Making Healthcare Safer for All Californians

Healthcare-Associated Infections in California Hospitals Annual Report, 2018

EXECUTIVE SUMMARY

The California Department of Public Health (CDPH) publishes healthcareassociated infections (HAI) data annually to provide vital information about the quality of hospital care and to monitor prevention progress (Health and Safety Code section 1288.55). This report presents California hospital HAI data for calendar year 2018.

In 2018, 401 California general acute care hospitals reported 2,428 fewer HAI than were reported in 2017. Hospitals prevented more HAI than in any previous reporting year for three infection types: central line-associated bloodstream infections (CLABSI), MRSA bloodstream infections (MRSA BSI), and *C. difficile* infections (CDI). Statewide incidence for all reportable infection types continues to be lower (better) than 2015 national baselines (Figure).

For the second straight year, the largest reductions in HAI incidence among

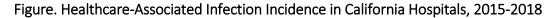
hospitals were reported in CDI, a type of life-threatening diarrheal infection that occurs when a patient inadvertently ingests the organism and is treated with certain antibiotics. Since 2015, California hospitals reduced overall CDI incidence by 41%, exceeding the 2020 CDI reduction goal.

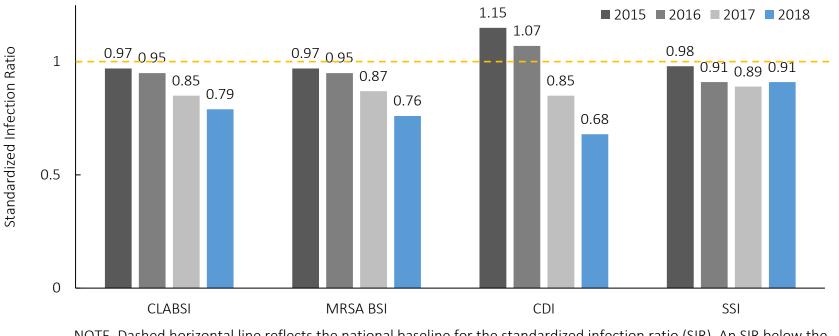
Although California HAI incidence continues to improve each year, HAI incidence is not decreasing for all infection types in all hospitals. In 2018, hospitals reported 168 more surgical site infections (SSI) than in 2017, accounting for a 2% overall increase in SSI incidence.

Long-term acute care (LTAC) hospitals, which provide complex care to patients that typically require prolonged hospital stays, continue to show little progress in HAI prevention and are unlikely to meet 2020 HAI reduction goals for MRSA bloodstream infections, CLABSI or CDI. California LTAC hospitals need to greatly accelerate their HAI prevention efforts to improve patient safety.

California hospitals have reduced C. difficile infection incidence by 41% since 2015, exceeding the 2020 reduction goal. In response to this report, CDPH is engaged in 10 HAI prevention projects and will provide HAI data to local health departments with plans to reduce countywide HAI incidence. CDPH is also targeting 10 hospitals with high HAI incidence over multiple years and will continue to provide assistance to 44 hospitals with the highest SSI incidence among all hospitals performing the same procedures. CDPH continues to collaborate with 20 hospitals that reported nearly half of all CLABSI in 2017 and released a statewide reduction strategy in July 2019.

CDPH recommends hospitals take HAIspecific prevention actions to reach the 2020 reduction goals. Hospitals should review SSI incidence for the past five years to identify procedures for which SSI have increased or have shown no prevention progress. Hospitals should also work with surgical teams to assess and improve infection prevention practices where gaps are identified.





NOTE. Dashed horizontal line reflects the national baseline for the standardized infection ratio (SIR). An SIR below the dashed line represents HAI prevention progress.

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

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