NATIONAL AND STATE HEALTHCARE ASSOCIATED INFECTIONS

PROGRESS REPORT

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

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

TABLE OF CONTENTS

Healthcare-associated infections 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. This *National and State Healthcare-Associated Infections Progress Report* expands and provides an update on 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. Please refer to the technical appendix for detailed statistics and references.

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 12,500 hospitals and other healthcare facilities provide data to NHSN. This vital information is then used for reporting, including for this HAI Progress Report, and for care improvement by facilities, states, regions, quality groups, and national public health agencies including CDC. The HAI Progress Report includes data from hospital wards, intensive care units and neonatal intensive care units.

The HAI Progress Report consists of national and state-by-state summaries of healthcare-associated infections. The Report helps measure progress toward the five-year HAI prevention goals outlined in the *National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination* (HAI Action Plan) set in 2009 by the U.S. Department of Health and Human Services (HHS). Progress is measured using the standardized infection ratio (SIR), a summary statistic used to track HAI prevention progress over time. The individual state progress reports include infection-specific SIRs, location-specific SIRs, and efforts states are taking to prevent HAIs. These customized reports can aid in identifying areas in need of improvement, and focusing prevention efforts nationally and within states.

Data in this report are from acute care hospitals only. National and state-level data include: central line-associated bloodstream infections, catheter-associated urinary tract infections, and surgical site infections. The report also offers a national look at hospital-onset *Clostridium difficile* (*C. difficile*) infections and hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA)

bloodstream infections. State-specific surgical site infection data are presented for colon surgery and abdominal hysterectomy surgery, two commonly reported surgeries.

The HAI Progress Report shows that significant reductions were reported in 2012 for nearly all infections. Central line-associated bloodstream infections and surgical site infections continue to approach the 5-year goals set in the HAI Action Plan. The report shows minimal decreases for both hospital-onset *C. difficile* infections and hospital-onset MRSA bloodstream infections. Catheter-associated urinary tract infections increased. This signals a need for additional prevention efforts to meet the 5-year goals for these infections.

On the national level, the report found:

- A 44 percent decrease in central line-associated bloodstream infections between 2008 and 2012
- A 20 percent decrease in infections related to the 10 surgical procedures tracked in the report between 2008 and 2012
- A 4 percent decrease in hospital-onset MRSA bloodstream infections between 2011 and 2012
- A 2 percent decrease in hospital-onset *C. difficile* infections between 2011 and 2012
- A 3 percent increase in catheter-associated urinary tract infections between 2009 and 2012

On the state level:

- None of the states performed better than the national SIR on all four infection types
- 16 states performed better than the national SIR on at least two infection types
- 2 states performed better than the national SIR on at least three infection types
- 16 states performed worse than the national SIR on at least two infection types
- 7 states performed worse than the national SIR on at least three infection types

The number of states performing better than the national SIR by infection type:

- CLABSI – 16 states
- CAUTI – 15 states
- SSI, colon – 7 states
- SSI, abdominal hysterectomy – 6 states

The number of states performing worse than the national SIR by infection type:

- CLABSI – 16 states
- CAUTI – 16 states
- SSI, colon – 14 states
- SSI, abdominal hysterectomy – 5 states

This report shows that although significant progress was made in some infection types, there is much more work to be done. Many patients are being harmed by preventable healthcare-associated infections. 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 targets stated in the HHS HAI Action Plan.

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.

STATE PROGRESS LANDSCAPE

STATE HAI PROGRESS

STATE	CLABSI				CAUTI			SSI - Colon Surgery			SSI - Abdominal Hysterectomy		
		2012 STATE SIR				2012 STATE SIR			2012 STATE SIR			2012 STATE SIR	
	# Facilities Reporting	vs. 2011 State SIR	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2009 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline
Alabama	76		↑	↓	90	↓	↓	74	↓	↓	64	↓	↓
Alaska	11		↑		12			9	↑		9		
Arkansas	49			↓	51			40			39		
Arizona	58		↑	↓	58	↑	↑	54	↑		51	↑	
California	352	↓	↓	↓	338	↓	↓	317	↓	↓	305		↓
Colorado	51	↓	↓	↓	50	↓		57		↓	56		
Connecticut	30		↑	↓	30	↑	↑	30	↑		28		
D.C.	8		↑	↓	7	↑	↑	7	↓	↓	7		
Delaware	8			↓	8			7			7		
Florida	187			↓	187	↓	↓	180	↓	↓	170		
Georgia	105	↓	↑	↓	107			99		↓	91		
Hawaii	15		↓	↓	15			13			10		
Iowa	48			↓	68			34			32		
Idaho	12		↓	↓	15			15			14	↓	
Illinois	146			↓	147			140	↓	↓	137		
Indiana	102	↑	↑	↓	104			105	↑		98	↓	↓
Kansas	46			↓	52			43			41		
Kentucky	71	↑	↑	↓	72	↑	↑	65		↓	61		
Louisiana	75		↑	↓	78	↓	↓	75	↑		81		
Massachusetts	67			↓	66	↑	↑	62		↓	61		
Maryland	47	↓		↓	38	↑	↑	10			8	↑	↑
Maine	22		↑		22	↑	↑	24	↑		21		
Michigan	95	↑	↓	↓	97			91		↓	86		
Minnesota	49			↓	51	↑	↑	49		↓	50		
Missouri	74		↓	↓	75			72	↓	↓	69		↓
Mississippi	46	↑	↑		46	↑	↑	41			43	↑	

Continued on next page

LEGEND

↓ 2012 state SIR is significantly lower than comparison group in column header

↑ 2012 state SIR is significantly higher than comparison group in column header

No arrow indicates there was not a significant change

STATE HAI PROGRESS

STATE	CLABSI				CAUTI			SSI - Colon Surgery			SSI - Abdominal Hysterectomy		
		2012 STATE SIR				2012 STATE SIR			2012 STATE SIR			2012 STATE SIR	
	# Facilities Reporting	vs. 2011 State SIR	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2009 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline	# Facilities Reporting	vs. 2012 Nat'l SIR	vs. 2008 Nat'l Baseline
Montana	12			↓	13			14		↓	14		
North Carolina	96		↓	↓	100	↑	↑	93		↓	89		↓
North Dakota	6		↓	↓	6	↓	↓	6	↑	↑	6		
Nebraska	19		↑	↓	20			20	↑		20		
New Hampshire	24			↓	23			26		↓	23		
New Jersey	72		↑	↓	72	↓	↓	71	↓	↓	66		
New Mexico	34			↓	34			27		↓	24		
Nevada	23	↓		↓	24			22	↑		19		
New York	174	↓	↑	↓	175	↑	↑	175		↓	162	↑	↑
Ohio	135		↓	↓	135	↓	↓	127		↓	123		
Oklahoma	55		↓	↓	61	↓	↓	61		↓	59		
Oregon	47		↓	↓	46	↑	↑	49		↓	46	↓	↓
Pennsylvania	175		↓	↓	190	↓	↓	162		↓	148		
Puerto Rico	18	↓	↑		18			0			0		
Rhode Island	11			↓	10	↑	↑	11	↑		11	↑	
South Carolina	65	↓	↑	↓	64	↑	↑	57	↑		54		
South Dakota	14	[illegible]	↓	[illegible]	18	↓	↓	14	[illegible]	[illegible]	14	[illegible]	[illegible]
Tennessee	94	↓		↓	95	↑	↑	90	↑		90		
Texas	277			↓	284	↓	↓	281		↓	281	↓	↓
Utah	26			↓	26	↑	↑	30	↑	↑	30		
Virginia	81	↓		↓	81	↓	↓	76		↓	67		
Vermont	7		↓	↓	5			6	↑	↑	11		
Washington	63			↓	61			62		↓	60	↓	↓
Wisconsin	78	↓	↓	↓	85	↓	↓	77		↓	71		
West Virginia	40		↓	↓	43	↓	↓	36			32		↓
Wyoming	20			↓	24			12			13		

LEGEND

↓ 2012 state SIR is significantly lower than comparison group in column header

↑ 2012 state SIR is significantly higher than comparison group in column header

No arrow indicates there was not a significant change

NATIONAL FACTSHEETS

NATIONAL

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (**HAIs**) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio** (**SIR**) is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data gives healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

NATIONAL PROGRESS OVERVIEW	NATIONAL SIR	CHANGES IN INFECTION VS. NATIONAL BASELINE
Central Line-associated Bloodstream Infections (**CLABSI**)	0.56	↓ 44%
Catheter-associated Urinary Tract Infections (**CAUTI**)	1.03	↑ 3%
Surgical Site Infections, Colon Surgery (**SSI**)	0.80	↓ 20%
Surgical Site Infections, Abdominal Hysterectomy Surgery (**SSI**)	0.89	↓ 11%
Hospital-onset *Clostridium difficile* Infections	0.98	↓ 2%
Hospital-onset MRSA Bloodstream Infections	0.96	↓ 4%*

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio** (**SIR**) is a statistic used to track healthcare-associated infection prevention progress over time. 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.

Learn how well your hospital prevents infections: **www.medicare.gov/hospitalcompare**

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE NATIONAL SIR IS:

MORE THAN 1 — There were more infections reported in the nation in 2012 compared to the national baseline data, **indicating there has been an increase in infections**.

1 — There were about the same number of infections reported in the nation in 2012 compared to the national baseline data, **indicating no progress has been made**.

LESS THAN 1 — There were fewer infections reported in the nation in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections**.

*Overall healthcare-associated invasive MRSA has decreased 31% since 2008.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NATIONAL

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (**HAIs**) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio** (**SIR**) is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN).

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

CLABSIs ↓ 44% LOWER COMPARED TO NAT'L BASELINE

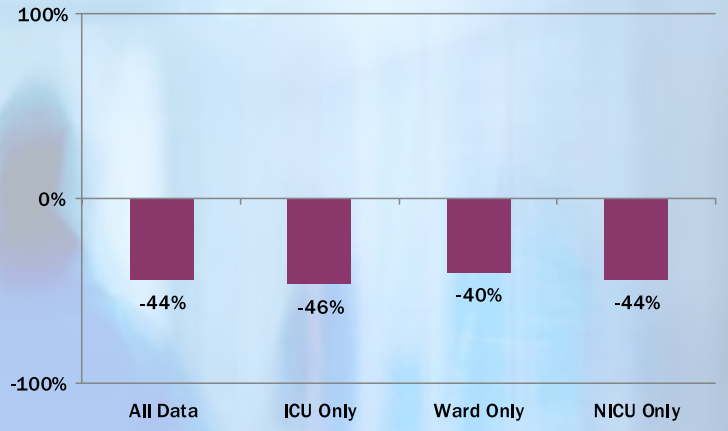
A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

US hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

3,516 hospitals across the nation reported CLABSI data in 2012.

11% **11% of hospitals have an SIR significantly worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 3% HIGHER COMPARED TO NAT'L BASELINE

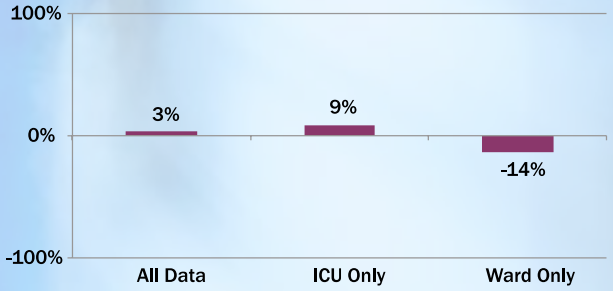
When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

US hospitals reported a significant increase in CAUTIs between 2011 and 2012.

3,597 hospitals across the nation reported CAUTI data in 2012.

13% **13% of hospitals have an SIR significantly worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



Learn how well your hospital prevents infections: **www.medicare.gov/hospitalcompare**

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NATIONAL

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (**HAIs**) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio** (**SIR**) is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN).

SURGICAL SITE INFECTIONS

SSIs: 10 COMMON SURGERIES ↓ 20% LOWER COMPARED TO NAT'L BASELINE

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

US hospitals reported a significant decrease in the number of SSIs overall between 2011 and 2012.

10% **10% of hospitals have an SIR worse than the national SIR of 0.80.**

PROCEDURE CATEGORY	# FACILITIES REPORTING	# PROCEDURES REPORTED	2012 NATIONAL SIR	PERCENT CHANGE SINCE 2008
Hip arthroplasty	1,653	232,613	0.84	16% decrease*
Knee arthroplasty	1,663	341,048	0.77	23% decrease*
Colon surgery	3,318	288,362	0.80	20% decrease*
Rectal surgery	299	5,927	0.76	24% decrease*
Abdominal hysterectomy	3,172	299,412	0.89	11% decrease*
Vaginal hysterectomy	663	29,762	0.89	11% decrease
Coronary artery bypass graft	718	106,494	0.71	29% decrease*
Other cardiac surgery	334	37,002	0.68	32% decrease*
Peripheral vascular bypass surgery	135	4,399	0.74	26% decrease*
Abdominal aortic aneurysm repair	202	1,787	0.32	68% decrease*
These 10 procedures combined	3,554	1,346,806	0.80	20% decrease*

Learn how well your hospital prevents infections:
www.medicare.gov/hospitalcompare

- 2012 HAI Progress Report: www.cdc.gov/hai/progress-report/
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**

* Statistically significant decrease since 2008

Almost all US hospitals report SSI data following colon surgeries and abdominal hysterectomy surgeries to NHSN.

SSIs: COLON SURGERY ↓ 20% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 11% LOWER COMPARED TO NAT'L BASELINE

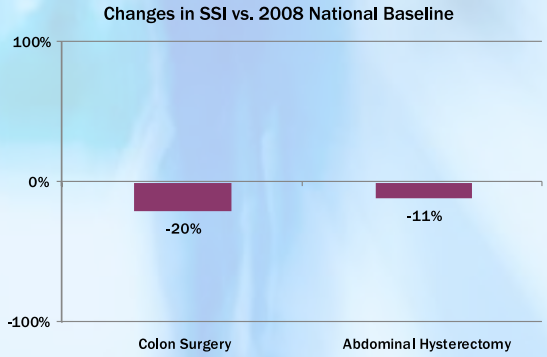
SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

US hospitals did not see a significant change in SSIs following colon surgery between 2011 and 2012.

288,362 colon surgeries were reported to NHSN in 2012.

3,318 hospitals across the nation reported SSI colon surgery data in 2012.

8% **8% of hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.**



US hospitals did not see a significant change in SSIs following abdominal hysterectomy surgery between 2011 and 2012.

299,412 abdominal hysterectomy surgeries were reported to NHSN in 2012.

3,172 hospitals across the nation reported SSI abdominal hysterectomy surgery data in 2012.

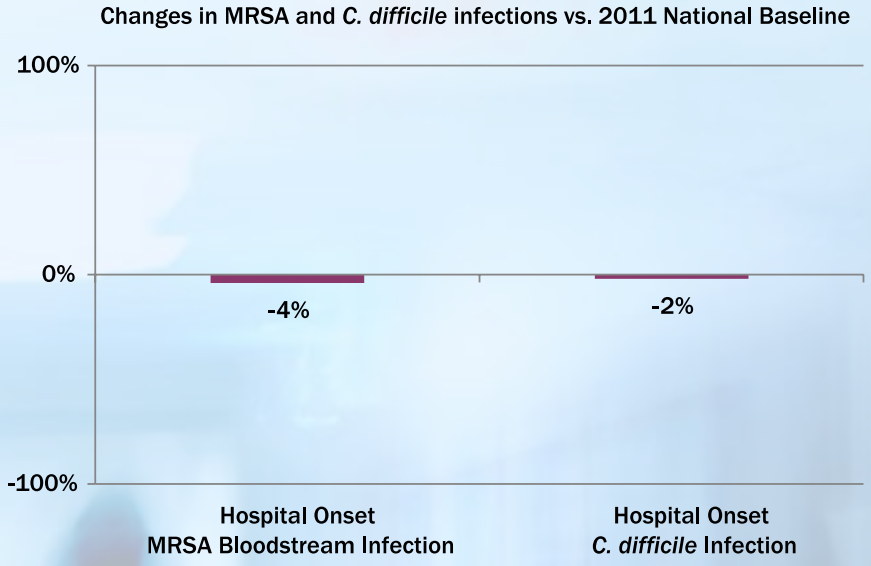
7% **7% of hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

NATIONAL

Healthcare-associated infections (**HAIs**) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio** (**SIR**) is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN).



Methicillin-resistant *Staphylococcus aureus* (MRSA) ↓ 4%* LOWER COMPARED TO NAT'L BASELINE

HOSPITAL-ONSET BLOODSTREAM INFECTIONS

MRSA is a type of staph bacteria usually spread by direct contact with an infected wound or from contaminated hands. In a healthcare setting, such as a hospital or nursing home, MRSA can cause serious bloodstream infections.

*Overall healthcare-associated invasive MRSA has decreased 31% since 2008.

1,175 hospitals across the nation reported MRSA bloodstream infection data in 2012.

8% **8% of hospitals have an SIR significantly worse than the national SIR of 0.96.**

Clostridium difficile (C.difficile) ↓ 2% LOWER COMPARED TO NAT'L BASELINE

HOSPITAL-ONSET 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 ***C. difficile***, bacteria that cause potentially deadly diarrhea. *C. difficile* is usually spread by contact with contaminated surfaces or contaminated hands.

1,681 hospitals across the nation reported *C. difficile* data in 2012.

13% **13% of hospitals have an SIR significantly worse than the national SIR of 0.98.**

Learn how well your hospital prevents infections: **www.medicare.gov/hospitalcompare**

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**

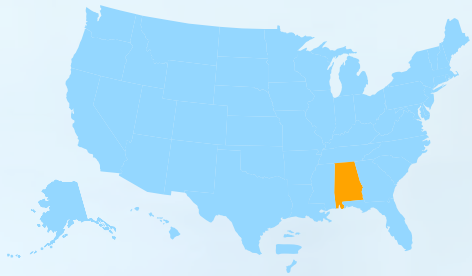
THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

STATE FACTSHEETS

ALABAMA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Alabama requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

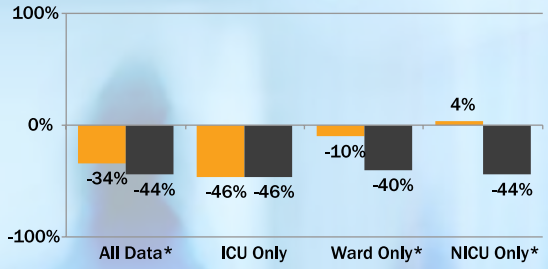
CLABSIs ↓ 34% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Alabama hospitals did not report a significant change in CLABSIs between 2011 and 2012.

11% **11% of Alabama hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

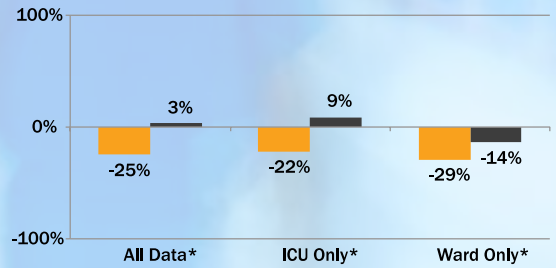
CAUTIs ↓ 25% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS ✓

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

7% **7% of Alabama hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 43% LOWER COMPARED TO NAT'L BASELINE

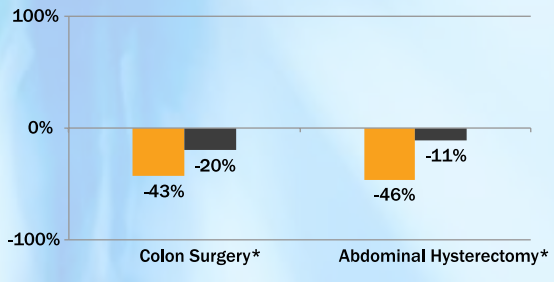
SSIs: ABDOMINAL HYSTERECTOMY ↓ 46% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

0 ZERO **0 Alabama hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



0 ZERO **0 Alabama hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ALABAMA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Alabama: **www.adph.org/hai/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS ALABAMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Alabama has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections

Alabama implemented prevention efforts to improve antibiotic stewardship and hand hygiene.

NUMBER OF ALABAMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 118+**		STATE SIR	NAT'L SIR
CLABSI 76 hospitals	Alabama's 2012 state **CLABSI** SIR is significantly worse than 2012 national SIR.	0.66	0.56
CAUTI 90 hospitals	Alabama's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.75	1.03
SSI, Colon Surgery 74 hospitals	Alabama's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.57	0.80
SSI, Abdominal Hysterectomy 64 hospitals	Alabama's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.54	0.89

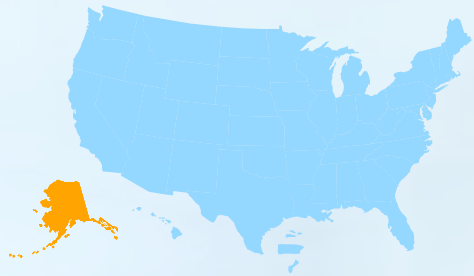
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ALASKA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Alaska requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

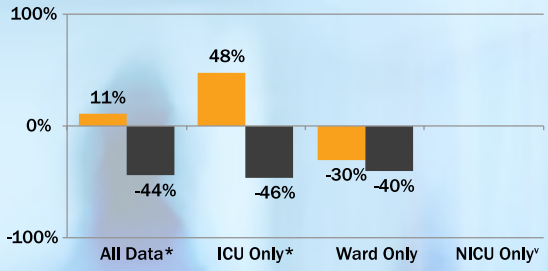
CLABSIs ⬆ 11% HIGHER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Alaska hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many Alaska hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

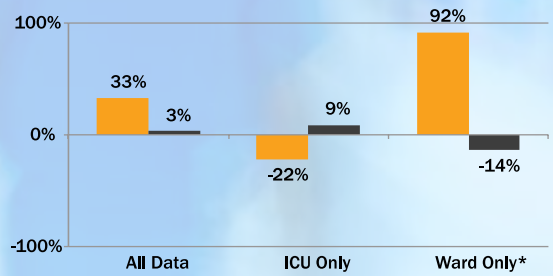
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ⬆ 33% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many Alaska hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

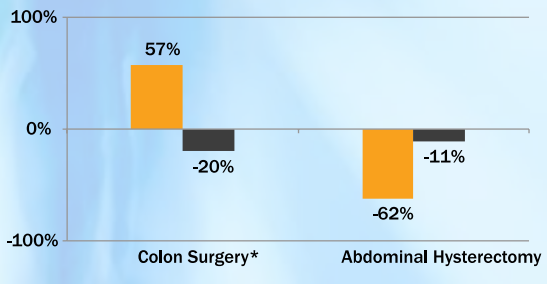
SSIs: COLON SURGERY ⬆ 57% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ⬇ 62% LOWER COMPARED TO NAT'L BASELINE

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

- **Not enough data** to report how many Alaska hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many Alaska hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ALASKA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Alaska: **www.epi.alaska.gov/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS ALASKA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Alaska has prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Catheter-associated urinary tract infections

NUMBER OF ALASKA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 26+**		STATE SIR	NAT'L SIR
CLABSI 11 hospitals	Alaska's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	**1.11**	**0.56**
CAUTI 12 hospitals	Alaska's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	**1.33**	**1.03**
SSI, Colon Surgery 9 hospitals	Alaska's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	**1.57**	**0.80**
SSI, Abdominal Hysterectomy 9 hospitals	Alaska's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	**0.38**	**0.89**

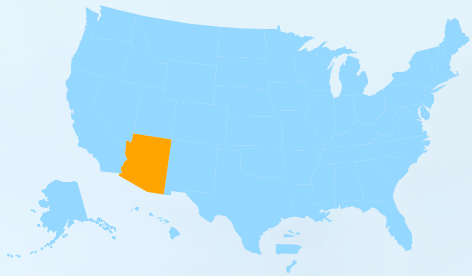
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ARIZONA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

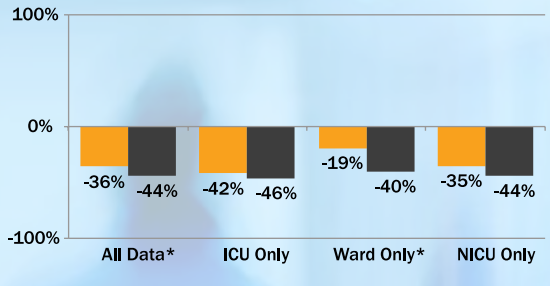
CLABSIs ↓ 36% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Arizona hospitals did not report a significant change in CLABSIs between 2011 and 2012.

11% **11% of Arizona hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

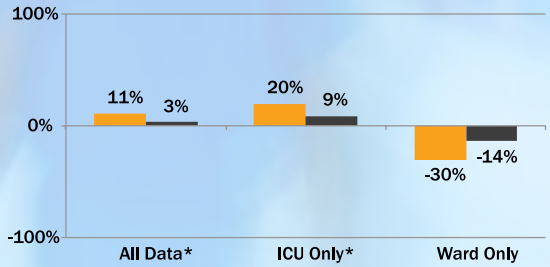
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 11% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% **11% of Arizona hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

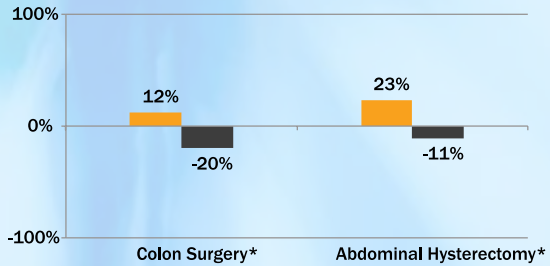
SSIs: COLON SURGERY ↑ 12% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 23% HIGHER COMPARED TO NAT'L BASELINE

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

12% **12% of Arizona hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



13% **13% of Arizona hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ARIZONA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Arizona: **www.preventHAIaz.gov**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS ARIZONA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Arizona has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections
- Multidrug-resistant organism infections

Arizona implemented prevention efforts in long-term care facilities and dialysis facilities.

NUMBER OF ARIZONA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 97+**		STATE SIR	NAT'L SIR
CLABSI 58 hospitals	Arizona's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.64	0.56
CAUTI 58 hospitals	Arizona's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.11	1.03
SSI, Colon Surgery 54 hospitals	Arizona's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.12	0.80
SSI, Abdominal Hysterectomy 51 hospitals	Arizona's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly worse than the 2012 national SIR.	1.23	0.89

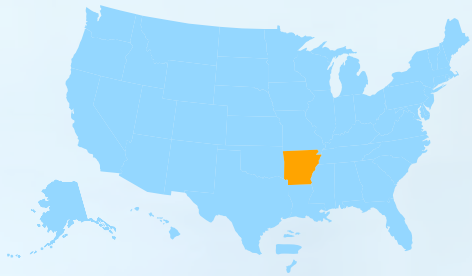
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ARKANSAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Arkansas requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

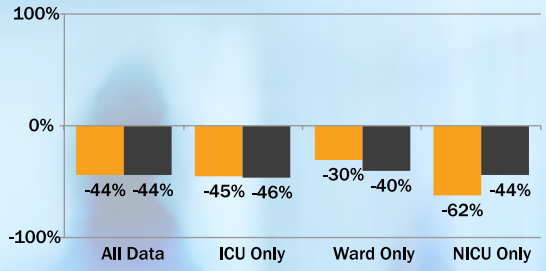
CLABSIs ↓ 44% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Arkansas hospitals did not report a significant change in CLABSIs between 2011 and 2012.

4% **4% of Arkansas hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

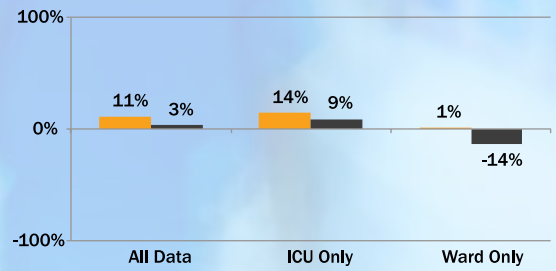
CAUTIs ↑ 11% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

13% **13% of Arkansas hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 2% LOWER COMPARED TO NAT'L BASELINE

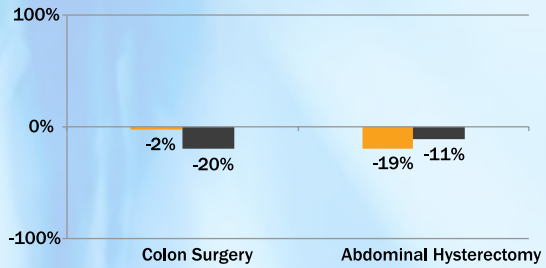
SSIs: ABDOMINAL HYSTERECTOMY ↓ 20% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

14% **14% of Arkansas hospitals have an SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Arkansas hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ARKANSAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Arkansas: **www.healthy.arkansas.gov/programsServices/epidemiology/Pages/HAI.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS ARKANSAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Arkansas has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated events

Arkansas implemented prevention efforts in dialysis facilities.

NUMBER OF ARKANSAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 87+**		STATE SIR	NAT'L SIR
CLABSI 49 hospitals	Arkansas' 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.56	0.56
CAUTI 51 hospitals	Arkansas' 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.11	1.03
SSI, Colon Surgery 40 hospitals	Arkansas' 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.98	0.80
SSI, Abdominal Hysterectomy 39 hospitals	Arkansas' 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.81	0.89

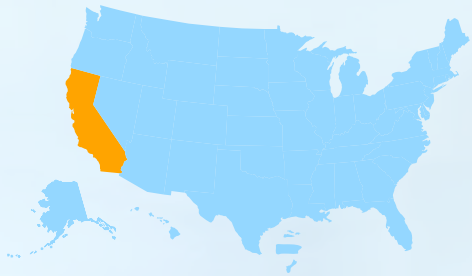
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

CALIFORNIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). California requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

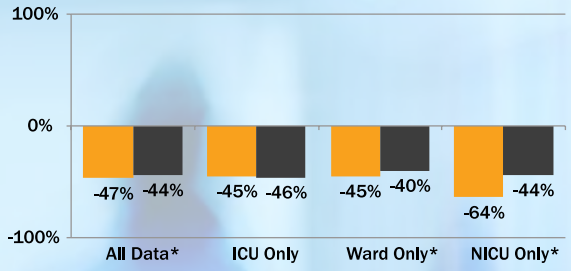
CLABSIs ↓ 47% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

California hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

12% 12% of California hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

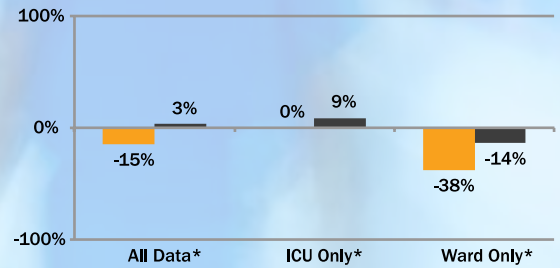
CAUTIs ↓ 15% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% 11% of California hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 30% LOWER COMPARED TO NAT'L BASELINE

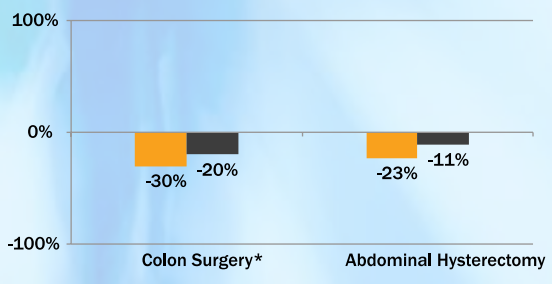
SSIs: ABDOMINAL HYSTERECTOMY ↓ 23% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY ✓

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

8% 8% of California hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



3% 3% of California hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

CALIFORNIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in California: **www.cdph.ca.gov/hai**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS CALIFORNIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

California has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Ventilator-associated pneumonia infections

California implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF CALIFORNIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 417+**		STATE SIR	NAT'L SIR
CLABSI 352 hospitals	California's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.53	0.56
CAUTI 338 hospitals	California's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.85	1.03
SSI, Colon Surgery 317 hospitals	California's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.70	0.80
SSI, Abdominal Hysterectomy 305 hospitals	California's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.77	0.89

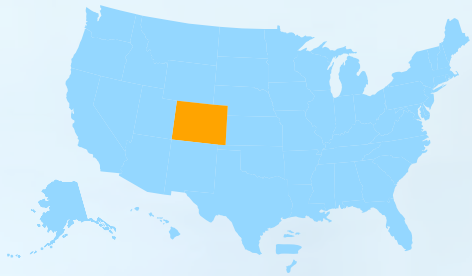
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

COLORADO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Colorado requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

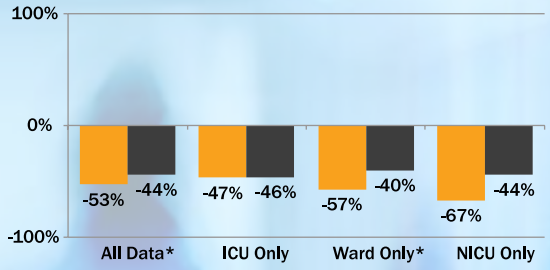
CLABSIs ↓ 53% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Colorado hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

6% **6% of Colorado hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

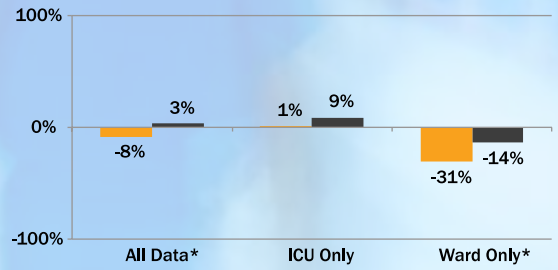
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 8% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

12% **12% of Colorado hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 26% LOWER COMPARED TO NAT'L BASELINE

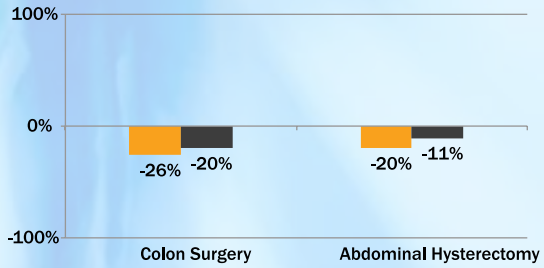
SSIs: ABDOMINAL HYSTERECTOMY ↓ 20% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

3% **3% of Colorado hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Colorado hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

COLORADO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Colorado: **www.healthfacilities.info**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS COLORADO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Colorado has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections

Colorado implemented prevention efforts in dialysis facilities, and implemented prevention efforts for hand hygiene.

NUMBER OF COLORADO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 94+**		STATE SIR	NAT'L SIR
CLABSI 51 hospitals	Colorado's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.47	0.56
CAUTI 50 hospitals	Colorado's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.92	1.03
SSI, Colon Surgery 57 hospitals	Colorado's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.74	0.80
SSI, Abdominal Hysterectomy 56 hospitals	Colorado's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.80	0.89

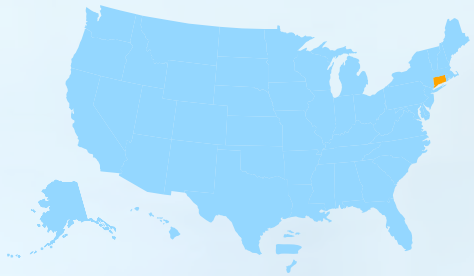
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

CONNECTICUT

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Connecticut requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

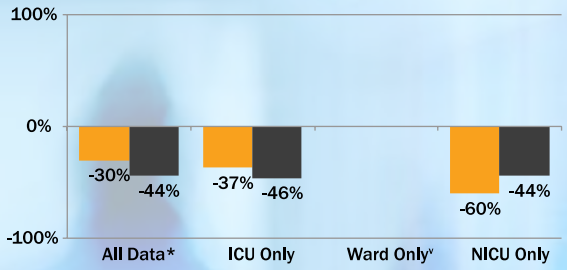
CLABSIs ↓ 30% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Connecticut hospitals did not report a significant change in CLABSIs between 2011 and 2012.

8% 8% of Connecticut hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

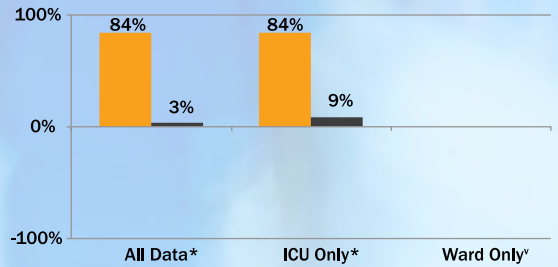
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS ✓

CAUTIs ↑ 84% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

44% 44% of Connecticut hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 1% LOWER COMPARED TO NAT'L BASELINE

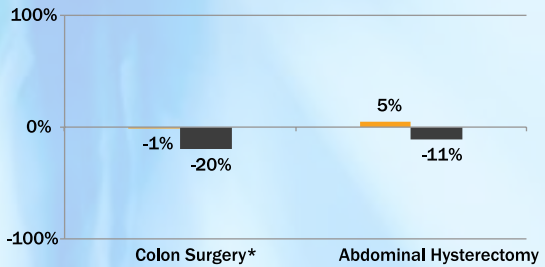
SSIs: ABDOMINAL HYSTERECTOMY ↑ 5% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY ✓

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

27% 27% of Connecticut hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



9% 9% of Connecticut hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

CONNECTICUT

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Connecticut: **www.ct.gov/dph/cwp/view.asp?a=3136&q=417318**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS CONNECTICUT DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Connecticut has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Connecticut implemented prevention efforts in long-term care facilities and dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF CONNECTICUT HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 41+**		STATE SIR	NAT'L SIR
CLABSI 30 hospitals	Connecticut's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.70	0.56
CAUTI 30 hospitals	Connecticut's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.84	1.03
SSI, Colon Surgery 30 hospitals	Connecticut's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	0.99	0.80
SSI, Abdominal Hysterectomy 28 hospitals	Connecticut's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.05	0.89

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

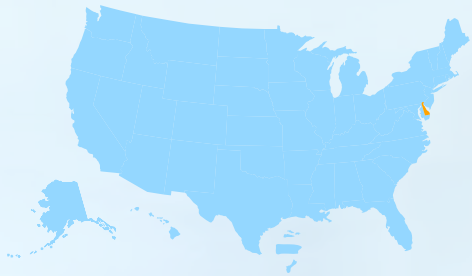
THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

HEALTHCARE ASSOCIATED INFECTIONS

PROGRESS

DELAWARE

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Delaware requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

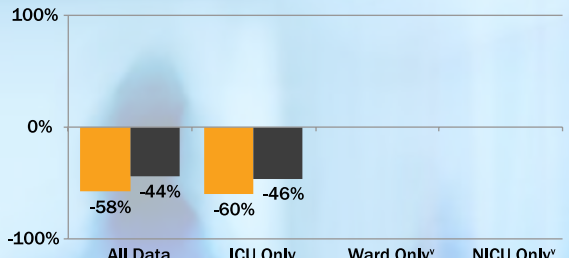
CLABSIs ⬇ 58% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Delaware hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many Delaware hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

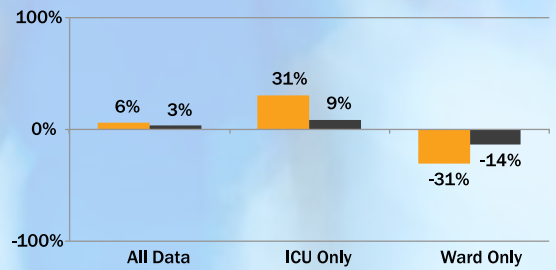
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

CAUTIs ⬆ 6% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many Delaware hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ⬇ 33% LOWER COMPARED TO NAT'L BASELINE

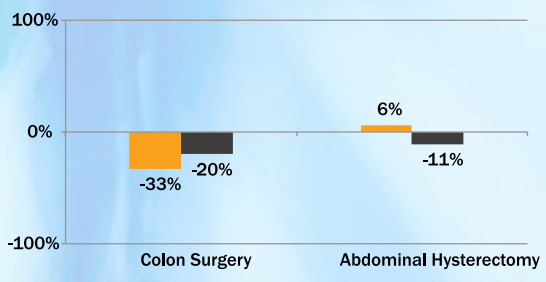
SSIs: ABDOMINAL HYSTERECTOMY ⬆ 6% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

- **Not enough data** to report how many Delaware hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many Delaware hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

DELAWARE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Delaware: **dhss.delaware.gov/dph/epi/delawarehai.html**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS DELAWARE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Delaware has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

Delaware implemented prevention efforts in long-term care facilities and dialysis facilities.

NUMBER OF DELAWARE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 13+**		STATE SIR	NAT'L SIR
CLABSI 8 hospitals	Delaware's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.42	0.56
CAUTI 8 hospitals	Delaware's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.06	1.03
SSI, Colon Surgery 7 hospitals	Delaware's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.67	0.80
SSI, Abdominal Hysterectomy 7 hospitals	Delaware's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.06	0.89

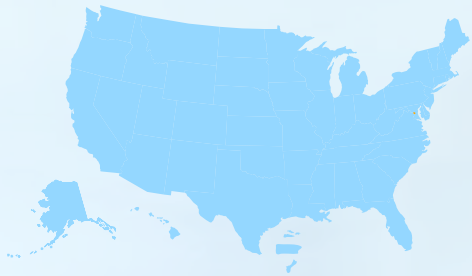
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

DISTRICT OF COLUMBIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). District of Columbia requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

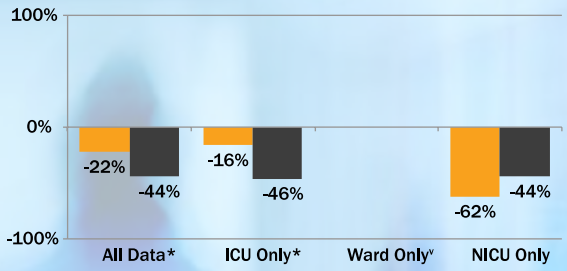
CLABSIs ↓ 22% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

District of Columbia hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many District of Columbia hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

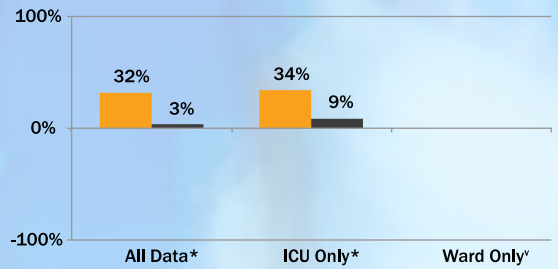
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 32% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many District of Columbia hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

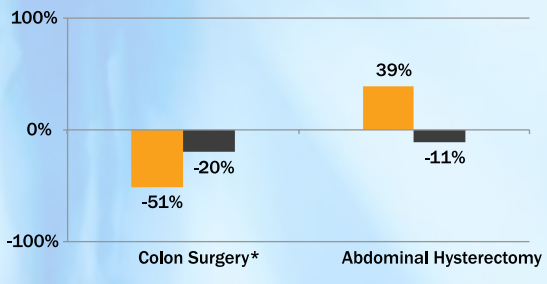
SSIs: COLON SURGERY ↓ 51% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 39% HIGHER COMPARED TO NAT'L BASELINE

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

- **Not enough data** to report how many District of Columbia hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many District of Columbia hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

DISTRICT OF COLUMBIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

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

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in District of Columbia: **doh.dc.gov/page/healthcare-associated-infections/**

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

District of Columbia has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections

NUMBER OF DISTRICT OF COLUMBIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 12+**		STATE SIR	NAT'L SIR
CLABSI 8 hospitals	District of Columbia's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.78	0.56
CAUTI 7 hospitals	District of Columbia's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.32	1.03
SSI, Colon Surgery 7 hospitals	District of Columbia's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.49	0.80
SSI, Abdominal Hysterectomy 7 hospitals	District of Columbia's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.39	0.89

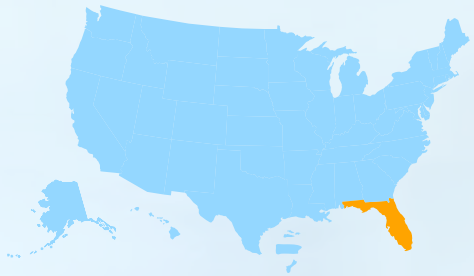
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

FLORIDA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

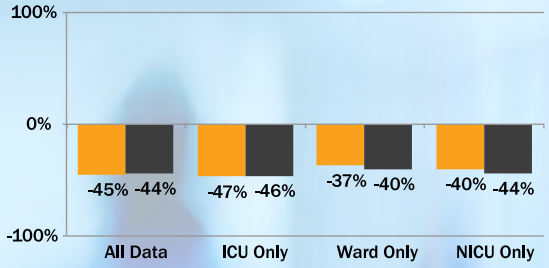
CLABSIs ↓ 45% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Florida hospitals did not report a significant change in CLABSIs between 2011 and 2012.

13% 13% of Florida hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

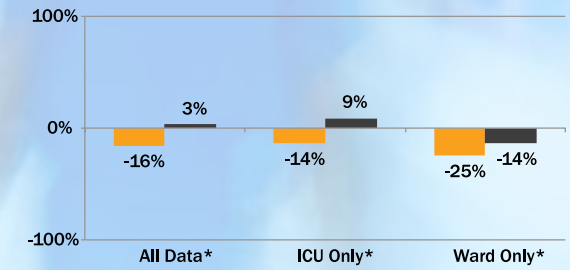
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 16% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

9% 9% of Florida hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

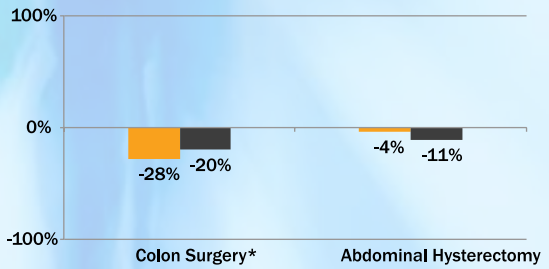
SSIs: COLON SURGERY ↓ 28% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 4% LOWER COMPARED TO NAT'L BASELINE

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

7% 7% of Florida hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



10% 10% of Florida hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

FLORIDA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Florida: **www.floridahealth.gov/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS FLORIDA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Florida has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections
- Ventilator-associated events

Florida implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF FLORIDA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 237+**		STATE SIR	NAT'L SIR
CLABSI 187 hospitals	Florida's 2012 state **CLABSI** SIR similar to the 2012 national SIR.	0.55	0.56
CAUTI 187 hospitals	Florida's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.84	1.03
SSI, Colon Surgery 180 hospitals	Florida's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.72	0.80
SSI, Abdominal Hysterectomy 170 hospitals	Florida's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.96	0.89

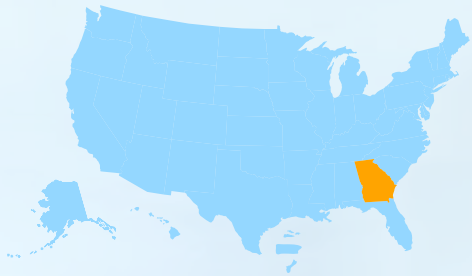
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

GEORGIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Georgia requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

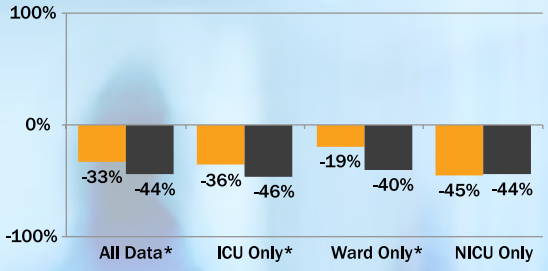
CLABSIs ↓ 33% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Georgia hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

18% 18% of Georgia hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

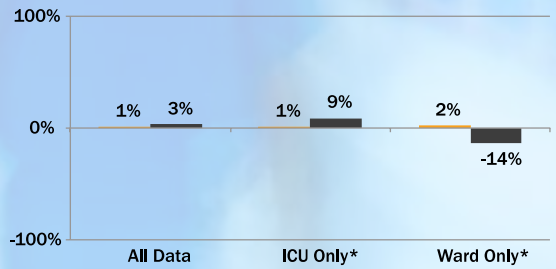
CAUTIs ↑ 1% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% 11% of Georgia hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 17% LOWER COMPARED TO NAT'L BASELINE

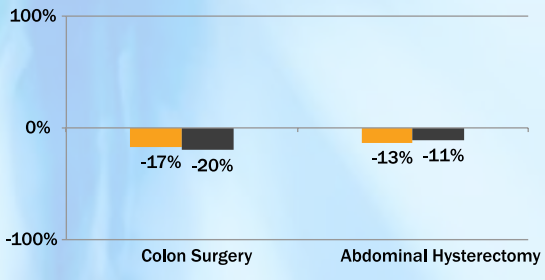
SSIs: ABDOMINAL HYSTERECTOMY ↓ 13% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

11% 11% of Georgia hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



3% 3% of Georgia hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

GEORGIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Georgia: **dph.georgia.gov/healthcare-associated-infections**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS GEORGIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Georgia has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections

Georgia implemented prevention efforts in long-term care facilities and dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF GEORGIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 166+**		STATE SIR	NAT'L SIR
CLABSI 105 hospitals	Georgia's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.67	0.56
CAUTI 107 hospitals	Georgia's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.01	1.03
SSI, Colon Surgery 99 hospitals	Georgia's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.83	0.80
SSI, Abdominal Hysterectomy 91 hospitals	Georgia's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.87	0.89

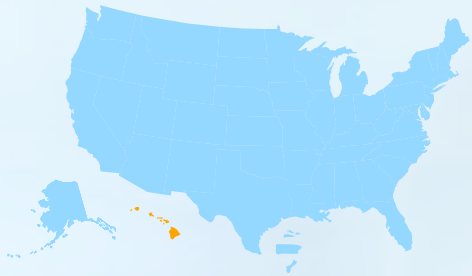
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

HAWAII

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Hawaii requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

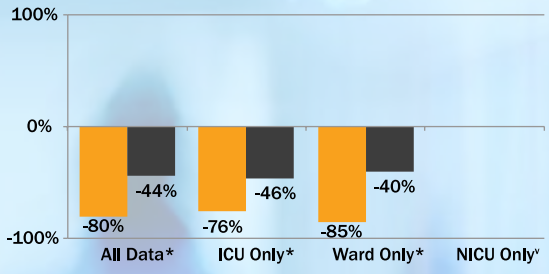
CLABSIs ↓ 80% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Hawaii hospitals did not report a significant change in CLABSIs between 2011 and 2012.

8% **8% of Hawaii hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

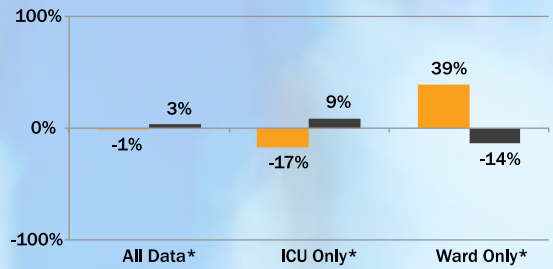
CAUTIs ↓ 1% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

15% **15% of Hawaii hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 3% LOWER COMPARED TO NAT'L BASELINE

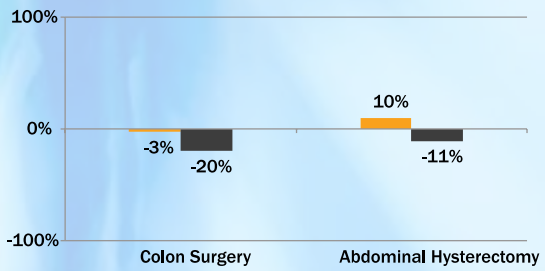
SSIs: ABDOMINAL HYSTERECTOMY ↑ 10% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

Not enough data to report how many Hawaii hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Hawaii hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

HAWAII

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Hawaii: **health.hawaii.gov/docd/dib/healthcare-associated-infections-hais/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS HAWAII DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Hawaii has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Catheter-associated urinary tract infections
- Surgical site infections
- MRSA infections

Hawaii implemented prevention efforts to improve antibiotic stewardship and hand hygiene.

NUMBER OF HAWAII HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 27+**		STATE SIR	NAT'L SIR
CLABSI 15 hospitals	Hawaii's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.20	0.56
CAUTI 15 hospitals	Hawaii's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.99	1.03
SSI, Colon Surgery 13 hospitals	Hawaii's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.97	0.80
SSI, Abdominal Hysterectomy 10 hospitals	Hawaii's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.10	0.89

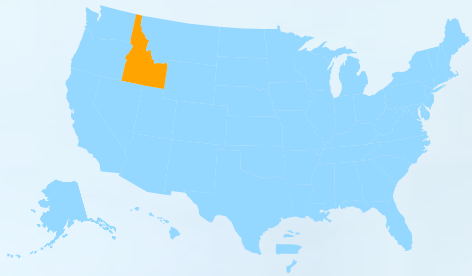
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

IDAHO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

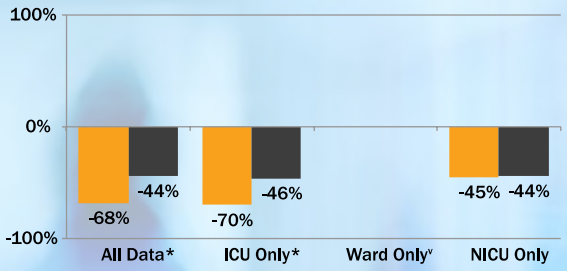
CLABSIs ⬇ 68% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Idaho hospitals did not report a significant change in CLABSIs between 2011 and 2012.

Not enough data to report how many Idaho hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

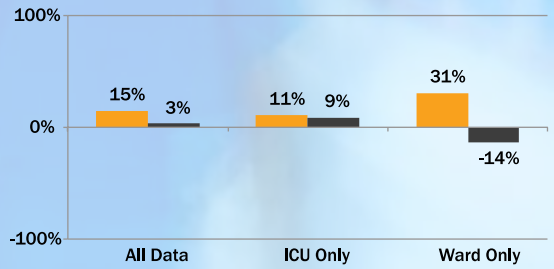
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ⬆ 15% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

22% **22% of Idaho hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY ✓

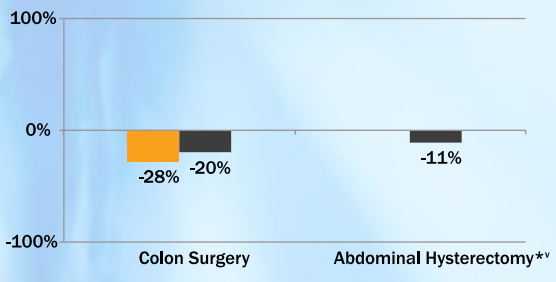
SSIs: COLON SURGERY ⬇ 28% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY 0 INFECTIONS IN 2012

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

Not enough data to report how many Idaho hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



0 ZERO **Idaho hospitals reported 0 abdominal hysterectomy SSIs to NHSN in 2012.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

IDAHO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Idaho: **healthandwelfare.idaho.gov/Health/tabid/60/Default.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS IDAHO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Idaho has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Idaho implemented prevention efforts to improve antibiotic stewardship and hand hygiene.

NUMBER OF IDAHO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 47+**		STATE SIR	NAT'L SIR
CLABSI 12 hospitals	Idaho's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.32	0.56
CAUTI 15 hospitals	Idaho's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.15	1.03
SSI, Colon Surgery 15 hospitals	Idaho's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.72	0.80
SSI, Abdominal Hysterectomy 14 hospitals	Idaho's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.00	0.89

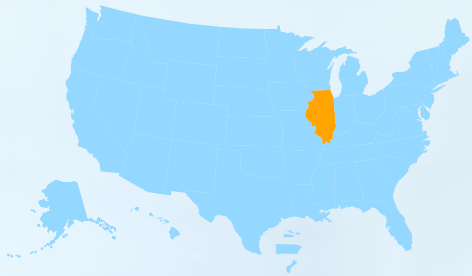
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ILLINOIS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Illinois requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

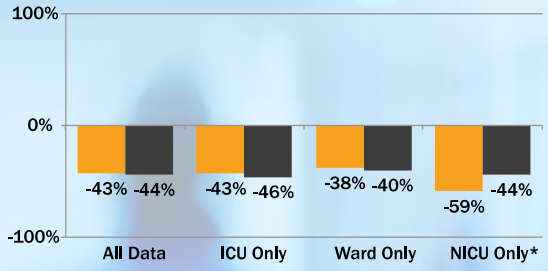
CLABSIs ↓ 43% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Illinois hospitals did not report a significant change in CLABSIs between 2011 and 2012.

10% 10% of Illinois hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

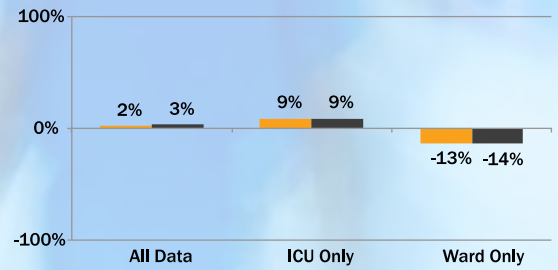
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 2% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

13% 13% of Illinois hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

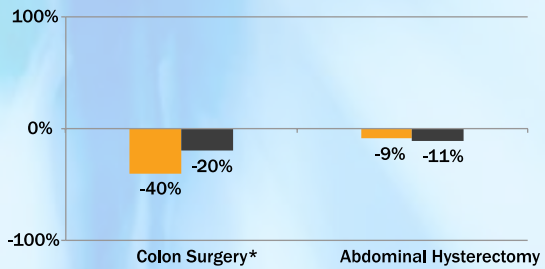
SSIs: COLON SURGERY ↓ 40% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 9% LOWER COMPARED TO NAT'L BASELINE

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

3% 3% of Illinois hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



9% 9% of Illinois hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

ILLINOIS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Illinois: **www.healthcarereportcard.illinois.gov**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS ILLINOIS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Illinois has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Multidrug-resistant organism infections
- Ventilator-associated events

Illinois implemented prevention efforts in long-term acute care hospitals and nursing homes, and to improve antibiotic stewardship.

NUMBER OF ILLINOIS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 207+**		STATE SIR	NAT'L SIR
CLABSI 146 hospitals	Illinois' 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.57	0.56
CAUTI 147 hospitals	Illinois' 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.02	1.03
SSI, Colon Surgery 140 hospitals	Illinois' 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.60	0.80
SSI, Abdominal Hysterectomy 137 hospitals	Illinois' 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.91	0.89

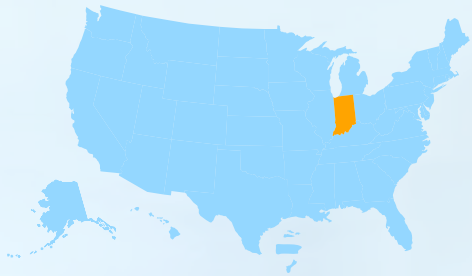
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

INDIANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Indiana requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

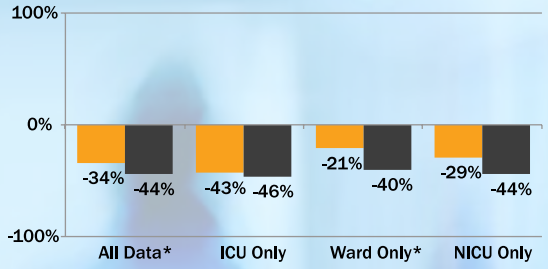
CLABSIs ↓ 34% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Indiana hospitals reported a significant increase in CLABSIs between 2011 and 2012.

11% 11% of Indiana hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

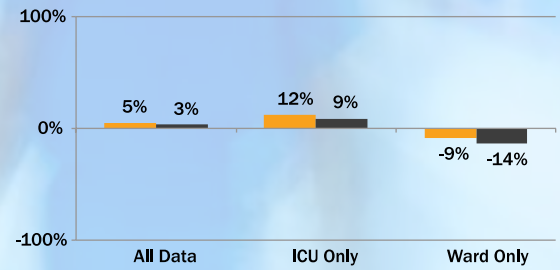
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

CAUTIs ↑ 5% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

6% 6% of Indiana hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↑ 4% HIGHER COMPARED TO NAT'L BASELINE

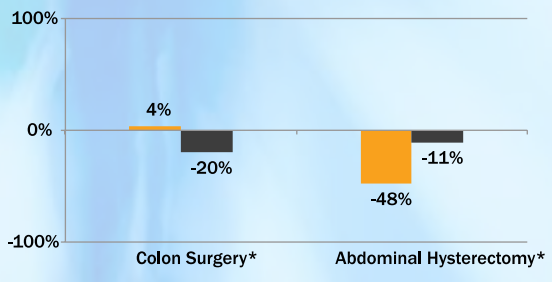
SSIs: ABDOMINAL HYSTERECTOMY ↓ 48% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

10% 10% of Indiana hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



6% 6% of Indiana hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

INDIANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Indiana: **www.in.gov/isdh/24769.htm**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS INDIANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Indiana has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections

Indiana implemented prevention efforts in nursing homes.

NUMBER OF INDIANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 148+**		STATE SIR	NAT'L SIR
CLABSI 102 hospitals	Indiana's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.66	0.56
CAUTI 104 hospitals	Indiana's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.05	1.03
SSI, Colon Surgery 105 hospitals	Indiana's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.04	0.80
SSI, Abdominal Hysterectomy 98 hospitals	Indiana's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.52	0.89

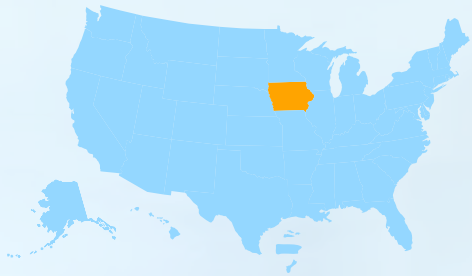
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

IOWA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

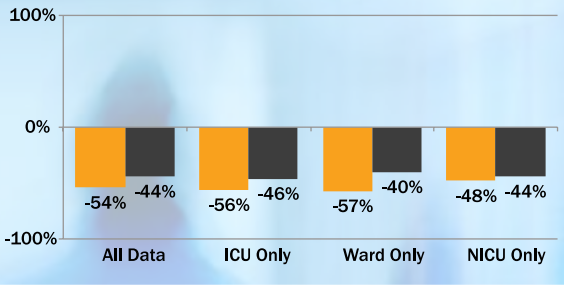
CLABSIs ↓ 54% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Iowa hospitals did not report a significant change in CLABSIs between 2011 and 2012.

0 ZERO **0 Iowa hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

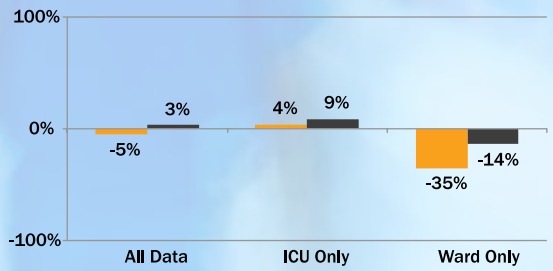
CAUTIs ↓ 5% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

6% 6% of Iowa hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 1% LOWER COMPARED TO NAT'L BASELINE

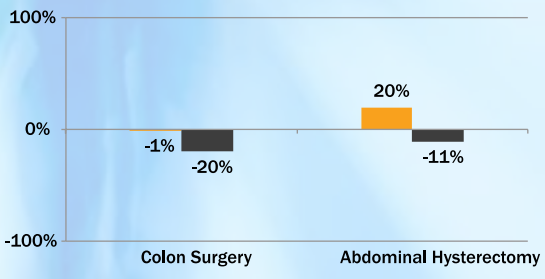
SSIs: ABDOMINAL HYSTERECTOMY ↑ 20% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

5% 5% of Iowa hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Iowa hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

IOWA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Iowa: **www.idph.state.ia.us/hai_prevention/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS IOWA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Iowa has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections

Iowa implemented prevention efforts in nursing homes and dialysis facilities and to improve antibiotic stewardship.

NUMBER OF IOWA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 122+**		STATE SIR	NAT'L SIR
CLABSI 48 hospitals	Iowa's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.46	0.56
CAUTI 68 hospitals	Iowa's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.95	1.03
SSI, Colon Surgery 34 hospitals	Iowa's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.99	0.80
SSI, Abdominal Hysterectomy 32 hospitals	Iowa's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.20	0.89

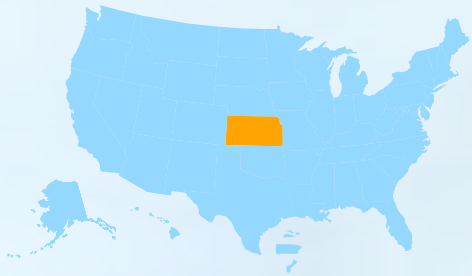
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

KANSAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

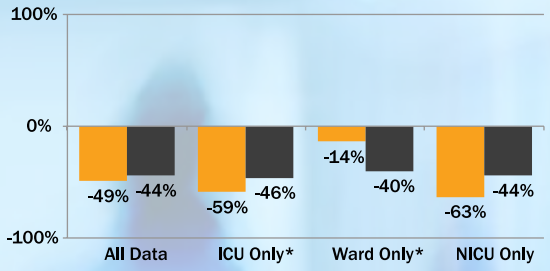
CLABSIs ↓ 49% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Kansas hospitals did not report a significant change in CLABSIs between 2011 and 2012.

11% **11% of Kansas hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

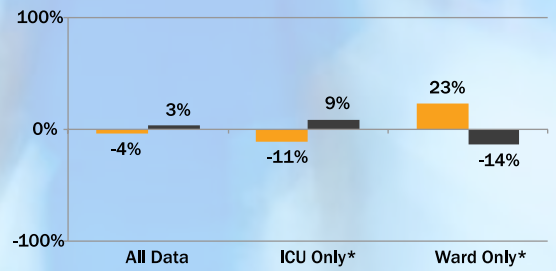
CAUTIs ↓ 4% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

12% **12% of Kansas hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 6% LOWER COMPARED TO NAT'L BASELINE

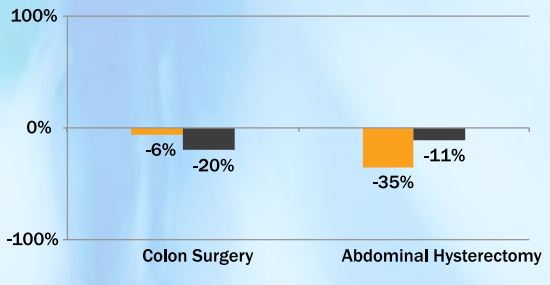
SSIs: ABDOMINAL HYSTERECTOMY ↓ 35% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

5% **5% of Kansas hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Kansas hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

KANSAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Kansas: **www.kdheks.gov/epi/hai.htm**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS KANSAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Kansas has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- Multidrug-resistant organism infections
- MRSA infections

Kansas implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF KANSAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 149+**		STATE SIR	NAT'L SIR
CLABSI 46 hospitals	Kansas 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.51	0.56
CAUTI 52 hospitals	Kansas 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.96	1.03
SSI, Colon Surgery 43 hospitals	Kansas 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.94	0.80
SSI, Abdominal Hysterectomy 41 hospitals	Kansas 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.65	0.89

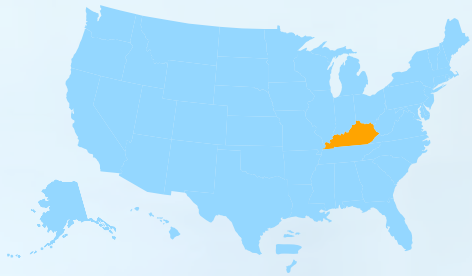
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

KENTUCKY

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

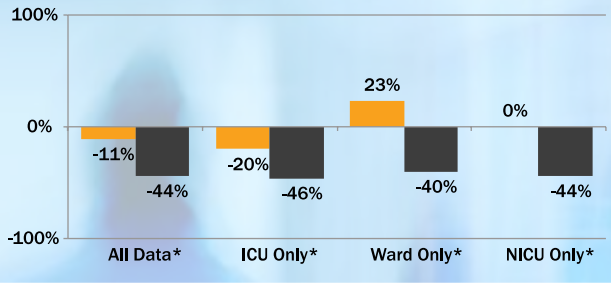
CLABSIs ↓ 11% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Kentucky hospitals reported a significant increase in CLABSIs between 2011 and 2012.

16% **16% of Kentucky hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

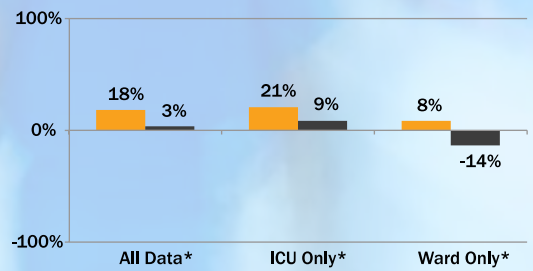
CAUTIs ↑ 18% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

18% **18% of Kentucky hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 21% LOWER COMPARED TO NAT'L BASELINE

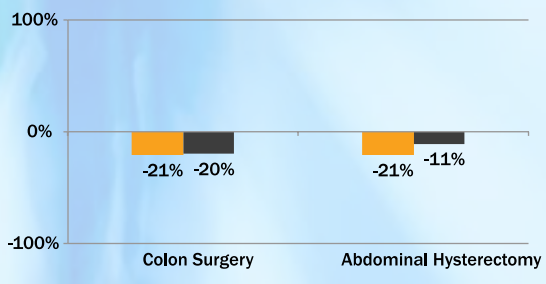
SSIs: ABDOMINAL HYSTERECTOMY ↓ 21% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

12% **12% of Kentucky hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



8% **8% of Kentucky hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

KENTUCKY

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Kentucky: **chfs.ky.gov/dph/epi/hai**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS KENTUCKY DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Kentucky has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- *Clostridium difficile*, deadly diarrheal infections

Kentucky implemented prevention efforts in nursing homes and to improve antibiotic stewardship.

NUMBER OF KENTUCKY HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 116+**		STATE SIR	NAT'L SIR
CLABSI 71 hospitals	Kentucky's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.89	0.56
CAUTI 72 hospitals	Kentucky's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.18	1.03
SSI, Colon Surgery 65 hospitals	Kentucky's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.79	0.80
SSI, Abdominal Hysterectomy 61 hospitals	Kentucky's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.79	0.89

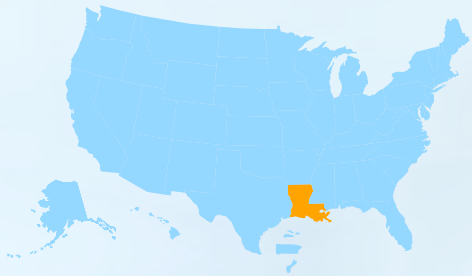
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

LOUISIANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

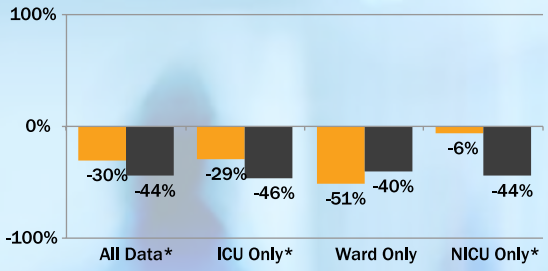
CLABSIs ↓ 30% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Louisiana hospitals did not report a significant change in CLABSIs between 2011 and 2012.

16% **16% of Louisiana hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

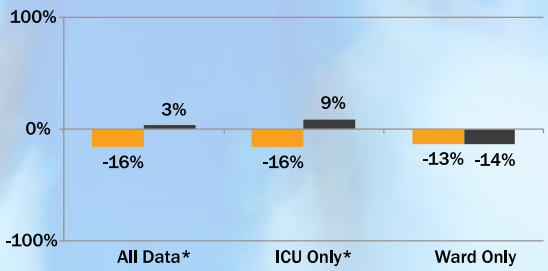
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

CAUTIs ↓ 16% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

10% **10% of Louisiana hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 1% LOWER COMPARED TO NAT'L BASELINE

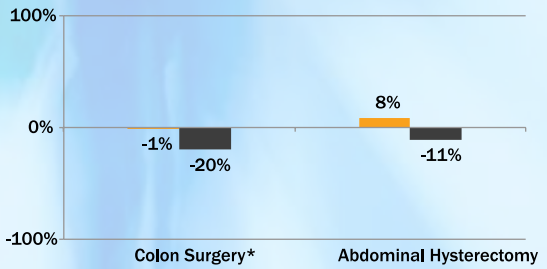
SSIs: ABDOMINAL HYSTERECTOMY ↑ 8% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

12% **12% of Louisiana hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



10% **10% of Louisiana hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

LOUISIANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Louisiana: **new.dhh.louisiana.gov/index.cfm/page/824**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS LOUISIANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Louisiana has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

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

NUMBER OF LOUISIANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 172+**		STATE SIR	NAT'L SIR
CLABSI 75 hospitals	Louisiana's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.70	0.56
CAUTI 78 hospitals	Louisiana's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.84	1.03
SSI, Colon Surgery 75 hospitals	Louisiana's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	0.99	0.80
SSI, Abdominal Hysterectomy 81 hospitals	Louisiana's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.08	0.89

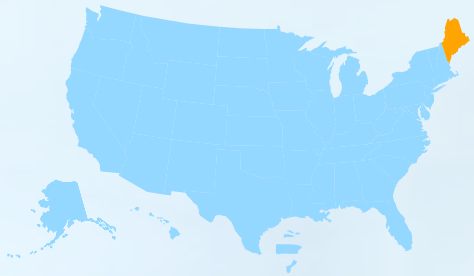
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MAINE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Maine requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

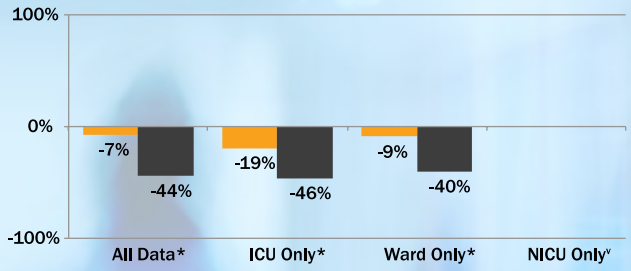
CLABSIs ↓ 7% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Maine hospitals did not report a significant change in CLABSIs between 2011 and 2012.

■ **Not enough data** to report how many Maine hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

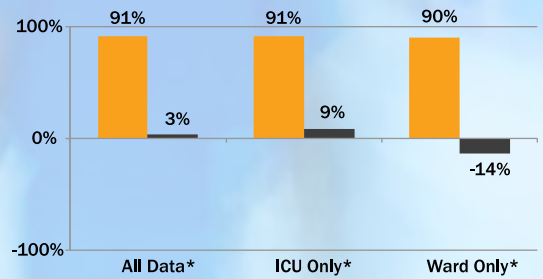
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 91% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

31% **31% of Maine hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

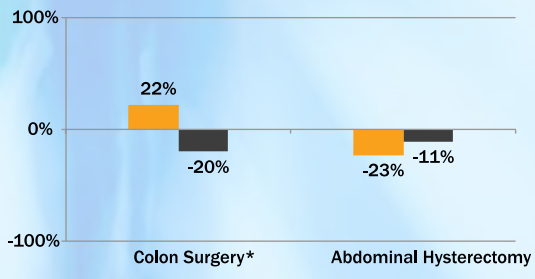
SSIs: COLON SURGERY ↑ 22% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 24% LOWER COMPARED TO NAT'L BASELINE

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

■ **Not enough data** to report how many Maine hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



■ **Not enough data** to report how many Maine hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MAINE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Maine: **www.maine.gov/dhhs/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MAINE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Maine has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Maine implemented prevention efforts to improve antibiotic stewardship and hand hygiene.

NUMBER OF MAINE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 41+**		STATE SIR	NAT'L SIR
CLABSI 22 hospitals	Maine's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.93	0.56
CAUTI 22 hospitals	Maine's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.91	1.03
SSI, Colon Surgery 24 hospitals	Maine's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.22	0.80
SSI, Abdominal Hysterectomy 21 hospitals	Maine's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.77	0.89

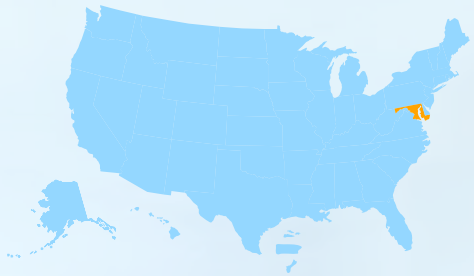
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MARYLAND

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Maryland requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

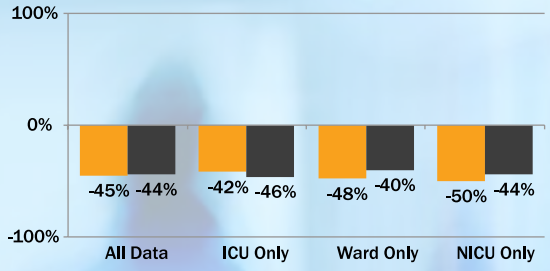
CLABSIs ↓ 45% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Maryland hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

10% **10% of Maryland hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

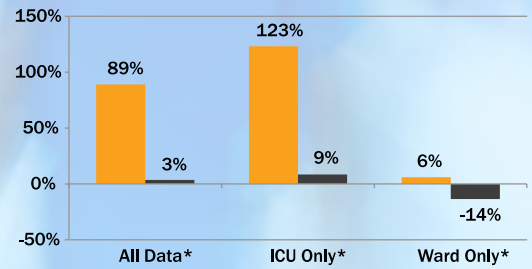
CAUTIs ↑ 89% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

18% **18% of Maryland hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 13% LOWER COMPARED TO NAT'L BASELINE

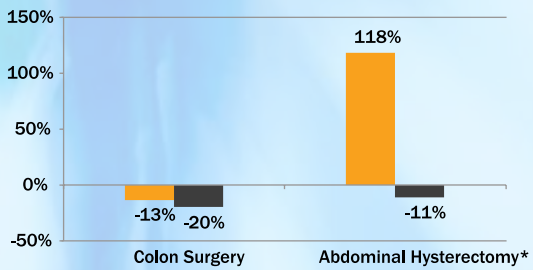
SSIs: ABDOMINAL HYSTERECTOMY ↑ 118% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

Not enough data to report how many Maryland hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Maryland hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MARYLAND

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Maryland: **mhcc.maryland.gov/consumerinfo/hospitalguide/hospital_guide/reports/healthcare_associated_infections/index.asp**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MARYLAND DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Maryland has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- Multidrug-resistant organism infections
- Ventilator-associated events

Maryland implemented prevention efforts in nursing homes, and to improve antibiotic stewardship and hand hygiene.

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

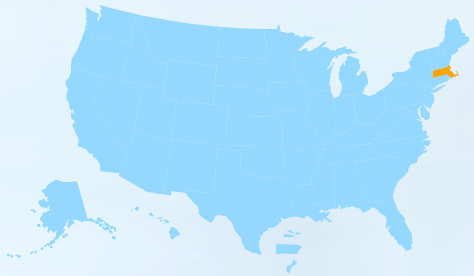
NUMBER OF MARYLAND HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 59+**		STATE SIR	NAT'L SIR
CLABSI 47 hospitals	Maryland's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.55	0.56
CAUTI 38 hospitals	Maryland's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.89	1.03
SSI, Colon Surgery 10 hospitals	Maryland's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.87	0.80
SSI, Abdominal Hysterectomy 8 hospitals	Maryland's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly worse than the 2012 national SIR.	2.18	0.89

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MASSACHUSETTS

HEALTHCARE ASSOCIATED INFECTIONS **PROGRESS**

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Massachusetts requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

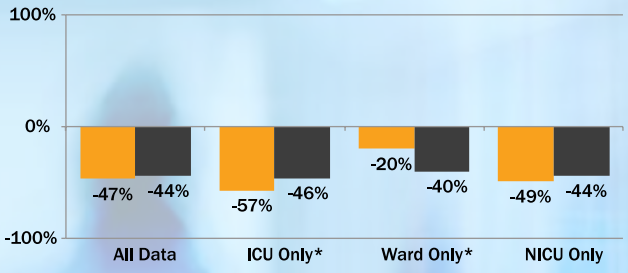
CLABSIs ↓ 47% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Massachusetts hospitals did not report a significant change in CLABSIs between 2011 and 2012.

7% **7% of Massachusetts hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

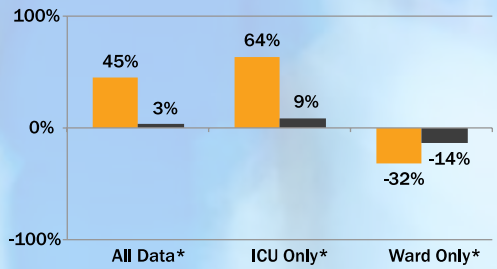
CAUTIs ↑ 45% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

15% **15% of Massachusetts hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 19% LOWER COMPARED TO NAT'L BASELINE

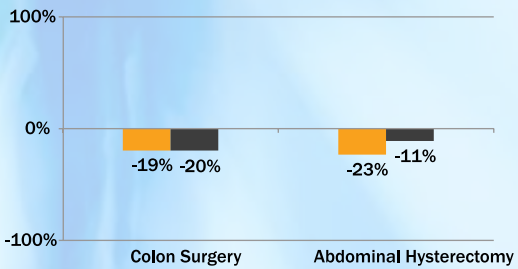
Q SSIs: ABDOMINAL HYSTERECTOMY ↓ 23% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

10% **10% of Massachusetts hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



8% **8% of Massachusetts hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MASSACHUSETTS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Massachusetts: **www.mass.gov/eohhs/gov/departments/dph/programs/hcq/healthcare-quality/health-care-facilities/hospitals/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MASSACHUSETTS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Massachusetts has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated pneumonia infections

Massachusetts implemented prevention efforts in long-term care facilities and dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF MASSACHUSETTS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 95+**		STATE SIR	NAT'L SIR
CLABSI 67 hospitals	Massachusetts' 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.53	0.56
CAUTI 66 hospitals	Massachusetts' 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.45	1.03
SSI, Colon Surgery 62 hospitals	Massachusetts' 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.81	0.80
SSI, Abdominal Hysterectomy 61 hospitals	Massachusetts' 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.77	0.89

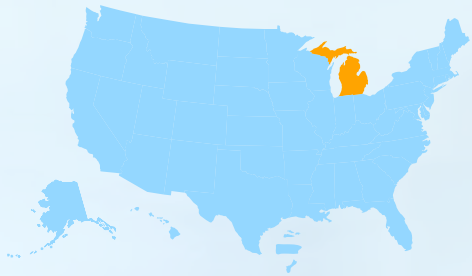
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MICHIGAN

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

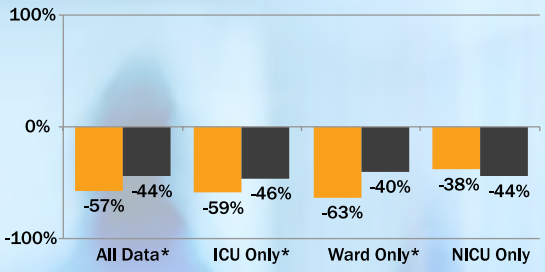
CLABSIs ↓ 57% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Michigan hospitals reported a significant increase in CLABSIs between 2011 and 2012.

2% 2% of Michigan hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

CAUTIs

NO CHANGE COMPARED TO NAT'L BASELINE

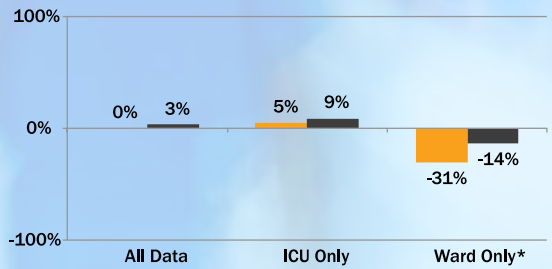
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

CAUTIs in state hospitals have not changed since 2009.

14% 14% of Michigan hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 14% LOWER COMPARED TO NAT'L BASELINE

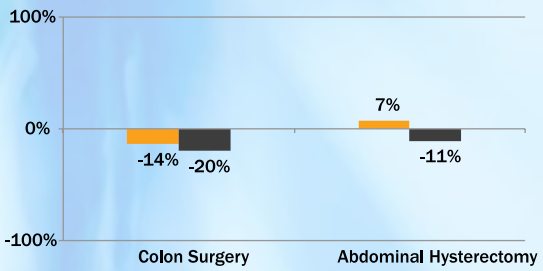
SSIs: ABDOMINAL HYSTERECTOMY ↑ 7% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

12% 12% of Michigan hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



8% 8% of Michigan hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MICHIGAN

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Michigan: **www.michigan.gov/hai**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MICHIGAN DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Michigan has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Carbapenem-resistant Enterobacteriaceae infections
- Ventilator-associated events

Michigan implemented prevention efforts in hand hygiene, and to improve antibiotic stewardship.

NUMBER OF MICHIGAN HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 157+**		STATE SIR	NAT'L SIR
CLABSI 95 hospitals	Michigan's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.43	0.56
CAUTI 97 hospitals	Michigan's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.00	1.03
SSI, Colon Surgery 91 hospitals	Michigan's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.86	0.80
SSI, Abdominal Hysterectomy 86 hospitals	Michigan's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.07	0.89

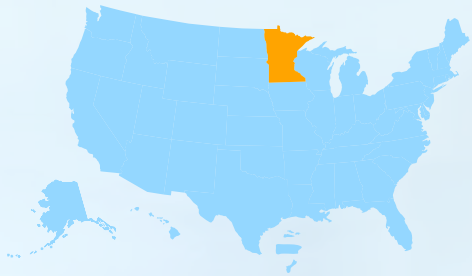
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MINNESOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

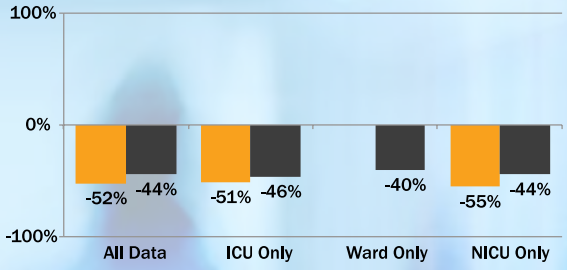
CLABSIs ↓ 52% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Minnesota hospitals did not report a significant change in CLABSIs between 2011 and 2012.

0 ZERO **0 Minnesota hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

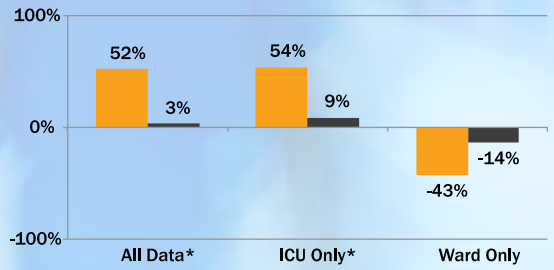
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 52% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

24% 24% of Minnesota hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

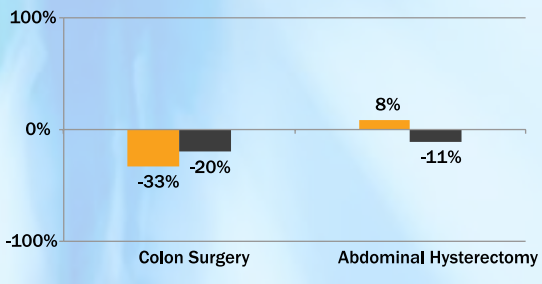
SSIs: COLON SURGERY ↓ 33% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 8% HIGHER COMPARED TO NAT'L BASELINE

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

4% 4% of Minnesota hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



9% 9% of Minnesota hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MINNESOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Minnesota: **www.health.state.mn.us/divs/idepc/dtopics/hai/index.html**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MINNESOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Minnesota has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections

Minnesota implemented prevention efforts in carbapenem-resistant Enterobacteriaceae infections, and to improve antibiotic stewardship.

NUMBER OF MINNESOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 144+**		STATE SIR	NAT'L SIR
CLABSI 49 hospitals	Minnesota's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.48	0.56
CAUTI 51 hospitals	Minnesota's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.52	1.03
SSI, Colon Surgery 49 hospitals	Minnesota's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.67	0.80
SSI, Abdominal Hysterectomy 50 hospitals	Minnesota's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.08	0.89

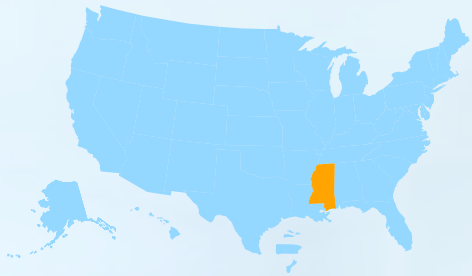
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MISSISSIPPI

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Mississippi requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

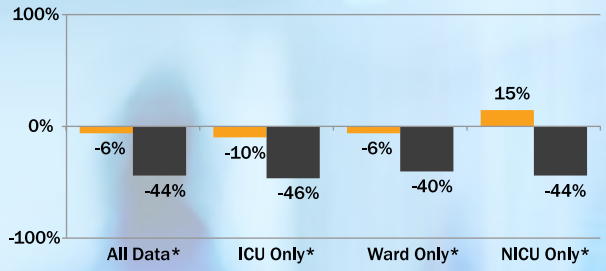
CLABSIs ↓ 6% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Mississippi hospitals reported a significant increase in CLABSIs between 2011 and 2012.

27% **27% of Mississippi hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

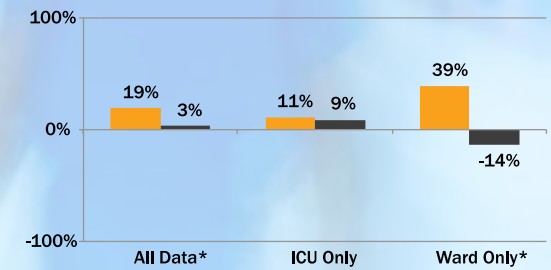
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 19% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

23% **23% of Mississippi hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

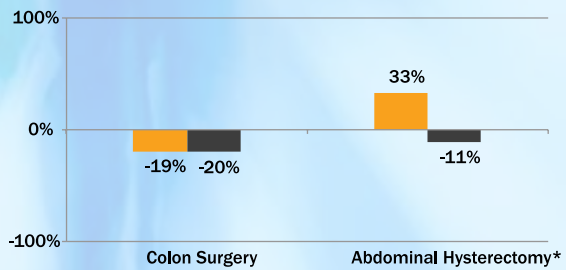
SSIs: COLON SURGERY ↓ 19% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 33% HIGHER COMPARED TO NAT'L BASELINE

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

13% **13% of Mississippi hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



20% **20% of Mississippi hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MISSISSIPPI

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Mississippi: **www.msdh.state.ms.us/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MISSISSIPPI DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Mississippi has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Multidrug-resistant organism infections

Mississippi implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF MISSISSIPPI HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 111+**		STATE SIR	NAT'L SIR
CLABSI 46 hospitals	Mississippi's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.94	0.56
CAUTI 46 hospitals	Mississippi's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.19	1.03
SSI, Colon Surgery 41 hospitals	Mississippi's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.81	0.80
SSI, Abdominal Hysterectomy 43 hospitals	Mississippi's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly worse than the 2012 national SIR.	1.33	0.89

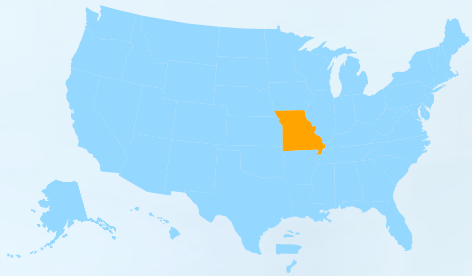
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MISSOURI

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

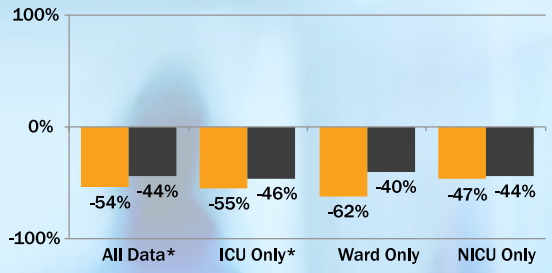
CLABSIs ↓ 54% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Missouri hospitals did not report a significant change in CLABSIs between 2011 and 2012.

6% 6% of Missouri hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

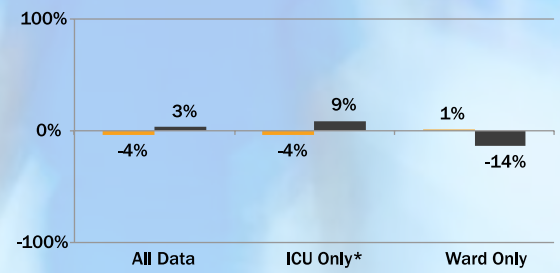
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 4% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

9% 9% of Missouri hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

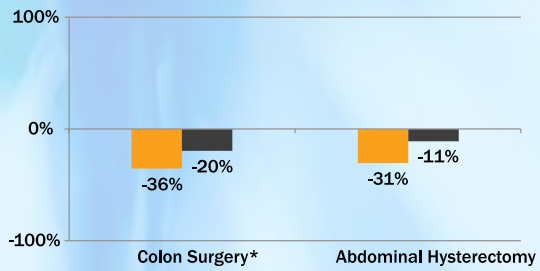
SSIs: COLON SURGERY ↓ 36% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 31% LOWER COMPARED TO NAT'L BASELINE

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

7% 7% of Missouri hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



0 ZERO 0 Missouri hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MISSOURI

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Missouri: **health.mo.gov/data/hai/index.php**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MISSOURI DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Missouri has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

Missouri implemented prevention efforts in long-term care facilities and ambulatory care facilities, and to improve antibiotic stewardship.

NUMBER OF MISSOURI HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 135+**		STATE SIR	NAT'L SIR
CLABSI 74 hospitals	Missouri's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.46	0.56
CAUTI 75 hospitals	Missouri's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.96	1.03
SSI, Colon Surgery 72 hospitals	Missouri's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.64	0.80
SSI, Abdominal Hysterectomy 69 hospitals	Missouri's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.69	0.89

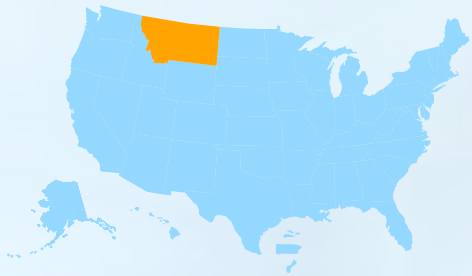
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MONTANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

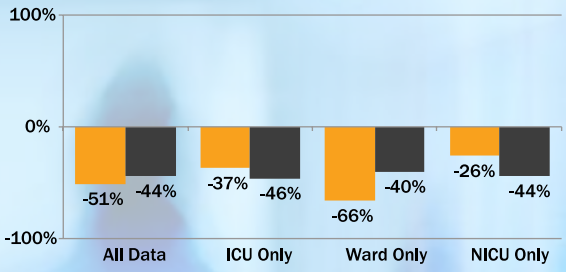
CLABSIs ↓ 51% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Montana hospitals did not report a significant change in CLABSIs between 2011 and 2012.

Not enough data to report how many Montana hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

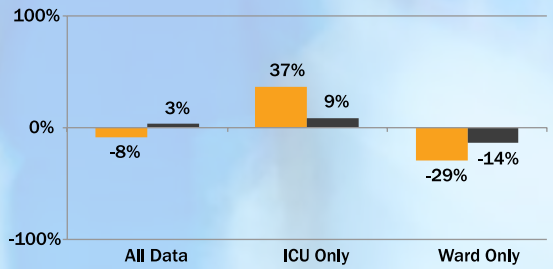
CAUTIs ↓ 8% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS ✓

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

0 ZERO **0 Montana hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 53% LOWER COMPARED TO NAT'L BASELINE

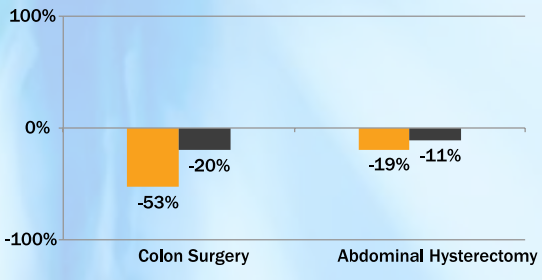
SSIs: ABDOMINAL HYSTERECTOMY ↓ 19% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

Not enough data to report how many Montana hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Montana hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

MONTANA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Montana: **www.dphhs.mt.gov/publichealth/haiprevention/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS MONTANA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Montana has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

Montana implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF MONTANA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 64+**		STATE SIR	NAT'L SIR
CLABSI 12 hospitals	Montana's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.49	0.56
CAUTI 13 hospitals	Montana's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.92	1.03
SSI, Colon Surgery 14 hospitals	Montana's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.47	0.80
SSI, Abdominal Hysterectomy 14 hospitals	Montana's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.81	0.89

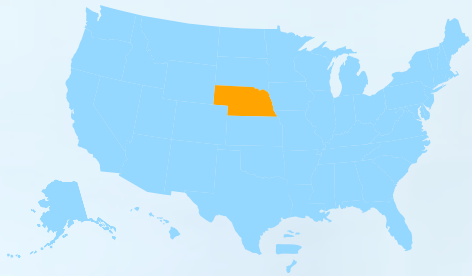
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEBRASKA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Nebraska requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

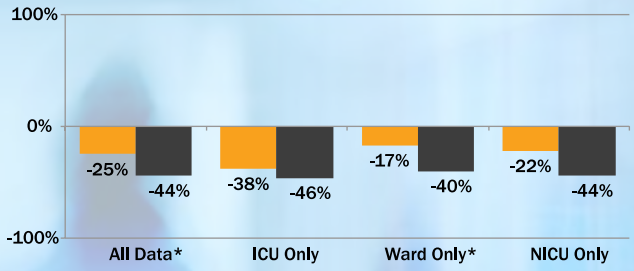
CLABSIs ↓ 25% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Nebraska hospitals did not report a significant change in CLABSIs between 2011 and 2012.

13% 13% of Nebraska hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

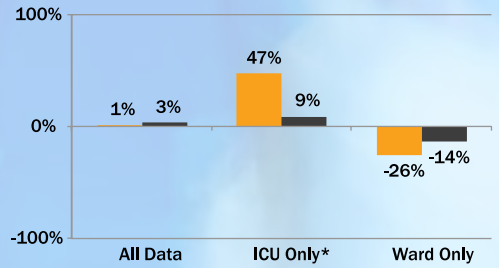
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 1% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% 11% of Nebraska hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

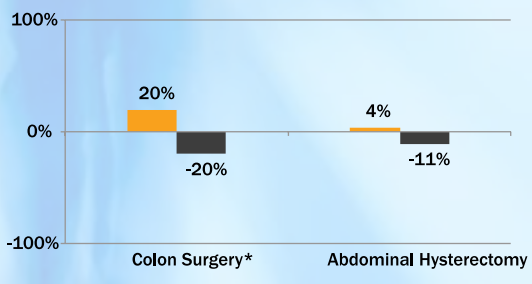
SSIs: COLON SURGERY ↑ 20% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 4% HIGHER COMPARED TO NAT'L BASELINE

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

31% 31% of Nebraska hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Nebraska hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEBRASKA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Nebraska: **dhhs.ne.gov/publichealth/Pages/public_health_support.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS NEBRASKA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Nebraska has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections

Nebraska implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF NEBRASKA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 95+**		STATE SIR	NAT'L SIR
CLABSI 19 hospitals	Nebraska's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.75	0.56
CAUTI 20 hospitals	Nebraska's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.01	1.03
SSI, Colon Surgery 20 hospitals	Nebraska's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.20	0.80
SSI, Abdominal Hysterectomy 20 hospitals	Nebraska's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.04	0.89

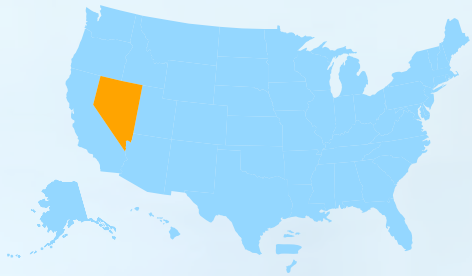
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEVADA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Nevada requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

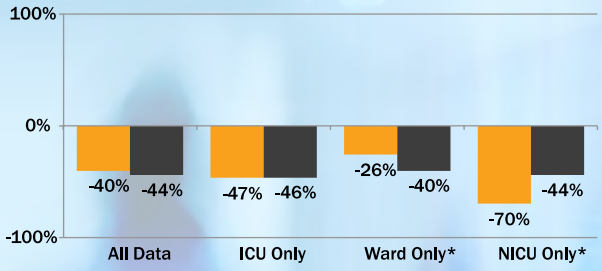
CLABSIs ↓ 40% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Nevada hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

21% **21% of Nevada hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

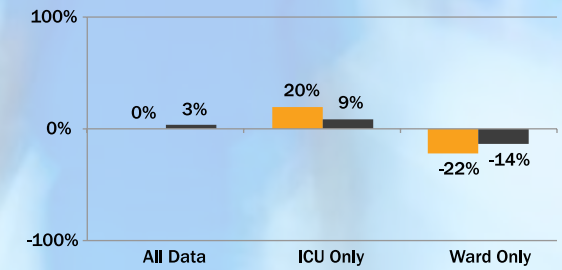
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs NO CHANGE COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

15% **15% of Nevada hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

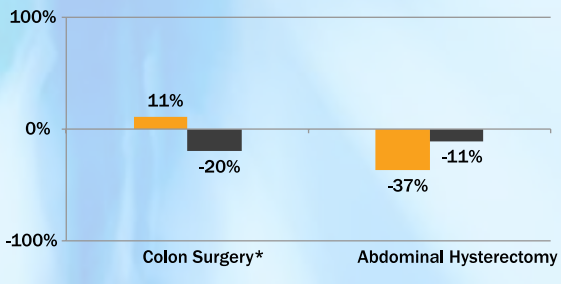
SSIs: COLON SURGERY ↑ 11% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 37% LOWER COMPARED TO NAT'L BASELINE

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

19% **19% of Nevada hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



■ **Not enough data** to report how many Nevada hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEVADA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Nevada: **health.nv.gov/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS NEVADA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Nevada has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Nevada implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF NEVADA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 46+**		STATE SIR	NAT'L SIR
CLABSI 23 hospitals	Nevada's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.60	0.56
CAUTI 24 hospitals	Nevada's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.00	1.03
SSI, Colon Surgery 22 hospitals	Nevada's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.11	0.80
SSI, Abdominal Hysterectomy 19 hospitals	Nevada's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.63	0.89

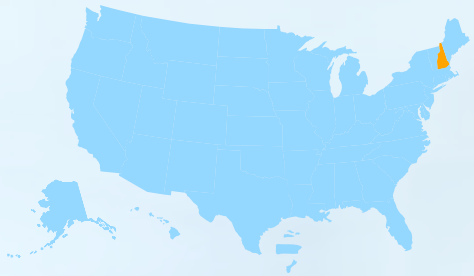
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW HAMPSHIRE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). New Hampshire requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

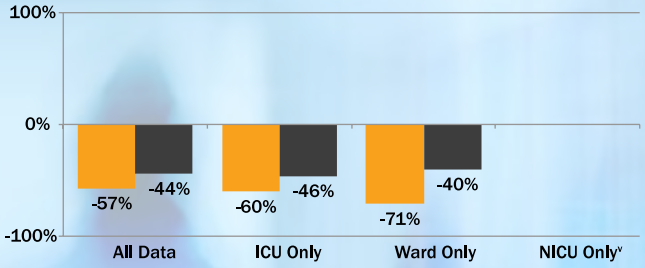
CLABSIs ↓ 57% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

New Hampshire hospitals did not report a significant change in CLABSIs between 2011 and 2012.

Not enough data to report how many New Hampshire hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

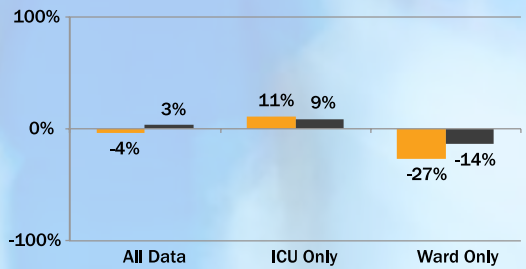
CAUTIs ↓ 4% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

7% **7% of New Hampshire hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 39% LOWER COMPARED TO NAT'L BASELINE

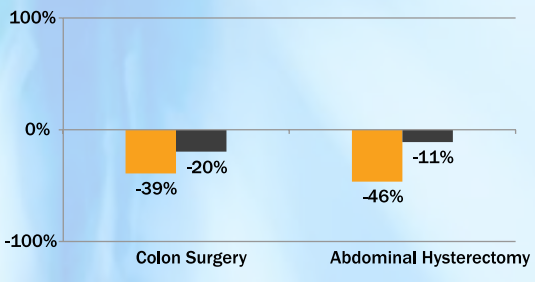
SSIs: ABDOMINAL HYSTERECTOMY ↓ 46% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

0 ZERO **0 New Hampshire hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many New Hampshire hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW HAMPSHIRE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in New Hampshire: **www.dhhs.nh.gov/DPHS/cdcs/hai/index.htm**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

New Hampshire has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

New Hampshire implemented prevention efforts in long-term care facilities and dialysis facilities, and for hand hygiene.

NUMBER OF NEW HAMPSHIRE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 29+**		STATE SIR	NAT'L SIR
CLABSI 24 hospitals	New Hampshire's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.43	0.56
CAUTI 23 hospitals	New Hampshire's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.96	1.03
SSI, Colon Surgery 26 hospitals	New Hampshire's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.61	0.80
SSI, Abdominal Hysterectomy 23 hospitals	New Hampshire's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.54	0.89

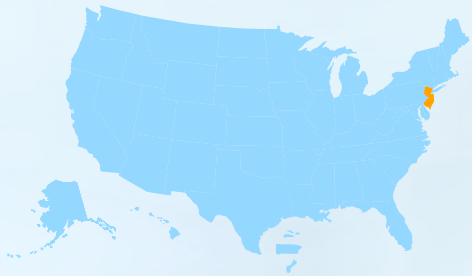
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW JERSEY

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). New Jersey requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

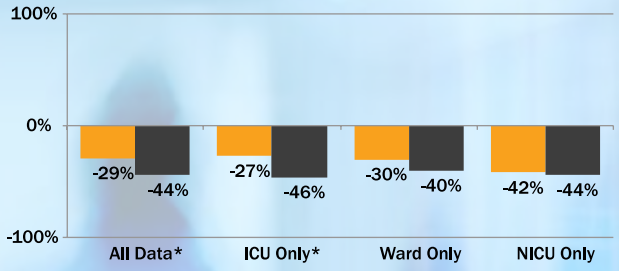
CLABSIs ↓ 29% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

New Jersey hospitals did not report a significant change in CLABSIs between 2011 and 2012.

16% **16% of New Jersey hospitals have an SIR worse than the national SIR of 0.56**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

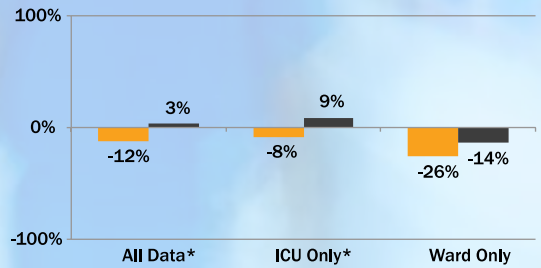
CAUTIs ↓ 12% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

14% **14% of New Jersey hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 38% LOWER COMPARED TO NAT'L BASELINE

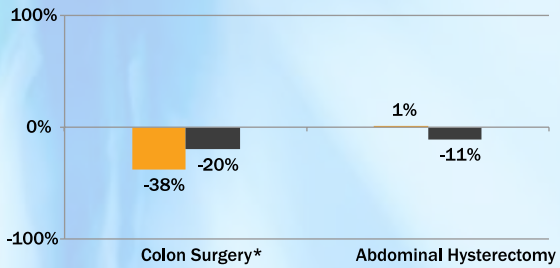
SSIs: ABDOMINAL HYSTERECTOMY ↑ 1% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

5% **5% of New Jersey hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



14% **14% of New Jersey hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW JERSEY

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in New Jersey: **www.state.nj.us/health/hais/index.shtml/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

New Jersey has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated phenomena infections

New Jersey implemented prevention efforts in ambulatory surgery centers, dialysis facilities, and nursing homes.

NUMBER OF NEW JERSEY HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 94+**		STATE SIR	NAT'L SIR
CLABSI 72 hospitals	New Jersey's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.71	0.56
CAUTI 72 hospitals	New Jersey's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.88	1.03
SSI, Colon Surgery 71 hospitals	New Jersey's 2012 state **Colon Surgery SSI** SIR is significantly better than the 2012 national SIR.	0.62	0.80
SSI, Abdominal Hysterectomy 66 hospitals	New Jersey's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.01	0.89

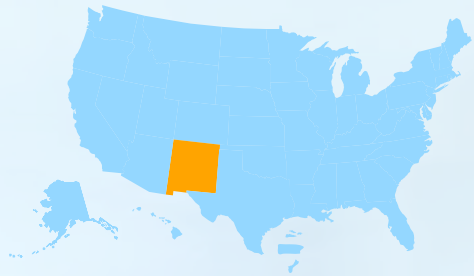
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW MEXICO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). New Mexico requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

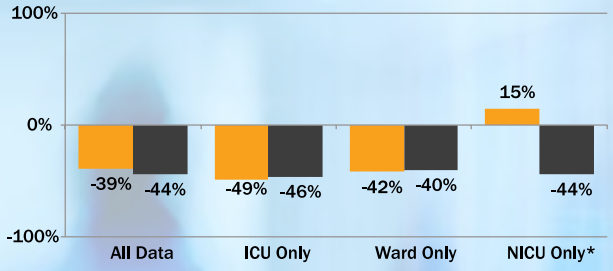
CLABSIs ↓ 39% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

New Mexico hospitals did not report a significant change in CLABSIs between 2011 and 2012.

14% **14% of New Mexico hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

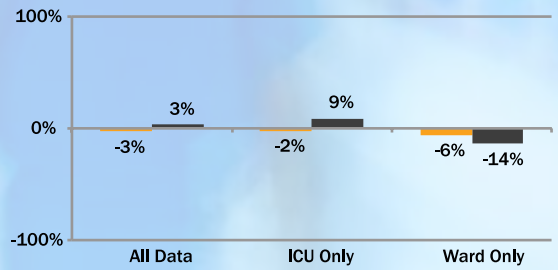
CAUTIs ↓ 3% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% **11% of New Mexico hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 41% LOWER COMPARED TO NAT'L BASELINE

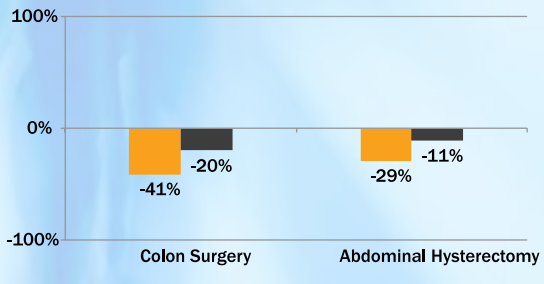
SSIs: ABDOMINAL HYSTERECTOMY ↓ 29% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

Not enough data to report how many New Mexico hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many New Mexico hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW MEXICO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in New Mexico: **nmhealth.org/hai/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS NEW MEXICO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

New Mexico has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

New Mexico implemented prevention efforts in long-term care facilities, and to improve antibiotic stewardship.

NUMBER OF NEW MEXICO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 48+**		STATE SIR	NAT'L SIR
CLABSI 34 hospitals	New Mexico's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.61	0.56
CAUTI 34 hospitals	New Mexico's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.97	1.03
SSI, Colon Surgery 27 hospitals	New Mexico's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.59	0.80
SSI, Abdominal Hysterectomy 24 hospitals	New Mexico's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.71	0.89

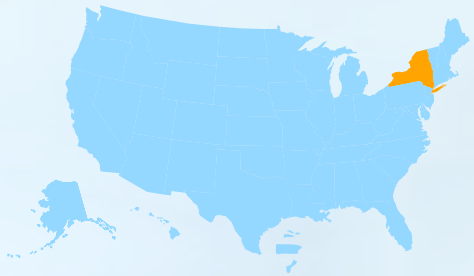
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW YORK

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). New York requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

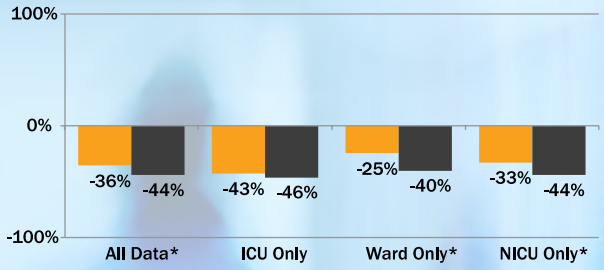
CLABSIs ↓ 36% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

New York hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

17% 17% of New York hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

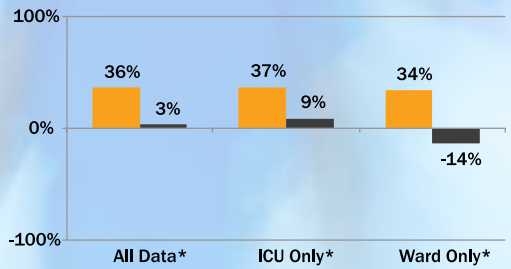
CAUTIs ↑ 36% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

28% 28% of New York hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 17% LOWER COMPARED TO NAT'L BASELINE

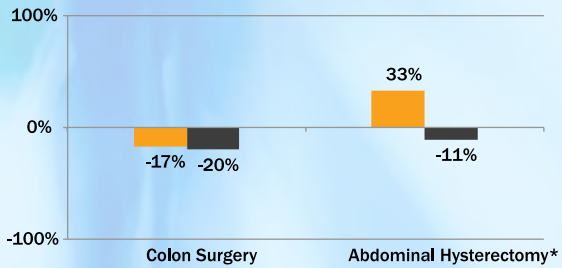
SSIs: ABDOMINAL HYSTERECTOMY ↑ 33% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY ✓

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

8% 8% of New York hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



15% 15% of New York hospitals have an abdominal hysterectomy SIR better than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NEW YORK

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in New York: **www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS NEW YORK DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

New York has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Multidrug-resistant organism infections
- Ventilator-associated events

New York implemented prevention efforts in long-term care facilities and dialysis facilities.

NUMBER OF NEW YORK HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 251+**		STATE SIR	NAT'L SIR
CLABSI 174 hospitals	New York's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	**0.64**	**0.56**
CAUTI 175 hospitals	New York's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	**1.36**	**1.03**
SSI, Colon Surgery 175 hospitals	New York's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	**0.83**	**0.80**
SSI, Abdominal Hysterectomy 162 hospitals	New York's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly worse than the 2012 national SIR.	**1.33**	**0.89**

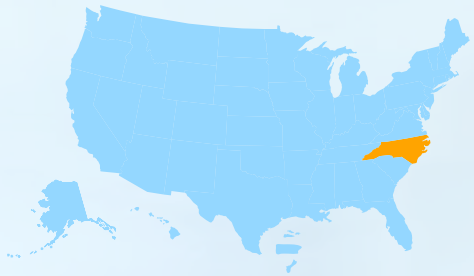
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NORTH CAROLINA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). North Carolina requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

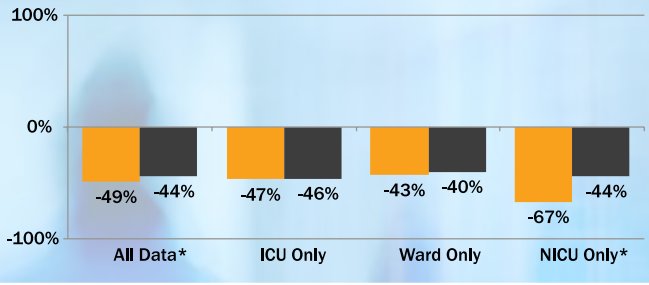
CLABSIs ↓ 49% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

North Carolina hospitals did not report a significant change in CLABSIs between 2011 and 2012.

7% **7% of North Carolina hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

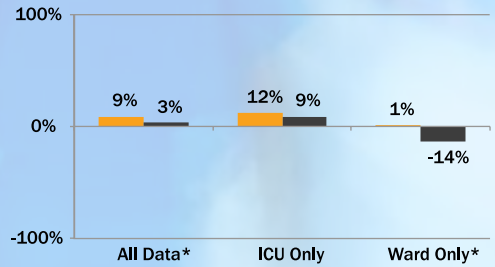
CAUTIs ↑ 9% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

8% **8% of North Carolina hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 23% LOWER COMPARED TO NAT'L BASELINE

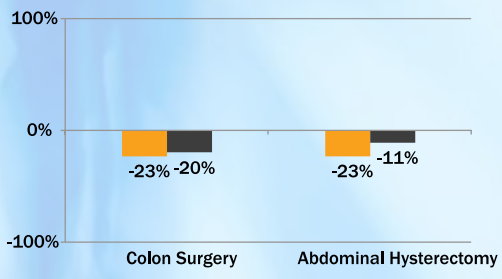
SSIs: ABDOMINAL HYSTERECTOMY ↓ 23% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

7% **7% of North Carolina hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



8% **8% of North Carolina hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NORTH CAROLINA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in North Carolina: **epi.publichealth.nc.gov/cd/diseases/hai.html**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

North Carolina has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections
- Ventilator-associated events

North Carolina implemented prevention efforts in long-term care facilities.

NUMBER OF NORTH CAROLINA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 133+**		STATE SIR	NAT'L SIR
CLABSI 96 hospitals	North Carolina's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.51	0.56
CAUTI 100 hospitals	North Carolina's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.09	1.03
SSI, Colon Surgery 93 hospitals	North Carolina's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.77	0.80
SSI, Abdominal Hysterectomy 89 hospitals	North Carolina's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.77	0.89

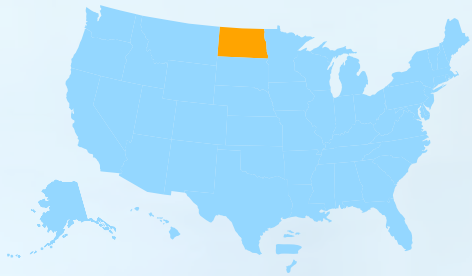
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NORTH DAKOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

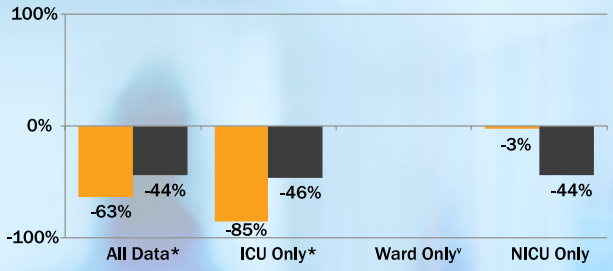
CLABSIs ↓ 63% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

North Dakota hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many North Dakota hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

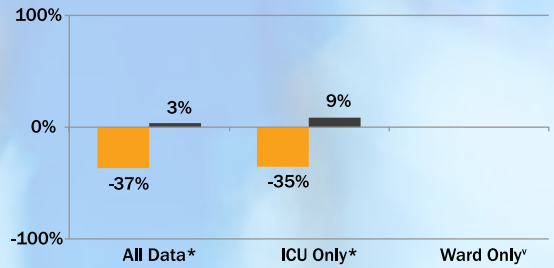
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 37% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many North Dakota hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↑ 68% HIGHER COMPARED TO NAT'L BASELINE

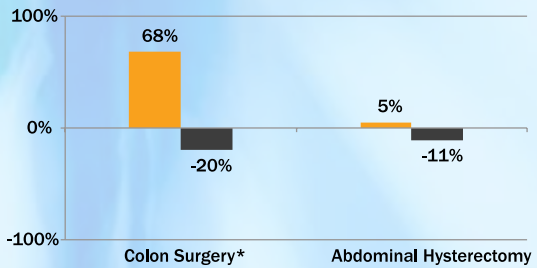
SSIs: ABDOMINAL HYSTERECTOMY ↑ 5% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

- **Not enough data** to report how many North Dakota hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many North Dakota hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

NORTH DAKOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in North Dakota: **www.ndhealth.gov/disease/hai/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS NORTH DAKOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

North Dakota has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Multidrug-resistant organism infections

North Dakota implemented prevention efforts in long-term care facilities, and to improve antibiotic stewardship and hand hygiene.

NUMBER OF NORTH DAKOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 48+**		STATE SIR	NAT'L SIR
CLABSI 6 hospitals	North Dakota's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.37	0.56
CAUTI 6 hospitals	North Dakota's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.63	1.03
SSI, Colon Surgery 6 hospitals	North Dakota's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.68	0.80
SSI, Abdominal Hysterectomy 6 hospitals	North Dakota's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.05	0.89

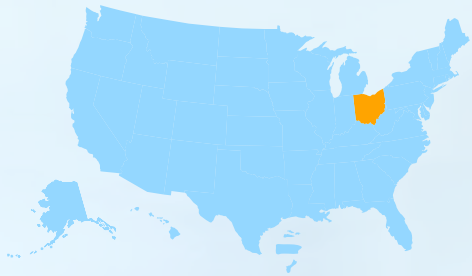
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OHIO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

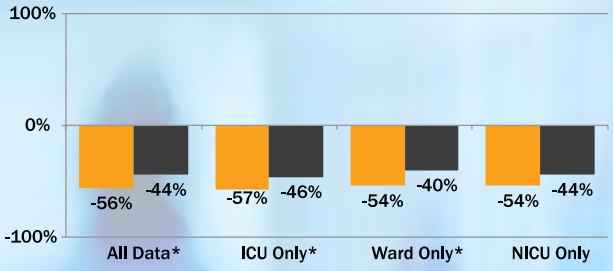
CLABSIs ↓ 56% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Ohio hospitals did not report a significant change in CLABSIs between 2011 and 2012.

4% 4% of Ohio hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

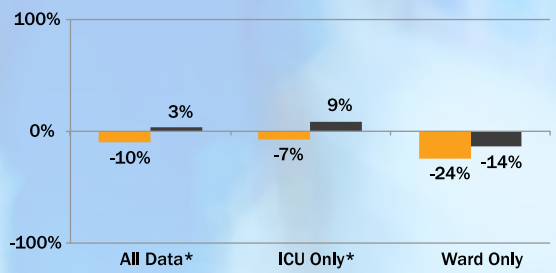
CAUTIs ↓ 10% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

12% 12% of Ohio hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 27% LOWER COMPARED TO NAT'L BASELINE

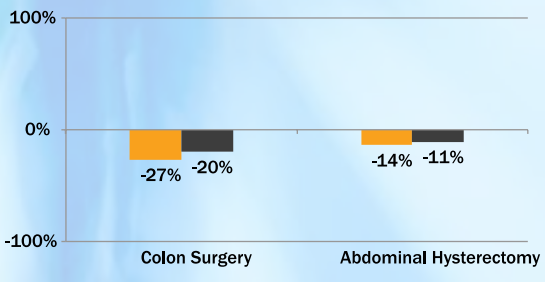
SSIs: ABDOMINAL HYSTERECTOMY ↓ 14% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

3% 3% of Ohio hospitals have a colon surgery SIR worse than the national SIR of 0.80

Changes in SSI vs. 2008 National Baseline



3% 3% of Ohio hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OHIO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Ohio: **www.odh.ohio.gov/odhprograms/dis/orbitdis/hai/haimain.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS OHIO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Ohio has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Ohio implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF OHIO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 203+**		STATE SIR	NAT'L SIR
CLABSI 135 hospitals	Ohio's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.44	0.56
CAUTI 135 hospitals	Ohio's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.90	1.03
SSI, Colon Surgery 127 hospitals	Ohio's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.73	0.80
SSI, Abdominal Hysterectomy 123 hospitals	Ohio's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.86	0.89

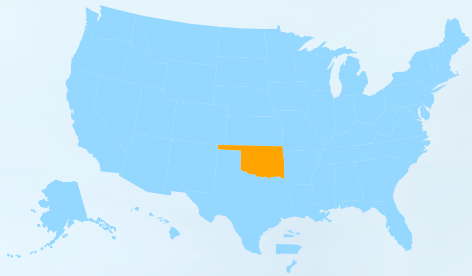
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OKLAHOMA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Oklahoma requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

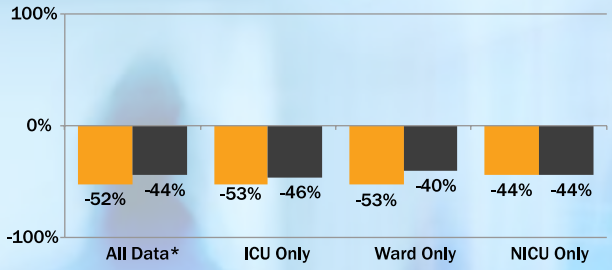
CLABSIs ↓ 52% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Oklahoma hospitals did not report a significant change in CLABSIs between 2011 and 2012.

7% **7% of Oklahoma hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

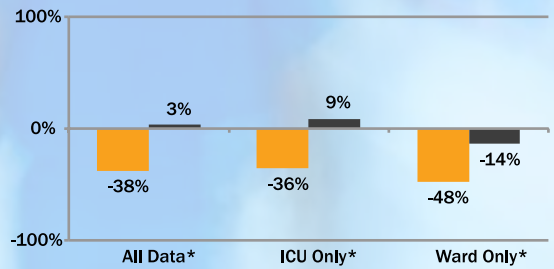
CAUTIs ↓ 38% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

3% **3% of Oklahoma hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 20% LOWER COMPARED TO NAT'L BASELINE

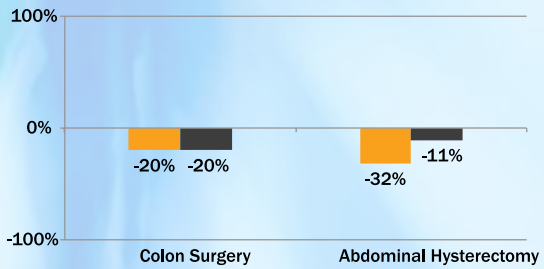
SSIs: ABDOMINAL HYSTERECTOMY ↓ 32% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

13% **13% of Oklahoma hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Oklahoma hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OKLAHOMA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

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

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Oklahoma: **www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Quality_Initiatives/Healthcare-Associated_Infections_Prevention_Program/**

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS OKLAHOMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Oklahoma has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

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

Oklahoma implemented prevention efforts in dialysis facilities.

NUMBER OF OKLAHOMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 144+**		STATE SIR	NAT'L SIR
CLABSI 55 hospitals	Oklahoma's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.48	0.56
CAUTI 61 hospitals	Oklahoma's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.62	1.03
SSI, Colon Surgery 61 hospitals	Oklahoma's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.80	0.80
SSI, Abdominal Hysterectomy 59 hospitals	Oklahoma's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.68	0.89

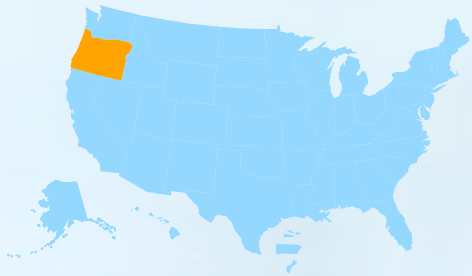
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OREGON

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Oregon requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

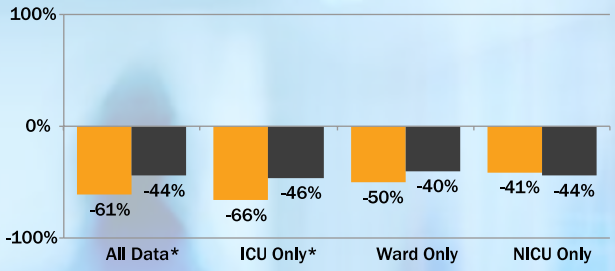
CLABSIs ↓ 61% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Oregon hospitals did not report a significant change in CLABSIs between 2011 and 2012.

0 ZERO **0 Oregon hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

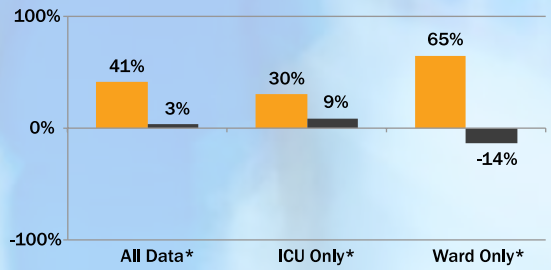
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 41% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

11% 11% of Oregon hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 25% LOWER COMPARED TO NAT'L BASELINE

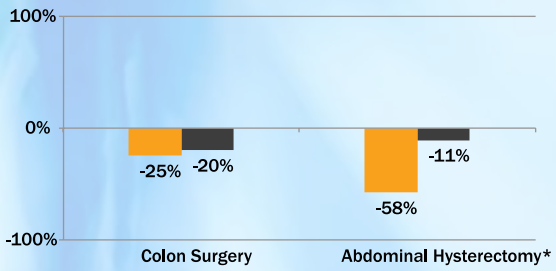
SSIs: ABDOMINAL HYSTERECTOMY ↓ 58% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

0 ZERO **0 Oregon hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Oregon hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

OREGON

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Oregon: **public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/index.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS OREGON DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Oregon has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections

Oregon implemented and led prevention efforts to improve antibiotic stewardship.

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

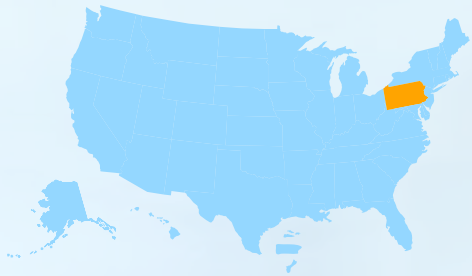
NUMBER OF OREGON HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 64+**		STATE SIR	NAT'L SIR
CLABSI 47 hospitals	Oregon's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.39	0.56
CAUTI 46 hospitals	Oregon's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.41	1.03
SSI, Colon Surgery 49 hospitals	Oregon's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.75	0.80
SSI, Abdominal Hysterectomy 46 hospitals	Oregon's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.42	0.89

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

PENNSYLVANIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Pennsylvania requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

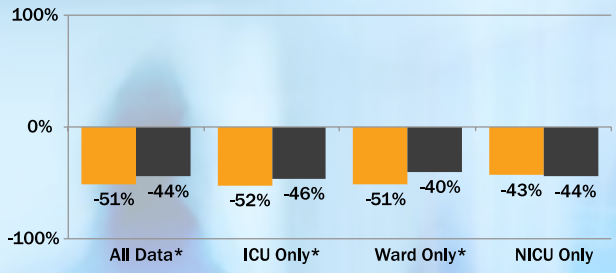
CLABSIs ↓ 51% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Pennsylvania hospitals did not report a significant change in CLABSIs between 2011 and 2012.

7% 7% of Pennsylvania hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

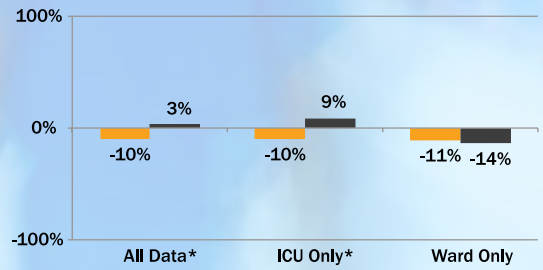
CAUTIs ↓ 10% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

8% 8% of Pennsylvania hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 22% LOWER COMPARED TO NAT'L BASELINE

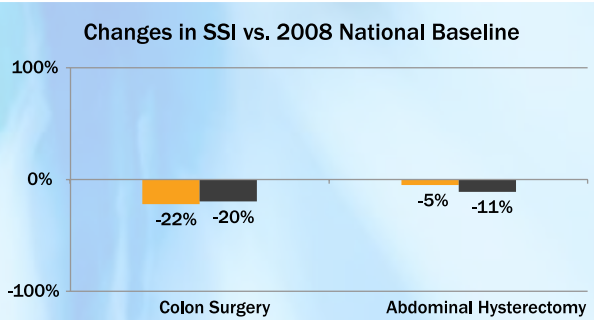
SSIs: ABDOMINAL HYSTERECTOMY ↓ 5% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

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

8% 8% of Pennsylvania hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



6% 6% of Pennsylvania hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

PENNSYLVANIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Pennsylvania: **www.portal.state.pa.us/portal/server.pt/community/healthcare_associated_infections/14234**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS PENNSYLVANIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Pennsylvania has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated events

Pennsylvania implemented prevention efforts in long-term care facilities, and to improve antibiotic stewardship.

NUMBER OF PENNSYLVANIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 221+**		STATE SIR	NAT'L SIR
CLABSI 175 hospitals	Pennsylvania's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.49	0.56
CAUTI 190 hospitals	Pennsylvania's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.90	1.03
SSI, Colon Surgery 162 hospitals	Pennsylvania's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.78	0.80
SSI, Abdominal Hysterectomy 148 hospitals	Pennsylvania's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.95	0.89

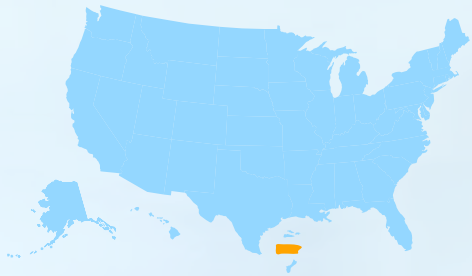
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

PUERTO RICO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

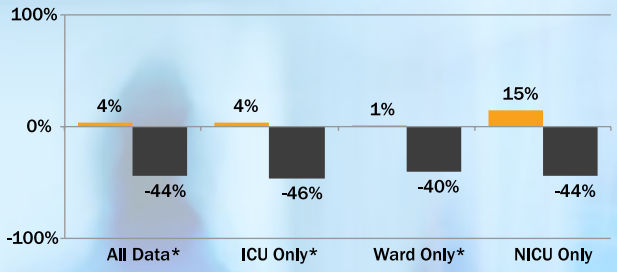
CLABSIs ⬆ 4% HIGHER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Puerto Rico hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

50% **50% of Puerto Rico hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

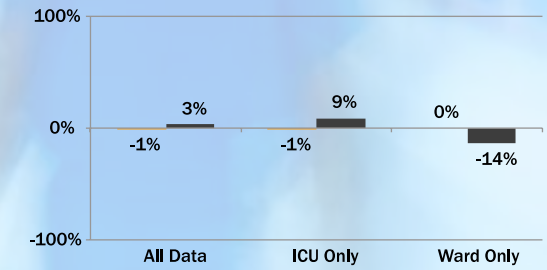
CAUTIs ⬇ 1% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

12% **12% of Puerto Rico hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY

SSIs: ABDOMINAL HYSTERECTOMY

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

Puerto Rico hospitals did not report 2012 colon surgery data to NHSN.

Puerto Rico hospitals did not report 2012 abdominal hysterectomy data to NHSN.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

PUERTO RICO

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Puerto Rico: **www.salud.gov.pr/Pages/default.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS PUERTO RICO DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Puerto Rico has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections
- Ventilator-associated pneumonia infections

Puerto Rico implemented prevention efforts in long-term care facilities, and to improve antibiotic stewardship.

NUMBER OF PUERTO RICO HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 59+**		STATE SIR	NAT'L SIR
CLABSI 18 hospitals	Puerto Rico's 2012 state **CLABSI** SIR is significantly higher than the 2012 national SIR.	1.04	0.56
CAUTI 18 hospitals	Puerto Rico's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.99	1.03
SSI, Colon Surgery 0 hospitals	Puerto Rico hospitals did not report 2012 colon surgery data to NHSN.	N/A	0.80
SSI, Abdominal Hysterectomy 0 hospitals	Puerto Rico hospitals did not report 2012 abdominal hysterectomy data to NHSN.	N/A	0.89

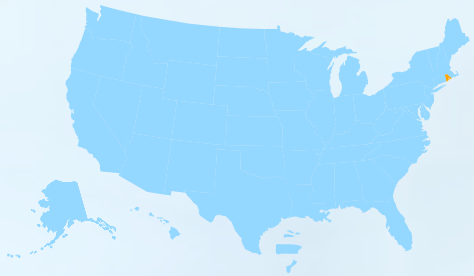
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

RHODE ISLAND

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

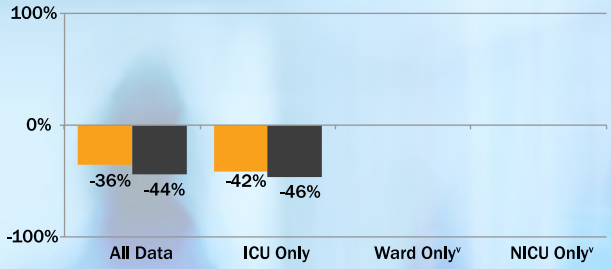
CLABSIs ↓ 36% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Rhode Island hospitals did not report a significant change in CLABSIs between 2011 and 2012

Not enough data to report how many Rhode Island hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

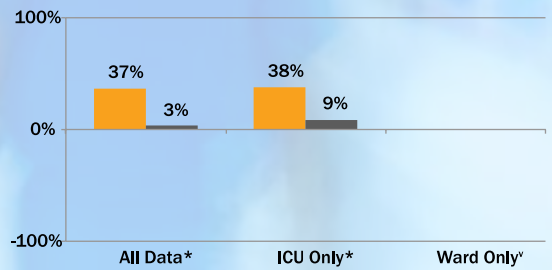
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↑ 37% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

30% **30% of Rhode Island hospitals have a SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

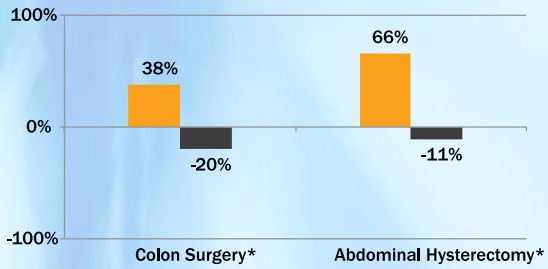
SSIs: COLON SURGERY ↑ 38% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↑ 66% HIGHER COMPARED TO NAT'L BASELINE

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

30% **30% of Rhode Island hospitals have a colon surgery SIR worse than the national SIR 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many Rhode Island hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

RHODE ISLAND

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

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

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Rhode Island: **www.health.ri.gov/programs/healthcarequalityreporting/index.php**

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

Rhode Island has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Cather-associated urinary tract infections
- Surgical site infections
- MRSA infections
- Multidrug-resistant organism infections
- Ventilator-associated pneumonia infections

Rhode Island implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF RHODE ISLAND HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 14+**		STATE SIR	NAT'L SIR
CLABSI 11 hospitals	Rhode Island's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.64	0.56
CAUTI 10 hospitals	Rhode Island's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.37	1.03
SSI, Colon Surgery 11 hospitals	Rhode Island's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.38	0.80
SSI, Abdominal Hysterectomy 11 hospitals	Rhode Island's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly worse than the 2012 national SIR.	1.66	0.89

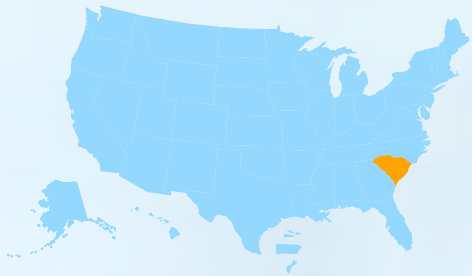
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

SOUTH CAROLINA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). South Carolina requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

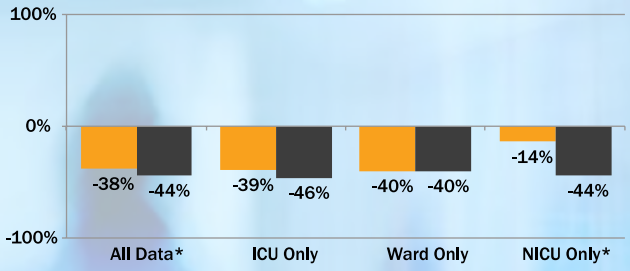
CLABSIs ↓ 38% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

South Carolina hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

12% 12% of South Carolina hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

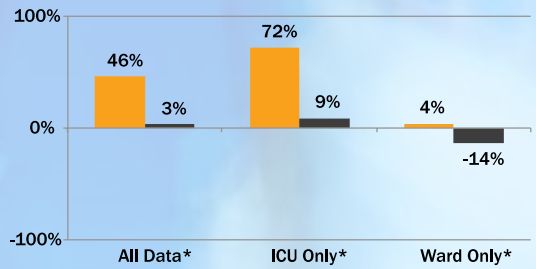
CAUTIs ↑ 46% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

20% 20% of South Carolina hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↑ 3% HIGHER COMPARED TO NAT'L BASELINE

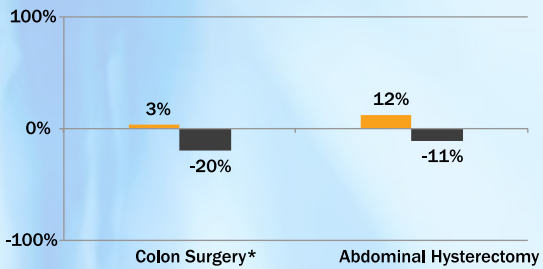
SSIs: ABDOMINAL HYSTERECTOMY ↑ 12% HIGHER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY ✓

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

17% 17% of South Carolina hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



8% 8% of South Carolina hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

SOUTH CAROLINA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in South Carolina: **www.scdhec.gov/health/disease/hai/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS SOUTH CAROLINA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

South Carolina has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated events

South Carolina implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF SOUTH CAROLINA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 81+**		STATE SIR	NAT'L SIR
CLABSI 65 hospitals	South Carolina's 2012 state **CLABSI** SIR is significantly worse than the 2012 national SIR.	0.62	0.56
CAUTI 64 hospitals	South Carolina's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.46	1.03
SSI, Colon Surgery 57 hospitals	South Carolina's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.03	0.80
SSI, Abdominal Hysterectomy 54 hospitals	South Carolina's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	1.12	0.89

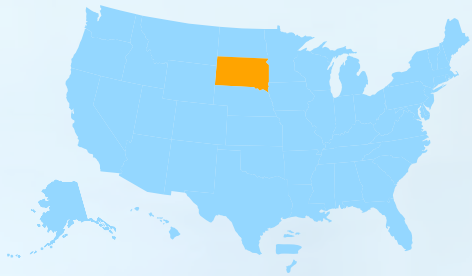
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

SOUTH DAKOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

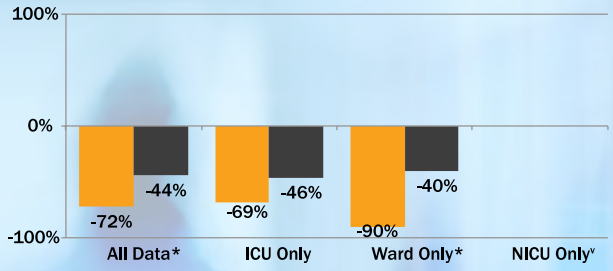
CLABSIs ↓ 72% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

South Dakota hospitals did not report a significant change in CLABSIs between 2011 and 2012.

Not enough data to report how many South Dakota hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

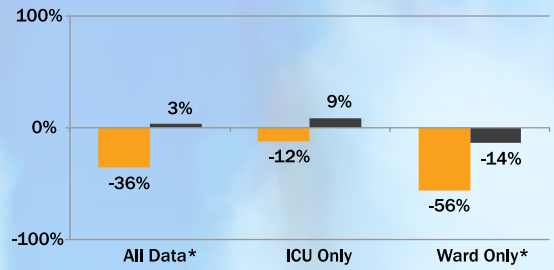
CAUTIs ↓ 36% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

0 ZERO **0 South Dakota hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↑ 8% HIGHER COMPARED TO NAT'L BASELINE

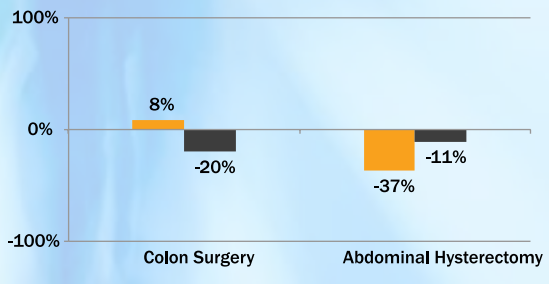
SSIs: ABDOMINAL HYSTERECTOMY ↓ 37% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

Not enough data to report how many South Dakota hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many South Dakota hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

SOUTH DAKOTA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in South Dakota: **doh.sd.gov/diseases/hai/default.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS SOUTH DAKOTA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

South Dakota has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Carbapenem-resistant Enterobacteriaceae infections

South Dakota implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF SOUTH DAKOTA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 64+**		STATE SIR	NAT'L SIR
CLABSI 14 hospitals	South Dakota's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.28	0.56
CAUTI 18 hospitals	South Dakota's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.64	1.03
SSI, Colon Surgery 14 hospitals	South Dakota's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	1.08	0.80
SSI, Abdominal Hysterectomy 14 hospitals	South Dakota's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.63	0.89

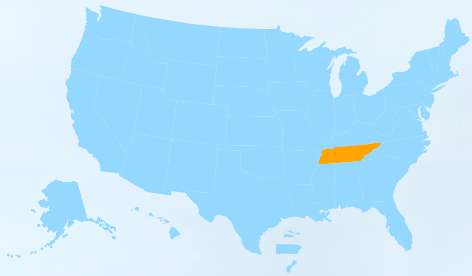
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

TENNESSEE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Tennessee requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

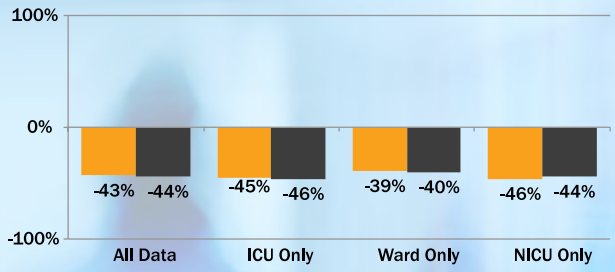
CLABSIs ↓ 43% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Tennessee hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

11% 11% of Tennessee hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

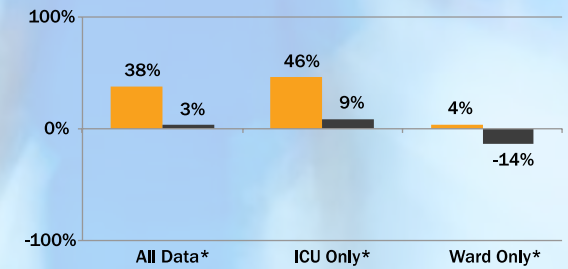
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

CAUTIs ↑ 38% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

16% 16% of Tennessee hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

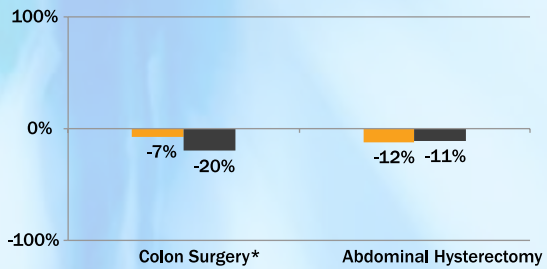
SSIs: COLON SURGERY ↓ 7% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 12% LOWER COMPARED TO NAT'L BASELINE

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

10% 10% of Tennessee hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



5% 5% of Tennessee hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

TENNESSEE

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Tennessee: **health.state.tn.us/ceds/hai/index.htm**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS TENNESSEE DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Tennessee has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections

Tennessee implemented prevention efforts in long-term care facilities and dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF TENNESSEE HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 154+**		STATE SIR	NAT'L SIR
CLABSI 94 hospitals	Tennessee's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.57	0.56
CAUTI 95 hospitals	Tennessee's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.38	1.03
SSI, Colon Surgery 90 hospitals	Tennessee's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	0.93	0.80
SSI, Abdominal Hysterectomy 90 hospitals	Tennessee's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.88	0.89

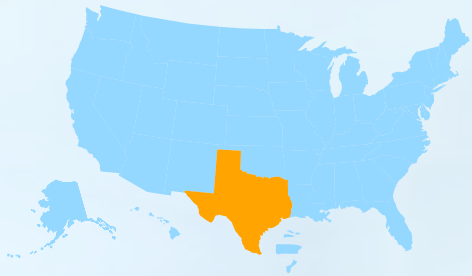
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

TEXAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Texas requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

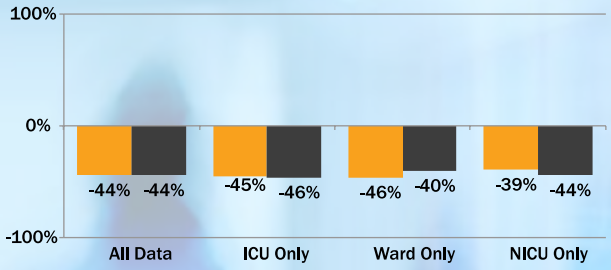
CLABSIs ↓ 44% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Texas hospitals did not report a significant change in CLABSIs between 2011 and 2012.

9% 9% of Texas hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

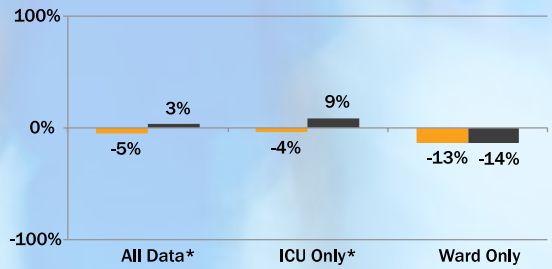
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 5% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

12% 12% of Texas hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

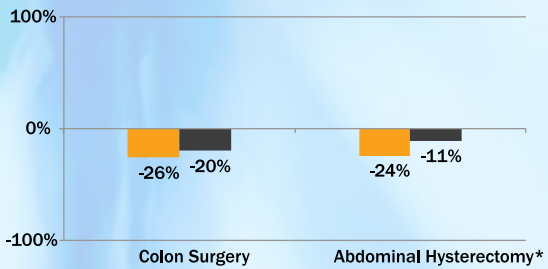
SSIs: COLON SURGERY ↓ 26% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 24% LOWER COMPARED TO NAT'L BASELINE

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

7% 7% of Texas hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



3% 3% of Texas hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

TEXAS

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Texas: **www.HAITexas.org**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS TEXAS DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Texas has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Surgical site infections

Texas implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF TEXAS HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 506+**		STATE SIR	NAT'L SIR
CLABSI 277 hospitals	Texas' 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.56	0.56
CAUTI 284 hospitals	Texas' 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.95	1.03
SSI, Colon Surgery 281 hospitals	Texas' 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.74	0.80
SSI, Abdominal Hysterectomy 281 hospitals	Texas' 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.76	0.89

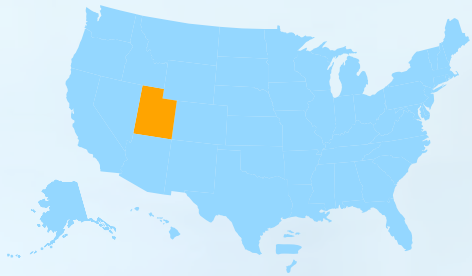
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

UTAH

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Utah requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

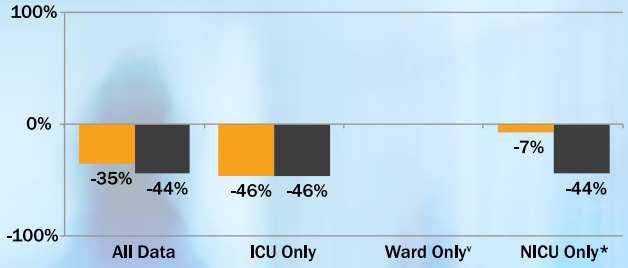
CLABSIs ↓ 35% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Utah hospitals did not report a significant change in CLABSIs between 2011 and 2012.

13% 13% of Utah hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

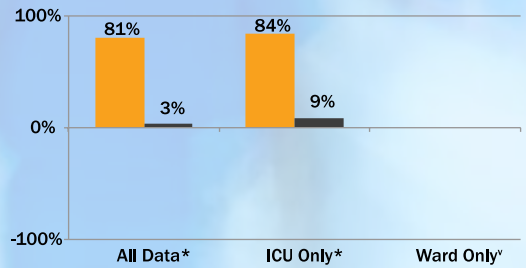
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS Q

CAUTIs ↑ 81% HIGHER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

29% 29% of Utah hospitals have an SIR worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY Q

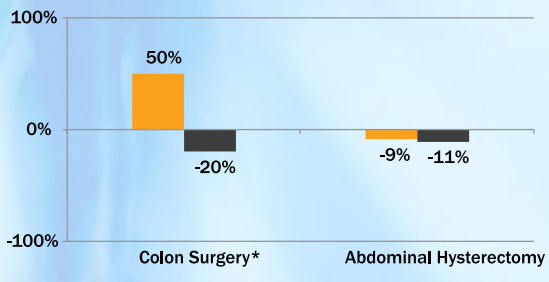
SSIs: COLON SURGERY ↑ 50% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 9% LOWER COMPARED TO NAT'L BASELINE

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

31% 31% of Utah hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



10% 10% of Utah hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

UTAH

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Utah: **health.utah.gov/epi/HAI**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS UTAH DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Utah has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Carbapenem-resistant Enterobacteriaceae infections
- Multidrug-resistant organism infections

Utah implemented prevention efforts in dialysis facilities, and to improve antibiotic stewardship.

NUMBER OF UTAH HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 53+**		STATE SIR	NAT'L SIR
CLABSI 26 hospitals	Utah's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.65	0.56
CAUTI 26 hospitals	Utah's 2012 state **CAUTI** SIR is significantly worse than the 2012 national SIR.	1.81	1.03
SSI, Colon Surgery 30 hospitals	Utah's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.50	0.80
SSI, Abdominal Hysterectomy 30 hospitals	Utah's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.91	0.89

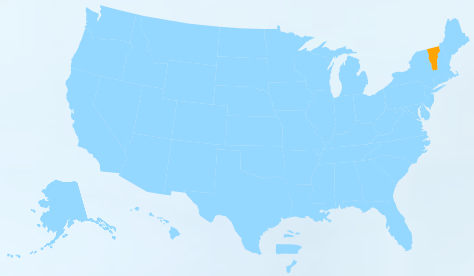
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

VERMONT

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Vermont requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

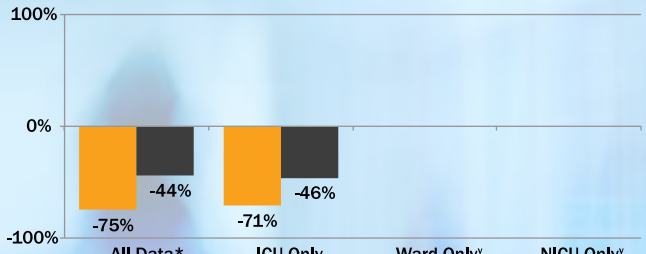
CLABSIs ↓ 75% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Vermont hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many Vermont hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

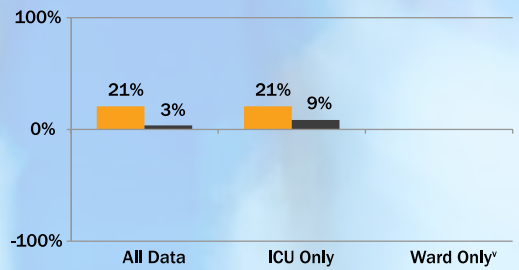
CAUTIs ↑ 21% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many Vermont hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↑ 89% HIGHER COMPARED TO NAT'L BASELINE

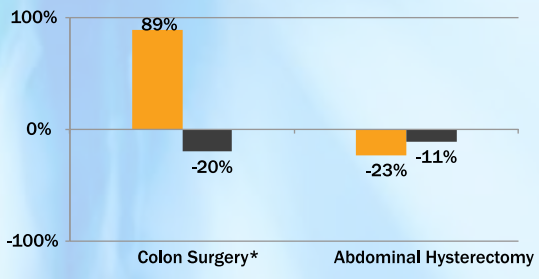
✓ SSIs: ABDOMINAL HYSTERECTOMY ↓ 23% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

- **Not enough data** to report how many Vermont hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many Vermont hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

VERMONT

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Vermont: **www.healthvermont.gov/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS VERMONT DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Vermont has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections
- Ventilator-associated events

Vermont implemented prevention efforts in long-term care facilities and dialysis facilities.

NUMBER OF VERMONT HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 16+**		STATE SIR	NAT'L SIR
CLABSI 7 hospitals	Vermont's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.25	0.56
CAUTI 5 hospitals	Vermont's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.21	1.03
SSI, Colon Surgery 6 hospitals	Vermont's 2012 state **Colon Surgery SSI** SIR is significantly worse than the 2012 national SIR.	1.89	0.80
SSI, Abdominal Hysterectomy 11 hospitals	Vermont's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.77	0.89

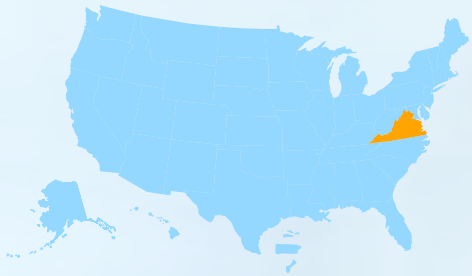
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

VIRGINIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Virginia requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



Q CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

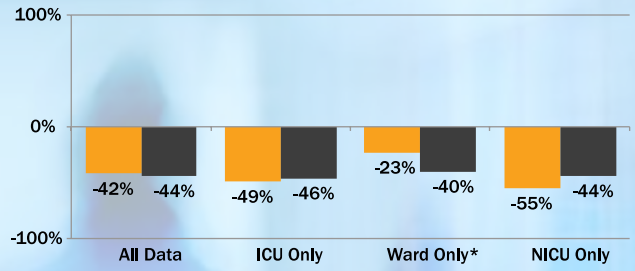
CLABSIs ↓ 42% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Virginia hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

8% **8% of Virginia hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

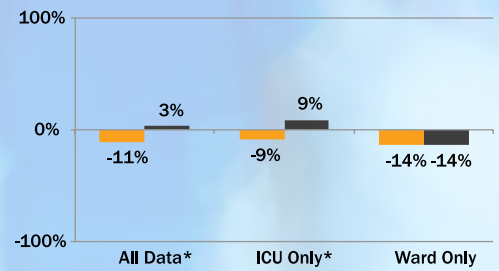
CAUTIs ↓ 11% LOWER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

8% **8% of Virginia hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 24% LOWER COMPARED TO NAT'L BASELINE

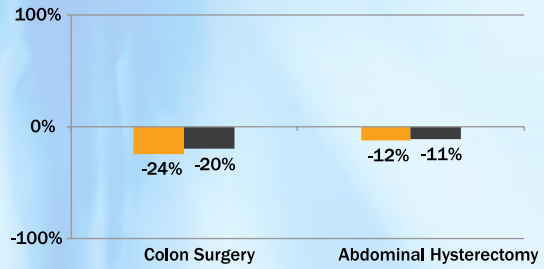
SSIs: ABDOMINAL HYSTERECTOMY ↓ 12% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

7% **7% of Virginia hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



11% **11% of Virginia hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

VIRGINIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Virginia: **www.vdh.virginia.gov/epidemiology/surveillance/hai/**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS VIRGINIA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Virginia has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated events

Virginia implemented prevention efforts in dialysis facilities, hospitals, and nursing homes.

NUMBER OF VIRGINIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 109+**		STATE SIR	NAT'L SIR
CLABSI 81 hospitals	Virginia's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.58	0.56
CAUTI 81 hospitals	Virginia's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.89	1.03
SSI, Colon Surgery 76 hospitals	Virginia's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.76	0.80
SSI, Abdominal Hysterectomy 67 hospitals	Virginia's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.88	0.89

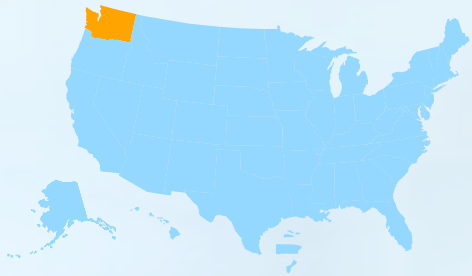
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WASHINGTON

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Washington requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

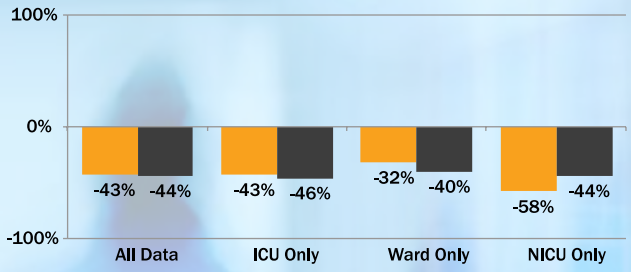
CLABSIs ↓ 43% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Washington hospitals did not report a significant change in CLABSIs between 2011 and 2012.

3% **3% of Washington hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

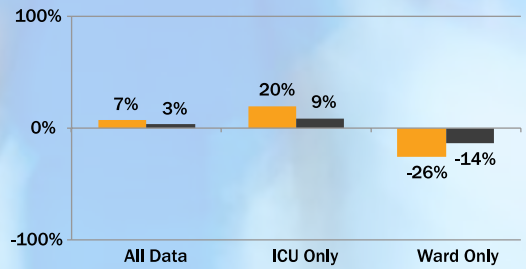
CAUTIs ↑ 7% HIGHER COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

16% **16% of Washington hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 32% LOWER COMPARED TO NAT'L BASELINE

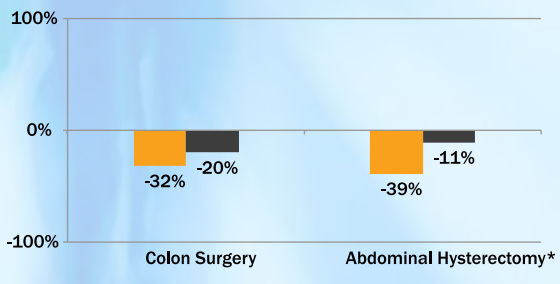
SSIs: ABDOMINAL HYSTERECTOMY ↓ 39% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

8% **8% of Washington hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



0 ZERO **0 Washington hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WASHINGTON

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Washington: **www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HealthcareAssociatedInfections.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS WASHINGTON DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

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

Washington has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- *Clostridium difficile*, deadly diarrheal infections
- MRSA infections
- Multidrug-resistant organism infections
- Ventilator-associated pneumonia infections

Washington implemented prevention efforts to improve antibiotic stewardship.

NUMBER OF WASHINGTON HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 103+**		STATE SIR	NAT'L SIR
CLABSI 63 hospitals	Washington's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.57	0.56
CAUTI 61 hospitals	Washington's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	1.07	1.03
SSI, Colon Surgery 62 hospitals	Washington's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.68	0.80
SSI, Abdominal Hysterectomy 60 hospitals	Washington's 2012 state **Abdominal Hysterectomy SSI** SIR is significantly better than the 2012 national SIR.	0.61	0.89

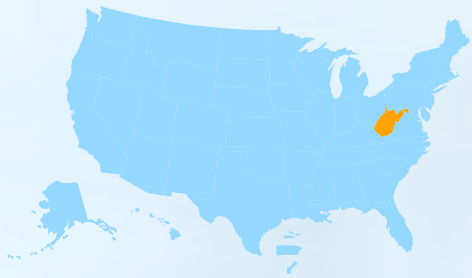
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WEST VIRGINIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). West Virginia requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

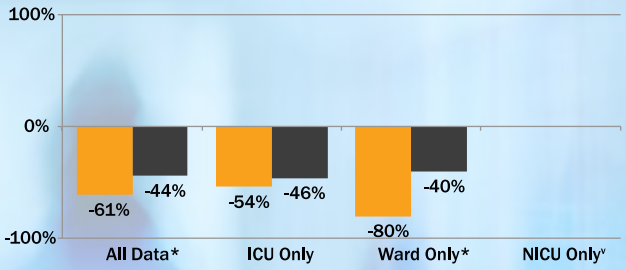
CLABSIs ↓ 61% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

West Virginia hospitals did not report a significant change in CLABSIs between 2011 and 2012.

14% **14% of West Virginia hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

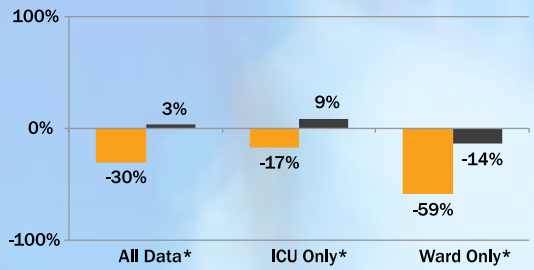
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 30% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

4% **4% of West Virginia hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

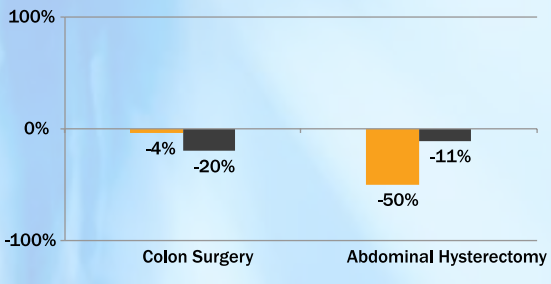
SSIs: COLON SURGERY ↓ 4% LOWER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 50% LOWER COMPARED TO NAT'L BASELINE

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

0 ZERO **0 West Virginia hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



Not enough data to report how many West Virginia hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WEST VIRGINIA

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in West Virginia: **www.dhhr.wv.gov/oeps/disease/HAI/Pages/default.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

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.

West Virginia has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Ventilator-associated pneumonia infections

West Virginia implemented prevention efforts in long-term care facilities.

NUMBER OF WEST VIRGINIA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 58+**		STATE SIR	NAT'L SIR
CLABSI 40 hospitals	West Virginia's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.39	0.56
CAUTI 43 hospitals	West Virginia's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.70	1.03
SSI, Colon Surgery 36 hospitals	West Virginia's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.96	0.80
SSI, Abdominal Hysterectomy 32 hospitals	West Virginia's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.50	0.89

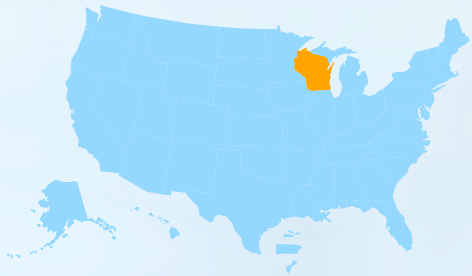
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WISCONSIN

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

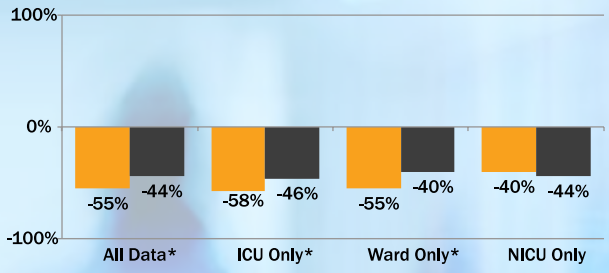
CLABSIs ↓ 55% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Wisconsin hospitals reported a significant decrease in CLABSIs between 2011 and 2012.

0 ZERO **0 Wisconsin hospitals have an SIR worse than the national SIR of 0.56.**

Changes in CLABSI vs. 2008 National Baseline



LEGEND

State National

✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness

Q State investigates data for this infection to assess completeness and quality

* Statistically significant difference

v Fewer than 5 facilities reported data

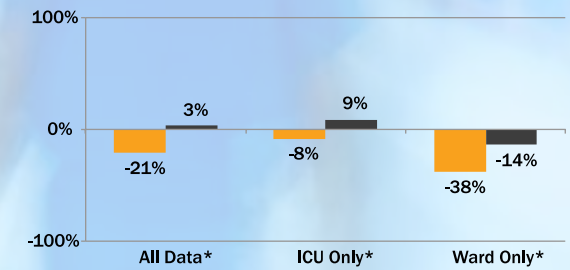
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 21% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

5% **5% of Wisconsin hospitals have an SIR worse than the national SIR of 1.03.**

Changes in CAUTI vs. 2009 National Baseline



SSIs: COLON SURGERY ↓ 17% LOWER COMPARED TO NAT'L BASELINE

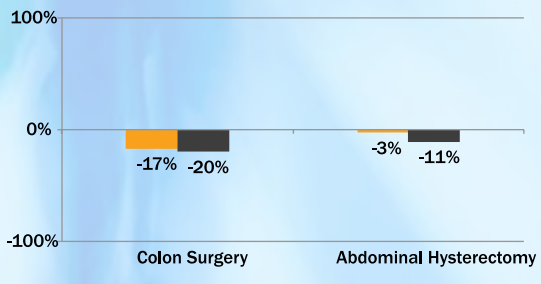
SSIs: ABDOMINAL HYSTERECTOMY ↓ 3% LOWER COMPARED TO NAT'L BASELINE

SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

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

9% **9% of Wisconsin hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

Changes in SSI vs. 2008 National Baseline



15% **15% of Wisconsin hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.**

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WISCONSIN

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Wisconsin: **www.dhs.wisconsin.gov/communicable/HAI/index.htm**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS WISCONSIN DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Wisconsin has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections
- Carbapenem-resistant Enterobacteriaceae infections

Wisconsin implemented prevention efforts in long-term care facilities and dialysis facilities.

NUMBER OF WISCONSIN HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 144+**		STATE SIR	NAT'L SIR
CLABSI 78 hospitals	Wisconsin's 2012 state **CLABSI** SIR is significantly better than the 2012 national SIR.	0.45	0.56
CAUTI 85 hospitals	Wisconsin's 2012 state **CAUTI** SIR is significantly better than the 2012 national SIR.	0.79	1.03
SSI, Colon Surgery 77 hospitals	Wisconsin's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	0.83	0.80
SSI, Abdominal Hysterectomy 71 hospitals	Wisconsin's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.97	0.89

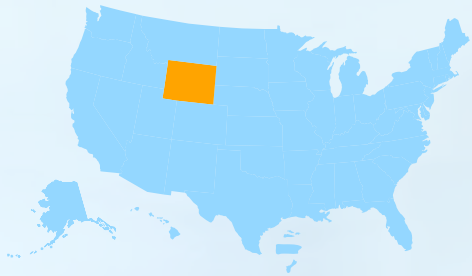
+ Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WYOMING

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Some states require hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

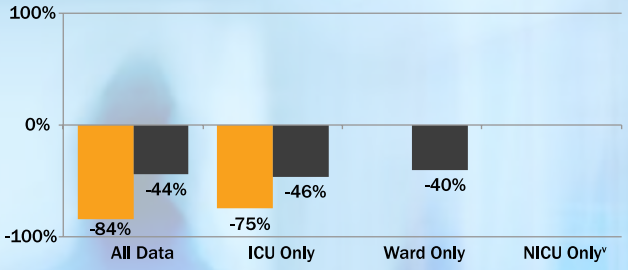
CLABSIs ↓ 84% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Wyoming hospitals did not report a significant change in CLABSIs between 2011 and 2012.

- **Not enough data** to report how many Wyoming hospitals have an SIR significantly worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- * Statistically significant difference
- v Fewer than 5 facilities reported data

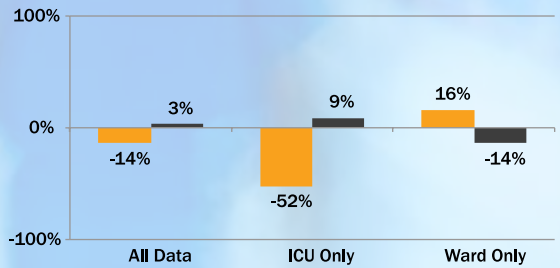
CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

CAUTIs ↓ 14% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

- **Not enough data** to report how many Wyoming hospitals have an SIR significantly worse than the national SIR of 1.03.

Changes in CAUTI vs. 2009 National Baseline



SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

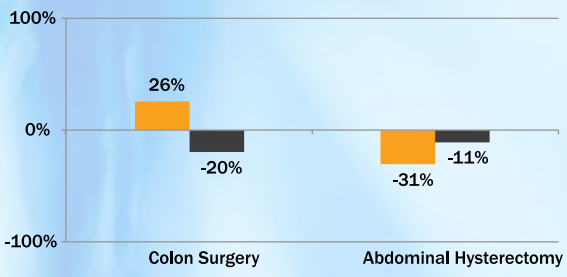
SSIs: COLON SURGERY ↑ 26% HIGHER COMPARED TO NAT'L BASELINE

SSIs: ABDOMINAL HYSTERECTOMY ↓ 31% LOWER COMPARED TO NAT'L BASELINE

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

- **Not enough data** to report how many Wyoming hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

Changes in SSI vs. 2008 National Baseline



- **Not enough data** to report how many Wyoming hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

WYOMING

HEALTHCARE ASSOCIATED INFECTIONS PROGRESS

Learn how your hospital is preventing infections: **www.medicare.gov/hospitalcompare**
For more information:

- 2012 HAI Progress Report: **www.cdc.gov/hai/progress-report/**
- Preventing HAIs: **www.cdc.gov/hai**
- NHSN: **www.cdc.gov/nhsn**
- HAIs in Wyoming: **health.wyo.gov/default.aspx**

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

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. 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.

✓Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

IF THE STATE SIR IS:

MORE THAN 1 — There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1 — There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1 — There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

WHAT IS WYOMING DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Wyoming has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *Clostridium difficile*, deadly diarrheal infections

NUMBER OF WYOMING HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012 **Total Hospitals: 31+**		STATE SIR	NAT'L SIR
CLABSI 20 hospitals	Wyoming's 2012 state **CLABSI** SIR is similar to the 2012 national SIR.	0.16	0.56
CAUTI 24 hospitals	Wyoming's 2012 state **CAUTI** SIR is similar to the 2012 national SIR.	0.86	1.03
SSI, Colon Surgery 12 hospitals	Wyoming's 2012 state **Colon Surgery SSI** SIR is similar to the 2012 national SIR.	1.26	0.80
SSI, Abdominal Hysterectomy 13 hospitals	Wyoming's 2012 state **Abdominal Hysterectomy SSI** SIR is similar to the 2012 national SIR.	0.69	0.89

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

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014

The *National and State Healthcare-Associated Infections 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, but catheter-associated urinary tract infections (CAUTI) have increased since 2009. CDC-recommended infection prevention strategies for several infection types, including CAUTI, have proven effective in a variety of patient care locations. CDC will continue to assist public health and clinical partners with implementation of those recommendations, especially as it relates to reversing the current CAUTI trend. 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 in 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 and report movement toward the HHS HAI Action Plan targets. These goals are most likely to be met with targeted efforts to cut infection types shown to be lagging behind and continued effort 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 *National and State Healthcare-Associated Infections Progress Report* presents data reported to NHSN for the calendar year 2012. The healthcare-associated infection (HAI) data was reported either by mandate or voluntarily from facilities in all 50 states, Washington, D.C., and Puerto Rico. Data included in the 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) and *Clostridium difficile* (*C. difficile*) events. To account for delayed reporting, data reported through September 3, 2013 were included.

Data in this report are from acute care hospitals only. Due to ongoing efforts to create more accurate location categories for long-term acute care and rehabilitation hospitals, data from these facilities were excluded. The CLABSI and CAUTI data are stratified using mutually exclusive categories: critical care units (ICUs) and wards. For this report, wards include step-down units and specialty care areas including hematology/oncology and bone marrow transplant units. CLABSI data is also reported from neonatal intensive care units (NICUs). The SSI data in this report include 10 commonly reported surgical procedures that approximate the procedures included in the Centers for Medicare & Medicaid Services (CMS) Surgical Care Improvement Project. Only deep incisional and organ/space infections detected during the same admission as the surgical procedure or upon readmission to the same facility that performed the surgical procedure are included in the reported SIRs; superficial incisional SSIs and those identified on post-discharge surveillance are excluded. 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 presence of HAI reporting mandates in their states and efforts to validate 2012 HAI data. This report followed the same methodology as last year's report to estimate the number of hospitals in each state. The risk adjustment methodology used to produce the CLABSI, CAUTI, and SSI SIRs are summarized in previous reports and have not changed. National 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 bedsize and affiliation with a medical school, admission prevalence rate, and laboratory identification method for *C. difficile* infections.

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 calendar year 2011. The SIRs published in this report compare the observed number of infections reported to NHSN during 2012 to the predicted number of infections based on infection rates during the referent period, adjusting for key risk factors. Progress in preventing CLABSI, CAUTI, and SSI was evaluated by comparing 2011 and 2012 SIRs by infection type and location category or the surgical procedure. SIRs between the two reporting years were compared for all reporting facilities, and only for facilities reporting the infection for at least one month in both years as a sensitivity analysis.

State-specific CLABSI SIRs have been included in previous reports; this report includes additional state-specific SIRs for CAUTI and SSIs following the two surgical procedures reported to the CMS Hospital Inpatient Quality Reporting (IQR) program, colon surgery and abdominal hysterectomy surgery. A state SIR was only calculated if at least 5 hospitals in the state reported any data for a given location category or surgical procedure in 2012. State SIRs were compared to the national SIR with the state's data removed; significance was assessed using a conditional binomial 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 category or procedure category; the percent of facilities significantly higher or lower than the national SIR was calculated both nationally and by state.

REFERENCES

Centers for Medicare and Medicaid Services. Inpatient Quality Reporting Program – Healthcare-associated Infections. Available at https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021. Accessed February 21, 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 February 21, 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. 2011 National and State Healthcare-Associated Infection Standardized Infection Ratio Report. Available at http://www.cdc.gov/hai/pdfs/SIR/SIR-Report_02_07_2013.pdf. Accessed February 21, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for central line-associated bloodstream infections. Available at http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html. Accessed February 21, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for catheter-associated urinary tract infections. Available at http://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html. Accessed February 21, 2014.

Centers for Disease Control and Prevention. Acute care hospital surveillance for surgical site infections. Available at http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html. Accessed February 21, 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 February 21, 2014.

US Department of Health and Human Services. National Action Plan to Prevent Health Care-Associated Infections. Available at http://www.health.gov/hai/prevent_hai.asp#hai_measures. Accessed February 21, 2014.

Centers for Disease Control and Prevention. NHSN validation guidance and toolkit; validation for 2012 central line-associated bloodstream infections in ICUs. Available at http://www.cdc.gov/nhsn/PDFs/CLABSI/toolkit-2012/2012-CLABSI-Validation-toolkit.pdf. Accessed February 21, 2014.

ACKNOWLEDGEMENTS

We thank the infection preventionists, hospital epidemiologists, and other dedicated hospital staff who report surveillance data to NHSN. We also thank our colleagues in HAI programs in state and local health departments.

This report was prepared by the following CDC staff: Kathryn Arnold, Lacey Avery, Ramona Bennett, Kristen Brinsley-Rainisch, Meredith Boyter, Nicole Coffin, Swapna Deshpande, Margaret Dudeck, Jonathan Edwards, Susan Fuller, Rosa Herrera, Renee Maciejewski, Paul Malpiedi, Fred Maxineau, L. Clifford McDonald, Rose Pecoraro, Kelly Peterson, Minn Soe, Jason Snow, Abbigail Tumpey, Lindsey Weiner, Matthew West, and Kim Zimmerman, Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Diseases.

NATIONAL AND STATE HEALTHCARE-ASSOCIATED INFECTIONS PROGRESS REPORT

Suggested citation: Centers for Disease Control and Prevention. 2012 National and State Healthcare-Associated Infections Progress Report. Published March 26, 2014. Available at www.cdc.gov/hai/progress-report/index.html.

CS244683-B