




Press Briefing Transcript

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- Audio recording (/media/releases/2011/t0301_vitalsigns.mp3)  (MP3, 3.60MB)

Operator: Today's conference call is being recorded. If you have any objections, disconnect at this time. I now would like to turn the conference call over to Mr. Tom Skinner, and sir, you may begin.

Tom Skinner: Thanks, Karen, and thank you for joining us for another release of a *Vital Signs* report on bloodstream infections in the United States years 2001, 2008, and 2009. Joining us today is Dr. Frieden, the director of the CDC, who will give opening remarks. Also with us today is Dr. Arjun Srinivasan, a medical epidemiologist from the division of health care quality promotion at the CDC who is available to answer questions. That's spelled a-r-j-u-n and last name s-r-i-n-i-v-a-s-a-n. With that, I'll turn it over to Dr. Frieden.

Tom Frieden: Thank you very much for joining us this afternoon. When I was in my medical training, it was common to have central line infections, and it was considered an acceptable part of medical practice. We now have a new normal in health care where central line infections are unacceptable and are seen as such, and we have seen and are reporting today dramatic progress saving lives and saving money by substantially reducing central line infections in intensive care units. Although these infections are still far too common, especially in hemodialysis centers, we think this is a model to improve health care more generally. I'll go into that in a little more detail over the next few minutes.

Central line associated bloodstream infections remain far too common. There are about 80,000 per year in patients with central lines. Between 12% and 25% of patients who have a central line infection may die. That means there are still at least 10,000 people per year in this country who die from central line infections. The impressive progress has been made in intensive care units where we have data over the past eight years from 2001 to 2009. There were 58% fewer, nearly 60% fewer central line associated bloodstream infections in 2009 than there were in 2001. In that eight-year time period that represents about 27,000 lives saved and about \$1.8 billion in cumulative health care costs avoided. This is major progress, but the data being released today identifies still areas where much more progress is needed, particularly in hemodialysis centers. It remains risky. There are 300 patients on dialysis every day in this country. There were 37,000 infections among those patients in 2008. That represents about 1 out of every 10 patients on hemodialysis getting an infection every year. Infection is the **[editor's note: infection is the second]** leading cause of death in these centers – in those patients, excuse me.

We have a long way to go, especially in hemodialysis. The number of patients on dialysis is expected to double in the next ten years **[editor's note: The number of patients on dialysis will likely increase by 41% by 2020]** as more people with diabetes and as the population ages develop renal failure, and it's more important we make it safer. There are still also a large number of infections in inpatient units outside of intensive care units, and more progress can be made there. We continue to think we can make even more progress in intensive care units as well. This is a model that shows that progress is possible and should be expected in improving medical care. This has been done through a package that started with rigorous science to understand what are the problems and how to address them led to very fruitful collaborations within the federal government, AHRQ, CMS at state level, state governments are playing a central role in improving the safety of hospitals in their jurisdictions and the private sector from nonprofit organizations that have been involved to health care institutions themselves to others who have been leaders in driving down rates of hospital associated and health care associated infections. This is a model we believe can be applied to other health care associated infections but other conditions. Tracking infections is critical, and CDC does that through the national health care safety network, which is now receiving information from more than 5,000 hospitals around the country.

There are a couple of key messages that are important in this report for health care providers and for patients. Central lines and other lines should only be used when essential. For patients on hemodialysis there are better ways for most patients. If patients begin the planning process early as their kidney failure gradually goes downhill, it's possible to start dialysis without using a central line. In many parts of the world, that's the norm. But in the U.S. Unfortunately that's the exception. Getting lines out as quickly as possible, not using them in the first place if they're not necessary, all very important. Accountability and transparency have been key to this progress, and we're fortunate we're able to continue to make this kind of progress because of prevention dollars and CDC is supporting state governments in reducing health care associated infections through dollars that are available through the prevention of public health fund. This is a great example of saving lives and saving money through rigorous science, collaboration between public and private sector, and meticulous monitoring to determine what's being done, what's working, and then to focus on where we can make the most progress. So I'll stop there.

Tom Skinner: Okay. Karen, I think we're ready for questions.

Operator: Okay. At this time we're going to open it up for question and answers. If you would like to ask a question, please press star one on your touch-tone phone. Please unmute your phone and record your name clearly when prompted. One moment please for the first question.

Tom Frieden: While we're waiting for the first question, there's been some – just to clarify a central line is a tube put into a large vein to give essential medicines or nutrition or in the case of dialysis to use and remove and clean the blood in somebody's kidneys who are not working.

Operator: You may ask your question.

Katherine Hobson: I have two quick questions. I assume you don't have the comparable historical figures for the non-ICU infections? And secondly, with those non-ICU settings in the hospital, can you explain what's going on there? Are those central lines inserted in the ICU and the patient is moved, or are those inserted in the other non-ICU wards?

Tom Frieden: You're correct. We don't have comparative information for the inpatient units outside of the intensive care units. While most of the lines are inserted in the intensive care unit, the patient would move to the floor where — some would be inserted in places — other places in the hospital.

Katherine Hobson: Thanks.

Operator: Once again—

Tom Skinner: Next question, Karen.

Operator: If you'd like to ask a question, press star one on your touch-tone phone.

Operator: Thank you. I have Bridget Kuehn from JAMA Medical News. You may ask your question.

Bridget Kuehn: Thank you for taking my call. Staph aureus in connection with this went down in the largest amount. Was that MRSA or just staph, and why do you think that infection caused by that bacteria were more effective than some of the other infections?

Tom Frieden: Dr. Srinivasan will take that question.

Arjun Srinivasan: That number in the *Vital Signs* reported includes all aureus in which the resistant are the subset. You bring up an important point, which is that the staph infections were decreased much more than the germs, the bacteria with these associated bloodstream infections. The differences are due to two main factors. One is staph aureus as a bacteria is more likely to be present on the skin when a catheter is put in. Efforts to improve the way the catheters are put in would impact staph aureus more than others. The other factor reducing staph aureus is the focus you're alluding to on preventing methicillin resistant staph aureus or MRSA present in hospitals. That combination of factors is reducing staph aureus. One of the other points this difference brings is we have to understand the differences to target the measures effectively. We say you can't fix a problem you don't know exists, and these differences between the pathogens points to the fact that we have to know the germ that's causing the infection so we can optimally design better prevention to target ones not reduced as much.

Bridget Kuehn: Thank you.

Tom Skinner: Karen, any more questions?

Operator: Once again, if you'd like to ask a question, please press star one on your touch-tone phone. There are no — one moment, please. We do have a question from Denise Grady with the New York Times. Your line is open. You may ask your question.

Denise Grady: Thanks. I'm looking at table 2 in the report. One thing I see is that these estimates on the numbers is — if I look at the intensive care units in 2001, it's possible that it goes from 27,000 up to 67,000, on 2009 it goes from 12,000 to 28,000. If we took the lower limit and the higher limit on the other, then the overall number of infections actually would not have changed. So is it — or could have even gone up. So given the large variability in these numbers, how sure are we that there really has been this sizable improvement here?

Tom Frieden: Thank you for your question. We're very confident in the fact that the improvement is real. The ranges you see in that table are ranges that would likely affect both sets of estimates. So, for example, if there were really 67,000 in 2001, then there were probably closer to 28,000 in 2009 and respectively at lower end if there were 27,000 and then likely 12,000. The best estimate is probably the best estimate, which is that they were 43,000 in 2001 and 18,000 in 2009. This is very consistent with what we see from a variety of other data sources, individual institutions, state-based initiatives, multi-state initiatives. It's very clear that from the standpoint of either an individual hospital or hospital system or a state that implementing a simple set of important prevention initiatives and policies can drive infection rates down by 50% to 80%.

Denise Grady: Thank you.

Tom Skinner: Next question, Karen.

Operator: Hiran Ratnayake with Delaware News Journal, your line is open.

Hiran Ratnayake: Is it possible to track data on the number of these types of infections in dialysis centers and are you planning on doing this in the near future?

Tom Frieden: The report is the first report of this kind to track, and we're increasing the monitoring the dialysis centers and working with the professional societies and others as well as CMS to do that. This report clearly identifies dialysis centers as a major new frontier in the effort to reduce central line associated bloodstream infections.

Operator: Next question, Karen.

Tom Skinner: Once again, if you'd like to ask a question, please press star one on your touch-tone phone. One moment, please.

Tom Frieden: Okay. If there are no more questions, I'll just emphasize again that what we're reporting today is very substantial progress. A 60% reduction – near 60% reduction in intensive care unit infections resulting in the prevention of 27,000 deaths and nearly \$2 billion in health care costs. But the identification of significant need for further progress, especially in hemodialysis why patients get a central line infection every year. This progress in reducing intensive care unit infections should be a model in terms of meticulous monitoring, great collaboration within the federal government as well as with the health care industry and others. State governments having an essential role in reducing central line infections, and we think that this can make significant progress in further reducing health care associated infections, which is an important priority for the health care system and a priority for the department of health and human services. This is one of the places where we can not only improve the quality of medical care but save a significant number of lives and a significant amount of money. Thank you all very much for your attention.

Operator: Thank you. That does conclude today's conference call. Thank you for participating. You may disconnect at this time.

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