

# Executive summary: Health care-associated infections in Oregon hospitals — 2014

**Health care-associated infections (HAIs)** can have devastating consequences for patients. The summary below shows how 2014 data from 61 Oregon hospitals compares to: 1) recent HAI data for the U.S. as a whole; and 2) national HAI reduction targets set for 2013 by the U.S. Department of Health and Human Services (HHS).\*

## CLABSIs†

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS 35 INFECTIONS

A CLABSI occurs when germs enter the blood along a tube (central line) placed in a large vein.

Oregon hospitals } ✓ Performed statistically better than the U.S.  
 ✓ Exceeded national reduction target set by HHS

## MRSA BLOODSTREAM INFECTIONS (MRSA BSIs)

HOSPITAL-ONSET MRSA BSI 61 LABORATORY-IDENTIFIED EVENTS

An MRSA BSI is a difficult to treat infection caused by germs that enter the body through wounds or medical devices.

Oregon hospitals } ✓ Performed statistically better than the U.S.  
 ✓ Exceeded national reduction target set by HHS

## C. Difficile infections

HOSPITAL-ONSET C. DIFFICILE 732 LABORATORY-IDENTIFIED EVENTS

*C. difficile* spreads to patients from unclean hands and surfaces in hospitals, leading to colon infection and diarrhea.

Oregon hospitals } ✓ Performed statistically better than the U.S.  
 ✗ Did not meet national reduction target set by HHS

## CAUTIs

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS 182 INFECTIONS

CAUTIs occur when germs travel up a urinary catheter that was not put in correctly, not kept clean, or left in too long.

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✗ Did not meet national reduction target set by HHS

## SSIs

SURGICAL SITE INFECTIONS

An SSI occurs when germs enter a surgical wound during or after surgery. The data below are for deep incisional and organ space SSIs only.

Coronary artery bypass graft (heart surgery) 10 SSI

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✓ Exceeded national reduction target set by HHS

Laminectomy (back surgery) 30 SSI

Oregon hospitals } ⚠ No recent national comparison available  
 ✓ Exceeded national reduction target set by HHS

Colon surgery 101 SSI

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✗ Did not meet national reduction target set by HHS

Abdominal hysterectomy surgery 25 SSI

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✗ Did not meet national reduction target set by HHS

Hip replacement surgery 56 SSI

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✗ Did not meet national reduction target set by HHS

Knee replacement surgery 41 SSI

Oregon hospitals } = Performed statistically equal to the U.S.  
 ✓ Exceeded national reduction target set by HHS

### THE TAKE AWAY

In 2014, Oregon hospitals exceeded national targets for reducing bloodstream infections and infections following heart, back and knee surgeries. More work is needed to prevent *C. difficile* infections, catheter-associated urinary tract infections and infections following colon, hysterectomy and hip surgeries.

\* Statistical comparisons made using the Oregon 2014 standardized infection ratio (SIR) for each infection; see table.

† All CLABSIs combined for adult and neonatal ICUs; see table for separate data by ICU type

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Health care-associated infection type	National baseline years	HHS reduction target*	# OR hospitals reporting†	2014 Oregon SIR‡	2014 SIR meets HHS reduction target?	2014 OR SIR vs. 2013 nat'l SIR <sup>  </sup>	2014 OR SIR vs. 2013 OR SIR <sup>§</sup>
<b>CLABSI in adult ICUs</b>	2006–2008	50% (SIR=0.5)	<b>41</b>	<b>0.24</b>	<b>✓ YES</b>	<b>✓</b> Statistically better	<b>↓ 16%</b>
<b>CLABSI in NICUs</b>	2006–2008	50% (SIR=0.5)	<b>7</b>	<b>0.60</b>	<b>✗ NO</b>	<b>=</b> Statistically equal	<b>↑ 103%</b>
<b>CAUTI in ICUs</b>	2009	25% (SIR=0.75)	<b>42</b>	<b>1.11</b>	<b>✗ NO</b>	<b>=</b> Statistically equal	<b>⊘ N/A</b> (no 2013 data)
<b><i>C. difficile</i> hospital-onset LabID events</b>	2010–2011	30% (SIR=0.7)	<b>61</b>	<b>0.73</b>	<b>✗ NO</b>	<b>✓</b> Statistically better	<b>↓ 4%</b>
<b>MRSA BSI hospital-onset LabID events</b>	2010–2011	25% (SIR=0.75)	<b>61</b>	<b>0.65</b>	<b>✓ YES</b>	<b>✓</b> Statistically better	<b>⊘ N/A</b> (no 2013 data)
<b>SSI: Heart (CBGB)</b>	2006–2008	25% (SIR=0.75)	<b>14</b>	<b>0.35</b>	<b>✓ YES</b>	<b>=</b> Statistically equal	<b>↓ 42%</b>
<b>SSI: Back (laminectomy)</b>	2006–2008	25% (SIR=0.75)	<b>22</b>	<b>0.53</b>	<b>✓ YES</b>	<b>⊘</b> No 2013 national data	<b>↓ 38%</b>
<b>SSI: Colon</b>	2006–2008	25% (SIR=0.75)	<b>41</b>	<b>0.85</b>	<b>✗ NO</b>	<b>=</b> Statistically equal	<b>↑ 10%</b>
<b>SSI: Abdominal hysterectomy</b>	2006–2008	25% (SIR=0.75)	<b>35</b>	<b>0.91</b>	<b>✗ NO</b>	<b>=</b> Statistically equal	<b>↓ 20%</b>
<b>SSI: Hip replacement</b>	2006–2008	25% (SIR=0.75)	<b>42</b>	<b>0.83</b>	<b>✗ NO</b>	<b>=</b> Statistically equal	<b>↑ 14%</b>
<b>SSI: Knee replacement</b>	2006–2008	25% (SIR=0.75)	<b>43</b>	<b>0.65</b>	<b>✓ YES</b>	<b>=</b> Statistically equal	<b>↓ 6%</b>

\* The U.S. Department of Health and Human Services (HHS) determined target 5-year HAI reductions in 2009: [www.health.gov/hcq/pdfs/HAI-Targets.pdf](http://www.health.gov/hcq/pdfs/HAI-Targets.pdf)

† Hospitals are exempt from reporting CLABSIs if fewer than 50 central line days, CAUTIs if they have no ICUs and specific SSIs if fewer than 20 procedures performed annually

‡ Standardized Infection Ratio: (observed infections)/(expected # based on risk-adjusted national baseline rates)

<sup>||</sup> No 2014 national data available at the time of report publication, so 2013 data were used, available here: [www.cdc.gov/hai/progress-report/index.html](http://www.cdc.gov/hai/progress-report/index.html)

<sup>§</sup> None of the changes in state SIRs from 2013 to 2014 were statistically significant