Oregon Health Authority

Communicable Disease Control

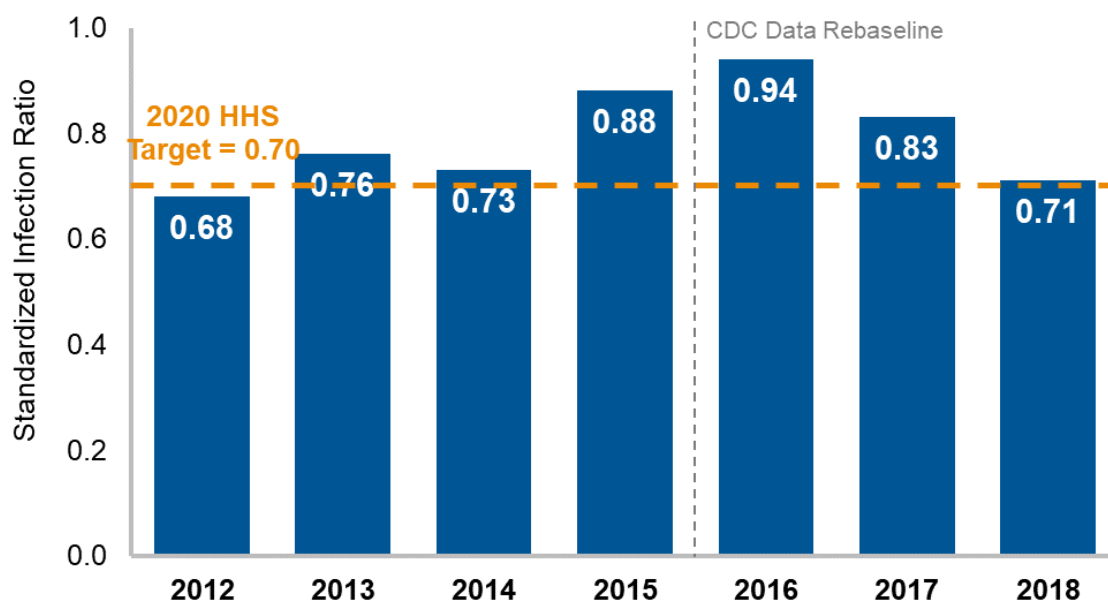
Clostridioides difficile incidence

Clostridioides difficile is a toxin-producing bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. *C. difficile* infections (CDI) are often linked to medical care and individuals taking antibiotics. Nationally, CDI is the most common healthcare-associated infection. Population-based surveillance and mandatory reporting through the National Healthcare Safety Network (NHSN) allow us to identify populations at higher risk of acquiring CDI in the state of Oregon.

In 2018, we continue to observe a decrease in Oregon's healthcare-onset, laboratory-identified CDI standardized infection ratio (SIR). The 2018 SIR of 0.71 (95% CI:0.65–0.76) corresponds to 29% fewer observed infections than predicted based on national baseline data. Oregon's 2018 CDI SIR is close to meeting the 2020 U.S. Department of Health and Human Services (HHS) reduction target of an SIR of 0.70, which corresponds to a 30% reduction in CDI.

FIGURE 1

Healthcare-onset C. difficile infections, Oregon Acute Care Hospitals, 2012–2018



Source: National Healthcare Safety Network (NHSN)

Methods to control the spread of *C. difficile* in hospitals include improving hand hygiene compliance, reducing unnecessary antibiotic prescribing, training healthcare employees to minimize risk of spread from patient-to-patient when caring for patients with active infections, and training hospital environmental services employees how to remove *C. difficile* from hospital environments. To help fight the spread of *C. difficile*, Oregon's inter-facility transfer communication law took effect in 2014, which requires health care facilities to notify receiving facilities of patient *C. difficile* status upon transfer. In 2017, the Healthcare-Associated Infections Program initiated implementation of CDC's Targeted Assessment for Prevention (TAP) Strategy. This strategy provides healthcare facilities with information to support CDI prevention, including new CDI data metrics, surveys of healthcare worker awareness and perceptions of CDI prevention strategies, and options for quality improvement projects.

Additional Resources: Oregon NHSN HAI Report

About the Data: Data source is the National Healthcare Safety Network (NHSN). Data is derived from mandatory case reporting by healthcare facilities. Data includes all cases of hospital-onset, laboratory identified *C. difficile* infections. The standardized infection ratio (SIR) is the Centers for Disease Control and Prevention's (CDC) recommended measure of performance relative to national baselines. The metric is the ratio of reported infections in a calendar year to the predicted infections for that same year based on risk-adjusted national baseline rates. CDC recently updated HAI baselines using data entered in NHSN in 2015. This "rebaseline" updates both the source of aggregate data and the risk adjustment methodology used to create the baselines. The changes in SIR from 2015 to 2016 may be, in part, a reflection of these updates. As of 2016, SIRs do not include critical access hospitals. CDI data for critical access hospitals can be found at: https://go.usa.gov/xUMGy

For More Information Contact: Valerie Ocampo, Valerie.L.Ocampo@state.or.us

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Oregon State Health Profile

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