Healthcare-associated Infections
HAI Elimination

# Toward Elimination

Newsletter for State Partners in HAI Prevention

Volume 14, March 2011

CDC Vitalsigns™

# CDC Report Focuses on CLABSI

On March 1, CDC released a Vital Signs report focused on bloodstream infections in patients with central lines. Each month, Vital Signs offers recent data and calls to action for important public health issues.

The main messages of the report are that major progress has been made in preventing CLABSIs in intensive care units, but too many infections remain in all settings including hospital wards and dialysis centers. We need to apply what we have learned in ICUs to other settings and infection types.

Report highlights:

- 58% fewer bloodstream infections occurred in hospital ICU patients with central lines in 2009 compared to 2001. About 18,000 of these occurred in ICUs. About 23,000 occurred in other areas of the hospital.
- Overall, the decrease in infections saved up to 27,000 lives and is associated with $1.8 billion excess medical costs. In 2009 alone, reducing infections saved about 3,000-6,000 lives and about $414 million in extra medical costs compared to 2001.
- Bloodstream infections from *Staphylococcus aureus* in ICU patients with central lines were reduced by 73%, more than from any other organism.
- About 350,000 people receive hemodialysis treatment at any given time. About 8 in 10 of these patients start treatment through a central line.
- Infections are one of the leading causes of hospitalization and death for patients on hemodialysis.
- About 37,000 bloodstream infections occurred in 2008 in hemodialysis patients with central lines.
- A hemodialysis patient is 100 times more likely to get a bloodstream infection from MRSA than the general population.

Vital Signs outlines actions the US government, state governments, hospitals, dialysis centers, other medical care locations, doctors, nurses, patients, and caregivers can take to reduce bloodstream infections in patients with central lines. Visit Vital Signs for the complete issue and for graphics, web content and other resources your state can use in its HAI prevention efforts.

**Join Rani Jeeva's (HHS) discussion:**
**Regional Projects Spurring Creative Strategies for HAI Prevention Across the US on CDC's Safe Healthcare Blog**

**www.cdc.gov/safehealthcare**

**ELC/EIP Grantee Calls**

**Dialysis: March 14, 1-2 PM EST**

**MDRO/LTC: March 22, 1-2 PM EST**

***Your PHAs will send the bridge line, password, and Webinar URL information for these calls.***

# CDC Posts New State-Specific Report
## of NHSN CLABSI Data

CDC's latest release of state-specific central line-associated bloodstream infection (CLABSI) data from the National Healthcare Safety Network was posted on March 2. This report included state-specific CLABSI standardized infection ratios (SIR) for states with a mandate to report CLABSI to the state health department. The SIR report compares data from July through December 2009 to national NHSN data from the referent period of 2006 through 2008. In addition to data from intensive care units (ICUs) and wards, which were included in the first report, this new report includes data from long-term acute care (LTAC) and specialty care locations.

The state report was published in conjunction with the national SIR report, which will includes CLABSI and surgical site infection (SSI) SIRs at the US level.

Visit http://www.cdc.gov/HAI/surveillance/statesummary.html for more information.

**NEW! Preventing infections in dialysis**

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## CDI Collaborative: Southeastern Pennsylvania

In 2009, a *Clostridium difficile* Infections (CDI) collaborative was formed in southeastern Pennsylvania by the Health Care Improvement Foundation (HCIF) supported with ARRA funding. The collaborative was designed to promote and accelerate evidence-based interventions aimed at reducing CDI by 30% in 18 months. Thirty-two organizations are currently enrolled in the collaborative. Members include hospitals/health systems, long-term acute care hospitals, rehabilitation centers, and nursing homes.

Early in 2010, organizations began collecting data. HCIF contracted with a software development firm to design a measurement module using the Pennsylvania Health Care Quality Alliance (PHCQA) web portal. The module allows organizational teams to submit data and run real-time trend and benchmarking reports, providing timely feedback to clinical teams for use in implementing targeted improvement strategies.

Current and planned activities include implementation of two webinar series and an in-person workshop. Dr. Carolyn Gould, CDC Medical Epidemiologist, kicked off a CDI prevention series featuring expert speakers addressing key challenges in CDI prevention. A future webinar series will be conducted among nursing homes across the region.

A highlight of the collaborative was the in-person workshop held in November, 2010. Keynote speaker Dr. Julie Mangino from the Ohio State University Medical Center shared some of the lessons learned from Ohio's statewide CDI collaborative, an initiative funded by the CDC's Epicenters Program. In addition, workshop attendees shared their organization's best practices and offered solutions to common challenges in CDI prevention.

**Explore the new**
**State-based HAI Prevention Activities Map**
**which replaces the HAI Recovery Act map and includes state-based HAI prevention activities financially and/or technically supported by CDC**

**www.cdc.gov/HAI/stateplans/HAIstatePlans-map.html**

## State Highlight: Connecticut

Dr. Alice Guh, MD, MPH, CDC's Division of Healthcare Quality Promotion (DHQP)

### Comprehensive Planning for HAI Surveillance and Prevention – Stakeholder Engagement

In November 2010, the Connecticut Department of Public Health (DPH) hosted a statewide HAI Stakeholder Engagement Conference, supported with ARRA funding. Discussions focused on reducing HAIs and development of a Health Improvement Plan (HIP) that includes HAI prevention throughout the state healthcare system.

The conference included presentations by leaders from a variety of healthcare settings including homecare and acute care hospitals. During the morning plenary, Alice Guh, MD, MPH with CDC's Division of Healthcare Quality Promotion (DHQP), gave a presentation about the science and epidemiology of HAI transmission. The afternoon plenary provided breakout sessions for five focus sector groups: hospitals, long term care facilities (LTCFs), ambulatory surgical centers (ASCs), homecare and hospice, and dialysis. The conference concluded with a panel that summarized the breakout sessions and HAI issues that cut across healthcare sectors. The proceedings of the conference are being used to write the background section of the new state HAI Health Improvement Plan.

DPH will continue to build newly robust relationships between the public health and medical communities on HAIs. At an upcoming "priority-setting" conference, DPH will work toward development of sector-specific goals and objectives. Once the plan is written, a third statewide conference will be held to focus on commitment to the plan, ensuring implementation, and celebrating shared achievement toward HAI prevention. http://www.ct.gov/dph/cwp/view.asp?a=3136&q=417318