Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are reported to CDC’s National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website. This report is based on 2014 data, published in 2016.

**CLABSIs**

**CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Vermont hospitals reported no significant change in CLABSIs between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 0.50, the value of the national SIR.

**CAUTIs**

**CATHETER-ASSOCIATED URINARY TRACT INFECTIONS**

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Vermont hospitals reported no significant change in CAUTIs between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 1.00, the value of the national SIR.

**MRSA Bacteremia**

**LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS**

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- Vermont hospitals reported no significant change in MRSA bacteremia between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 0.87, the value of the national SIR.

**C. difficile Infections**

**LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS**

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- Vermont hospitals reported no significant change in *C. difficile* infections between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 0.92, the value of the national SIR.

**SSIs**

**SURGICAL SITE INFECTIONS**

When germs get into an area where surgery is or was performed, patients can get a surgical site infection. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

- Vermont hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 0.83, the value of the national SIR.

- Vermont hospitals reported no significant change in SSIs related to colon surgery between 2013 and 2014.
- Not enough data to report how many hospitals had an SIR significantly higher (worse) than 0.98, the value of the national SIR.
Healthcare-associated infection (HAI) data give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

<table>
<thead>
<tr>
<th>HAI Type</th>
<th># of Vermont Hospitals that Reported Data to CDC's NHSN, 2014†</th>
<th>2014 State SIR vs. 2013 State SIR</th>
<th>2014 State SIR vs. 2014 Nat'l SIR</th>
<th>2014 State SIR vs. Nat'l Baseline‡</th>
<th>2014 State SIR</th>
<th>2014 Nat'l SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLABSI</strong></td>
<td>7</td>
<td>↑ 79%</td>
<td>↓ 9%</td>
<td>↓ 55%</td>
<td>0.45</td>
<td>0.50</td>
</tr>
<tr>
<td>Nat'l Baseline: 2008</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>CAUTI</strong></td>
<td>5</td>
<td>↑ 56%</td>
<td>↑ 35%</td>
<td>↑ 35%</td>
<td>1.35</td>
<td>1.00</td>
</tr>
<tr>
<td>Nat'l Baseline: 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Abdominal Hysterectomy</strong></td>
<td>12</td>
<td>↑ 102%</td>
<td>↑ 58%</td>
<td>↑ 30%</td>
<td>1.30</td>
<td>0.83</td>
</tr>
<tr>
<td>Nat'l Baseline: 2008</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SSI, Colon Surgery</strong></td>
<td>6</td>
<td>↓ 16%</td>
<td>↑ 94%</td>
<td>↑ 89%</td>
<td>1.89</td>
<td>0.98</td>
</tr>
<tr>
<td>Nat'l Baseline: 2008</td>
<td></td>
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</tr>
<tr>
<td><strong>MRSA Bacteremia</strong></td>
<td>10</td>
<td>↓ 23%</td>
<td>↓ 76%</td>
<td>↓ 79%</td>
<td>0.21</td>
<td>0.87</td>
</tr>
<tr>
<td>Nat'l Baseline: 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. difficile Infections</strong></td>
<td>9</td>
<td>↓ 1%</td>
<td>↓ 40%</td>
<td>↓ 45%</td>
<td>0.55</td>
<td>0.92</td>
</tr>
<tr>
<td>Nat'l Baseline: 2011</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

† The number of hospitals that reported to NHSN and are included in the SIR calculation. This number may vary across HAI types; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

‡ Nat'l baseline time period varies by HAI type. See first column of this table for specifics.

### WHAT IS THE STANDARDIZED INFECTION RATIO?

The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. 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 IS VERMONT DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Vermont has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:
- Multidrug-resistant infections (MRSA, *C. difficile*, CRE, other)
- Long-term care facilities
- Antibiotic stewardship

For prevention effort details, see glossary.