CONSUMERS UNION NEWS RELEASE

For Immediate Release: Tuesday, February 12, 2013
Contact: Michael McCauley, mmccauley@consumer.org or 415-902-9537 (cell) or 415-431-6747, ext 126; Lisa McGiffert, lmcgiffert@consumer.org or 512-477-4431, ext 115

CDC Report Shows National Decline in Number of Hospital Infections

But Most Hospitals Have Not Shown Statistically Significant Improvement Since Five Years Ago; More Effort Needed To Protect Patients

WASHINGTON, D.C. – A new report by the Centers for Disease Control and Prevention (CDC) issued today shows that the number of central line-associated bloodstream infections in hospitals nationwide has been reduced markedly. More modest reductions have been achieved in certain surgical site infections and urinary tract infections since the agency first started reporting national trend data three years ago.

Although infections have decreased overall, the report also indicates that most individual hospitals have not demonstrated a statistically significant improvement since 2008.

The report shows that hospitals can effectively prevent infections when they dedicate adequate resources and attention. Nationally, at least 10 percent of hospitals reported zero infections in every category of infection covered in the report. But more work needs to be done for every hospital to reach that goal, according to Consumers Union, the policy and advocacy arm of Consumer Reports.

"There's been a concerted push in recent years to reduce central line-associated bloodstream infections in ICUs and those efforts are clearly beginning to pay off," said Lisa McGiffert, director of Consumers Union's Safe Patient Project (www.safepatientproject.org). "We need to bring the same focus and energy to preventing all types of infections with the ultimate goal of eliminating them. A small percentage of hospitals have been able to attain zero infections, showing that it can be done. Unfortunately, most hospitals have not shown statistically significant improvement since five years ago."

National hospital infection reporting follows a multi-year campaign by Consumers Union and other consumer advocates to mandate such disclosure. The CDC estimates that nearly 100,000 people die each year due to hospital-acquired infections and the hospital costs associated with these infections are estimated to be as high as $45 billion annually.

The report highlights patient infection data from 2011 reported by hospitals in all 50 states and the District of Columbia and Puerto Rico. Thirty states and the District of Columbia require hospitals to publicly report their infections and almost all require reporting to the CDC's National Health Safety Network (NHSN). Most hospitals in the remaining states voluntarily reported data in exchange for financial incentives provided by Medicare, or in preparation for those incentives.

The report covers central line-associated bloodstream infections (CLABSIs), certain surgical site infections (SSIs), and catheter-associated urinary tract infections (CAUTIs). As part of the 2008 National Action Plan to Prevent Healthcare-Associated Infections, the Department of Health and Human Services set out to reduce CLABSIs by 50 percent and SSIs and CAUTIs by 25 percent by 2013.

Some of the data detailed in the report are expressed as a Standardized Infection Ratio (SIR), which was developed by the CDC to allow comparisons to the baseline. The Standardized Infection Ratio compares the number of infections reported to the CDC in 2011 to the number of infections that would be predicted based on national, historical baseline data. Among the key findings of the report:

- Nationally, hospitals reported 41 percent fewer CLABSIs in 2011 compared to 2008. According to the CDC, only 22 percent of hospitals reported a statistically significant decrease compared to the baseline. However, half of the hospitals had a Standardized Infection Ratio for CLABSIs that was at least 53 percent lower than the baseline.

- The report estimates that each CLABSI in ICUs resulted in $26,000 in additional charges for Medicare patients, with an estimated national total of $322 million in additional costs annually for all CLABSIs in the ICU. The report notes that this annual estimate likely underestimates the cost since it is based on the Medicare reimbursement rate and does not factor in higher rates typically paid by private insurers.

- Nationally, hospitals reported 17 percent fewer SSIs in 2011 compared to 2008. In seven of nine types of surgical site infections reported in 2011, at least 25 percent of hospitals reported zero infections. According to the CDC, only 12 percent of hospitals reported a statistically significant decrease compared to the baseline. However, about half of the hospitals had a Standardized Infection Ratio for SSIs that was at least 29 percent lower than the baseline.

- Nationally, hospitals reported 7 percent fewer CAUTIs in 2011 compared to 2009. Most of this reduction was achieved in hospital wards, which showed a statistically significant reduction of 15 percent since 2009. Changes in critical care units and neonatal care units were not statistically significant. Little progress was made between 2010 and 2011. According to the CDC, only 13 percent of hospitals reported a statistically significant decrease compared to the baseline. However, about half of the hospitals in the report had a Standardized Infection Ratio for CAUTIs that was at least 33 percent lower than the baseline.

Over the past ten years, significant resources have been devoted to helping hospitals reduce surgical infections and CLABSIs (with a focus on the ICU environment). These efforts have been typically done through voluntary collaboratives and training funded by the federal government. Results tied to these efforts are rarely provided on a hospital specific basis, but nationally measures are being reported and demonstrating some positive changes. Future prevention efforts should measure individual hospital progress and target those hospitals that are not achieving improvements.

The CDC report noted that it is critical for the data reported by hospitals to be subject to more widespread validation to ensure its accuracy. Twenty five states completed validation studies of reported CLABSI data, while only eight states validated data for CAUTIs and 15 did so for SSIs.

“All 50 states should be validating the accuracy of the infection data reported by their hospitals,” said McGiffert. “Medicare should require validation and provide states with the resources to do this so the public can trust these numbers.”

The CDC report details aggregate state-specific rates for CLABSIs and will provide similar trend data for SSIs and CAUTIs when it releases its report next year based on 2012 data. The CDC report does not disclose hospital-specific rates for the covered infections. Hospital-specific rates are available for facilities in those states that mandate public reporting, although not all states have disclosed these rates for 2011 yet. Hospital-specific infection rate information is also available on the federal Hospital Compare web site. For tips on finding infection information on Hospital Compare, see Consumers Union’s Tips for Finding Your Hospital’s Information.

For more consumer-friendly information on nearly 4,000 hospitals in all states, including infection information and a safety score for more than 2,000 hospitals, see Consumer Reports Ratings (available to Consumer Reports online subscribers). And see Consumer Reports’ hospital survival guide for advice on staying safe in the hospital.

###