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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:

- CLABS - 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
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- **No arrow** indicates there was not a significant change
NATIONAL FACTSHEETS
NATIONAL HEALTHCARE-ASSOCIATED INFECTIONS

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.

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

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.

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.

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

- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014
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).

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

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

Learn how well your hospital prevents infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
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).

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

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

* Statistically significant decrease since 2008

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

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.

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
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

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.

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

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.

1.175 hospitals across the nation reported MRSA bloodstream infection data in 2012.

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

1.681 hospitals across the nation reported C. difficile data in 2012.

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

- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
ALABAMA

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.

**LEGEND**

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

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

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**

CAUTIs ↓ 25% 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.

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

**SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY**

SSIs: Colon Surgery ↓ 43% LOWER COMPARED TO NAT’L BASELINE

Surgeons 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 Alabama hospitals have a colon surgery SIR worse than the national SIR of 0.80.

SSIs: Abdominal Hysterectomy ↓ 46% LOWER COMPARED TO NAT’L BASELINE

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**
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>0.66</td>
<td>0.56</td>
</tr>
<tr>
<td>76 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>0.75</td>
<td>1.03</td>
</tr>
<tr>
<td>90 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>0.57</td>
<td>0.80</td>
</tr>
<tr>
<td>74 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>0.54</td>
<td>0.89</td>
</tr>
<tr>
<td>64 hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.

Learn how your hospital is preventing infections: www.medicare.gov/hospitalcompare
For more information:
- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
- HAIs in Alabama: www.adph.org/hai/
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.

**LEGEND**

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

**ALASKA**

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**

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.

**CAUTIs**

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.

**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 Alaska hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.
- **Not enough data** to report how many Alaska hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.
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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>11</td>
<td>1.11</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>12</td>
<td>1.33</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>9</td>
<td>1.57</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>9</td>
<td>0.38</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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.

FOR MORE INFORMATION:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Alaska: [www.epi.alaska.gov/](http://www.epi.alaska.gov/)

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

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Healthcare-associated infections (HAI) 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)

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

Catheter-Associated Urinary Tract Infections (CAUTIs)

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

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

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI, 58 hospitals</td>
<td>0.64</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI, 58 hospitals</td>
<td>1.11</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery, 54 hospitals</td>
<td>1.12</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy, 51 hospitals</td>
<td>1.23</td>
<td>0.89</td>
</tr>
</tbody>
</table>

NOTES:

- 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

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

- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
- HAIs in Arizona: www.preventHAIaz.gov
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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIs)**

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.

- **44%** of Arkansas hospitals have an SIR worse than the national SIR of 0.56.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTIs)**

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

**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.

- **2%** of Arkansas hospitals have an SIR worse than the national SIR of 0.80.

SSIs: Colon Surgery **2%** Lower Compared to Nat’l Baseline

SSIs: Abdominal Hysterectomy **20%** Lower Compared to Nat’l Baseline

**THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014**
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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Total Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>49 hospitals</td>
<td>0.56</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>51 hospitals</td>
<td>1.11</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>40 hospitals</td>
<td>0.98</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>39 hospitals</td>
<td>0.81</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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.

**Central Line-Associated Bloodstream Infections (CLABSIs)**

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

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

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

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

**Notes:**
- This report is based on 2012 data, published March 2014.

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.

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

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 DOES THE STANDARDIZED INFECTION RATIO MEAN?

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>0.53</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>0.85</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>0.70</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>0.77</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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

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

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

**SSIs: ABDOMINAL HYSTERECTOMY**

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

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THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014
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.

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

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>51</td>
<td>0.47</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>50</td>
<td>0.92</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>57</td>
<td>0.74</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>56</td>
<td>0.80</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Colorado’s 2012 state SIR is significantly better than the 2012 national SIR.

Colorado’s 2012 state SIR is similar to the 2012 national SIR.

Learn how your hospital is preventing infections: www.medicare.gov/hospitalcompare

For more information:
- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
- HAIs in Colorado: www.healthfacilities.info

This report is based on 2012 data, published March 2014.
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)**

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

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

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

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

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.

*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 CONNECTICUT HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI 30 hospitals</td>
<td>Connecticut’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.</td>
<td>0.70</td>
</tr>
<tr>
<td>CAUTI 30 hospitals</td>
<td>Connecticut’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.</td>
<td>1.84</td>
</tr>
<tr>
<td>SSI, Colon Surgery 30 hospitals</td>
<td>Connecticut’s 2012 state Colon Surgery SSI SIR is significantly worse than the 2012 national SIR.</td>
<td>0.99</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy 28 hospitals</td>
<td>Connecticut’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>1.05</td>
</tr>
</tbody>
</table>

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014.
Healthcare-associated infections (HAI s) 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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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.

- **CLABSIs ↓ 58% 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.

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

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

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

**SSIs: ABDOMINAL HYSTERECTOMY ↑ 6% HIGHER COMPARED TO NAT’L BASELINE**

This report is based on 2012 data, published March 2014.
DELAWARE 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.

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

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Delaware’s 2012 SIR</th>
<th>National’s 2012 SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>Delaware’s 2012 state CLABSI SIR is similar to the 2012 national SIR.</td>
<td>0.42</td>
</tr>
<tr>
<td>8 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>Delaware’s 2012 state CAUTI SIR is similar to the 2012 national SIR.</td>
<td>1.06</td>
</tr>
<tr>
<td>8 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>Delaware’s 2012 state Colon Surgery SSI SIR is similar to the 2012 national SIR.</td>
<td>0.67</td>
</tr>
<tr>
<td>7 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>Delaware’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>1.06</td>
</tr>
<tr>
<td>7 hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Delaware: [dhss.delaware.gov/dph/epi/delawarehai.html](http://dhss.delaware.gov/dph/epi/delawarehai.html)
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

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.

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 District of Columbia hospitals have an SIR significantly worse than the national SIR of 1.03.

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 District of Columbia hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

- 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.
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.

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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>8 hospitals</td>
<td>0.78</td>
<td>0.56</td>
<td>District of Columbia’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>7 hospitals</td>
<td>1.32</td>
<td>1.03</td>
<td>District of Columbia’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>7 hospitals</td>
<td>0.49</td>
<td>0.80</td>
<td>District of Columbia’s 2012 state Colon Surgery SSI SIR is significantly better than the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>7 hospitals</td>
<td>1.39</td>
<td>0.89</td>
<td>District of Columbia’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
</tr>
</tbody>
</table>

+ 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

Learn how your hospital is preventing infections: www.medicare.gov/hospitalcompare

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
Healthcare-associated infections (HAI) 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**

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

**CATHERETER-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.

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

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

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

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

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

**THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014**
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals</th>
<th>FLORIDA’S 2012 SIR</th>
<th>NATIONAL SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>187 hospitals</td>
<td>Florida’s 2012 state CLABSI SIR similar to the 2012 national SIR.</td>
<td>0.55</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>187 hospitals</td>
<td>Florida’s 2012 state CAUTI SIR is significantly better than the 2012 national SIR.</td>
<td>0.84</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>180 hospitals</td>
<td>Florida’s 2012 state Colon Surgery SSI SIR is significantly better than the 2012 national SIR.</td>
<td>0.72</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>170 hospitals</td>
<td>Florida’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>0.96</td>
</tr>
</tbody>
</table>

+ 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.
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.

**GEORGIA**

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**

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

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

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

**SSIs: ABDOMINAL HYSTERECTOMY**

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

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WHAT IS THE STANDARDIZED INFECTION RATIO?

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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*

<table>
<thead>
<tr>
<th>Condition</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI 105 hospitals</td>
<td>0.67</td>
<td>0.56</td>
</tr>
<tr>
<td>Georgia’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAUTI 107 hospitals</td>
<td>1.01</td>
<td>1.03</td>
</tr>
<tr>
<td>Georgia’s 2012 state CAUTI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI, Colon Surgery 99 hospitals</td>
<td>0.83</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy 91 hospitals</td>
<td>0.87</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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

Learn how your hospital is preventing infections: www.medicare.gov/hospitalcompare

For more information:

- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
- HAIs in Georgia: dph.georgia.gov/healthcare-associated-infections
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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIs)**

Changes in CLASI vs. 2008 National Baseline

- **State**: -80%
- **National**: -44%
- **ICU Only**: -76%
- **Ward Only**: -46%
- **NICU Only**: -40%

**LEGEND**
- **State** examines data and reviews medical charts for this infection to confirm accuracy and completeness.
- **Statistically significant difference**
- **Fewer than 5 facilities reported data**

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

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTIs)**

Changes in CAUTI vs. 2009 National Baseline

- **State**: -1%
- **National**: -17%
- **Ward Only**: -9%
- **ICU Only**: -39%

**LEGEND**
- **State** investigates data for this infection to assess completeness and quality.

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

**SURGICAL SITE INFECTIONS: COLON SURGERY**

Changes in SSI vs. 2008 National Baseline

- **State**: -3%
- **National**: -20%
- **Abdominal Hysterectomy**: -11%

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

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.

**SURGICAL SITE INFECTIONS: ABDOMINAL HYSTERECTOMY**

- **State**: 10%
- **National**: 0%

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

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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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>Hawaii’s 2012 State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>15</td>
<td>0.99</td>
<td>1.03</td>
</tr>
<tr>
<td>CLABSI</td>
<td>15</td>
<td>0.20</td>
<td>0.56</td>
</tr>
<tr>
<td>Colon Surgery SSI</td>
<td>13</td>
<td>0.97</td>
<td>0.80</td>
</tr>
<tr>
<td>Abdominal Hysterectomy SSI</td>
<td>10</td>
<td>1.10</td>
<td>0.89</td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
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**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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.

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

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

Surgeons 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.

**SSIs: ABDOMINAL HYSTERECTOMY 0 INFECTIONS IN 2012**

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

**LEGEND**

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

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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

<table>
<thead>
<tr>
<th>Infection</th>
<th>Number of Hospitals</th>
<th>2012 Idaho State SIR</th>
<th>2012 National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>12</td>
<td>0.32</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>15</td>
<td>1.15</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>15</td>
<td>0.72</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>14</td>
<td>0.00</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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.*

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- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Idaho: [healthandwelfare.idaho.gov/Health/tabid/60/Default.aspx](http://healthandwelfare.idaho.gov/Health/tabid/60/Default.aspx)
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### Central Line-Associated Bloodstream Infections (CLABSIs)

- **Status:** Statistically significant difference
- **Fewer than 5 facilities reported data**
- **State examines data and reviews medical charts for this infection to confirm accuracy and completeness**

**ILEINOIS**

- **LEGEND**
  - [ ] Fewer than 5 facilities reported data
  - [ ] State investigates data for this infection to assess completeness and quality
  - [ ] Statistically significant difference

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

### Catheter-Associated Urinary Tract Infections (CAUTIs)

- **Status:** Fewer than 5 facilities reported data
- **State investigates data for this infection to assess completeness and quality**

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

### Surgical Site Infections: Colon Surgery

- **Status:** Lower compared to national 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%** of Illinois hospitals have a colon surgery SIR worse than the national SIR of 0.80.

### Surgical Site Infections: Abdominal Hysterectomy

- **Status:** Lower compared to national baseline

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

<table>
<thead>
<tr>
<th>NUMBER OF ILLINOIS HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Hospitals: 207</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLABSI</strong> 146 hospitals</td>
<td>Illinois’ 2012 state CLABSI SIR is similar to the 2012 national SIR.</td>
<td>0.57</td>
</tr>
<tr>
<td><strong>CAUTI</strong> 147 hospitals</td>
<td>Illinois’ 2012 state CAUTI SIR is similar to the 2012 national SIR.</td>
<td>1.02</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong> 140 hospitals</td>
<td>Illinois’ 2012 state Colon Surgery SSI SIR is significantly better than the 2012 national SIR.</td>
<td>0.60</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong> 137 hospitals</td>
<td>Illinois’ 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>0.91</td>
</tr>
</tbody>
</table>

*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.*
Healthcare-associated infections (HAI) 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.

**INDIANA**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

Changes in CLABSI vs. 2008 National Baseline

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

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

**SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY**

Changes in SSI vs. 2008 National Baseline

- **SSIs: Colon Surgery ↑ 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.

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

- **SSIs: Abdominal Hysterectomy ↓ 48%** LOWER COMPARED TO NAT’L BASELINE

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Hospitals Reported</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>102 hospitals</td>
<td>0.66</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>104 hospitals</td>
<td>1.05</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>105 hospitals</td>
<td>1.04</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>98 hospitals</td>
<td>0.52</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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**

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

**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.

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

**SURGICAL SITE INFECTIONS: COLON 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% of Iowa hospitals have a colon surgery SIR worse than the national SIR of 0.80.

**SSIS: ABDOMINAL HYSSTERECTOMY**

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 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.

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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Total Hospitals</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>48 hospitals</td>
<td>0.46</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>68 hospitals</td>
<td>0.95</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>34 hospitals</td>
<td>0.99</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>32 hospitals</td>
<td>1.20</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Iowa: [www.idph.state.ia.us/hai_prevention/](http://www.idph.state.ia.us/hai_prevention/)
Healthcare-associated infections (HAI) 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**

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

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

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

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

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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>Description</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>46 hospitals</td>
<td>CLABSI</td>
<td>0.51</td>
<td>0.56</td>
</tr>
<tr>
<td>52 hospitals</td>
<td>CAUTI</td>
<td>0.96</td>
<td>1.03</td>
</tr>
<tr>
<td>43 hospitals</td>
<td>SSI, Colon Surgery</td>
<td>0.94</td>
<td>0.80</td>
</tr>
<tr>
<td>41 hospitals</td>
<td>SSI, Abdominal Hysterectomy</td>
<td>0.65</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Kansas: [www.kdheks.gov/epi/hsi.htm](http://www.kdheks.gov/epi/hsi.htm)

This report is based on 2012 data, published March 2014.
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)

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

Catheter-Associated Urinary Tract Infections (CAUTIs)

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

Surgical Site Infections: Colon 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% of Kentucky hospitals have a colon surgery SIR worse than the national SIR of 0.80.

Surgical Site Infections: Abdominal Hysterectomy

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.
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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>71 hospitals</td>
<td>0.89</td>
</tr>
<tr>
<td>Kentucky’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>72 hospitals</td>
<td>1.18</td>
</tr>
<tr>
<td>Kentucky’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>65 hospitals</td>
<td>0.79</td>
</tr>
<tr>
<td>Kentucky’s 2012 state Colon Surgery SSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>61 hospitals</td>
<td>0.79</td>
</tr>
<tr>
<td>Kentucky’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\*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.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Kentucky: [chfs.ky.gov/dph/epi/hai](http://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.
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)**

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

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

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

**Surgical Site Infections: Colon 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%** of Louisiana hospitals have a colon surgery SIR worse than the national SIR of 0.80.

**Surgical Site Infections: Abdominal Hysterectomy**

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

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

<table>
<thead>
<tr>
<th>NUMBER OF LOUISIANA HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitals: 172*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLABSI, 75 hospitals</td>
<td>Louisiana’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.</td>
<td>0.70</td>
</tr>
<tr>
<td>CAUTI, 78 hospitals</td>
<td>Louisiana’s 2012 state CAUTI SIR is significantly better than the 2012 national SIR.</td>
<td>0.84</td>
</tr>
<tr>
<td>SSI, Colon Surgery, 75 hospitals</td>
<td>Louisiana’s 2012 state Colon Surgery SSI SIR is significantly worse than the 2012 national SIR.</td>
<td>0.99</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy, 81 hospitals</td>
<td>Louisiana’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>1.08</td>
</tr>
</tbody>
</table>
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.

**MAINE**

**HEALTHCARE ASSOCIATED INFECTIONS PROGRESS**

Central Line-Associated Bloodstream Infections (CLABSIs)

- **CLABSIs** ↓ 7%
  - Lower compared to national baseline

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

- Not enough data to report how many Maine hospitals have a SIR significantly worse than the national SIR of 0.56.

Catheter-Associated Urinary Tract Infections (CAUTIs)

- **CAUTIs** ↑ 91%
  - Higher compared to national baseline

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

Surgical Site Infections:

- **Colon Surgery** ↑ 22%
  - Higher compared to national baseline

- **Abdominal Hysterectomy** ↓ 24%
  - Lower compared to national baseline

31% of Maine hospitals have a SIR worse than the national SIR of 0.89.

This report is based on 2012 data, published March 2014.
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.

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

<table>
<thead>
<tr>
<th>HAI Category</th>
<th>Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central line-associated bloodstream infections (CLABSI)</td>
<td>22 hospitals</td>
<td>0.93</td>
<td>0.56</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infections (CAUTI)</td>
<td>22 hospitals</td>
<td>1.91</td>
<td>1.03</td>
</tr>
<tr>
<td>Clostridium difficile, deadly diarrheal infections (SSI, Colon Surgery)</td>
<td>24 hospitals</td>
<td>1.22</td>
<td>0.80</td>
</tr>
<tr>
<td>MRSA infections (SSI, Abdominal Hysterectomy)</td>
<td>21 hospitals</td>
<td>0.77</td>
<td>0.89</td>
</tr>
</tbody>
</table>

* 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.
**MARYLAND**

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

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

**CAUTIs** ↑ 89% **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.

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

### 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.

- **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**
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.

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.

NUMBER OF MARYLAND HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>47 hospitals</td>
<td>0.55</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>38 hospitals</td>
<td>1.89</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>10 hospitals</td>
<td>0.87</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>8 hospitals</td>
<td>2.18</td>
<td>0.89</td>
</tr>
</tbody>
</table>

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

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

**CAUTIs ↑ 45% 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.

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

### SURGICAL SITE INFECTIONS: COLON SURGERY

**SSIs: COLON SURGERY ↓ 19% 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% of Massachusetts hospitals have a colon surgery SIR worse than the national SIR of 0.80.

### SURGICAL SITE INFECTIONS: ABDOMINAL HYSTERECTOMY

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

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

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

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 DOES THE STANDARDIZED INFECTION RATIO MEAN?

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

<table>
<thead>
<tr>
<th></th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Hospitals:</strong> 95*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **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
Healthcare-associated infections (HAs) 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)**

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

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTIs)**

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

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

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

**LEGEND**

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

**THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014**
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Hospitals</th>
<th>Michigan’s 2012 SIR</th>
<th>National’s 2012 SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>95</td>
<td>Michigan’s 2012 CLABSI SIR is significantly better than the 2012 national SIR.</td>
<td>0.43</td>
</tr>
<tr>
<td>CAUTI</td>
<td>97</td>
<td>Michigan’s 2012 CAUTI SIR is similar to the 2012 national SIR.</td>
<td>1.00</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>91</td>
<td>Michigan’s 2012 Colon Surgery SSI SIR is similar to the 2012 national SIR.</td>
<td>0.86</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>86</td>
<td>Michigan’s 2012 Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>1.07</td>
</tr>
</tbody>
</table>

*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 (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)**

- **Changes in CLABSIs vs. 2008 National Baseline**
  - 52% lower compared to national baseline

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

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

- **Changes in CAUTI vs. 2009 National Baseline**
  - 52% higher compared to national baseline

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

**Surgical Site Infections (SSIs): Colon Surgery**

- **Changes in SSI vs. 2008 National Baseline**
  - 33% lower compared to national baseline

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

**Surgical Site Infections: Abdominal Hysterectomy**

- **Changes in SSI vs. 2008 National Baseline**
  - 8% higher compared to national baseline

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

This report is based on 2012 data, published March 2014.
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.

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

<table>
<thead>
<tr>
<th>Infection</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>Minnesota’s 2012 state <strong>CLABSI</strong> SIR is similar to the 2012 national SIR.</td>
<td>0.48</td>
</tr>
<tr>
<td>49 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>Minnesota’s 2012 state <strong>CAUTI</strong> SIR is significantly worse than the 2012 national SIR.</td>
<td>1.52</td>
</tr>
<tr>
<td>51 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>Minnesota’s 2012 state <strong>Colon Surgery SSI</strong> SIR is similar to the 2012 national SIR.</td>
<td>0.67</td>
</tr>
<tr>
<td>49 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>Minnesota’s 2012 state <strong>Abdominal Hysterectomy SSI</strong> SIR is similar to the 2012 national SIR.</td>
<td>1.08</td>
</tr>
<tr>
<td>50 hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Minnesota: [www.health.state.mn.us/divs/idepc/dtopics/hai/index.html](http://www.health.state.mn.us/divs/idepc/dtopics/hai/index.html)
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.

**MISSISSIPPI**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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

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

**CLABSIs ↓ 6%** LOWER COMPARED TO NAT’L BASELINE

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

**CATHERET-ASSOCIATED URINARY TRACT INFECTIONS**

**SSIs: COLON SURGERY ↓ 19%** 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.

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

**SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTEROECTOMY SURGERY**

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

- **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**
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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>2012 State SIR</th>
<th>2012 National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitals: 111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLABSI 46 hospitals</td>
<td>0.94</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI 46 hospitals</td>
<td>1.19</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery 41 hospitals</td>
<td>0.81</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy 43 hospitals</td>
<td>1.33</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Mississippi’s 2012 state CLABSI SIR is significantly worse than the 2012 national SIR.

Mississippi’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.

Mississippi’s 2012 state Colon Surgery SSI SIR is similar to the 2012 national SIR.

Mississippi’s 2012 state Abdominal Hysterectomy SSI SIR is significantly worse than the 2012 national SIR.

+ 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.
Healthcare-associated infections (HAI) 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**

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Reporting Hospitals</th>
<th>Missouri’s 2012 SIR</th>
<th>Missouri’s 2012 SIR Compared to National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>74 hospitals</td>
<td>0.46</td>
<td>Missouri’s 2012 CLABSI SIR is significantly better than the 2012 national SIR.</td>
</tr>
<tr>
<td>CAUTI</td>
<td>75 hospitals</td>
<td>0.96</td>
<td>Missouri’s 2012 CAUTI SIR is similar to the 2012 national SIR.</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>72 hospitals</td>
<td>0.64</td>
<td>Missouri’s 2012 Colon Surgery SSI SIR is significantly better than the 2012 national SIR.</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>69 hospitals</td>
<td>0.69</td>
<td>Missouri’s 2012 Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Missouri: [health.mo.gov/data/hai/index.php](http://health.mo.gov/data/hai/index.php)

*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.*
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.

### Montana

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

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.

### 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 Montana hospitals have an SIR worse than the national SIR of 1.03.

### Surgical Site Infections: Colon 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.

### Surgical Site Infections: Abdominal Hysterectomy

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>12 hospitals</td>
<td>0.49</td>
<td>0.56</td>
</tr>
<tr>
<td>Montana’s 2012 state CLABSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAUTI</td>
<td>13 hospitals</td>
<td>0.92</td>
<td>1.03</td>
</tr>
<tr>
<td>Montana’s 2012 state CAUTI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>14 hospitals</td>
<td>0.47</td>
<td>0.80</td>
</tr>
<tr>
<td>Montana’s 2012 state Colon Surgery SSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>14 hospitals</td>
<td>0.81</td>
<td>0.89</td>
</tr>
<tr>
<td>Montana’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ 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 (HAI) 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.

**NEBRASKA**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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

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

**SSIs: COLON SURGERY** 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.

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

**SSIs: ABDOMINAL HYSTERECTOMY** 4% HIGHER COMPARED TO NAT’L BASELINE

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

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

<table>
<thead>
<tr>
<th>NUMBER OF NEBRASKA HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical site infections</td>
<td>19 hospitals</td>
<td>Nebraska’s 2012 state <strong>CLABSI</strong> SIR is significantly worse than the 2012 national SIR.</td>
</tr>
<tr>
<td><em>Clostridium difficile</em>, deadly diarrheal infections</td>
<td>20 hospitals</td>
<td>Nebraska’s 2012 state <strong>CAUTI</strong> SIR is similar to the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>20 hospitals</td>
<td>Nebraska’s 2012 state <strong>Colon Surgery SSI</strong> SIR is significantly worse than the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>20 hospitals</td>
<td>Nebraska’s 2012 state <strong>Abdominal Hysterectomy SSI</strong> SIR is similar to the 2012 national SIR.</td>
</tr>
</tbody>
</table>

*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 (HAI) 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

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.**

- **40%** LOWER COMPARED TO NAT’L BASELINE

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

### CAUTIs

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

### 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.

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

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

SSIs: ABDOMINAL HYSTERECTOMY **37%** LOWER COMPARED TO NAT’L BASELINE

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

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?

<table>
<thead>
<tr>
<th>IF THE STATE SIR IS:</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORE THAN 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were more infections reported in the state in 2012 compared to the national baseline data, indicating there has been an increase in infections.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LESS THAN 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were fewer infections reported in the state in 2012 compared to the national baseline data, indicating progress has been made in preventing infections.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>NUMBER OF NEVADA HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitals: 46*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLABSI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 hospitals</td>
<td>Nevada’s 2012 state <strong>CLABSI</strong> SIR is similar to the 2012 national SIR.</td>
<td>0.60</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 hospitals</td>
<td>Nevada’s 2012 state <strong>CAUTI</strong> SIR is similar to the 2012 national SIR.</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 hospitals</td>
<td>Nevada’s 2012 state <strong>Colon Surgery SSI</strong> SIR is significantly worse than the 2012 national SIR.</td>
<td>1.11</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 hospitals</td>
<td>Nevada’s 2012 state <strong>Abdominal Hysterectomy SSI</strong> SIR is similar to the 2012 national SIR.</td>
<td>0.63</td>
</tr>
</tbody>
</table>

*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.
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.

**NEW HAMPSHIRE**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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.

**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%** of New Hampshire hospitals have an SIR worse than the national SIR of 1.03.

**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.

- **0 New Hampshire hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

- **46%** fewer 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.
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>24 hospitals</td>
<td>0.43</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>23 hospitals</td>
<td>0.96</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>26 hospitals</td>
<td>0.61</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>23 hospitals</td>
<td>0.54</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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 (HAI) 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.

**NEW JERSEY**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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% of New Jersey hospitals have an SIR worse than the national SIR of 0.56

**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.

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

**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% of New Jersey hospitals have a colon surgery SIR worse than the national SIR of 0.80.

14% of New Jersey hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

**LEGEND**

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

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014
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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI 72 hospitals</td>
<td>0.71</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI 72 hospitals</td>
<td>0.88</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery 71 hospitals</td>
<td>0.62</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy 66 hospitals</td>
<td>1.01</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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.

### 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.

**LEGEND**

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

<table>
<thead>
<tr>
<th>SIR of New Mexico</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.56</td>
<td>1.03</td>
</tr>
</tbody>
</table>

**CHANGES IN CLABSIS VS. 2008 NATIONAL BASELINE**

![Graph showing changes in CLABSIs](chart)

- 14% of New Mexico hospitals have an SIR worse than the national SIR of 0.56.

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

**CAUTIs**: 3% 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.

**LEGEND**

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

<table>
<thead>
<tr>
<th>SIR of New Mexico</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.03</td>
<td>1.03</td>
</tr>
</tbody>
</table>

**CHANGES IN CAUTI VS. 2009 NATIONAL BASELINE**

![Graph showing changes in CAUTIs](chart)

- 11% of New Mexico hospitals have an SIR worse than the national SIR of 1.03.

### SURGICAL SITE INFECTIONS: COLON SURGERY

**SSIs**: 41% 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.

**LEGEND**

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

<table>
<thead>
<tr>
<th>SIR of New Mexico</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.80</td>
<td>0.89</td>
</tr>
</tbody>
</table>

**CHANGES IN SSI VS. 2008 NATIONAL BASELINE**

![Graph showing changes in SSIs](chart)

**SSIs**: 41% LOWER COMPARED TO NAT’L BASELINE

**SSIs**: ABDOMINAL HYSTERECTOMY 29% LOWER COMPARED TO NAT’L BASELINE

**LEGEND**

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

<table>
<thead>
<tr>
<th>SIR of New Mexico</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.89</td>
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</tr>
</tbody>
</table>

**CHANGES IN SSI VS. 2008 NATIONAL BASELINE**

![Graph showing changes in SSIs](chart)

- 29% of New Mexico hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

**NOT ENOUGH DATA**

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

**NOT ENOUGH DATA**

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

**LEGEND**

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

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NEW MEXICO
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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Reporting Hospitals</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>34</td>
<td>0.61</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>34</td>
<td>0.97</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>27</td>
<td>0.59</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>24</td>
<td>0.71</td>
<td>0.89</td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.
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**

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% of New York hospitals have an SIR worse than the national SIR of 0.56.

**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% of New York hospitals have an SIR worse than the national SIR of 1.03.

**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% of New York hospitals have a colon surgery SIR worse than the national SIR of 0.80.

15% of New York hospitals have an abdominal hysterectomy SIR better than the national SIR of 0.89.
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central line-associated bloodstream infections (CLABSI)</td>
<td>174 hospitals</td>
<td>0.64</td>
<td>0.56</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infections (CAUTI)</td>
<td>175 hospitals</td>
<td>1.36</td>
<td>1.03</td>
</tr>
<tr>
<td>Surgical site infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile, deadly diarrheal infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multidrug-resistant organism infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilator-associated events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon Surgery SSI</td>
<td>175 hospitals</td>
<td>0.83</td>
<td>0.80</td>
</tr>
<tr>
<td>Abdominal Hysterectomy SSI</td>
<td>162 hospitals</td>
<td>1.33</td>
<td>0.89</td>
</tr>
</tbody>
</table>

This report is based on 2012 data, published March 2014.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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%** of North Carolina hospitals have an SIR worse than the national SIR of 0.56.

**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%** of North Carolina hospitals have an SIR worse than the national SIR of 1.03.

**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%** of North Carolina hospitals have a colon surgery SIR worse than the national SIR of 0.80.

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

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

**THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014**
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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitals: 133*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infections</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>96 hospitals</td>
<td>North Carolina’s 2012 state CLABSI SIR is significantly better than the 2012 national SIR.</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>100 hospitals</td>
<td>North Carolina’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.</td>
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<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>93 hospitals</td>
<td>North Carolina’s 2012 state Colon Surgery SSI SIR is similar to the 2012 national SIR.</td>
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<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>89 hospitals</td>
<td>North Carolina’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
</tr>
</tbody>
</table>

*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 (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.

**NORTH DAKOTA**

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.

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**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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.

---

**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 North Dakota hospitals have an SIR significantly worse than the national SIR of 1.03.

---

**SURGICAL SITE INFECTIONS: COLON 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.

---

**SURGICAL SITE INFECTIONS: ABDOMINAL HYSTERECTOMY**

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

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

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<tr>
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<th>Hospitals</th>
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<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>6 hospitals</td>
<td>0.37</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>6 hospitals</td>
<td>0.63</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>6 hospitals</td>
<td>1.68</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy SSI</td>
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<td>1.05</td>
<td>0.89</td>
</tr>
</tbody>
</table>

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- HAIs in North Dakota: [www.ndhealth.gov/disease/hai/](http://www.ndhealth.gov/disease/hai/)
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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% of Ohio hospitals have an SIR worse than the national SIR of 0.56.

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

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% of Ohio hospitals have a colon surgery SIR worse than the national SIR of 0.80

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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>0.44</td>
<td>0.56</td>
</tr>
<tr>
<td>135 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>0.90</td>
<td>1.03</td>
</tr>
<tr>
<td>135 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>0.73</td>
<td>0.80</td>
</tr>
<tr>
<td>127 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>0.86</td>
<td>0.89</td>
</tr>
<tr>
<td>123 hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Ohio: [www.odh.ohio.gov/odhprograms/dis/orbitdis/hai/haimain.aspx](http://www.odh.ohio.gov/odhprograms/dis/orbitdis/hai/haimain.aspx)
Healthcare-associated infections (HAI) 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

**Central Line-Associated Bloodstream Infections (CLABSIs)**

- **52% lower compared to national 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% of Oklahoma hospitals have an SIR worse than the national SIR of 0.56.

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

- **38% lower compared to national 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.

- 3% of Oklahoma hospitals have an SIR worse than the national SIR of 1.03.

### SURGICAL SITE INFECTIONS: COLON SURGERY

**Surgical Site Infections: Colon Surgery**

- **20% lower compared to national 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% of Oklahoma hospitals have a colon surgery SIR worse than the national SIR of 0.80.

### SURGICAL SITE INFECTIONS: ABDOMINAL HYSTERECTOMY

**Surgical Site Infections: Abdominal Hysterectomy**

- **32% lower compared to 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.
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.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>0.48</td>
<td>0.56</td>
</tr>
<tr>
<td>55 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>0.62</td>
<td>1.03</td>
</tr>
<tr>
<td>61 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>0.80</td>
<td>0.80</td>
</tr>
<tr>
<td>61 hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>0.68</td>
<td>0.89</td>
</tr>
<tr>
<td>59 hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 (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)
- **Lower compared to national baseline (61%)**
- **Legend:**
  - ▶️ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
  - ✤ State investigates data for this infection to assess completeness and quality
  - ▼ Statistically significant difference
  - ◯ Fewer than 5 facilities reported data

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 Oregon hospitals have an SIR worse than the national SIR of 0.56.

### Catheter-Associated Urinary Tract Infections (CAUTIs)
- **Higher compared to national baseline (41%)**

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

### Surgical Site Infections
- **Colon Surgery:** **Lower compared to national baseline (25%)**
- **Abdominal Hysterectomy:** **Lower compared to national baseline (58%)**

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 Oregon hospitals have a colon surgery SIR worse than the national SIR of 0.80.
- 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
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.

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.

NUMBER OF OREGON HOSPITALS THAT REPORTED DATA TO CDC’S NHSN IN 2012

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI 47 hospitals</td>
<td>0.39</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI 46 hospitals</td>
<td>1.41</td>
<td>1.03</td>
</tr>
<tr>
<td>Colon Surgery SSI 49 hospitals</td>
<td>0.75</td>
<td>0.80</td>
</tr>
<tr>
<td>Abdominal Hysterectomy SSI 46 hospitals</td>
<td>0.42</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Oregon: [public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/index.aspx](http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/index.aspx)
Healthcare-associated infections (HAI) 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.

**Central Line-Associated Bloodstream Infections (CLABSIs)**

- **51% lower compared to national 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% of Pennsylvania hospitals have an SIR worse than the national SIR of 0.56.

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

- **10% lower compared to national 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.

- 8% of Pennsylvania hospitals have an SIR worse than the national SIR of 1.03.

**Surgical Site Infections: Colon Surgery and Abdominal Hysterectomy Surgery**

- **22% lower compared to national baseline**
- **5% lower compared to national 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.

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

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

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

<table>
<thead>
<tr>
<th>HAI Type</th>
<th>Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Line-Associated Bloodstream Infections (CLABSI)</strong></td>
<td>175 hospitals</td>
<td>0.49</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>Catheter-Associated Urinary Tract Infections (CAUTI)</strong></td>
<td>190 hospitals</td>
<td>0.90</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Surgical Site Infections (SSI, Colon Surgery)</strong></td>
<td>162 hospitals</td>
<td>0.78</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>Surgical Site Infections (SSI, Abdominal Hysterectomy)</strong></td>
<td>148 hospitals</td>
<td>0.95</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*(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.

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Pennsylvania: [www.portal.state.pa.us/portal/server.pt/community/healthcare_associated_infections/14234](http://www.portal.state.pa.us/portal/server.pt/community/healthcare_associated_infections/14234)
Healthcare-associated infections (HAI) 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.

**Puerto Rico**

- **Central Line-Associated Bloodstream Infections (CLABSIs)**
  - **Changes in CLABSI vs. 2008 National Baseline**
  - **Puerto Rico hospitals reported a significant decrease in CLABSIs between 2011 and 2012.**
  - **50% of Puerto Rico hospitals have an SIR worse than the national SIR of 0.56.**

- **Catheter-Associated Urinary Tract Infections (CAUTIs)**
  - **Changes in CAUTI vs. 2009 National Baseline**
  - **Puerto Rico hospitals have an SIR worse than the national SIR of 1.03.**

- **Surgical Site Infections: Colon Surgery**
  - Puerto Rico hospitals did not report 2012 colon surgery data to NHSN.

- **Surgical Site Infections: Abdominal Hysterectomy**
  - Puerto Rico hospitals did not report 2012 abdominal hysterectomy data to NHSN.

---

**LEGEND**

- ✔️ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- ✗ State investigates data for this infection to assess completeness and quality
- ▲ Statistically significant difference
- ▼ Fewer than 5 facilities reported data

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THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014
PUERTO RICO

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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>18</td>
<td>1.04</td>
<td>0.56</td>
</tr>
<tr>
<td></td>
<td>18 hospitals</td>
<td>Puerto Rico’s 2012 state <strong>CLABSI</strong> SIR is significantly higher than the 2012 national SIR.</td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>18</td>
<td>0.99</td>
<td>1.03</td>
</tr>
<tr>
<td></td>
<td>18 hospitals</td>
<td>Puerto Rico’s 2012 state <strong>CAUTI</strong> SIR is similar to the 2012 national SIR.</td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>0</td>
<td>N/A</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>0 hospitals</td>
<td>Puerto Rico hospitals did not report 2012 colon surgery data to NHSN.</td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>0</td>
<td>N/A</td>
<td>0.89</td>
</tr>
<tr>
<td></td>
<td>0 hospitals</td>
<td>Puerto Rico hospitals did not report 2012 abdominal hysterectomy data to NHSN.</td>
<td></td>
</tr>
</tbody>
</table>

+ 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.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Puerto Rico: [www.salud.gov.pr/Pages/default.aspx](http://www.salud.gov.pr/Pages/default.aspx)
Healthcare-associated infections (HAI) 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.

**CATHERETER-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% of Rhode Island hospitals have a SIR worse than the national SIR of 1.03.

**SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY**

SsIs: Colon Surgery ↑ 38% 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% of Rhode Island hospitals have a colon surgery SIR worse than the national SIR 0.80.

SsIs: Abdominal Hysterectomy ↑ 66% Higher Compared to Nat’l 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.
**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.

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
- Catheter-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**

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Line-Associated Bloodstream Infections</strong></td>
<td>11</td>
<td>0.64</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>Catheter-Associated Urinary Tract Infections</strong></td>
<td>10</td>
<td>1.37</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Surgical Site Infections</strong></td>
<td>11</td>
<td>1.38</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>MRSA Infections</strong></td>
<td>11</td>
<td>1.66</td>
<td>0.89</td>
</tr>
<tr>
<td><strong>Multidrug-Resistant Organism Infections</strong></td>
<td>11</td>
<td>1.66</td>
<td>0.89</td>
</tr>
<tr>
<td><strong>Ventilator-Associated Pneumonia Infections</strong></td>
<td>11</td>
<td>1.66</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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**

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
Healthcare-associated infections (HAI) 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.

**SOUTH CAROLINA**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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%** of South Carolina hospitals have an SIR worse than the national SIR of 0.56.

**LEGEND**

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

**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%** of South Carolina hospitals have an SIR worse than the national SIR of 1.03.

**SURGICAL SITE INFECTIONS: COLON 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%** of South Carolina hospitals have a colon surgery SIR worse than the national SIR of 0.80.

**SSIs: ABDOMINAL HYSTERECTOMY**

- **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**
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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>65 hospitals</td>
<td>0.62</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>64 hospitals</td>
<td>1.46</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>57 hospitals</td>
<td>1.03</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>54 hospitals</td>
<td>1.12</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (HAI) 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.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**

**CAUTIs ↓ 36% 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.

- **0 South Dakota hospitals have an SIR worse than the national SIR of 1.03.**

**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.

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

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

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>14</td>
<td>0.28</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>18</td>
<td>0.64</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>14</td>
<td>1.08</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>14</td>
<td>0.63</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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.

**TENNESSEE**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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

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

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

5% of Tennessee hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.
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.

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

<table>
<thead>
<tr>
<th></th>
<th>STATE SIR</th>
<th>NAT’L SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Hospitals:</strong> 154*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLABSI</strong> 94 hospitals</td>
<td>0.57</td>
<td>0.56</td>
</tr>
<tr>
<td>Tennessee’s 2012 state CLABSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong> 95 hospitals</td>
<td>1.38</td>
<td>1.03</td>
</tr>
<tr>
<td>Tennessee’s 2012 state CAUTI SIR is significantly worse than the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong> 90 hospitals</td>
<td>0.93</td>
<td>0.80</td>
</tr>
<tr>
<td>Tennessee’s 2012 state Colon Surgery SSI SIR is significantly worse than the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong> 90 hospitals</td>
<td>0.88</td>
<td>0.89</td>
</tr>
<tr>
<td>Tennessee’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ 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 (HAI) 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)**

- **Lower compared to national baseline:** 44%
- **Texas hospitals did not report a significant change in CLABSIs between 2011 and 2012.**
- 9% of Texas hospitals have an SIR worse than the national SIR of 0.56.

**Catheter-Associated Urinary Tract Infections (CAUTIs)**

- **Lower compared to national baseline:** 5%
- 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% of Texas hospitals have an SIR worse than the national SIR of 1.03.

**Surgical Site Infections:**

- **Colon Surgery:** 26%
- 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% of Texas hospitals have a colon surgery SIR worse than the national SIR of 0.80.
- **Abdominal Hysterectomy:** 24%
- 3% of Texas hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.
TEXAS 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.

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*

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>277 hospitals</td>
<td>0.56</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td>284 hospitals</td>
<td>0.95</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>281 hospitals</td>
<td>0.74</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>281 hospitals</td>
<td>0.76</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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)

- **Changes in CLABSI vs. 2008 National Baseline**
  - **State:** -35%
  - **National:** -44%
  - **Ward Only:** -46%
  - **NICU Only:** -44%

- **Utah hospitals did not report a significant change in CLABSIs between 2011 and 2012.**

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

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

### Catheter-Associated Urinary Tract Infections (CAUTIs)

- **Changes in CAUTI vs. 2009 National Baseline**
  - **State:** 81%
  - **National:** 3%
  - **Ward Only:** 9%

- **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% of Utah hospitals have an SIR worse than the national SIR of 1.03.**

### Surgical Site Infections: Colon Surgery and Abdominal Hysterectomy Surgery

- **LEGEND**

- **SSIs: Colon Surgery**
  - **Changes in SSI vs. 2008 National Baseline**
    - **State:** 50%
    - **National:** -20%
    - **Ward Only:** -9%

  - **50% of Utah hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

- **SSIs: Abdominal Hysterectomy**
  - **Changes in SSI vs. 2008 National Baseline**
    - **State:** -11%
    - **National:** -9%

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

- **31% of Utah hospitals have a colon surgery SIR worse than the national SIR of 0.80.**

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*THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014*
UTAH 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.

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

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>State SIR</th>
<th>Nat’l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI 26 hospitals</td>
<td>0.65</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI 26 hospitals</td>
<td>1.81</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery 30 hospitals</td>
<td>1.50</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy 30 hospitals</td>
<td>0.91</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Utah: [health.utah.gov/epi/HAI](http://health.utah.gov/epi/HAI)

**THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014**
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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

- **CLABSIs ↓ 75%** LOWER COMPARED TO NAT’L BASELINE

  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.

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**

- **CAUTIs ↑ 21%** 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 Vermont hospitals have an SIR significantly worse than the national SIR of 1.03.

**SURGICAL SITE INFECTIONS: COLON SURGERY**

- **SSIs: COLON SURGERY ↑ 89%** 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 Vermont hospitals have a colon surgery SIR significantly worse than the national SIR of 0.80.

**SURGICAL SITE INFECTIONS: ABDOMINAL HYSTERECTOMY**

- **SSIs: ABDOMINAL HYSTERECTOMY ↓ 23%** LOWER COMPARED TO NAT’L BASELINE

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

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?

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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

<table>
<thead>
<tr>
<th>Infections</th>
<th>Vermont Hospitals</th>
<th>Vermont’s 2012 State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>7</td>
<td>Vermont’s 2012 state CLABSI SIR is significantly better than the 2012 national SIR.</td>
<td>0.25</td>
</tr>
<tr>
<td>CAUTI</td>
<td>5</td>
<td>Vermont’s 2012 state CAUTI SIR is similar to the 2012 national SIR.</td>
<td>1.21</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td>6</td>
<td>Vermont’s 2012 state Colon Surgery SSI SIR is significantly worse than the 2012 national SIR.</td>
<td>1.89</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td>11</td>
<td>Vermont’s 2012 state Abdominal Hysterectomy SSI SIR is similar to the 2012 national SIR.</td>
<td>0.77</td>
</tr>
</tbody>
</table>

+ 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.

Learn how your hospital is preventing infections: www.medicare.gov/hospitalcompare
For more information:
- Preventing HAIs: www.cdc.gov/hai
- NHSN: www.cdc.gov/nhsn
- HAIs in Vermont: www.healthvermont.gov/

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014
Healthcare-associated infections (HAI) 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.

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

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

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

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

- **11%** of Virginia hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.
VIRGINIA 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.

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**

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Number of Hospitals</th>
<th>2012 State SIR</th>
<th>2012 National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>81 hospitals</td>
<td>0.58</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>81 hospitals</td>
<td>0.89</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>76 hospitals</td>
<td>0.76</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>67 hospitals</td>
<td>0.88</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
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.

**WASHINGT**

**Healthcare-ass**ociated 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.

**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.

**WASHINGTON**

**HEALTHCARE ASSOCIATED INFECTIONS**

**PROGRESS**

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

**CAUTIs**

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

**SSIs: Colon 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% of Washington hospitals have a colon surgery SIR worse than the national SIR of 0.80.

**SSIs: Abdominal Hysterectomy**

0 Washington hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.

**LEGEND**

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

**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.

**WASHINGTON**

**HEALTHCARE ASSOCIATED INFECTIONS**

**PROGRESS**

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

**CAUTIs**

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

**SSIs: Colon 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% of Washington hospitals have a colon surgery SIR worse than the national SIR of 0.80.
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.

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

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>Hospitals Reporting</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong> 63 hospitals</td>
<td></td>
<td>0.57</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong> 61 hospitals</td>
<td></td>
<td>1.07</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong> 62 hospitals</td>
<td></td>
<td>0.68</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong> 60 hospitals</td>
<td></td>
<td>0.61</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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.
**HEALTHCARE ASSOCIATED INFECTIONS PROGRESS**

**WEST VIRGINIA**

Healthcare-associated infections (HAI) 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

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% of West Virginia hospitals have an SIR worse than the national SIR of 0.56.

### 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.

4% of West Virginia hospitals have an SIR worse than the national SIR of 1.03.

### 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.

0 West Virginia hospitals have a colon surgery SIR worse than the national SIR of 0.80.

### SSIs: ABDOMINAL HYSTERECTOMY

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospitals</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>40 hospitals</td>
<td>0.39</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>43 hospitals</td>
<td>0.70</td>
<td>1.03</td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>36 hospitals</td>
<td>0.96</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>32 hospitals</td>
<td>0.50</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)

For more information:

- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in West Virginia: [www.dhhr.wv.gov/oeps/disease/HAI/Pages/default.aspx](http://www.dhhr.wv.gov/oeps/disease/HAI/Pages/default.aspx)
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**Central Line-Associated Bloodstream Infections**

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 Wisconsin hospitals have an SIR worse than the national SIR of 0.56.

**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.

5% of Wisconsin hospitals have an SIR worse than the national SIR of 1.03.

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

15% of Wisconsin hospitals have an abdominal hysterectomy SIR worse than the national SIR of 0.89.
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.

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**

<table>
<thead>
<tr>
<th>Condition</th>
<th>State SIR</th>
<th>National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78 hospitals</td>
<td>0.45</td>
<td>0.56</td>
</tr>
<tr>
<td>CAUTI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 hospitals</td>
<td>0.79</td>
<td>1.03</td>
</tr>
<tr>
<td>SSI, Colon Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77 hospitals</td>
<td>0.83</td>
<td>0.80</td>
</tr>
<tr>
<td>SSI, Abdominal Hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>71 hospitals</td>
<td>0.97</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*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 (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.

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.

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.

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.

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

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.

- 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

<table>
<thead>
<tr>
<th>Number of Wyoming Hospitals Reporting Data</th>
<th>2012 State SIR</th>
<th>2012 National SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospitals: 31*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central line-associated bloodstream infections (CLABSI)</td>
<td>0.16</td>
<td>0.56</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infections (CAUTI)</td>
<td>0.86</td>
<td>1.03</td>
</tr>
<tr>
<td>Surgical site infections (SSI)</td>
<td>1.26</td>
<td>0.80</td>
</tr>
<tr>
<td>Colon Surgery (SSI)</td>
<td>0.69</td>
<td>0.89</td>
</tr>
<tr>
<td>Abdominal Hysterectomy (SSI)</td>
<td>0.69</td>
<td>0.89</td>
</tr>
</tbody>
</table>

+ 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.

Leaves: How your hospital is preventing infections: medicare.gov/hospitalcompare
For more information:
- Preventing HAIs: cdc.gov/hai
- NHSN: cdc.gov/nhsn
- HAIs in Wyoming: health.wyo.gov/default.aspx

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


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