% HIGHER COMPARED TO NAT'L BASELINE\*

New York hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

16% Among the 120 hospitals in New York with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

3% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

23% Among the 176 hospitals in New York with enough data to calculate an SIR, 23% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



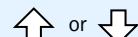
**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



**LEGEND**



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

# NEW YORK

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in New York: [www.health.ny.gov/statistics/facilities/hospital/hospital\\_acquired\\_infections/](http://www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections/)
- New York validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF NEW YORK HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 251 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 172  | ⬇️ 11%  | ⬆️ 5%                                | ⬇️ 44%  | 0.56           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 172  | ⬇️ 7%   | ⬆️ 21%                               | ⬆️ 26%  | 1.26           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 158  | ⬇️ 9%   | ⬆️ 45%                               | ⬆️ 22%  | 1.22           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 171  | ⬆️ 52%  | ⬆️ 47%                               | ⬆️ 31%  | 1.31           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 179  | 2012 SIR not available                            | ⬆️ 11%                               | ⬆️ 1%   | 1.01           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 180  | 2012 SIR not available                            | ⬆️ 9%                                | ⬇️ 3%   | 0.97           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NEW YORK DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

New York has a state mandate to publicly report at least one HAI to NHSN. New York is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# NORTH CAROLINA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

47% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

North Carolina hospitals reported no significant change in CLABSIs between 2012 and 2013.

7% Among the 60 hospitals in North Carolina with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

14% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

North Carolina hospitals reported no significant change in CAUTIs between 2012 and 2013.

13% Among the 77 hospitals in North Carolina with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 1.06.

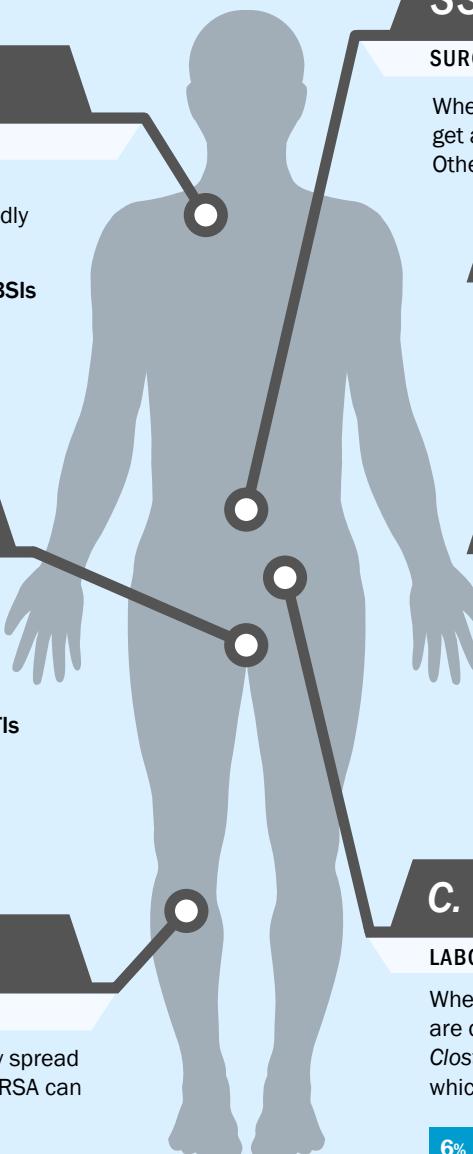
## MRSA Bacteremia

6% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

2% Among the 57 hospitals in North Carolina with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

2%

HIGHER COMPARED TO NAT'L BASELINE

North Carolina hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

13% Among the 23 hospitals in North Carolina with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

9%

LOWER COMPARED TO NAT'L BASELINE

North Carolina hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

9% Among the 55 hospitals in North Carolina with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

19%

LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

6% Among the 96 hospitals in North Carolina with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# NORTH CAROLINA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

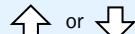
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in North Carolina: [epi.publichealth.nc.gov/cd/diseases/hai.html](http://epi.publichealth.nc.gov/cd/diseases/hai.html)
- North Carolina validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF NORTH CAROLINA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 133 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 98   | ▲ 4%  | ▼ 1%                                 | ▼ 47%   | 0.53           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 98   | ▲ 4%  | ▲ 8%                                 | ▲ 14%   | 1.14           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 89   | ▲ 33%   | ▲ 19%                                | ▲ 2%  | 1.02           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 93   | ▲ 18%   | ▼ 1%                                 | ▼ 9%  | 0.91           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 100  | 2012 SIR not available                            | ▲ 3%                                 | ▼ 6%  | 0.94           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 100  | 2012 SIR not available                            | ▼ 10%                                | ▼ 19%   | 0.81           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NORTH CAROLINA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

North Carolina has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Antibiotic stewardship



# NORTH DAKOTA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

63% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- North Dakota hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

30% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- North Dakota hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

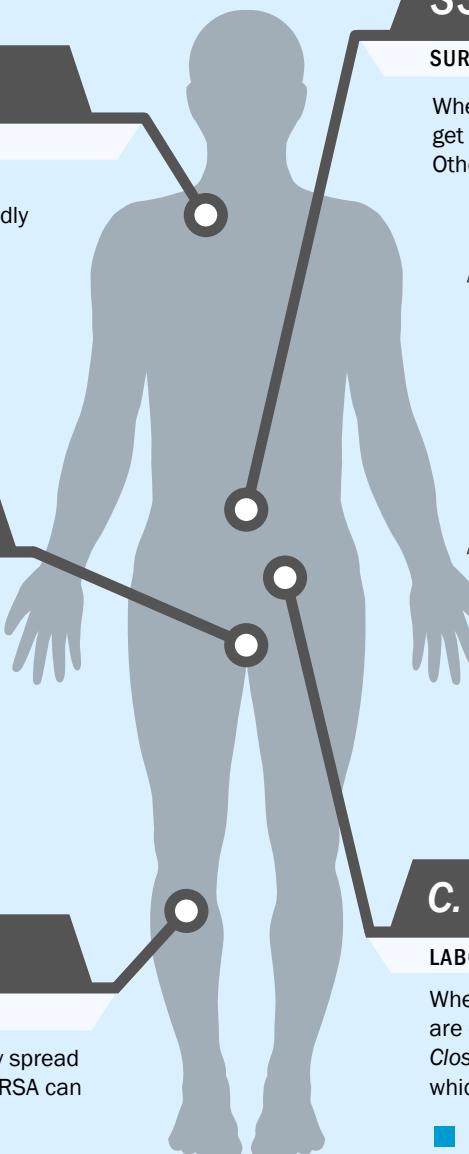
## MRSA Bacteremia

16% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

58% HIGHER COMPARED TO NAT'L BASELINE

- North Dakota hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

20% HIGHER COMPARED TO NAT'L BASELINE

- North Dakota hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

19% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# NORTH DAKOTA

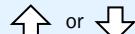
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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- HAIs and prevention activities in North Dakota: [www.ndhealth.gov/disease/hai/](http://www.ndhealth.gov/disease/hai/)
- North Dakota validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF NORTH DAKOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 48 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 6   | ↑ 2%  | ↓ 30%                                | ↓ 63%   | 0.37           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 6   | ↑ 11%   | ↓ 34%                                | ↓ 30%   | 0.70           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 6   | ↑ 50%   | ↑ 84%                                | ↑ 58%   | 1.58           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 6   | ↓ 24%   | ↑ 30%                                | ↑ 20%   | 1.20           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 11  | 2012 SIR not available                            | ↑ 27%                                | ↑ 16%   | 1.16           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 11  | 2012 SIR not available                            | ↓ 10%                                | ↓ 19%   | 0.81           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS NORTH DAKOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# OHIO

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**58%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Ohio hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 3%** Among the 92 hospitals in Ohio with enough data to calculate an SIR, 3% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**8%** LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Ohio hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 9%** Among the 105 hospitals in Ohio with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 1.06.

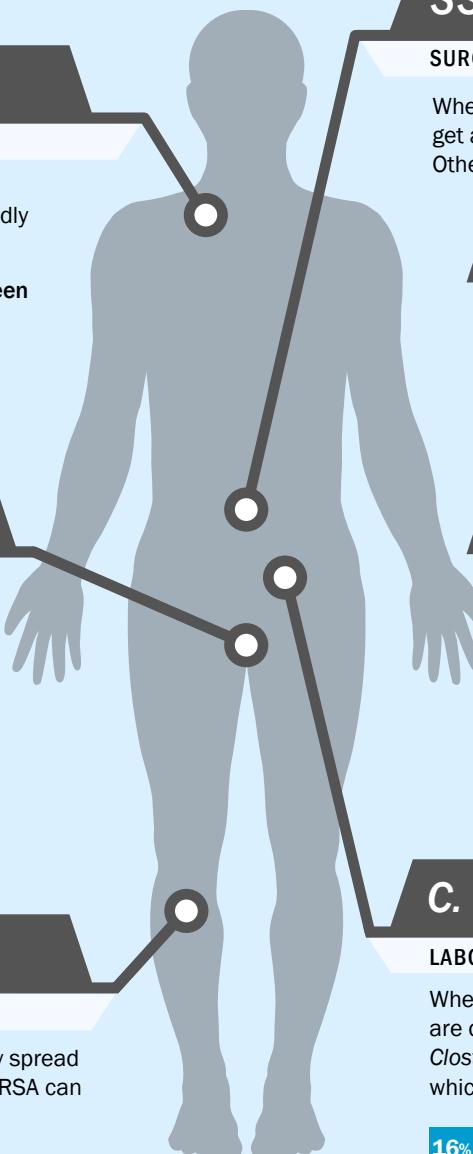
## MRSA Bacteremia

**16%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 3%** Among the 87 hospitals in Ohio with enough data to calculate an SIR, 3% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**36%** LOWER COMPARED TO NAT'L BASELINE\*

- Ohio hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 3%** Among the 39 hospitals in Ohio with enough data to calculate an SIR, 3% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**9%** LOWER COMPARED TO NAT'L BASELINE

- Ohio hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 8%** Among the 89 hospitals in Ohio with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**7%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 16%** Among the 135 hospitals in Ohio with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# OHIO

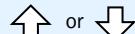
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

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- HAIs and prevention activities in Ohio: [www.odh.ohio.gov/odhprograms/dis/orbitdis/ai/ai\\_main.aspx](http://www.odh.ohio.gov/odhprograms/dis/orbitdis/ai/ai_main.aspx)
- Ohio validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF OHIO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 203 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 137  | ⬇ 5%  | ⬇ 23%                                | ⬇ 58%   | 0.42           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 136  | ⬆ 2%  | ⬇ 14%                                | ⬇ 8%  | 0.92           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 128  | ⬇ 27%   | ⬇ 26%                                | ⬇ 36%   | 0.64           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 131  | ⬆ 26%   | ⬇ 1%                                 | ⬇ 9%  | 0.91           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 144  | 2012 SIR not available                            | ⬇ 8%                                 | ⬇ 16%   | 0.84           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 144  | 2012 SIR not available                            | ⬆ 3%                                 | ⬇ 7%  | 0.93           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS OHIO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Ohio has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile)
- Long-term care facilities



# OKLAHOMA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

61% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Oklahoma hospitals reported no significant change in CLABSIs between 2012 and 2013.

**4%** Among the 27 hospitals in Oklahoma with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

23% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Oklahoma hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**5%** Among the 37 hospitals in Oklahoma with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 1.06.

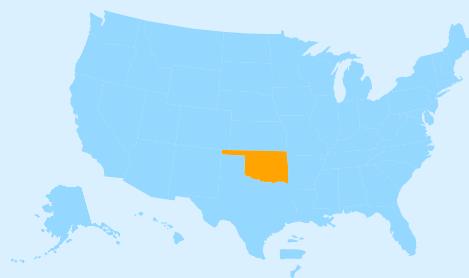
## MRSA Bacteremia

4% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**10%** Among the 21 hospitals in Oklahoma with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

50% LOWER COMPARED TO NAT'L BASELINE\*

Oklahoma hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

15% HIGHER COMPARED TO NAT'L BASELINE

Oklahoma hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**12%** Among the 25 hospitals in Oklahoma with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

11% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**9%** Among the 70 hospitals in Oklahoma with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# OKLAHOMA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

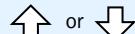
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Oklahoma: [www.ok.gov/health/Protective\\_Health/Medical\\_Facilities\\_Service/Quality\\_Initiatives/Healthcare-Associated\\_Infections\\_Prevention\\_Program/](http://www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Quality_Initiatives/Healthcare-Associated_Infections_Prevention_Program/)
- Oklahoma validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF OKLAHOMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 144 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 53   | 18%   | 27%                                  | 61%   | 0.39           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 58   | 24%   | 28%                                  | 23%   | 0.77           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 62   | 27%   | 43%                                  | 50%   | 0.50           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 56   | 39%   | 25%                                  | 15%   | 1.15           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 91   | 2012 SIR not available                            | 14%                                  | 4%  | 1.05           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 91   | 2012 SIR not available                            | 1%                                   | 11%   | 0.89           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS OKLAHOMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Oklahoma has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections



# OREGON

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

70% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Oregon hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 4% Among the 23 hospitals in Oregon with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

16% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Oregon hospitals reported a significant decrease in CAUTIs between 2012 and 2013.
- 14% Among the 28 hospitals in Oregon with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 1.06.

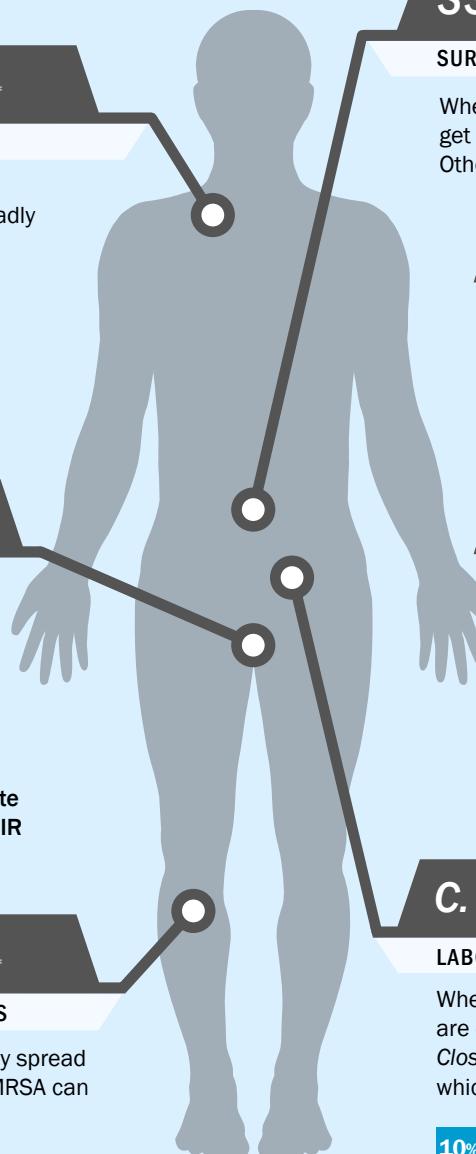
## MRSA Bacteremia

38% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 0% Among the 19 hospitals in Oregon with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

12% HIGHER COMPARED TO NAT'L BASELINE

- Oregon hospitals reported a significant increase in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

25% LOWER COMPARED TO NAT'L BASELINE\*

- Oregon hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 0% Among the 23 hospitals in Oregon with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

24% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 10% Among the 49 hospitals in Oregon with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# OREGON

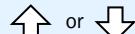
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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For additional information:

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Oregon: [public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/index.aspx](http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/index.aspx)
- Oregon validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF OREGON HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 64 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 49  | ⬇ 23%   | ⬇ 44%                                | ⬇ 70%   | 0.30           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 50  | ⬇ 18%   | ⬆ 9%                                 | ⬆ 16%   | 1.16           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 46  | ⬆ 164%  | ⬆ 30%                                | ⬆ 12%   | 1.12           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 50  | ⬇ 5%  | ⬇ 18%                                | ⬇ 25%   | 0.75           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 49  | 2012 SIR not available                            | ⬇ 33%                                | ⬇ 38%   | 0.62           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 59  | 2012 SIR not available                            | ⬇ 16%                                | ⬇ 24%   | 0.76           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS OREGON DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Oregon has a state mandate to publicly report at least one HAI to NHSN. Oregon is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship



# PENNSYLVANIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

51%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Pennsylvania hospitals reported no significant change in CLABSIs between 2012 and 2013.

Among the 127 hospitals in Pennsylvania with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

2%

HIGHER COMPARED  
TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Pennsylvania hospitals reported a significant increase in CAUTIs between 2012 and 2013.

Among the 153 hospitals in Pennsylvania with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

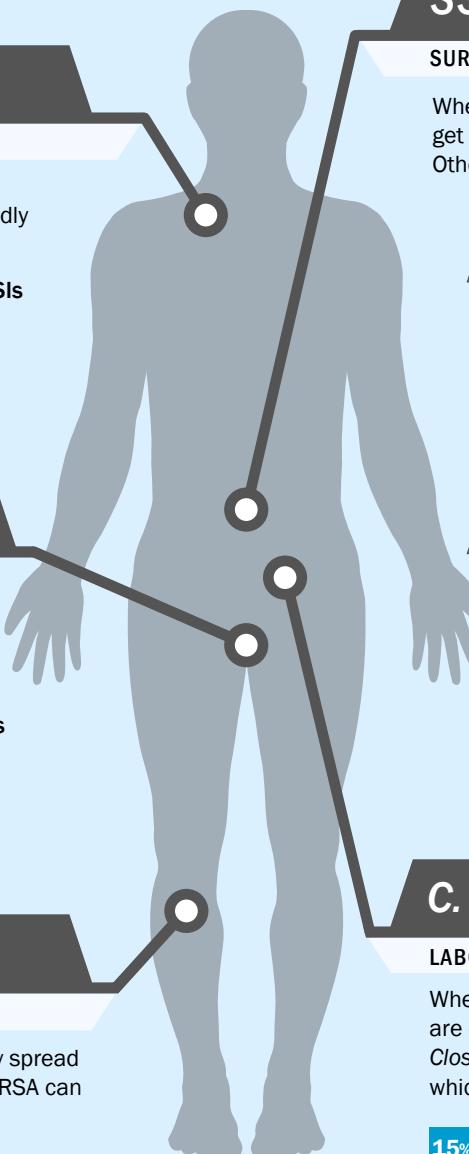
8%

HIGHER COMPARED  
TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 105 hospitals in Pennsylvania with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

7%

LOWER COMPARED  
TO NAT'L BASELINE

Pennsylvania hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Among the 35 hospitals in Pennsylvania with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

11%

LOWER COMPARED  
TO NAT'L BASELINE\*

Pennsylvania hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 111 hospitals in Pennsylvania with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

5%

LOWER COMPARED  
TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 158 hospitals in Pennsylvania with enough data to calculate an SIR, 15% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# PENNSYLVANIA

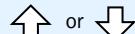
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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- Pennsylvania validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF PENNSYLVANIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 221 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 172  | ↑ 1%  | ↓ 9%                                 | ↓ 51%   | 0.49           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 184  | ↑ 13%   | ↓ 4%                                 | ↑ 2%  | 1.02           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 146  | ↓ 4%  | ↑ 8%                                 | ↓ 7%  | 0.93           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 160  | ↑ 13%   | ↓ 3%                                 | ↓ 11%   | 0.89           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 168  | 2012 SIR not available                            | ↑ 18%                                | ↑ 8%  | 1.08           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 167  | 2012 SIR not available                            | ↑ 5%                                 | ↓ 5%  | 0.95           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS PENNSYLVANIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Pennsylvania has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections



# PUERTO RICO

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

22%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Puerto Rico hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 12 hospitals in Puerto Rico with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

21%

LOWER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Puerto Rico hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

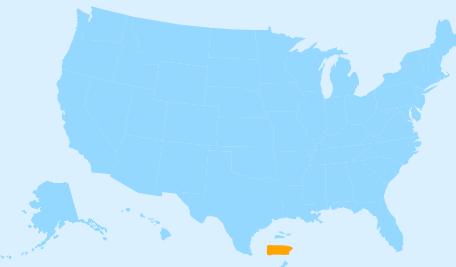
Among the 17 hospitals in Puerto Rico with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

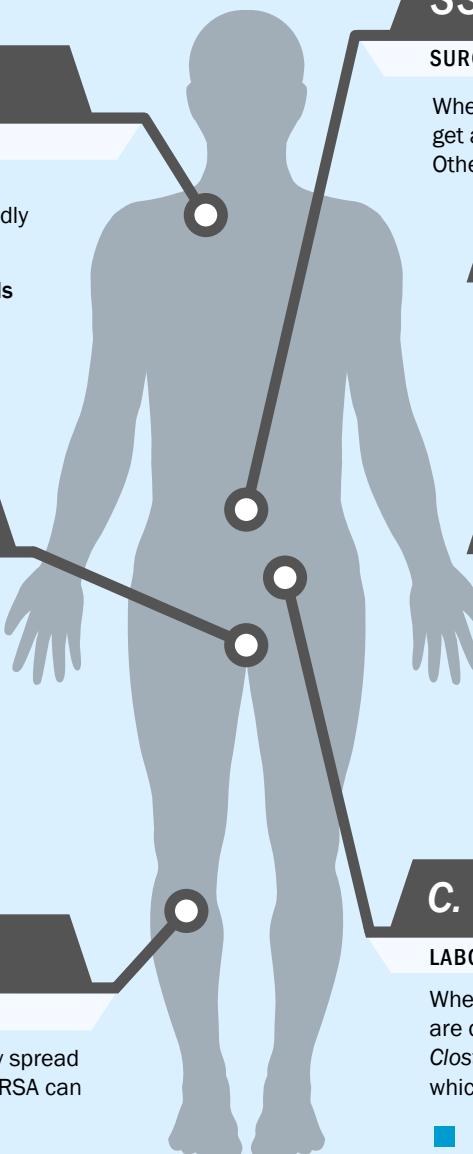
### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

Puerto Rico hospitals did not report 2013 abdominal hysterectomy data to NHSN.

#### SSI: Colon Surgery

Puerto Rico hospitals did not report 2013 colon surgery data to NHSN.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

## *C. difficile* Infections

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# PUERTO RICO

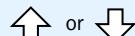
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

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- HAIs and prevention activities in Puerto Rico: [www.salud.gov.pr/Pages/default.aspx](http://www.salud.gov.pr/Pages/default.aspx)
- Puerto Rico validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF PUERTO RICO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 59 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |  |
|--|--|---|--------------------------------------|---|----------------|----------------|--|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 18   | ⬇️ 24%  | ⬆️ 45%                               | ⬇️ 22%  | 0.78           | 0.54           |  |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 18   | ⬇️ 20%  | ⬇️ 25%                               | ⬇️ 21%  | 0.79           | 1.06           |  |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 0  |   |                                      |   |                |                |  |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 0  |   |                                      |   |                |                |  |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 3  | 2012 SIR not available                            |                                      |   |                |                |  |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 4  | 2012 SIR not available                            |                                      |   |                |                |  |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS PUERTO RICO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Antibiotic stewardship



# RHODE ISLAND

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

33% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Rhode Island hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

27% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Rhode Island hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 10 hospitals in Rhode Island with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 1.06.

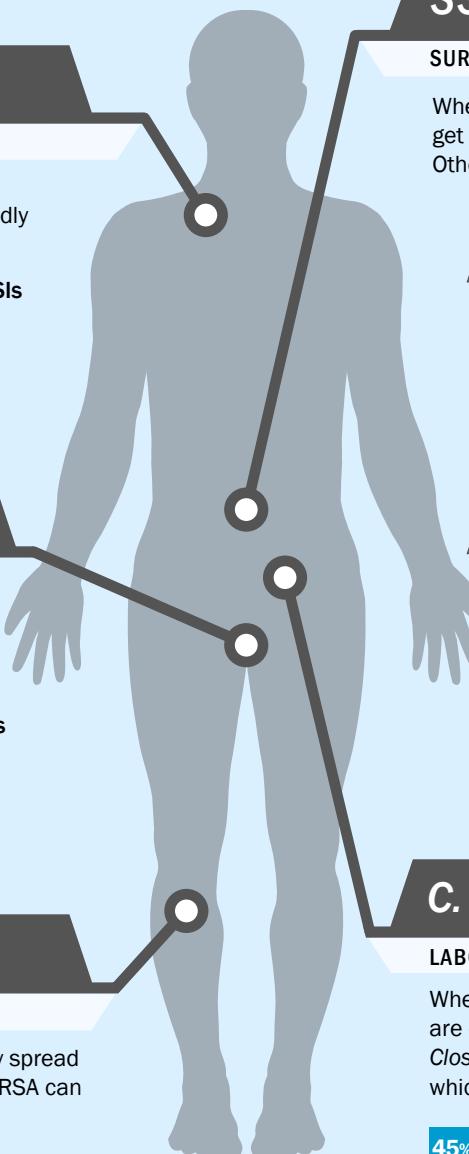
## MRSA Bacteremia

10% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

32% LOWER COMPARED TO NAT'L BASELINE

- Rhode Island hospitals reported a significant decrease in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

32% HIGHER COMPARED TO NAT'L BASELINE

- Rhode Island hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

18% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 11 hospitals in Rhode Island with enough data to calculate an SIR, 45% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# RHODE ISLAND

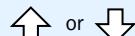
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Rhode Island: [www.health.ri.gov/diseases/healthcareacquiredinfections/](http://www.health.ri.gov/diseases/healthcareacquiredinfections/)
- Rhode Island validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF RHODE ISLAND HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 14 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 11  | ▲ 8%  | ▲ 25%                                | ▼ 33%   | 0.67           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 10  | ▼ 6%  | ▲ 20%                                | ▲ 27%   | 1.27           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 11  | ▼ 59%   | ▼ 21%                                | ▼ 32%   | 0.68           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 11  | ▼ 4%  | ▲ 43%                                | ▲ 32%   | 1.32           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 11  | 2012 SIR not available                            | ▼ 1%                                 | ▼ 10%   | 0.91           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 11  | 2012 SIR not available                            | ▲ 31%                                | ▲ 18%   | 1.18           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS RHODE ISLAND DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Rhode Island has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (MRSA, C. difficile)
- Long-term care facilities

- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# SOUTH CAROLINA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

43% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

South Carolina hospitals reported no significant change in CLABSIs between 2012 and 2013.

12% Among the 41 hospitals in South Carolina with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

28% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

South Carolina hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

16% Among the 51 hospitals in South Carolina with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

7% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

9% Among the 32 hospitals in South Carolina with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

19% LOWER COMPARED TO NAT'L BASELINE

South Carolina hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

0% Among the 15 hospitals in South Carolina with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

4% LOWER COMPARED TO NAT'L BASELINE

South Carolina hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

7% Among the 28 hospitals in South Carolina with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

26% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

5% Among the 63 hospitals in South Carolina with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# SOUTH CAROLINA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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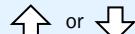
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- South Carolina validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF SOUTH CAROLINA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 81 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 65  | ⬇️ 7%   | ⬆️ 7%                                | ⬇️ 43%  | 0.58           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 64  | ⬇️ 12%  | ⬆️ 21%                               | ⬆️ 28%  | 1.28           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 51  | ⬇️ 28%  | ⬇️ 6%                                | ⬇️ 19%  | 0.82           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 57  | ⬇️ 10%  | ⬆️ 4%                                | ⬇️ 4%   | 0.96           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 66  | 2012 SIR not available                            | ⬆️ 2%                                | ⬇️ 7%   | 0.93           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 64  | 2012 SIR not available                            | ⬇️ 19%                               | ⬇️ 26%  | 0.74           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS SOUTH CAROLINA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

South Carolina has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (*C. difficile*)



# SOUTH DAKOTA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

81% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- South Dakota hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

26% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- South Dakota hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Among the 11 hospitals in South Dakota with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

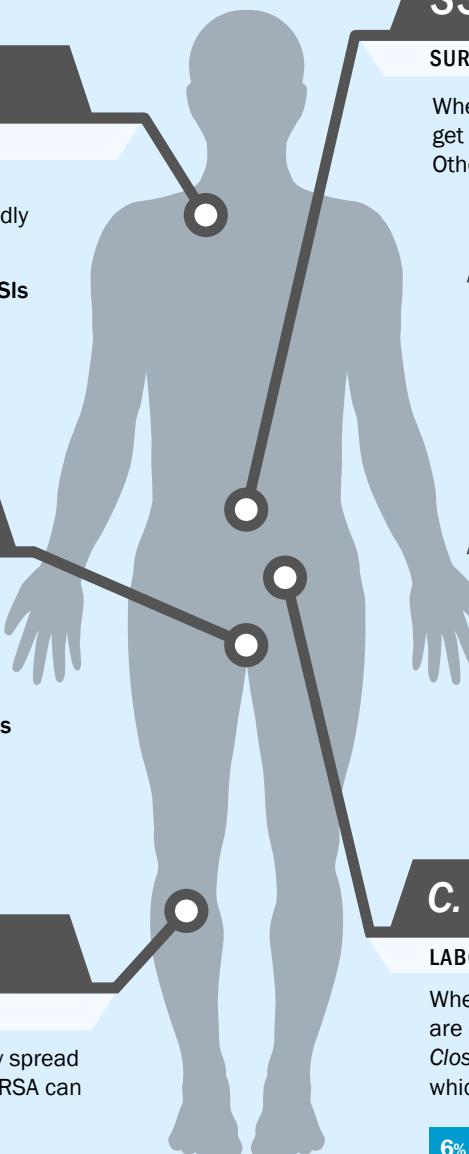
## MRSA Bacteremia

20% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

60% HIGHER COMPARED TO NAT'L BASELINE

- South Dakota hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

2% LOWER COMPARED TO NAT'L BASELINE

- South Dakota hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

28% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 16 hospitals in South Dakota with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# SOUTH DAKOTA

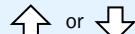
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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- South Dakota validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF SOUTH DAKOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 64 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 16  | ⬇ 29%   | ⬇ 64%                                | ⬇ 81%   | 0.19           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 18  | ⬆ 15%   | ⬇ 30%                                | ⬇ 26%   | 0.74           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 14  | ⬆ 156%  | ⬆ 85%                                | ⬆ 60%   | 1.60           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 14  | ⬇ 9%  | ⬆ 7%                                 | ⬇ 2%  | 0.98           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 23  | 2012 SIR not available                            | ⬇ 13%                                | ⬇ 20%   | 0.80           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 23  | 2012 SIR not available                            | ⬇ 20%                                | ⬇ 28%   | 0.72           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS SOUTH DAKOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# TENNESSEE

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

52% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Tennessee hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

Among the 56 hospitals in Tennessee with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

24% HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Tennessee hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

Among the 69 hospitals in Tennessee with enough data to calculate an SIR, 19% had an SIR significantly worse than the national SIR of 1.06.

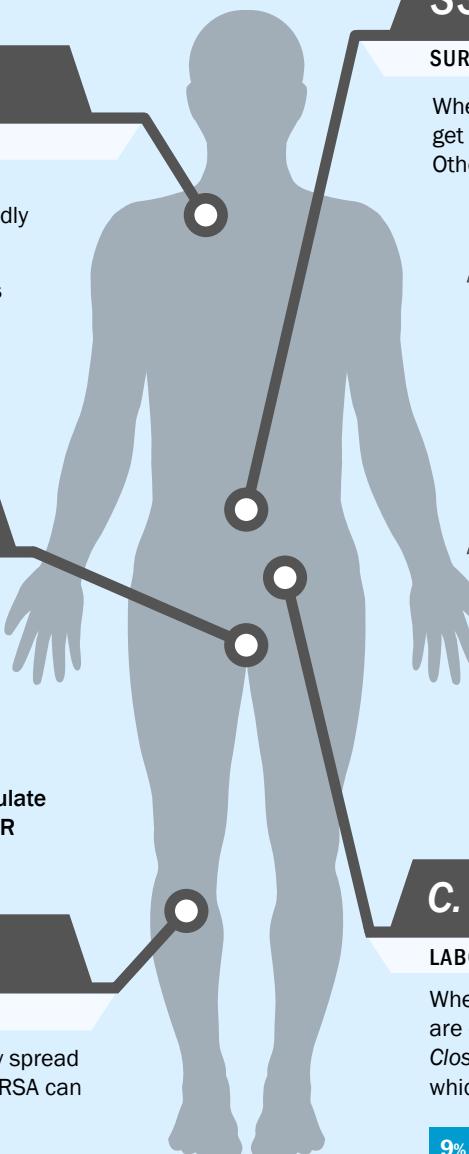
## MRSA Bacteremia

13% HIGHER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Among the 50 hospitals in Tennessee with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

11% LOWER COMPARED TO NAT'L BASELINE

Tennessee hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

Among the 20 hospitals in Tennessee with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

9% LOWER COMPARED TO NAT'L BASELINE

Tennessee hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

Among the 50 hospitals in Tennessee with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

23% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Among the 106 hospitals in Tennessee with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



## HEALTHCARE ASSOCIATED INFECTIONS PROGRESS



# TENNESSEE

### HEALTHCARE-ASSOCIATED INFECTION (HAI)

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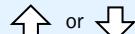
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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Tennessee: [health.state.tn.us/ceds/hai/index.htm](http://health.state.tn.us/ceds/hai/index.htm)
- Tennessee validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



#### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF TENNESSEE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 154 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 95  | 14%   | 10%                                  | 52%   | 0.49           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 94  | 10%   | 17%                                  | 24%   | 1.24           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 87  | 2%  | 3%                                   | 11%   | 0.89           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 95  | 2%  | 1%                                   | 9%  | 0.91           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 115   | 2012 SIR not available                            | 24%                                  | 13%   | 1.13           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 115   | 2012 SIR not available                            | 16%                                  | 23%   | 0.77           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS TENNESSEE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Tennessee has a state mandate to publicly report at least one HAI to NHSN. Tennessee is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections

- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile, CRE)
- Long-term care facilities
- Antibiotic stewardship



# TEXAS

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**↓ 49%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Texas hospitals reported no significant change in CLABSIs between 2012 and 2013.

**8%** Among the 204 hospitals in Texas with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**↑ 3%** HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

**■** Texas hospitals reported a significant increase in CAUTIs between 2012 and 2013.

**10%** Among the 230 hospitals in Texas with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 1.06.

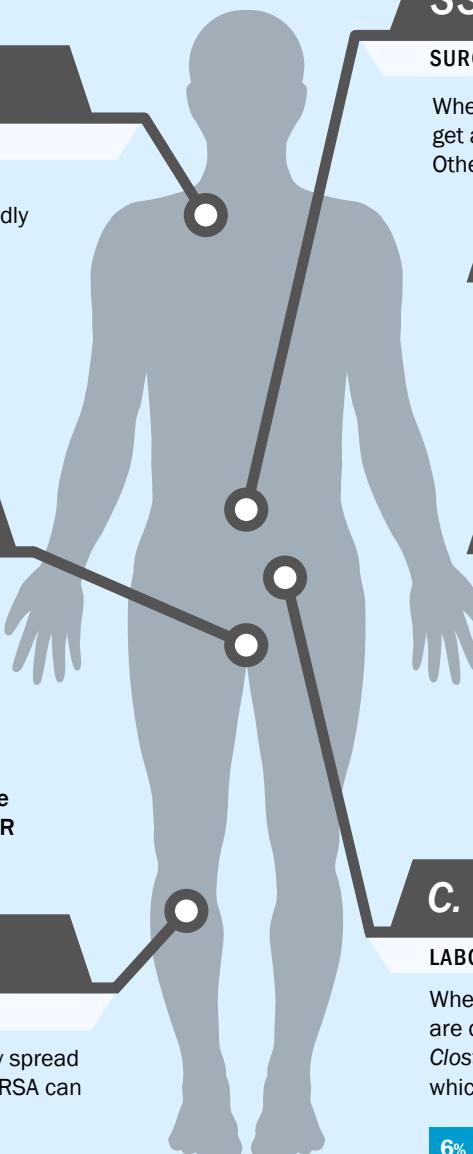
## MRSA Bacteremia

**↓ 13%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**5%** Among the 159 hospitals in Texas with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**↓ 28%** LOWER COMPARED TO NAT'L BASELINE\*

Texas hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**4%** Among the 75 hospitals in Texas with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**↓ 23%** LOWER COMPARED TO NAT'L BASELINE\*

Texas hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

**■** Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**5%** Among the 166 hospitals in Texas with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**↓ 19%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**6%** Among the 299 hospitals in Texas with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# TEXAS

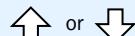
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Texas: [www.texashai.org](http://www.texashai.org)
- Texas validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF TEXAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 506 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 281   | ⬇ 7%  | ⬇ 5%                                 | ⬇ 49%   | 0.51           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 289   | ⬆ 9%  | ⬇ 3%                                 | ⬆ 3%  | 1.03           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 290   | ⬇ 3%  | ⬇ 18%                                | ⬇ 28%   | 0.73           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 285   | ⬆ 3%  | ⬇ 17%                                | ⬇ 23%   | 0.78           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 359   | 2012 SIR not available                            | ⬇ 5%                                 | ⬇ 13%   | 0.87           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 359   | 2012 SIR not available                            | ⬇ 11%                                | ⬇ 19%   | 0.81           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS TEXAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Texas has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (*C. difficile*)



# UTAH

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**34%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Utah hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 7%** Among the 14 hospitals in Utah with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**64%** HIGHER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Utah hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 25%** Among the 16 hospitals in Utah with enough data to calculate an SIR, 25% had an SIR significantly worse than the national SIR of 1.06.

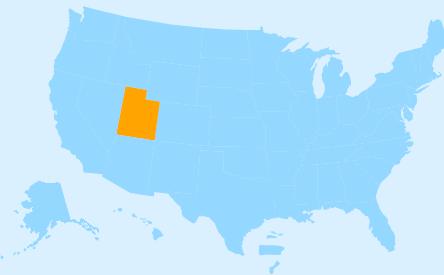
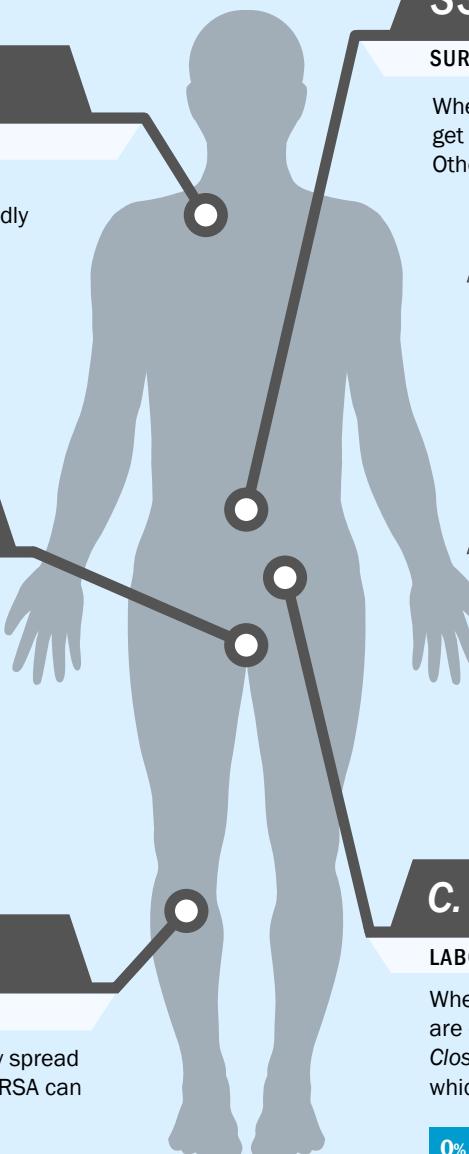
## MRSA Bacteremia

**40%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 0%** Among the 10 hospitals in Utah with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**8%** HIGHER COMPARED TO NAT'L BASELINE

- Utah hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**16%** HIGHER COMPARED TO NAT'L BASELINE

- Utah hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

- 13%** Among the 15 hospitals in Utah with enough data to calculate an SIR, 13% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**16%** LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 0%** Among the 29 hospitals in Utah with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# UTAH

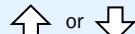
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

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For additional information:

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- HAIs and prevention activities in Utah: [health.utah.gov/epi/diseases/HAI/](http://health.utah.gov/epi/diseases/HAI/)
- Utah validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF UTAH HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 53 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 26  | ↑ 2%  | ↑ 23%                                | ↓ 34%   | 0.66           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 26  | ↓ 11%   | ↑ 56%                                | ↑ 64%   | 1.64           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 29  | ↑ 17%   | ↑ 26%                                | ↑ 8%  | 1.08           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 30  | ↓ 23%   | ↑ 26%                                | ↑ 16%   | 1.16           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 37  | 2012 SIR not available                            | ↓ 35%                                | ↓ 40%   | 0.60           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 35  | 2012 SIR not available                            | ↓ 7%                                 | ↓ 16%   | 0.84           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS UTAH DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Utah has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# VERMONT

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

75% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Vermont hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

14% LOWER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Vermont hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

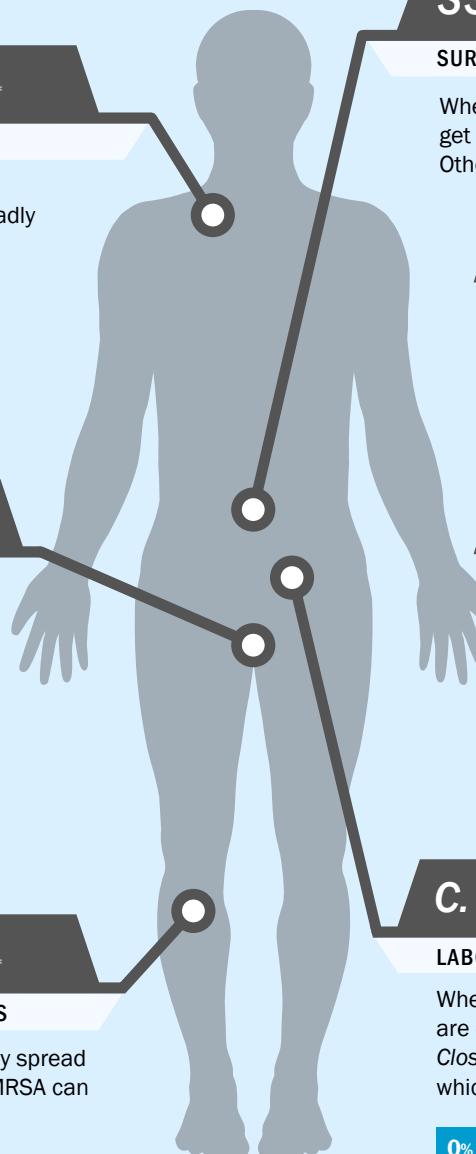
## MRSA Bacteremia

73% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

36% LOWER COMPARED TO NAT'L BASELINE

- Vermont hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

121% HIGHER COMPARED TO NAT'L BASELINE\*

- Vermont hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

42% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 11 hospitals in Vermont with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# VERMONT

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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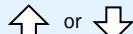
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### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF VERMONT HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 16 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 7  | ↑ 1%  | ↓ 53%                                | ↓ 75%   | 0.25           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 5  | ↓ 29%   | ↓ 18%                                | ↓ 14%   | 0.87           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 12   | ↓ 33%   | ↓ 24%                                | ↓ 36%   | 0.65           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 6  | ↑ 17%   | ↑ 140%                               | ↑ 121%  | 2.21           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 13   | 2012 SIR not available                            | ↓ 71%                                | ↓ 73%   | 0.27           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 13   | 2012 SIR not available                            | ↓ 36%                                | ↓ 42%   | 0.58           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS VERMONT DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Vermont has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Antibiotic stewardship



# VIRGINIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

50% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Virginia hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 4%** Among the 50 hospitals in Virginia with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

5% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Virginia hospitals reported a significant increase in CAUTIs between 2012 and 2013.
- 8%** Among the 62 hospitals in Virginia with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 1.06.

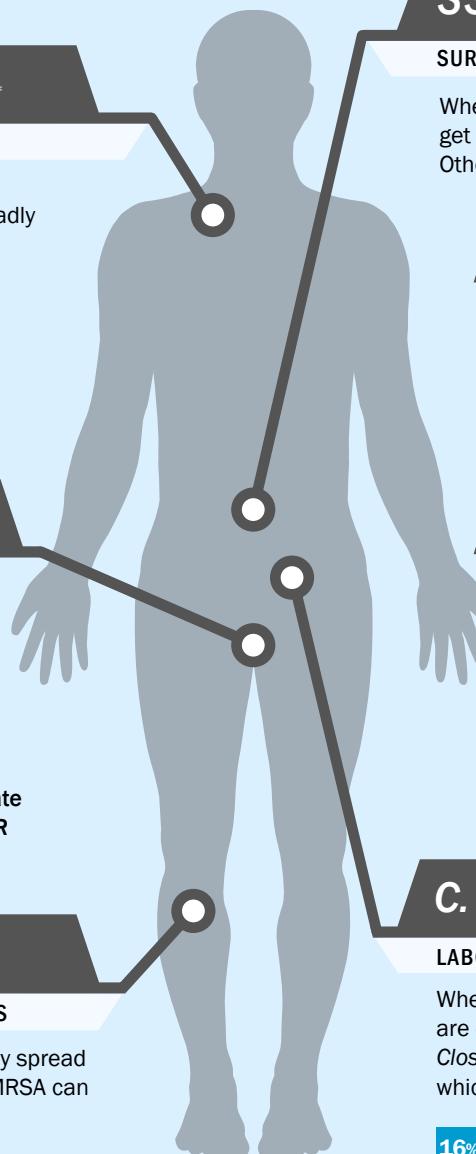
## MRSA Bacteremia

9% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 9%** Among the 47 hospitals in Virginia with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

20% LOWER COMPARED TO NAT'L BASELINE

- Virginia hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 0%** Among the 19 hospitals in Virginia with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

10% LOWER COMPARED TO NAT'L BASELINE

- Virginia hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 7%** Among the 43 hospitals in Virginia with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

2% LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 16%** Among the 79 hospitals in Virginia with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# VIRGINIA

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

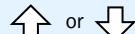
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Virginia: [www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/](http://www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/)
- Virginia validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF VIRGINIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 109 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 81   | ⬇ 13%   | ⬇ 7%                                 | ⬇ 50%   | 0.50           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 81   | ⬆ 17%   | ⬇ 1%                                 | ⬆ 5%  | 1.05           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 66   | ⬇ 7%  | ⬇ 7%                                 | ⬇ 20%   | 0.80           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 75   | ⬆ 17%   | ⬇ 2%                                 | ⬇ 10%   | 0.90           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 84   | 2012 SIR not available                            | ⬇ 1%                                 | ⬇ 9%  | 0.91           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 84   | 2012 SIR not available                            | ⬆ 8%                                 | ⬇ 2%  | 0.98           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS VIRGINIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Virginia has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities
- Antibiotic stewardship



# WASHINGTON

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

46% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Washington hospitals reported no significant change in CLABSIs between 2012 and 2013.

**11%** Among the 45 hospitals in Washington with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

1% HIGHER COMPARED TO NAT'L BASELINE

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Washington hospitals reported no significant change in CAUTIs between 2012 and 2013.

**11%** Among the 47 hospitals in Washington with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

22% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**6%** Among the 33 hospitals in Washington with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

19% LOWER COMPARED TO NAT'L BASELINE

Washington hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**0%** Among the 11 hospitals in Washington with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

6% LOWER COMPARED TO NAT'L BASELINE

Washington hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.

Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

**0%** Among the 38 hospitals in Washington with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

5% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**16%** Among the 58 hospitals in Washington with enough data to calculate an SIR, 16% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.



# WASHINGTON

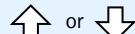
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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For additional information:

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Washington: [www.doh.wa.gov>YouandYourFamily/IllnessandDisease/HealthcareAssociatedInfections](http://www.doh.wa.gov>YouandYourFamily/IllnessandDisease/HealthcareAssociatedInfections)
- Washington validation efforts: [www.cdc.gov/ai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/ai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF WASHINGTON HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 103 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 83   | ⬇ 5%  | ⬇ < 1%                               | ⬇ 46%   | 0.54           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 69   | ⬇ 6%  | ⬇ 4%                                 | ⬆ 1%  | 1.01           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 64   | ⬆ 32%   | ⬇ 6%                                 | ⬇ 19%   | 0.81           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 70   | ⬆ 39%   | ⬆ 3%                                 | ⬇ 6%  | 0.95           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 59   | 2012 SIR not available                            | ⬇ 15%                                | ⬇ 22%   | 0.78           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 61   | 2012 SIR not available                            | ⬆ 5%                                 | ⬇ 5%  | 0.95           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS WASHINGTON DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Washington has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (MRSA, C. difficile, CRE, and others)
- Long-term care facilities
- Hand hygiene
- Antibiotic stewardship
- Healthcare personnel influenza vaccination



# WEST VIRGINIA

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**65%** LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

West Virginia hospitals reported no significant change in CLABSIs between 2012 and 2013.

**0%** Among the 24 hospitals in West Virginia with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**41%** LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

West Virginia hospitals reported no significant change in CAUTIs between 2012 and 2013.

**0%** Among the 27 hospitals in West Virginia with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

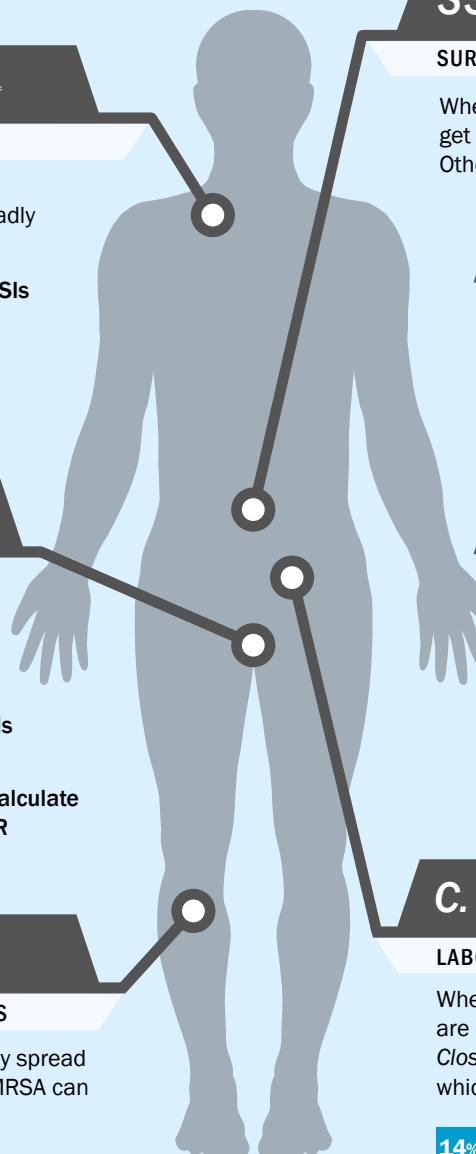
**7%**

LOWER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

**6%** Among the 18 hospitals in West Virginia with enough data to calculate an SIR, 6% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**21%** LOWER COMPARED TO NAT'L BASELINE

West Virginia hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

**Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.**

#### SSI: Colon Surgery

**3%** LOWER COMPARED TO NAT'L BASELINE

West Virginia hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.

**Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.**

**12%** Among the 17 hospitals in West Virginia with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**2%**

HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

**14%** Among the 36 hospitals in West Virginia with enough data to calculate an SIR, 14% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



# WEST VIRGINIA

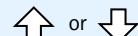
HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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- HAIs and prevention activities in West Virginia: [www.dhhr.wv.gov/oeps/disease/HAI/Pages/default.aspx](http://www.dhhr.wv.gov/oeps/disease/HAI/Pages/default.aspx)
- West Virginia validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



| HAI TYPE   | # OF WEST VIRGINIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 58 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 43   | ⬇ 8%  | ⬇ 35%                                | ⬇ 65%   | 0.35           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 47   | ⬇ 15%   | ⬇ 44%                                | ⬇ 41%   | 0.59           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 34   | ⬆ 63%   | ⬇ 8%                                 | ⬇ 21%   | 0.79           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 36   | ⬆ 1%  | ⬆ 5%                                 | ⬇ 3%  | 0.97           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 39   | 2012 SIR not available                            | ⬆ 1%                                 | ⬇ 7%  | 0.93           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 41   | 2012 SIR not available                            | ⬆ 13%                                | ⬆ 2%  | 1.02           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS WEST VIRGINIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

West Virginia has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

- Multidrug-resistant infections (*C. difficile*)
- Long-term care facilities
- Antibiotic stewardship



# WISCONSIN

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

52% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Wisconsin hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 4% Among the 50 hospitals in Wisconsin with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

17% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Wisconsin hospitals reported no significant change in CAUTIs between 2012 and 2013.
- 5% Among the 61 hospitals in Wisconsin with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 1.06.

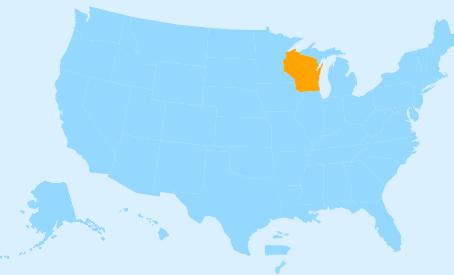
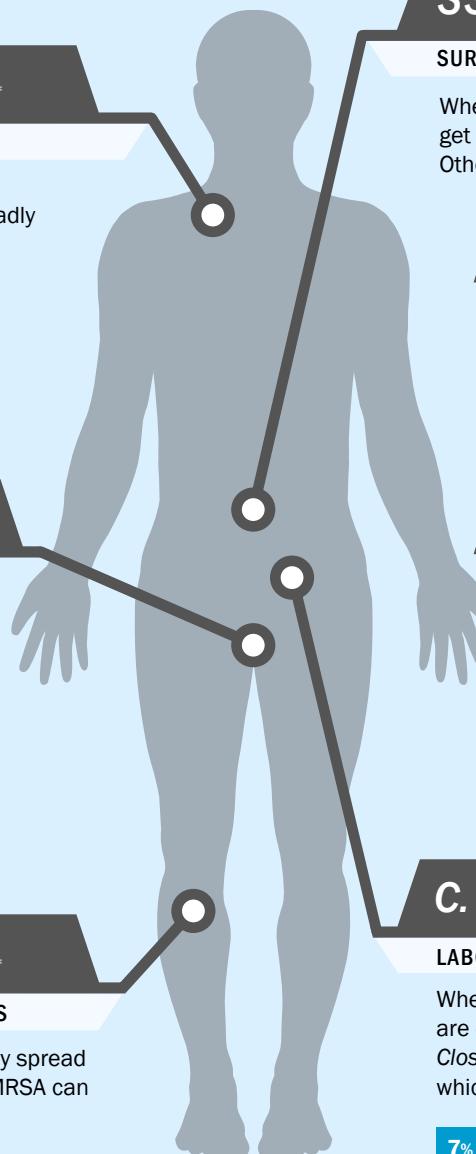
## MRSA Bacteremia

44% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 0% Among the 29 hospitals in Wisconsin with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

38% LOWER COMPARED TO NAT'L BASELINE\*

- Wisconsin hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- 8% Among the 12 hospitals in Wisconsin with enough data to calculate an SIR, 8% had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

9% LOWER COMPARED TO NAT'L BASELINE

- Wisconsin hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 2% Among the 48 hospitals in Wisconsin with enough data to calculate an SIR, 2% had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

13% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 7% Among the 82 hospitals in Wisconsin with enough data to calculate an SIR, 7% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# WISCONSIN

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

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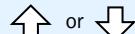
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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Wisconsin: [www.dhs.wisconsin.gov/communicable/HAI/index.htm](http://www.dhs.wisconsin.gov/communicable/HAI/index.htm)
- Wisconsin validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF WISCONSIN HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 144 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|---|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 90  | ↑ 10%   | ↓ 11%                                | ↓ 52%   | 0.48           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 102   | ↑ 5%  | ↓ 22%                                | ↓ 17%   | 0.83           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 75  | ↓ 33%   | ↓ 29%                                | ↓ 38%   | 0.62           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 84  | ↑ 12%   | ↓ 1%                                 | ↓ 9%  | 0.91           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 88  | 2012 SIR not available                            | ↓ 39%                                | ↓ 44%   | 0.56           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 95  | 2012 SIR not available                            | ↓ 4%                                 | ↓ 13%   | 0.87           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS WISCONSIN DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (*C. difficile*, CRE)
- Long-term care facilities



# WYOMING

HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS



## CLABSIs

**↓ 47%**

LOWER COMPARED  
TO NAT'L BASELINE

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Wyoming hospitals reported no significant change in CLABSIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

**↓ 47%**

LOWER COMPARED  
TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Wyoming hospitals reported no significant change in CAUTIs between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

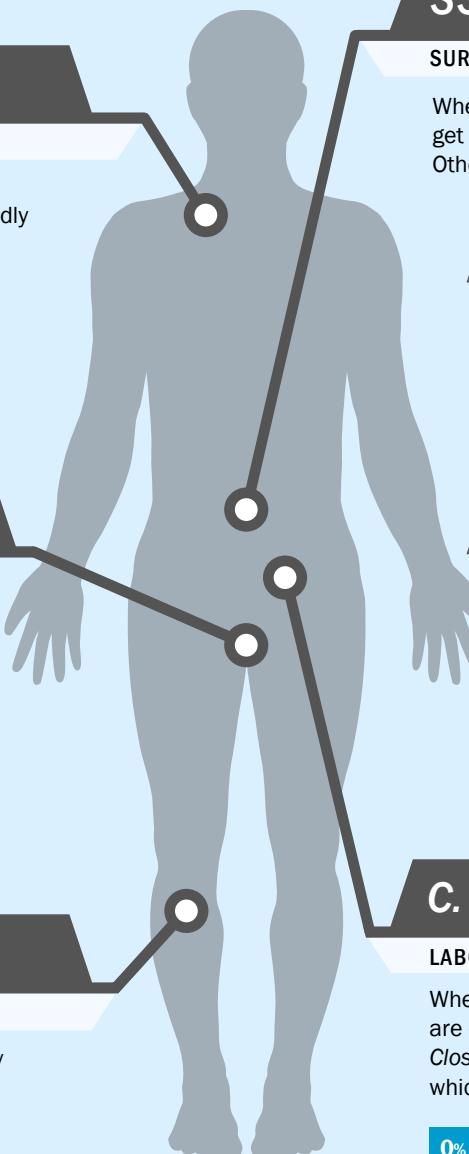
**↓ 30%**

LOWER COMPARED  
TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.



## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

#### SSI: Abdominal Hysterectomy

**↑ 28%**

HIGHER COMPARED  
TO NAT'L BASELINE

- Wyoming hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

#### SSI: Colon Surgery

**↓ 57%**

LOWER COMPARED  
TO NAT'L BASELINE

- Wyoming hospitals reported no significant change in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.92.

## *C. difficile* Infections

**↓ 19%**

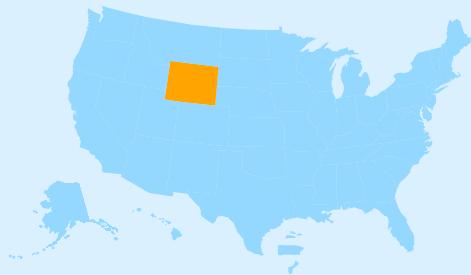
LOWER COMPARED  
TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET *C. difficile* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Among the 19 hospitals in Wyoming with enough data to calculate an SIR, 0% had an SIR significantly worse than the national SIR of 0.90.

\* Statistically significant.





**HEALTHCARE  
ASSOCIATED  
INFECTIONS  
PROGRESS**



# WYOMING

## HEALTHCARE-ASSOCIATED INFECTION (HAI)

DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

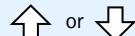
- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Wyoming: [www.health.wyo.gov/phsd/epiid/HAIgeneral.html](http://www.health.wyo.gov/phsd/epiid/HAIgeneral.html)
- Wyoming validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



### LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

| HAI TYPE   | # OF WYOMING HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013<br>Total Hospitals in State: 31 <sup>+</sup> | 2013 STATE SIR VS.<br>2012 State SIR <sup>‡</sup> | 2013 STATE SIR VS.<br>2013 Nat'l SIR | 2013 STATE SIR VS.<br>Nat'l Baseline <sup>‡</sup> | 2013 STATE SIR | 2013 NAT'L SIR |
|--|--|---|--------------------------------------|---|----------------|----------------|
| <b>CLABSI</b><br>Nat'l Baseline: 2008                      | 21   | ↑ 225%  | ↓ 2%                                 | ↓ 47%   | 0.53           | 0.54           |
| <b>CAUTI</b><br>Nat'l Baseline: 2009                       | 24   | ↓ 41%   | ↓ 50%                                | ↓ 47%   | 0.53           | 1.06           |
| <b>SSI, Abdominal Hysterectomy</b><br>Nat'l Baseline: 2008 | 13   | ↑ 85%   | ↑ 49%                                | ↑ 28%   | 1.28           | 0.86           |
| <b>SSI, Colon Surgery</b><br>Nat'l Baseline: 2008          | 12   | ↓ 66%   | ↓ 53%                                | ↓ 57%   | 0.43           | 0.92           |
| <b>MRSA Bacteremia</b><br>Nat'l Baseline: 2011             | 14   | 2012 SIR not available                            | ↓ 23%                                | ↓ 30%   | 0.70           | 0.92           |
| <b>C. difficile Infections</b><br>Nat'l Baseline: 2011     | 27   | 2012 SIR not available                            | ↓ 10%                                | ↓ 19%   | 0.81           | 0.90           |

<sup>+</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS WYOMING DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Prevention efforts to reduce specific HAIs:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Multidrug-resistant infections (MRSA, C. difficile)
- Long-term care facilities

The *National and State Healthcare-Associated Infection Progress Report* should be used by health departments, hospital associations, professional societies, healthcare systems and facilities, and quality improvement groups to identify infections that need additional prevention efforts. As identified in this report, most infections are decreasing. Despite this progress, the nation did not reach the 2013 goals established by the HAI Action Plan in 2009, and catheter-associated urinary tract infections (CAUTI) have increased since 2009.

Together with health care and public health partners, CDC is working to bring increased attention to HAI prevention and reverse the CAUTI trend. Early data from 2014 shows that these infections have started to decrease. CDC-recommended infection prevention strategies for several infection types, including CAUTI, have proven effective in a variety of patient care locations. CDC continues to assist public health and clinical partners with implementation of those recommendations. In addition, CDC is working with health departments and quality improvement groups to specifically identify and assist hospitals in need of infection prevention assistance.

State health department efforts to assess the quality and completeness of data reported to NHSN are critical to improving confidence data validity. Ongoing interactions between state and federal public health agencies and their partners in the healthcare sector will be vital to sustaining and extending HAI tracking and prevention.

CDC will continue to measure progress at the state and national levels. Prevention goals are most likely to be met with targeted efforts to cut infection types shown to be lagging behind and to make further progress on the infection types headed in the right direction. Preventing HAIs is possible, but it will take a conscious effort by clinicians, healthcare facilities and systems, public health, quality improvement groups, and the federal government to work together toward protecting patients and saving lives.

## METHODS

The current *National and State Healthcare-Associated Infections Progress Report* presents data reported to the National Healthcare Safety Network ([NHSN](#)) for the calendar year 2013. The healthcare-associated infection (HAI) data were reported either by mandate or voluntarily from hospitals in all 50 states, Washington, D.C., and Puerto Rico. Data included in the annual report use standardized NHSN definitions for central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), and laboratory identified methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia (bloodstream infections) and *Clostridium difficile* (*C. difficile*) events. To account for delayed reporting, data reported through July 1, 2014, were included.

Data in this report are from acute care and critical access hospitals only. To focus on HAIs among acute care hospital patients, data from long-term acute care facilities and rehabilitation hospitals were excluded (HAI rates for these settings are available on CDC's [NHSN website](#)). The CLABSI and CAUTI data are inclusive of data reported from all applicable locations within hospitals. CLABSI and CAUTI data stratified by location type (e.g. critical care units and wards) are available on CDC's HAI Progress Report website (see [Data Tables](#)). For this report, wards include step-down units and specialty care areas including hematology/

oncology and bone marrow transplant units. CLABSI data are also reported from neonatal intensive care units (NICUs). The national SSI data included in this report include 10 select procedures that approximate the procedures included in the Centers for Medicare & Medicaid Services (CMS) Surgical Care Improvement Project (SCIP). Only deep incisional and organ/space infections detected during the same admission as the surgical procedure or upon readmission to the same hospital that performed the surgical procedure are included in the reported SIRs; superficial incisional SSIs and those identified on post-discharge surveillance are excluded. The state-specific SSI data included in this report only include data from the two surgical procedures reported to the CMS Hospital Inpatient Quality Reporting (IQR) program – colon surgery and abdominal hysterectomy surgery. Data reported for MRSA bacteremia and *C. difficile* infections are only cases classified as hospital-onset, but community-acquired cases are reported to NHSN and are included in the risk adjustment to produce the SIR.

In addition to the NHSN data used to produce the SIRs in this report, several external data sources were used to provide additional metrics. State health department HAI programs were contacted to assess status and specific requirements of state HAI reporting mandates to NHSN, as well as efforts to validate 2013 HAI data and prevention collaboratives that occurred from January

2013 to December 2014. This report indicates the presence of a state reporting mandate by either the state health department or the hospital association. Validation efforts were classified into two categories for each HAI type: data checked for quality and additional in-depth data review. The following criteria were used to assign credit to states that performed data quality checks: state health department had access to 2013 NHSN data, performed regular data cleaning/quality checks on at least 6 months of 2013 data prior to July 1, 2014, and indicated that hospitals would be contacted if data errors, outliers, or missing information were found. A state received credit for additional in-depth data review if the state performed any type of audit of their hospitals' data prior to July 1, 2014, meaning the state health department reviewed hospital medical records and/or laboratory records to confirm proper case ascertainment and data entry into NHSN. Validation efforts should be taken into account when evaluating an individual state's performance. States that perform more vigorous data validation activities are more likely to find hospital records of infections, and therefore these states may have higher SIRs compared to states that do not perform validation. Not all state health departments have access to NHSN data or have access to NHSN data from every hospital included in this report.

This report followed the same methodology as last year's report to estimate the number of hospitals in each state. The CLABSI

and SSI SIRs continue to use a referent period of January 2006 to December 2008. The CAUTI SIRs use a referent period of calendar year 2009, and the MRSA bacteremia and *C. difficile* infection SIRs use a referent period of January 2010 to December 2011. The **risk adjustment methodology** used to produce the CLABSI, CAUTI, and SSI SIRs are summarized in previous reports and have not changed. State-specific SIRs for hospital-onset MRSA bacteremia and *C. difficile* infections are included for the first time in this report and are risk adjusted for facility bed size, affiliation with a medical school, admission prevalence rate, and laboratory identification method for *C. difficile* infections.

The SIRs published in this report compare the observed number of infections reported to NHSN during 2013 to the predicted number of infections based on infection rates during the referent period, adjusting for key risk factors. Annual progress in preventing CLABSIs, CAUTIs, SSIs, MRSA bacteremia, and *C. difficile* infections was evaluated by comparing 2012 and 2013 SIRs by infection type and location or surgical procedure category. SIRs between the two reporting years were compared for all reporting facilities in each state, and the change in SIRs was assessed for statistical significance using a mid-p exact test. For any state with a referent SIR of 0, the percent change was reflected as greater than 100 percent. A state SIR was only calculated if at least five hospitals in the state reported data for a given location category

or surgical procedure in 2013. State SIRs were compared to the national SIR with the state's data removed; significance was assessed using a mid-p exact test. Facility-specific SIRs were calculated if the facility had at least one predicted HAI for a given location category or surgical procedure. These facility-specific SIRs were used to create a distribution if at least 20 facilities had sufficient data to calculate an SIR. Additionally, the facility-specific SIRs were compared to the national SIR for each location or procedure category; if at least 10 facilities in each category had sufficient data to calculate an SIR, the percent of facilities significantly higher or lower than the national SIR was calculated both nationally and by state.

For complete data tables and a glossary of terms, please visit CDC's HAI Progress Report website at [www.cdc.gov/hai/progress-report](http://www.cdc.gov/hai/progress-report).

## REFERENCES

Centers for Medicare and Medicaid Services. Inpatient Quality Reporting Program – Healthcare-associated infections. Available at <https://www.qualitynet.org/dcs/ContentServer?c=Page&page name=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021>. Accessed December 23, 2014.

Dudeck MA, Weiner LM, Allen-Bridson K, et al. National Healthcare Safety Network (NHSN) report, data summary for 2012, Device-associated Module. *Am J Infect Control* 2013; 41(12):1148-66.

Mu Y, Edwards JR, Horan TC, et al. Improving risk-adjusted measures of surgical site infection for the National Healthcare Safety Network. *Infect Control Hosp Epidemiol* 2011; 32(10): 970-986.

Dudeck MA, Weiner LM, Malpiedi PJ, et al. Risk adjustment for healthcare-facility onset *C. difficile* and MRSA bacteremia Laboratory-Identified Event reporting in NHSN. Available at <http://www.cdc.gov/nhsn/PDFs/mrsa-cdi/RiskAdjustment-MRSA-CDI.pdf>. Accessed December 23, 2014.

Sievert DM, Ricks P, Edwards JR, et al. Antimicrobial-resistant pathogens associated with healthcare-associated infections: summary of data reported to the National Healthcare Safety Network at the Centers for Disease Control and Prevention, 2009-10. *Infection Control Hosp Epidemiol* 2013; 34(1):1-14.

Centers for Disease Control and Prevention. 2012 *National and State Healthcare-Associated Infections Progress Report*. Published March 26, 2014. Available at <http://www.cdc.gov/nhsn/dataStat.html#nr>. Accessed December 23, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for central line-associated bloodstream infections. <http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html>. Accessed December 23, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for catheter-associated urinary tract infections. <http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html>. Accessed December 23, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for surgical site infections. <http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html>. Accessed December 23, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for *C. difficile*, MRSA, and other drug-resistant infections. Available at <http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html>. Accessed December 23, 2014.

US Department of Health and Human Services. National Action Plan to Prevent Healthcare-associated Infections. Available at [http://www.health.gov/hai/prevent\\_hai.asp#hai\\_measures](http://www.health.gov/hai/prevent_hai.asp#hai_measures). Accessed December 23, 2014.

Centers for Disease Control and Prevention. NHSN validation guidance and toolkit; validation for 2013 central line-associated bloodstream infections in ICUs. Available at <http://www.cdc.gov/nhsn/validation/index.html>. Accessed December 23, 2014.

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Terms and topics from CDC's *National and State Healthcare-Associated Infections Progress Report*.

Click on the category to locate specific terms:

[Organizational Structure](#) • [Infections Reported](#)  
[Prevention Collaboratives](#) • [Calculations](#)

## ORGANIZATIONAL STRUCTURE

**Centers for Disease Control and Prevention (CDC):** Housed within **U.S. Department of Health and Human Services**, CDC is charged with protecting the public health of the Nation by providing leadership and direction in the prevention of and control of diseases and other preventable conditions, and responding to public health emergencies. CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S.

**Emerging Infections Program (EIP):** A national resource utilized for surveillance, prevention, and control of emerging infectious diseases. EIP is a network of 10 state health departments (CA, CO, CT, GA, MD, MN, NM, NY, OR, TN) and their collaborators in local health departments, academic institutions, other federal agencies, and public health and clinical laboratories; infection preventionists; and healthcare providers. The EIP population is roughly representative of the U.S. population on the basis of demographic characteristics, such as age, gender, race, and more.

**Hospital Compare:** A consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. Hospital Compare was created through the efforts of the **Centers for Medicare & Medicaid Services (CMS)**, in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other Federal agencies. Hospitals participating in the CMS quality reporting program submit healthcare-associated infection data to CDC's National Healthcare Safety Network (NHSN). NHSN shares these data with CMS for public posting on Hospital Compare, which helps consumers make informed decisions about their health care.

**National Healthcare Safety Network (NHSN):** CDC's NHSN is the nation's most widely used healthcare-associated (HAI) infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate HAIs. In addition, NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates.

## INFECTIONS REPORTED

**Catheter-associated urinary tract infection (CAUTI):** A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys. *In this report*, the CAUTI data include all infections reported to National Healthcare Safety Network from all applicable locations, including intensive care units and wards.

**Central line-associated bloodstream infection (CLABSI):** When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood. *In this report*, the CLABSI data include all infections reported to National Healthcare Safety Network from all applicable locations, including intensive care units, neonatal intensive care unit, and wards.

***Clostridium difficile* (*C. difficile*, *C. diff*):** When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *C. difficile*, bacteria that cause life-threatening diarrhea. Often, *C. difficile* infections occur in hospitalized or recently hospitalized patients. *In this report*, the *C. difficile* data include all

laboratory identified hospital-onset infections reported to National Healthcare Safety Network from all inpatient locations in the facility, with the exception of the neonatal intensive care units and well-baby locations.

**Healthcare-associated infection (HAI):** Infection patients can get while receiving medical treatment in hospitals, outpatient clinics, nursing homes, and other facilities where people receive care.

**Hospital-onset HAI:** For reporting to National Healthcare Safety Network, an infection is considered hospital-onset if the patient begins to show infection symptoms on or after the fourth day of admission.

**Laboratory identified (LabID) Event:** For reporting to National Healthcare Safety Network, an infection is considered laboratory identified when a patient sample is tested and confirmed by laboratory test only (i.e., clinical evaluation of the patient is not required).

**Methicillin-resistant *Staphylococcus aureus* (MRSA):** A type of staph bacteria that is resistant to many antibiotics. *In this report*, the MRSA data include all laboratory identified hospital-onset MRSA bacteremia (bloodstream infections) reported to National Healthcare Safety Network from all inpatient locations in the facility.

**Surgical site infection (SSI):** When germs get into an area where surgery is or was performed, patients can get a surgical site infection. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

**Implanted material:** An object or material inserted or grafted into the body, such as prosthetic joints.

## PREVENTION COLLABORATIVES

**Antibiotic resistance (antimicrobial resistance):** Antibiotic resistance is the result of bacteria changing in ways that reduce or eliminate the effectiveness of antibiotics. Antimicrobial resistance is a result of microorganisms changing in ways that reduce or eliminate the effectiveness of drugs, chemicals, or other agents used to cure or prevent infections. Antibiotic resistance is one type of antimicrobial resistance.

**Antibiotic stewardship:** Coordinated efforts and programs to improve the use of antimicrobials. For example, facilities with antibiotic stewardship programs have made a commitment to always use antibiotics appropriately and safely – only when they are needed to prevent or treat disease, and to choose the right antibiotics and to administer them in the right way in every case.

### Carbapenem-resistant Enterobacteriaceae (CRE) infections:

A family of germs that is difficult to treat because they have high levels of resistance to antibiotics. CRE infections are most commonly seen in people with exposure to healthcare settings, like hospitals and long-term care facilities.

**Hand hygiene:** The practice of cleaning hands to prevent the spread of disease-causing germs.

**Healthcare personnel influenza vaccination:** Influenza, or the flu, is a mild to severe respiratory illness caused by a virus. The contagious illness can easily spread from person to person, including from healthcare workers to patients. Vaccination is the best way to prevent getting and spreading the flu.

**Long-term care facilities (LTCF):** Nursing homes, skilled nursing facilities, and assisted living facilities (collectively known as long-term care facilities) provide a variety of services, both medical and personal care, to people who are unable to manage independently in the community.

**Multi-drug resistant organism (MDRO) infections:** An infection caused by a germ that are resistant to multiple classes of antimicrobials. In some cases, the germs have become so resistant that no available antibiotics are effective against them.

**Prevention collaboratives:** Prevention projects that consist of multiple hospitals within a state to target an infection as a team, implement prevention strategies, share experiences between facilities, measure progress as a group, and provide feedback to clinicians and staff.

**Ventilator-associated events (VAE):** A ventilator is a machine used to help a patient breathe by giving oxygen through a tube placed in a patient's mouth or nose, or through a hole in the front of the neck. An infection may occur if germs enter a patient through the tube, such as pneumonia or bacterial infections in the blood.

## CALCULATIONS

**National baseline:** Aggregated data reported to the National Healthcare Safety Network (NHSN) by all facilities during a baseline period that is used to “predict” the number of infections expected to occur in a hospital, state, or in the country. Many federal and state mandates were not enacted during the baseline time periods, and therefore not all states or facilities may have contributed to the baseline (see **State mandate**).

*In this report*, the number of predicted infections is an estimate based on infections reported to NHSN during the following time periods:

- 2006 to 2008: CLABSI and SSI
- 2009: CAUTI
- 2010 to 2011: MRSA bacteremia and *C. difficile* infections

Infection types presented have different baseline years for comparison. All healthcare-associated infections will undergo re-baseline against 2015 data for successive years.

**Statistical significance:** Term used in the context of a statistical hypothesis test to determine if a finding is unlikely to have occurred by chance alone. A statistically significant test result means it is unlikely that the two groups sampled are different simply by chance alone (suggesting that the two populations sampled are, in fact, different). *In this report*, statistical hypothesis testing is used to compare a calculated Standardized Infection Ratio value (see SIR) to the value of 1.0. A statistical significant result from this test means there is statistical evidence that the calculated SIR is different than what would be predicted from the national data. *In this report*, statistical hypothesis testing is also used to compare two SIRs to each other.

**Standardized Infection Ratio (SIR):** A summary statistic that can be used to track healthcare-associated infection (HAI) prevention progress over time; lower SIRs are better. The SIR compares

the number of infections in a facility or state to the number of infections that were “predicted” to have occurred, based on previous years of reported data (see **National baseline**). The SIR is not calculated when the number of predicted infections is less than 1. *In this report*, the SIRs compare the observed number of infections reported to National Healthcare Safety Network (NHSN) during 2013 to the predicted number of infections based on the referent period, adjusting for key risk factors.

**Risk adjustment:** A process used to level the playing field by adjusting for the differences in risk. When the data are risk-adjusted, it makes it possible to fairly compare hospital performance. *In this report*, the SIRs are adjusted for risk factors that may impact the number of infections reported by a hospital, such as type of patient care location, bed size of the hospital, patient age, and other factors.

**National 2013 SIR:** A summary statistic calculated from all reported HAIs that occurred in the country in 2013. It was calculated as the total number of observed infections in the country, divided by the total number of predicted infections in the country in 2013.

**State 2013 SIR:** A summary statistic calculated from all reported HAIs that occurred in an individual state in 2013.

It was calculated as the total number of observed infections from all hospitals in the state, divided by the total number of predicted infections in the state in 2013.

**State mandate (for data reporting):** A state legislative or regulatory requirement (enacted by the state’s government) requiring hospitals in the state to report healthcare-associated infections to the National Healthcare Safety Network.

**Validation:** Double-checking, or confirming, healthcare-associated infection (HAI) data reported to the National Healthcare Safety Network (NHSN). This generally involves an assessment to ensure all relevant infections were captured in the system. It may also involve checking the accuracy, or quality, of the submitted data. Currently, state health departments may use different methods to validate the HAI data that hospitals submit to NHSN. For example, some states only validate data from one facility while other states validate more widely. Validation efforts should be taken into account when evaluating an individual state’s performance. States that validate data or use advanced tools to detect HAIs may find and report more infections than states that do not validate.

*In this report*, state validation efforts are specified and classified into two categories for each HAI type – data checked for quality and additional in-depth data review.

**Data Quality:** State health departments may assess a hospital's overall reported HAI data for data entry errors, outliers, or missing information. This does not involve reviewing medical records.

*In this report*, the following criteria were used to assign credit to states that performed data quality checks:

- State health department had access to 2013 data from NHSN.
- State health department performed quality checks on at least 6 months of 2013 NHSN data prior to July 1, 2014.
- State health department contacted hospitals when data errors, outliers, or missing information were found.

**“Additional In-depth Data Review”:** State health departments may perform a review, or “audit”, of a hospital’s medical records to ensure the hospital reported all HAIs to NHSN. The auditing process may identify more HAIs in a hospital than originally reported. As such, states that perform data audits may have a higher SIR when compared to states that do not perform data audits. *In this report*, credit is given to states that performed any type of audit of their hospitals’ data prior to July 1, 2014.

# NATIONAL AND STATE HEALTHCARE-ASSOCIATED INFECTIONS PROGRESS REPORT

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