

**“National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination” Data Update
October 2011**

#	Metric Title	Comparison Metric	Measurement System	National Baseline	Baseline Information or Notes	National 2013 Target	Progress Information or Notes
1	Central Line-Associated Bloodstream Infections (CLABSI)	CLABSI Standardized Infection Ratio (SIR)	CDC National Healthcare Safety Network (NHSN)	2006-2008	Baseline: 1,385 facilities, 3,972 locations; 62% ICU <ul style="list-style-type: none"> 7,434,389 central line-days reported 48 states reporting 2009: 1,603 facilities; 4,872 locations; 62% ICU	50% reduction in CLABSI in ICU and ward-located patients or 0.50 SIR	2009: SIR = 0.82 2010: SIR = 0.67 (9,716 observed ÷ 14,521 predicted CLABSIs) <ul style="list-style-type: none"> ICU SIR = 0.65; non-ICU SIR = 0.74 33% fewer CLABSIs reported than predicted 2,256 facilities reporting 52% ICU
2	Central Line Insertion Practices (CLIP) Adherence	CLIP adherence percentage	CDC NHSN	2009	<ul style="list-style-type: none"> 345 facilities, 743 locations reporting 70% ICU 16 states reporting 92% CLIP adherence 	100% adherence with central line bundle	2010: 94.5% adherence <ul style="list-style-type: none"> 1,309 locations reporting 55% ICU
3	<i>Clostridium difficile</i> Infections	Hospitalizations with <i>C. difficile</i> per 1,000 discharges	AHRQ Healthcare Cost and Utilization Project (HCUP)	2008	<ul style="list-style-type: none"> 11.7 per 1,000 discharges ~35 million hospitalizations ~4,300 hospitals 42 states reporting 	30% reduction in hospitalizations with <i>C. difficile</i> per 1,000 patient discharges	2009: <ul style="list-style-type: none"> 11.3 per 1,000 discharges 2010 (Projected): <ul style="list-style-type: none"> 11.5 per 1,000 discharges 2011 (Projected): <ul style="list-style-type: none"> 11.9 per 1,000 discharges
4	<i>Clostridium difficile</i> Infections	<i>C. difficile</i> SIR	CDC NHSN	2009-2010	2009: <ul style="list-style-type: none"> 250 facilities, 417 locations reporting 52% facility-wide inpatient; 15% ICU 25 states reporting 2010 (through Aug): <ul style="list-style-type: none"> 389 facilities, 643 locations reporting 53% facility-wide inpatient; 14% ICU 27 states reporting 	30% reduction in facility-wide healthcare facility-onset <i>C. difficile</i> LabID event or 0.70 SIR	2010: <ul style="list-style-type: none"> Part of baseline period Data not yet available
5	Catheter-Associated Urinary Tract Infections (CAUTI)	CAUTI SIR	CDC NHSN	2009	<ul style="list-style-type: none"> 639 facilities, 2,642 locations reporting 40% ICU 3,881,311 catheter-days reported 	25% reduction in CAUTI in ICU and ward-located patients or 0.75 SIR	2010: SIR = 0.93 <ul style="list-style-type: none"> SIR = 8,441 (observed) ÷ 9,061 (predicted) CAUTIs = 0.93 7% fewer CAUTIs reported than predicted 1,005 facilities reporting from 3,662 locations; 40% ICU

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6	MRSA Invasive Infections (population)	MRSA incidence rate (healthcare-associated) per 100,000 persons	CDC Emerging Infections Program (EIP) Active Bacterial Core Surveillance (ABCs)	2007-2008	<ul style="list-style-type: none"> Active laboratory and population-based surveillance for invasive MRSA infections within 9 EIP ABCs catchment areas (~19 million) 2007-2008 healthcare-associated rate: 26.24/100,000 persons Incidence estimation projected to nation, using U.S. Census data, adjusting for age and race 	50% reduction in incidence of healthcare-associated invasive MRSA infections	<u>2009: 23.14 per 100,000</u> <ul style="list-style-type: none"> 11.8% reduction <u>2010: 21.46 per 100,000</u> <ul style="list-style-type: none"> 18.2% reduction Estimated 13,478 fewer cases than baseline
7	MRSA Bacteremia (hospital)	MRSA bacteremia SIR	CDC NHSN	2009-2010	<u>2009:</u> <ul style="list-style-type: none"> 508 facilities, 888 locations reporting 5% facility-wide inpatient; 56% ICU 50 states reporting <u>2010 (through Aug):</u> <ul style="list-style-type: none"> 612 facilities, 971 locations reporting 16% facility-wide inpatient; 48% ICU 50 states reporting 	25% reduction in facility-wide healthcare facility-onset MRSA bacteremia LabID event or 0.75 SIR	<u>2010:</u> <ul style="list-style-type: none"> <i>Part of baseline period</i> <i>Data not yet available</i>
8	Surgical Site Infections (SSI)	SSI SIR	CDC NHSN	2006-2008	<ul style="list-style-type: none"> 801 facilities reporting 613,263 SCIP procedures reported 43 states reporting <p><i>* 2009 SIR estimate updated from previously reported 0.95 as 3 additional facilities reported since last year's report</i></p>	25% reduction in admission and readmission SSI or 0.75 SIR	<u>2009: SIR = 0.98</u> <ul style="list-style-type: none"> 2% fewer SSIs than predicted 949 facilities reporting* <u>2010: SIR = 0.90</u> <ul style="list-style-type: none"> 10% fewer SSIs than predicted 1,386 facilities reporting
9	Surgical Care Improvement Project (SCIP) Process Measures Adherence	SCIP adherence percentage (SCIP Inf 1, 2, 3, 4, 6)	CMS SCIP	2006-2008	<ul style="list-style-type: none"> Based on 3,600-3,700 hospitals reporting per quarter since mid-2006 Calendar quarter hospitals required to report each measure for Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU): <ul style="list-style-type: none"> SCIP Inf 1 – 3Q 2006 SCIP Inf 2 – 1Q 2007 SCIP Inf 3 – 3Q 2006 SCIP Inf 4 – 1Q 2008 SCIP Inf 6 – 1Q 2008 	95% adherence to process measures to prevent SSI	<u>2009:</u> <ul style="list-style-type: none"> SCIP Inf 1 – 96% SCIP Inf 2 – 98% SCIP Inf 3 – 92% SCIP Inf 4 – 92% SCIP Inf 6 – 99% <u>2010:</u> <ul style="list-style-type: none"> <i>Data not yet available</i>