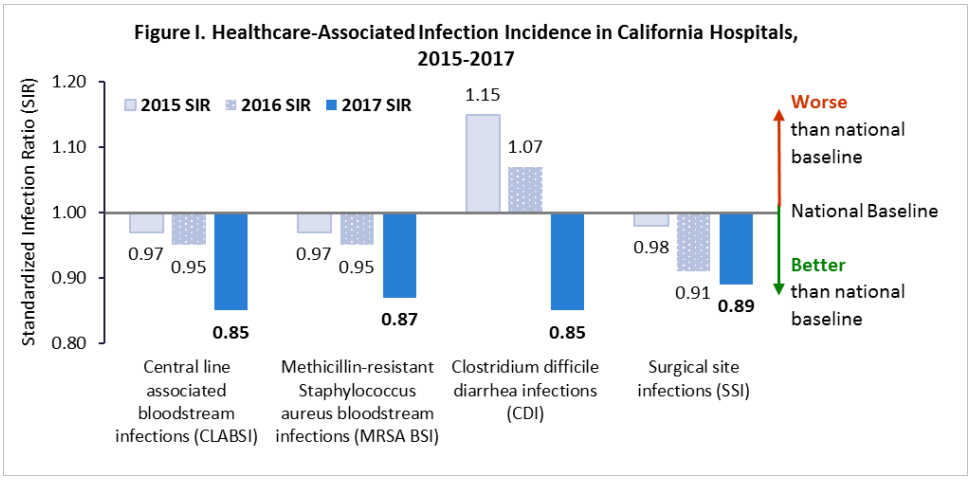
California Department of Public Health
Healthcare-Associated Infections in California Hospitals Annual Report
January to December 2017

Executive Summary

The California Department of Public Health (CDPH) publishes healthcare-associated infections (HAI) data to prompt hospitals to take action to prevent infections and provide to consumers vital information about the quality of hospital care (Health and Safety Code section 1288.55).

This report presents California hospital HAI data for calendar year 2017. From 2016 to 2017, California hospitals made the most substantial progress in HAI prevention since reporting began in 2009. In 2017, hospitals reported 2,602 fewer HAI than reported in 2016. Statewide incidence for all reportable infection types is now lower or "better" than 2015 national baselines (Figure I).



The 2017 reductions occurred most notably for *C. difficile* infections (CDI), a type of life-threatening diarrhea that occurs when a patient inadvertently ingests the organism and is treated with certain antibiotics, and Vancomycin-resistant Enterococcus bloodstream infections (VRE BSI), invasive infections caused by a gut organism that has acquired resistance to certain antibiotics. The statewide CDI incidence decreased by 26% since 2015. For the first time, statewide VRE BSI rates decreased for all hospital types (teaching, community (small, medium, and large), and pediatric) except long-term acute care (LTAC) hospitals.

Despite overall improvement, HAI incidence is not decreasing for all infection types in all hospitals. In response to this report, CDPH is taking specific action including coordinating with the California Hospital Association and others engaged in statewide HAI prevention projects and providing HAI trend data and support to local health departments to address regional HAI issues. CDPH is also continuing to provide support to nine hospitals with high HAI incidence over multiple years and providing onsite assistance to 44 hospitals with the highest surgical site infection (SSI) incidence. To help develop a statewide reduction strategy, CDPH will also convene 20 hospitals that reported nearly half of all central line associated bloodstream infections (CLABSI).

CDPH recommends that all hospitals implement a facility-wide adherence monitoring program to evaluate health care provider and staff compliance with care practices known to prevent hospitalized patients from acquiring HAI. Members of the public should ask their doctors and other health care providers if they have adherence monitoring programs and other actions to prevent HAI.

To view the full report, please visit the CDPH website:
https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AnnualHAIReports.aspx.

To request a copy of the report, please contact:

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