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Changing epidemiology of methicillin-resistant *Staphylococcus aureus* in the Veterans Affairs Healthcare System, 2002–2009

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1 **Changing Epidemiology of Methicillin-Resistant *Staphylococcus aureus* in the Veterans**
2 **Affairs Healthcare System, 2002-2009**

3

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23 **ABSTRACT**

24 **Purpose**

25 The epidemiology of infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA)
26 is changing. Temporal trends and differences between healthcare settings must be described to
27 better predict future risk factors associated with this dangerous bacterial infection.

28

29 **Methods**

30 A national MRSA-infected cohort was identified from 2002 through 2009 in the Veterans Affairs
31 Healthcare System of the United States: hospital (HOS), long-term care (LTC), and outpatient
32 (OPT). We analyzed within-setting time trends using generalized linear mixed models and
33 between-setting differences with χ^2 and Wilcoxon rank-sum tests.

34

35 **Results**

36 The incidence of *S. aureus*, methicillin-susceptible *S. aureus*, and MRSA infections increased
37 significantly over time in all three settings based on modeled annual percent changes ($p < 0.001$).
38 MRSA incidence rates rose by 14%, 10%, and 37% per year in the HOS, LTC, and OPT settings
39 respectively. Among 56,345 MRSA-infected patients, comorbidity burden was highest among
40 LTC inpatients ($n=4,427$) and lowest among outpatients ($n=7,250$), with an average absolute
41 difference in specific comorbidities of +2% and -7% respectively compared to HOS inpatients
42 ($n=44,668$). Over time, there was a significant ($p \leq 0.02$) decrease in previous inpatient
43 admissions and surgeries (all settings); diabetes with complications and surgical site infections
44 (HOS, OPT); median length of stay and inpatient mortality (HOS, LTC). Alternatively, obesity,
45 chronic renal disease, and depression were more common between 2002 and 2009 ($p \leq 0.02$).

46

47 **Conclusions**

48 Over the past eight years, we observed significant changes in the epidemiology of MRSA
49 infections, including decreases in traditional MRSA risk factors, improvements in clinical
50 outcomes, and increases in other patient characteristics that may affect risk.

51 **INTRODUCTION**

52 Over the past decade, substantial shifts in the molecular and clinical epidemiology of methicillin-
53 resistant *Staphylococcus aureus* (MRSA) infections have been reported [1-12]. Although MRSA
54 infections were once predominantly hospital-acquired, this insidious pathogen has evolved and is
55 now pervasive in communities across the United States (U.S.) [2-4]. Ensuing evidence has
56 documented the rise in community-associated MRSA (CA-MRSA) and decline in invasive
57 healthcare-associated MRSA (HA-MRSA), altering the distribution of attributed exposure and
58 onset, strain characteristics, and predominant infection types [1-12]. However, in this era of
59 epidemiologic change, knowledge of trends in patient characteristics is limited.

60

61 We therefore sought to describe the underlying patient populations infected with MRSA from
62 diverse healthcare settings of a single source population. Our objectives were to quantify
63 differences in patient demographics, comorbidities, clinical characteristics, and outcomes
64 between healthcare settings and describe within-setting changes over time among hospital
65 inpatients, long-term care inpatients, and outpatients in the national Veterans Affairs (VA)
66 Healthcare System.

67

68 **METHODS**

69 **Study Design and Population.** To describe the epidemiology of MRSA from January 1, 2002
70 through December 31, 2009, we utilized national databases documenting care provided by the
71 VA Healthcare System in the U.S. [13]. This retrospective, observational study identified
72 MRSA-infected adult patients (≥ 18 years of age) from inpatient settings, consisting of hospital

73 admissions and long-term care facility admissions, and the outpatient setting. This study was
74 reviewed and approved by the Providence VA Medical Center Institutional Review Board.

75

76 **Incidence.** We assessed changes in MRSA incidence rates over time in the context of
77 *Staphylococcus aureus* (*S. aureus*) infections. Utilizing International Classification of Diseases,
78 9th Revision (ICD-9) diagnosis codes, we identified *S. aureus* infections (ICD-9 038.11, 038.12,
79 041.11, 041.12, 482.41, 482.42, V09.0), which were then categorized as methicillin-resistant
80 (038.12, 041.12, 482.42, V09.0), or methicillin-susceptible (MSSA) based on the absence of a
81 MRSA code [10]. The yearly incidence rate was calculated for each setting as the number of *S.*
82 *aureus*, MSSA, and MRSA-related hospitalizations, long-term care admissions, or outpatient
83 visits per 1,000 admissions or visits.

84

85 **Characteristics of MRSA-Infected Patients.** If patients had more than one MRSA-related
86 admission or visit during the study period, the first encounter was selected for inclusion.
87 Comorbidities were assessed from ICD-9 codes present during the MRSA-related admission/visit
88 and any inpatient admission or visit in the previous year [14, 15]. Previous healthcare exposures,
89 including inpatient admissions and surgeries, were captured in the year prior to the MRSA-
90 related admission/visit. Infection type was categorized as bacteremia (ICD-9 038.11, 038.12,
91 790.7), endocarditis (421.0), skin and soft tissue infection (ICD-9 681-682, 528.3), surgical site
92 infection (998.5), osteomyelitis (730.0-730.2), and pneumonia (482-486) based on diagnoses
93 present during the MRSA-related admission/visit [10, 15].

94

95 **Statistical Analyses.** Differences in patient demographics, comorbidities, clinical
96 characteristics, and outcomes between healthcare settings were analyzed with χ^2 and Wilcoxon
97 rank-sum tests for categorical and continuous variables respectively. Within healthcare settings,
98 we assessed the significance of temporal trends over the study years using generalized linear
99 mixed models. Due to changes in coding practices, sensitivity analyses were carried out
100 excluding MRSA-infected patients diagnosed in 2009. A p-value of <0.05 was considered
101 statistically significant and all analyses were performed using SAS (SAS Institute Inc., Cary,
102 NC, Version 9.2).

103

104 **RESULTS**

105 The incidence of *S. aureus*, MSSA, and MRSA infections increased significantly over time in all
106 three settings based on modeled annual percent changes (p<0.001). MRSA-related
107 hospitalizations increased from 6.7 in 2002 to 15.9 in 2009, from 8.3 to 15.9 MRSA-related
108 long-term care admissions, and from 0.01 to 0.08 MRSA-related outpatient clinic visits per 1,000
109 admissions/visits (Fig 1). MRSA incidence rates increased annually by 37% in the outpatient
110 setting, 10% in long-term care, and 14% in hospitals. Similarly, modeled MSSA incidence rates
111 rose each year by 18% in the outpatient setting, 4% in long-term care, and 4% in hospitals. We
112 observed a 4% increase per year in the modeled incidence for *S. aureus*-related long-term care
113 admissions, a 5% increase per year for hospital admissions, and a 21% increase per year for
114 outpatient visits. Sensitivity analyses demonstrated agreement, with the exception of non-
115 significant changes over time in MSSA incidence for the hospital and long-term care settings.

116

117 MRSA-infected long-term care inpatients (n=4,427) and outpatients (n=7,250) differed
118 significantly ($p \leq 0.035$) from those hospitalized (n=44,668) on most characteristics assessed
119 including demographics, comorbidities, previous healthcare exposures, and infection type (Table
120 1). Comorbidity burden was highest among MRSA-infected long-term care inpatients and
121 lowest among outpatients, with an average absolute difference in specific comorbidities of +2%
122 and -7% respectively compared to hospital inpatients. Skin and soft tissue infections were the
123 most commonly reported infection type in each healthcare setting (hospital 31%; long-term care
124 18%; outpatient 23%), followed by pneumonia among inpatients (hospital 16%; long-term care
125 16%) and osteomyelitis among outpatients (4%). Endocarditis was reported in less than 1% of
126 the MRSA-infected cohort and site of infection could not be determined from diagnosis codes in
127 33% of patients (hospital 29%; long-term care 34%; outpatient 56%) [10, 15].

128
129 Over time, the median Charlson Comorbidity Index changed significantly only among MRSA-
130 infected outpatients, decreasing from 3 in 2002 to 1 in 2009 ($p=0.034$). Temporal trends within
131 healthcare settings are presented in Table 2. Significant decreases ($p \leq 0.037$) were observed in
132 the modeled annual percent change of MRSA-infected patients with cerebrovascular disease
133 (hospital 0.4%; long-term care 0.8%), diabetes with complications (hospital 0.4%; outpatient
134 1.7%), dialysis (hospital 0.2%), and peripheral vascular disease (hospital 0.6%; outpatient 1.8%).
135 Inpatient admissions and surgeries in the year prior to the MRSA-related admission/visit were
136 significantly ($p \leq 0.02$) less common over time in all three settings (hospital 2.3% and 1.8%; long-
137 term care 0.9% and 1.3%; outpatient 3.4% and 2.4%). Alternatively, in each healthcare setting,
138 obesity and depression were more commonly reported from 2002 through 2009 in MRSA-

139 infected patients ($p \leq 0.02$; hospital 1.4% and 1.2%; long-term care 1.2% and 1.7%; outpatient
140 1.1% and 1.0%).

141
142 Non-significant increases were observed in skin and soft tissue infections over the study period
143 in all three settings. Among MRSA-infected long-term care inpatients, infection type was
144 relatively unchanged over time, except for a significant decrease ($p < 0.001$) in pneumonia (1.5%
145 modeled annual percent change). Surgical site infections and osteomyelitis decreased
146 significantly each year among hospital inpatients and outpatients (hospital 0.6% and 0.6%;
147 outpatient 0.4% and 1.4%), while pneumonia increased 1.2% per year in the hospital setting.
148 Among MRSA-infected inpatients, annualized decreases in median length of stay (hospital: 11
149 days in 2002 to 6 days in 2009; long-term care: 52 days to 36 days) and inpatient mortality
150 (hospital 0.9%; long-term care 1.7%) were significant ($p \leq 0.01$). Changes in patient
151 characteristics over time were similar in sensitivity analyses including data from 2002 through
152 2008.

153

154 **DISCUSSION**

155 Our research uniquely assessed a comprehensive set of patient characteristics in three distinct
156 clinical settings of a nationwide healthcare provider, with a well-defined source population, in
157 the US. From this large, national epidemiologic study, significant increases in MRSA incidence
158 rates were discerned over the past eight years in the VA Healthcare System. Our findings are
159 similar to other national studies that have described rising MRSA incidence rates over the past
160 decade among children and adults in the U.S. and Canada [6, 10, 16]. Unlike the diverse

161 healthcare settings we evaluated, these other studies were restricted to a single clinical setting,
162 specifically hospitals [6, 10, 16].

163
164 In both the hospital and long-term care settings, we observed non-significant declines in MRSA
165 incidence rates between 2008 and 2009. The interaction of several contributing factors may
166 explain these reduced rates. VA infection control policies targeting MRSA were enhanced under
167 a nationwide directive, with full implementation in acute care facilities by December 31, 2007
168 and expansion to other healthcare settings during 2009 [17]. The MRSA Prevention Initiative
169 established active MRSA colonization surveillance and emphasizes contact precautions, hand
170 hygiene, and cultural transformation as components of the overall MRSA prevention bundle,
171 broadening infection control awareness through education [17, 18].

172
173 Additionally, the introduction of new diagnosis codes for MRSA infections may have impacted
174 coding practices. Previously, MRSA could only be coded as a secondary diagnosis (V09.0),
175 however primary ICD-9 codes for MRSA bacterial infection (041.12), MRSA septicemia
176 (038.12), and MRSA pneumonia (482.42) were adopted in 2009. Lastly, shifts in MRSA
177 exposure and onset likely played a role in the recent decline, as CA-MRSA has gained a larger
178 share of MRSA infections with subsequent reductions in HA-MRSA [2-5]. Active laboratory
179 surveillance in 9 U.S. metropolitan areas revealed substantial yearly rate decreases in the
180 incidence of invasive HA-MRSA infections from 2005 through 2008 [5]. We suspect the decline
181 we observed in hospital MRSA incidence was considerably less than the reported HA-MRSA
182 rate drop due to increases in invasive infections requiring inpatient care caused by CA-MRSA
183 [1-5].

184

185 As expected, MRSA-infected long-term care inpatients had a higher comorbidity burden than
186 hospital inpatients, and those hospitalized were in poorer health than outpatients. In quantifying
187 differences between healthcare settings, we found most comorbidities differed by several
188 percentage points comparing hospitalized and long-term care inpatients, although this difference
189 was more pronounced between outpatients and hospital inpatients.

190

191 In regards to temporal trends among patients infected with MRSA, we observed significant
192 declines in previously established MRSA risk factors, including diabetes with complications [19-
193 21], previous hospitalization [7, 20, 21], previous surgery [23], and dialysis [17, 22, 23]. Also
194 significant over time were increases in obesity and depression. Possible explanations for these
195 increases include changes in the underlying patient population infected with MRSA in the VA
196 Healthcare System, increased awareness and reporting, or the potential for these diseases to
197 affect the risk of developing MRSA infections. Overall, MRSA-infected patients appeared
198 healthier over the study period in each of the three settings and clinical outcomes improved. Our
199 findings are consistent with rising rates of CA-MRSA and the distinct clinical epidemiology of
200 CA-MRSA [2-5, 24].

201

202 A considerable limitation in our study and several others [10, 25, 26], is the use of diagnosis
203 codes to identify MRSA infections. Due to the lack of microbiology research databases in U.S.
204 healthcare systems, we are limited to diagnosis codes extracted from administrative data and
205 electronic medical records [10, 13, 25, 26]. Until health informatics advancements are made to

206 extract and link such data, the only way to ascertain MRSA trends in large populations is with
207 diagnosis codes.

208

209 Similar to other research using diagnosis codes, we could only determine site of infection in two-
210 thirds of the cohort [10]. This may explain the absence of significant increases in MRSA skin
211 and soft tissue infections over time. Three of the MRSA diagnosis codes await validation as they
212 were recently implemented (038.12, 041.12, 482.42). The original MRSA diagnosis code
213 (V09.0) has suboptimal sensitivity but a high positive predictive value, indicating
214 underascertainment [10, 27, 28]. It is important to note that coding accuracy in VA databases is
215 reportedly higher than other healthcare systems [29, 30]. Further, sensitivity has been found to
216 increase with greater numbers of available diagnosis code entries, which is relatively high in the
217 VA databases (13 entries per admission plus 5 per bed section, 10 per outpatient visit) [10, 13,
218 27, 28]. The generalizability of the findings should be interpreted in the context of our source
219 population, comprising 5.5 million patients treated annually by the VA Healthcare System,
220 which is the largest integrated healthcare system in the country.

221

222 In conclusion, MRSA incidence rates rose significantly over the past eight years in the VA
223 Healthcare System. We observed significant changes in the epidemiology of MRSA infections
224 among hospital inpatients, long-term care inpatients, and outpatients from the same source
225 population. Over time, MRSA-infected patients appeared healthier, with fewer exposures to
226 MRSA risk factors and improved clinical outcomes, suggesting CA-MRSA has gained
227 considerable ground in the VA Healthcare System nationally.

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233

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236

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241

242 **POTENTIAL CONFLICTS OF INTEREST**

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TABLES

Table 1. Demographics, comorbidities, clinical characteristics, and outcomes by healthcare setting among MRSA-infected patients in the Veterans Affairs Healthcare System

Covariates	Hospital N = 44,668	Long-term care ^a N = 4,427	Outpatient clinic ^a N = 7,250
Median age, y (IQR)	63 (55-76)	68 (58-79)	60 (52-72)
Male	43,337 (97.0)	4,305 (97.2) ^{NS}	6,711 (92.6)
Race			
White	33,445 (74.9)	3,462 (78.2)	5,206 (71.8)
African American	8,758 (19.6)	709 (16.0)	1,175 (16.2)
Hispanic	2,417 (5.4)	187 (4.2)	301 (4.2)
Region of facility			
North	5,297 (11.9)	749 (16.9)	874 (12.0)
South	18,887 (42.3)	1,333 (30.1)	3,275 (45.2)
Midwest	9,537 (21.3)	1,309 (29.6)	1,462 (20.2)
West	10,947 (24.5)	1,036 (23.4)	1,639 (22.6)
Admitted from home	38,155 (85.4)	1,471 (33.2)	--
Median Charlson Comorbidity Index (IQR)	3 (1-5)	3 (2-6)	1 (0-3)
Comorbidities			
Amputation	3,321 (7.4)	503 (11.4)	322 (4.4)
Cancer	9,943 (22.3)	1,110 (25.1)	1,056 (14.6)

Cerebrovascular disease	7,441 (16.7)	960 (21.7)	631 (8.7)
Chronic renal disease	9,438 (21.1)	921 (20.8) ^{NS}	775 (10.7)
Chronic respiratory disease	15,925 (35.7)	1,688 (38.1)	1,683 (23.2)
Congestive heart failure	10,588 (23.7)	1,127 (25.5)	796 (11.0)
Depression	15,219 (34.1)	1,813 (41.0)	2,322 (32.0)
Diabetes	19,092 (42.7)	1,965 (44.4)	2,503 (34.5)
Diabetes with complications	9,238 (20.7)	1,032 (23.3)	1,010 (13.9)
Dialysis	1,517 (3.4)	142 (3.2) ^{NS}	87 (1.2)
Hypertension	31,925 (71.5)	3,304 (74.6)	4,474 (61.7)
Obesity	6,945 (15.5)	597 (13.5)	1,292 (17.8)
Paralysis	3,130 (7.0)	310 (7.0) ^{NS}	177 (2.4)
Peripheral vascular disease	9,320 (20.9)	1,136 (25.7)	919 (12.7)
Previous healthcare exposures			
Inpatient admission	27,408 (61.4)	3,630 (82.0)	2,211 (30.5)
Surgery	9,214 (20.6)	1,493 (33.7)	694 (9.6)
Infection type			
Bacteremia	6,650 (14.9)	591 (13.4)	191 (2.6)
Skin and soft tissue	13,892 (31.1)	805 (18.2)	1,656 (22.8)
Surgical site infection	2,803 (6.3)	343 (7.8)	186 (2.6)
Osteomyelitis	4,022 (9.0)	524 (11.8)	255 (3.5)
Pneumonia	7,149 (16.0)	696 (15.7) ^{NS}	141 (1.9)
Outcomes			
Inpatient mortality	2,701 (6.0)	1,006 (22.7)	--

Follow-up MRSA admission	27,731 (62.1)	2,236 (50.5)	2,427 (33.5)
Median length of stay, d (IQR)	7 (4-15)	45 (21-105)	--

Data are no. (%), unless otherwise indicated. MRSA, methicillin-resistant *Staphylococcus aureus*; IQR, interquartile range; NS, non-significant.

^a For all covariates, differed significantly compared to MRSA-infected hospitalized patients ($p \leq 0.035$), unless otherwise indicated (NS). Determined from χ^2 or Wilcoxon Rank-Sum tests as appropriate.

Table 2. Temporal trends in demographics, comorbidities, clinical characteristics, and outcomes by healthcare setting among MRSA-infected patients in the Veterans Affairs Healthcare System

Covariates	Hospital			Long-term care			Outpatient clinic		
	N = 44,668			N = 4,427			N = 7,250		
	2002	2009	↓↑ ^a	2002	2009	↓↑ ^a	2002	2009	↓↑ ^a
Median age, y	67	63	NS	71	66	↓	70	60	↓
Male	97.7	96.4	↓	97.6	96.2	NS	95.5	92.8	NS
White	77.3	72.3	NS	81.0	75.0	↓	78.3	71.3	↓
Hispanic	5.4	5.4	NS	5.0	5.0	NS	3.0	4.4	NS
Admitted from home	80.5	87.1	↑	28.0	39.5	↑	--	--	--
Median Charlson Comorbidity Index	3	3	NS	3	4	NS	3	1	↓
Comorbidities									
Amputation	9.1	6.6	↓	13.1	11.2	NS	12.6	3.4	↓
Cancer	24.3	22.4	NS	24.9	26.4	NS	20.2	13.8	NS
Cerebrovascular disease	19.7	16.7	↓	24.5	20.5	↓	11.1	8.0	NS
Chronic renal disease	19.1	23.3	↑	13.3	26.7	↑	10.6	11.1	NS
Chronic respiratory disease	37.9	33.7	NS	42.3	37.8	NS	33.3	22.8	NS

Congestive heart failure	26.5	22.5	NS	27.3	26.9	NS	19.2	9.6	↓
Depression	28.8	37.1	↑	36.1	45.9	↑	26.8	35.2	↑
Diabetes	42.7	43.6	NS	43.2	47.2	NS	42.4	33.1	↓
Diabetes with complications	23.1	20.3	↓	22.8	24.0	NS	22.7	12.6	↓
Dialysis	4.7	3.2	↓	4.0	3.6	NS	1.5	1.1	NS
Hypertension	66.3	75.5	↑	67.2	80.0	↑	66.7	61.9	NS
Obesity	10.0	18.7	↑	9.3	18.6	↑	12.1	19.2	↑
Paralysis	9.0	6.3	↓	9.3	6.7	NS	4.5	2.2	↓
Peripheral vascular disease	25.5	19.7	↓	24.0	27.6	NS	23.7	10.7	↓
Previous healthcare exposures									
Inpatient admission	72.7	56.9	↓	84.3	78.3	↓	52.5	28.9	↓
Surgery	29.6	17.5	↓	38.7	27.9	↓	28.8	8.1	↓
Infection type									
Bacteremia	18.0	15.1	↓	10.9	12.2	NS	2.5	3.0	NS
Skin and soft tissue	22.9	32.0	NS	15.0	16.2	NS	15.2	21.0	NS
Surgical site infection	8.7	5.5	↓	8.8	7.2	NS	5.1	1.4	↓
Osteomyelitis	11.4	8.4	↓	9.5	10.3	NS	12.6	2.2	↓
Pneumonia	19.8	11.3	↓	20.7	9.0	↓	2.0	2.2	NS

Outcomes

Inpatient mortality	9.9	4.1	↓	28.7	17.4	↓	--	--	--
Follow-up MRSA admission	68.3	46.2	↓	54.2	32.9	NS	62.1	21.9	↓
Median length of stay, d	11	6	↓	52	36	↓	--	--	--

Data are %, unless otherwise indicated. MRSA, methicillin-resistant *Staphylococcus aureus*; NS, non-significant.

^a Increased (↑) or decreased (↓) significantly over time ($p \leq 0.037$), unless otherwise indicated (NS), as determined from generalized linear mixed models.

FIGURE

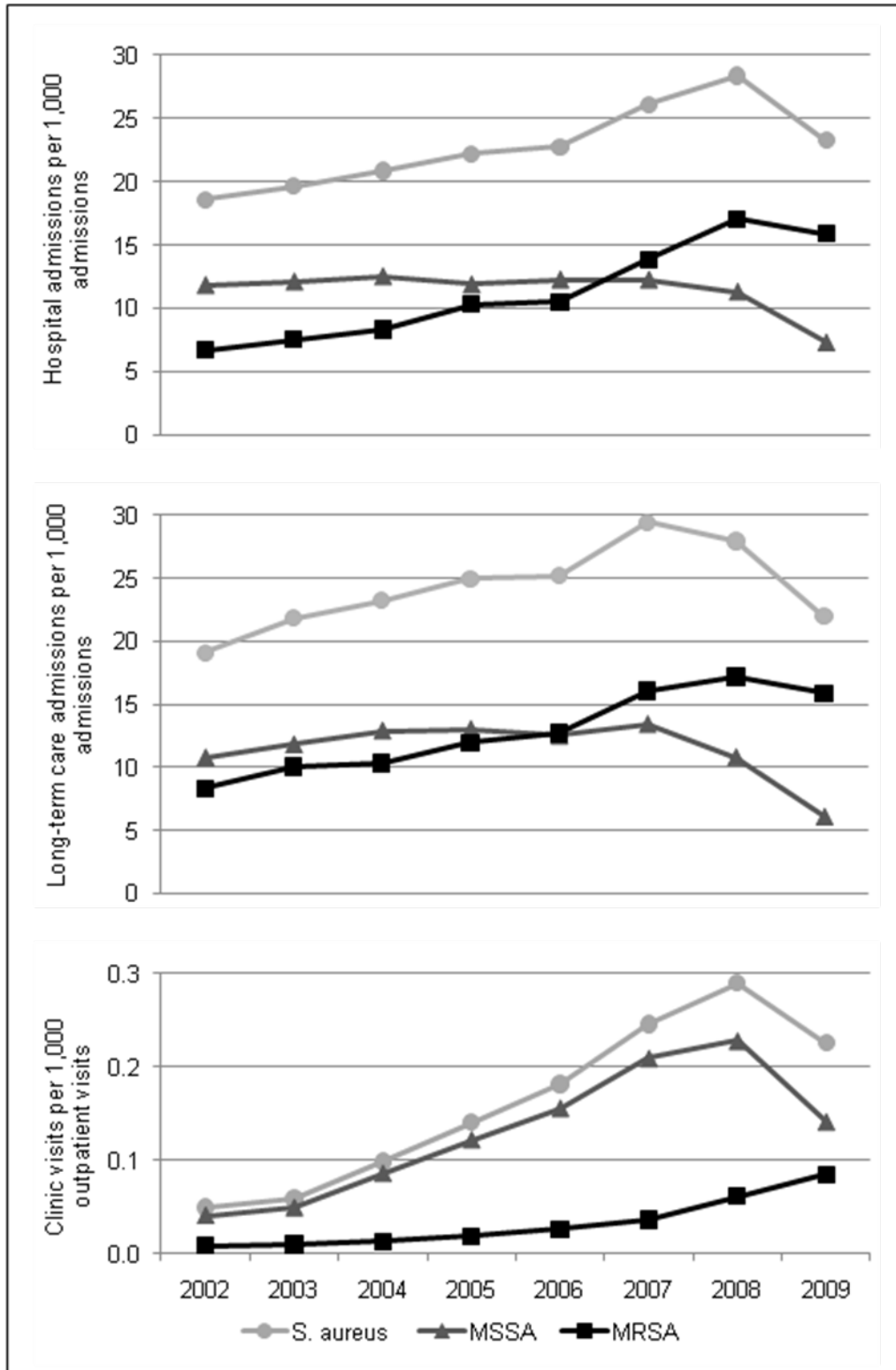


Fig 1 Incidence of *Staphylococcus aureus* (*S. aureus*), methicillin-susceptible *S. aureus* (MSSA), and methicillin-resistant *S. aureus* (MRSA) hospital admissions, long-term care admissions, and outpatient clinic visits per 1,000 admissions or visits in the Veterans Affairs Healthcare System, 2002-2009