The role of the public health analyst in the delivery of technical assistance to state health departments for healthcare-associated infection prevention *

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Abstract

Introduction—Aligned with the goals of the DHHS Action Plan to Prevent Healthcare Associated Infections (HAIs), in 2009 CDC awarded cooperative agreements to 51 state and territorial health departments for purposes of developing and implementing strategies to reduce HAIs. These cooperative agreements through the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) were supported by the American Recovery and Reinvestment Act (ARRA).

Objectives—To systematically describe the technical assistance (TA) delivered by CDC public health analysts to state health departments as part of the ELC cooperative agreement supported by ARRA to develop, implement and/or expand HAI prevention programs.

Research Design—Exploratory, qualitative

Subjects—CDC public health analysts who provided TA to grantees of the ELC cooperative agreement supported by ARRA from September 2009 – December 2011.

Measures—Eight semi-structured interviews using a standardized script. Interviews were audio recorded; responses transcribed, thematically coded and analyzed using a qualitative immersion approach.

Results—Four convergent themes were identified, creating a framework of activities for the delivery of TA: acting as a liaison, facilitating training, providing administrative and program management support, and sharing/disseminating information to states. Having a liaison and providing informational resources to states were perceived as critical components of TA for HAI program sustainability.

Conclusions—Findings provide a framework of core TA activities needed to build and sustain capacity in state HAI prevention programs through the cooperative agreement structure. This

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categorization of themes can be used to assist other agencies and entities in planning for and provision of TA when utilizing cooperative agreements.

Introduction

In August 2009, the Centers for Disease Control and Prevention (CDC) awarded $35.8 million in cooperative agreements to 51 health department grantees in 49 states, the District of Columbia, and Puerto Rico for the purpose of reducing healthcare-associated infections (HAIs). This cooperative agreement program, known as the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC), was supported by the American Recovery and Reinvestment Act, Public Law 111-5 (ARRA). Federal funding dedicated to HAI prevention strategies was intended to support progress towards the national targets for HAI incidence reduction established in the U.S. Department of Health and Human Services (HHS) *National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination.*[1]

As part of the ELC cooperative agreement supported by ARRA, CDC provided technical assistance (TA) to these 51 grantees to support HAI program capacity-building activities in three areas: infrastructure, surveillance and prevention. These broad capacity building categories complemented the HHS Action Plan objectives of coordinating HAI initiatives and enhancing capacity at the state and local level (infrastructure), standardizing HAI measurement and metrics (surveillance), and targeting reductions in epidemiologically important HAIs (prevention). Infrastructure capacity building activities were intended to establish or enhance states' capacity to develop a HAI prevention program through hiring of staff, providing assistance to facilities, training, and coordinating the HAI efforts of local stakeholders. Capacity building activities for HAI surveillance aimed to increase facility participation in the National Healthcare Safety Network (NHSN) surveillance system enhance the validity of data reported to NHSN, and to facilitate states' use of this standardized reporting system to monitor HAIs. Prevention capacity building activities aimed to support states' efforts to establish multi-facility collaboratives focused on HAI prevention strategies for targeted HAIs. States applied and competed for awards in one, two, or all three of the capacity-building areas (infrastructure, surveillance, and prevention). CDC reviewed applications and distributed funding to states based on merit of the application. Seventeen states received funding for infrastructure only; 12 states received funding for two of the three capacity-building areas; and 22 states received funding for infrastructure, surveillance, and prevention. State health departments received awards ranging from $174,000 to $2,600,000.

Description of ELC Cooperative Agreement Supported by ARRA - HAI Program Technical Assistance

Through the ELC cooperative agreement supported by ARRA, CDC provided numerous staff members, resources, and activities to grantees for their HAI program. Subject matter experts (SMEs) were designated for each of the targeted infections and healthcare settings based on the HHS Action Plan, developing a portfolio of evidence-based materials for states to utilize in their implementation efforts. User support and training were provided for NHSN enrollment, reporting, and analysis.

Each state was assigned a CDC-based public health analyst (PHA) as a point of contact for providing one-on-one support to state grantees as they implemented or expanded HAI prevention programs. PHAs delivered extensive guidance to states for program management, continuously monitoring state-specific spending and HAI activities to maximize the impact of funding. At program outset, PHAs were tasked with facilitating information exchange between states and CDC through a variety of mechanisms (Figure). PHAs coordinated monthly conference calls hosted by CDC with all grantees, providing a forum for sharing and collaboration between and across states and SMEs at CDC. PHAs also facilitated access to SMEs and CDC-developed resources such as detailed toolkits, how-to guides, and slide sets that were designed to inform states' HAI prevention activities and were provided through direct correspondence, the HAI website, and via Epi-X, an interactive web-based tool that allowed real-time information sharing among states and the CDC.

During the program period, CDC also hosted three annual meetings, which convened representatives from all state grantees, SMEs at CDC, and several external partners in HAI prevention. These meetings were facilitated by PHAs and involved in-person collaboration and sharing among the grantees and stakeholders to improve program success. PHAs also conducted site visits and organized trainings such as a regional 'train the trainer' course. Overall, the HAI-program support provided to states by CDC through the PHAs significantly contributed to the successful implementation of the ELC cooperative agreement supported by ARRA.

This article describes, from the perspective of the PHA, the (1) types of TA provided during the ELC cooperative agreement supported by ARRA, focusing on activities related to HAI program infrastructure, surveillance, and prevention; (2) barriers and facilitators to the provision of TA to states; and (3) how TA has evolved since the program ended and the most critical components of TA for HAI program sustainability. As part of a larger evaluation of state health department HAI prevention programs documenting state-level HAI program success,[2, 3] this exploratory, qualitative study sought to define TA in the context of building the capacity state programs via a cooperative agreement with a federal agency, and to provide a deeper understanding of the core TA activities employed by the PHAs to support progress towards HHS Action Plan goals.

Methods

Hour-long semi-structured, face-to-face interviews were conducted with persons at CDC/ Division of Healthcare Quality Promotion (DHQP) responsible for providing TA during the program period (September 2009 – December 2011) to assist states to develop or enhance HAI prevention programs. Five PHAs were hired by CDC/DHQP on or around August 2009 (one month prior to distribution of funds from the ELC cooperative agreement supported by ARRA to states) specifically to provide TA to states for development of HAI program capacity. Each PHA was assigned a group of states to work with for the duration of the grant; assignments were made by HHS region so that PHAs would be familiar with regional HAI-related activities and could promote regional connections between states. Two CDC/ DHQP senior-level staff supervised the PHAs' work and were responsible for high-level oversight of all states receiving funds for from the ELC cooperative agreement supported by

ARRA for HAI program capacity building. For this study, six PHAs (the five original hires and one PHA who replaced an original hire who left during the funding period) and two senior level-staff were interviewed between November 2012 and January 2013. Given the federal perspective of this study, and that PHAs at CDC were directly responsible for delivering TA to states during the ELC cooperative agreement supported by ARRA program period, they were the primary source of information about how TA was defined, the types of TA provided, how TA was implemented, as well as the context in which those activities and services were delivered.

A team in the CDC/DHQP Office of Prevention Research and Evaluation developed a standardized interview script containing questions about respondents' (1) background and experience in public health; (2) experience at CDC/DHQP, with focused attention on the types of TA provided to states through the ELC cooperative agreement supported by ARRA to increase capacity in infrastructure, surveillance, and prevention; and (3) thoughts on the relationship between TA and HAI Program sustainability. Questions were open-ended and respondents could provide more than one response for each question. During each interview there was one interviewer and one note-taker from CDC/DHQP's evaluation team. All interviews were audio-recorded and transcribed.

Transcribed interviews were thematically coded by three members of the evaluation team including a behavioral scientist, an epidemiologist, and an evaluation fellow. The team utilized immersion methodology to comprehend the scope and meaning of responses within the entire context of the interview.[4] Individual members of the study team ascribed themes to the transcript and met as a group to develop standardized codes by consensus; these refined codes were then assigned to the transcripts. MAXQDA 10, a qualitative data analysis software package, was used to organize and summarize codes.

Results

Eight public health analysts who delivered TA to states during the ELC cooperative agreement supported by ARRA-funding period were interviewed. There was a range in respondents' academic background and public health experience. Academic background of those interviewed included degrees at the Bachelors', Masters' and post-graduate levels, with half having a Masters' degree. Respondents had a median of 15.5 years' experience working in public health, with a range of five to 20 years' experience.

When asked to define TA, the most common theme elucidated was knowledge sharing and dissemination, which included providing both programmatic and subject matter expertise, as exemplified in the following: *"[TA is] the sharing and dissemination of knowledge to the state health departments in order to help them meet their capacity goals to build programs to address healthcare-associated infections."* Other common themes in respondents' definitions of TA were acting as a liaison and maintaining relationships. During the program period, PHAs provided several types of TA to states that were common across infrastructure, surveillance, and prevention funding categories. As shown in the Table, these convergent types of TA were characterized as acting as a liaison, facilitating training, providing

administrative and program management support, and sharing/disseminating information to states.

Acting as a liaison, which was the single most frequently reported type of TA, included connecting states to other states, connecting states to SMEs, and connecting states to internal partners: *"I connected [states] with other states that had HAI mandates so that they could craft their law around what had come before and not have to reinvent the wheel."* Facilitating training to states was another type of TA that was convergent and included a regional train-the-trainer program, as well as training on HAI surveillance and prevention. Commonly reported types of TA focusing on administrative tasks included overall program management, advising on hiring, and assisting with funding issues, the majority of which were funding redirections. Responses that were categorized as facilitating the sharing and dissemination of knowledge encompassed the following activities: sharing practical knowledge across states; developing and organizing conference calls and webinars; and posting tools on a shared website.

While certain types of TA were convergent across the three funding categories, to an extent, the types of TA that states received depended on the funding they were awarded. Unlike TA directed towards HAI prevention, TA related to capacity building in infrastructure and surveillance was focused on very specific programmatic tasks associated with, for example, hiring staff to establish a new HAI program or getting health department access to and using NHSN data for the first time. Responses indicated that many states with funding only for infrastructure lacked experience with HAI prevention programs, thereby signaling a need for TA focused on program structure and development.

Types of TA that were uniquely associated with the infrastructure funding category included providing guidance on how to establish and structure a multi-disciplinary advisory committee, facilitating needs assessments, and assisting with the development of State Plans for HAI prevention. Alternatively, the provision of TA related to surveillance focused on helping states become more familiar with and use NHSN. Specifically, respondents reported assisting states by facilitating the data use agreement process conferring state access to NHSN data and by facilitating access to NHSN documents (e.g., definitions, training materials and validation protocols). Other types of TA unique to surveillance were facilitating healthcare facility enrollment in NHSN and providing guidance to states on aggregating and reporting NHSN data.

Unanimously, all respondents reported that TA varied across states depending on the state's baseline capacity for HAI programming, amount of funding received, and whether states had an existing mandate for HAI reporting. Further, respondents reported that the nature of the TA provided changed over the course of the program. Responses illuminated how TA varied according to states' needs, with clear differences between "*beginner*" states and those with a "*robust program*" already in place. "*The states were obviously at a spectrum of different starting points… what made sense in a state that had been doing lots of HAI work wouldn't make sense for a beginner state."* Not only did TA vary across states, it changed over the program period as states' focus shifted from program planning and staffing to training and making connections to SMEs, other states, and internal state partners. Additionally,

responses indicated that as the program developed, states' questions changed, becoming "*more sophisticated and more involved*." One respondent described the change in TA over time as *"It was ramping up at the beginning and then it did morph as the program continued to grow and expand…technical assistance was much more technical."* Another respondent described the change in TA over time specifically in the context of states that initially did not have HAI prevention infrastructure in place: *"So at the beginning it was establishing that [infrastructure] … helping them reach out to the right people in their state to get people on the advisory board, getting the relationships, then it expanded into working with the hospitals on special projects, helping the state guide initiatives, helping them engage their hospitals to enroll in NHSN so they were reporting and getting on board with surveillance and prevention."*

When respondents were asked to describe barriers encountered in providing TA, responses reflected a perception of individual, personal-level barriers as well as external factors that existed in the environment in which TA was provided. One of the most frequently self-reported barriers was lack of specific HAI content area expertise inherent in a new program on the part of the PHAs providing TA: *"knowing the acronyms and speaking the language was a barrier… it was a new program and we were learning as we went."* Another commonly noted barrier to provision of TA was lack of funding to states to carry out program goals, which included delays in the length of time to receive funding at state health departments, and constraints of federal funding, such as limitations on how states may use grant funds and retain staff. *"States are in a position where they want to do, they want to learn, but they don't have the resources to do it… Again, it's the funding and keeping the (state health department staff) on board and not losing them to hospitals or different programs."* Other reported barriers included the delay in time to hire critical staff at the states, and that *"no two states are alike and they all have their own challenges."*

While PHAs reported on barriers to the provision of TA, they also explained what facilitated their ability to assist states. Responses elucidating these facilitators were categorized into two themes related to learning and communication. Of the two themes, learning was the most commonly reported facilitator, specifically referring to the "*knowledge*" process by which PHAs, the providers of TA, learned by "immersion" in to the HAI program and the related subject matter. Having open communication with states, and dedicated people with whom to communicate – specifically the HAI coordinator also facilitated the provision of TA.

After describing barriers and facilitators encountered in providing TA, respondents reflected upon what they wished they had to optimize their TA to states during the program period. Among responses, most PHAs indicated that they would like to have had more knowledge and experience with HAI-specific content, a gap inherent in any new endeavor, which narrowed as the program developed and PHAs expanded their subject-matter knowledge and experience. Also to help respondents provide TA to states, another reported wish was to have been part of the drafting and writing of the Funding Opportunity Announcement (FOA) sent to states such that it included guidance for tracking and measuring program outcomes: *"if you begin with the end in mind, it helps not only structure your activities but it allows you to know whether you're on track or not."* Additionally, respondents reported wishing they had

more funding to help states, along with more time to spend with them. Specifically, respondents wished they had more time to do site visits and to guide states.

When asked what advice respondents would give to CDC employees and others responsible for providing TA to state programs in the future, the most common piece of advice was to establish and maintain good working relationships with states. This included maintaining regular communication with states and *"learning all you can about the program and about the state and what or who's on first? The players, the partners, and be willing to listen and learn along with them."* Another piece of advice respondents had was to be knowledgeable about the content area and to have access to a portfolio of resources to assist answering states' questions.

Regarding components of TA perceived to be most critical to HAI program sustainability, respondents unanimously reported that having someone to serve as a liaison to the states was most important. For respondents, serving as a liaison to states meant being the principal source of information, connecting states to SMEs at CDC or other partner organizations, connecting states to other states, as well as to internal state partners: *"having that liaison that the States can call for whatever their needs are. I think that's probably the single most critical thing… because without regular contact with the States there's just no way to provide the assistance, without [PHAs] reaching out and knowing what's going on in the states our ability to provide assistance becomes purely passive."* The provision of information resources to states, along with training, also was perceived to be very critical to program sustainability. Being a conduit for information for states was another component of TA reported to be important to program sustainability: *"being the conduit of information, taking what you know is going on in the state and sharing it, not only with other states, but also with leadership so that everybody is on the same page and knows what's going on."*

Respondents unanimously reported that TA had changed since the ELC cooperative agreement supported by ARRA funding period ended, which was perceived primarily to be due to how states continued to be funded, and a focus on differing priorities. *"TA has changed in the sense that (the states) are asking more specific questions. They're smarter about what they're doing… Our support has become much more subject matter oriented… we're through the phase of trying to educate people about what healthcare-associated infections are, and what steps we need to take, and now we're really more focused on implementation of prevention activities."*

Discussion

This exploratory evaluation examined TA delivered by PHAs to states to develop or enhance HAI prevention programs during the ELC cooperative agreement supported by ARRA funding period from September 2009 through December 2011. This study contributes to the extant public health literature on TA on the basis of its federal-level perspective and systematic approach used to comprehensively characterize TA to states. The most common themes related to TA provision across infrastructure, surveillance and prevention activity categories included: acting as a liaison, facilitating training, providing administrative and program management support, and sharing/disseminating information to states. This

categorization and template of themes can be used to assist other agencies and entities in discrete planning for and provision of future TA efforts.

Findings from this qualitative study of TA to states funded by the ELC cooperative agreement supported by ARRA suggest that TA varied across states and was not static over time. Although the largest source of variation in TA across states was due to differences in program funding, from the beginning of the ELC cooperative agreement supported by ARRA funding period, TA varied across states due to other state-level factors, such as baseline infrastructure, level of expertise and whether a state had a reporting mandate in place. Similarly, responses indicated that the focus of TA activities shifted during the program period as HAI programs developed and states became "more sophisticated," as well as after the ELC cooperative agreement supported by ARRA program period due to changes in funding to states. Finally, state's lack of HAI infrastructure and experience and CDC PHA staff with limited HAI-specific content area expertise inherent at a program's inception were perceived as possible barriers to provision of TA, while across the board, learning through immersion into the program and content area was reported to assist respondents in most effectively delivering TA. Therefore, in principle, as TA evolves in tandem with program development and growth, and having continual access to resources for knowledge acquisition and training for those providing TA is important. Providers of TA can benefit from having a foundation of knowledge in a program's content area and by having the skills to communicate and build relationships with states, which respondents perceived as critical components of TA for program sustainability.

Respondents also reported that establishing relationships and maintaining good communication with states facilitated their delivery of TA, examples of which are highlighted in the framework: acting as a liaison, facilitating training, providing administrative and program management support, and sharing/disseminating information. During the program, strong relationships and communication with grantees combined with the four core types of TA (Table) elicited through these interviews and provided by PHAs allowed states to establish or strengthen their HAI prevention programs. These findings are congruent with previous studies in which authors found that ongoing dialogue between TA providers and TA recipients bolstered program implementation.[3,5,6] When designing a new program that may necessitate the provision of TA, several recommendations can be made using the four convergent themes as a framework (Table). For example, it is recommended that providers of TA are prepared to triage questions with access to SMEs who can assist with responding to technical and content-specific inquiries and that information should be shared among all stakeholders on a consistent basis, making available ample opportunities for information exchange to support collective learning and continuous improvement.

There were several limitations to this study. Findings were based on self-reported responses from a small sample of those providing TA to states and might not be generalizable to other contexts where TA is delivered as information reported was specific to a particular time period and State HAI program. This assessment was conducted from the viewpoint of the PHA and did not include the perspective of those who received TA; future evaluations of TA should include this perspective as well. Additionally, responses might have been subject to

recall bias given that the interviews took place approximately one year after the conclusion of the ELC cooperative agreement supported by ARRA.

In general, public health studies describe TA typically provided by state and local governments, local foundations, and coalitions of prevention providers and delivered to community-based organizations[7,8] and have primarily examined the products of TA from the recipients' (i.e., program) perspective, and focused less on how TA was functionally delivered. While the public health literature contains studies that describe TA provided at the local/community level,[5, 9–15] there are only a few studies that describe federal-level TA to states.[7] The provision of TA is an element of CDC's strategic mission to "strengthen support for state, tribal, local, and territorial public health"[16] and thus, in practice, it could be expected that the implementation of CDC programs and projects includes TA; in the literature, however, the concept of TA at the federal level, its operationalization and effect on state-level capacity-building have not been systematically studied or described in detail. Findings from this qualitative study, in particular, the framework of convergent categories of TA, will help CDC/DHHS and other stakeholders understand the core elements, logistics and operationalization of TA for states' HAI programs, contributing to future HAI program efforts. Other agencies that deliver TA to states or other entities also may benefit from utilization of the framework and recommendations presented here to facilitate planning for the provision of TA.

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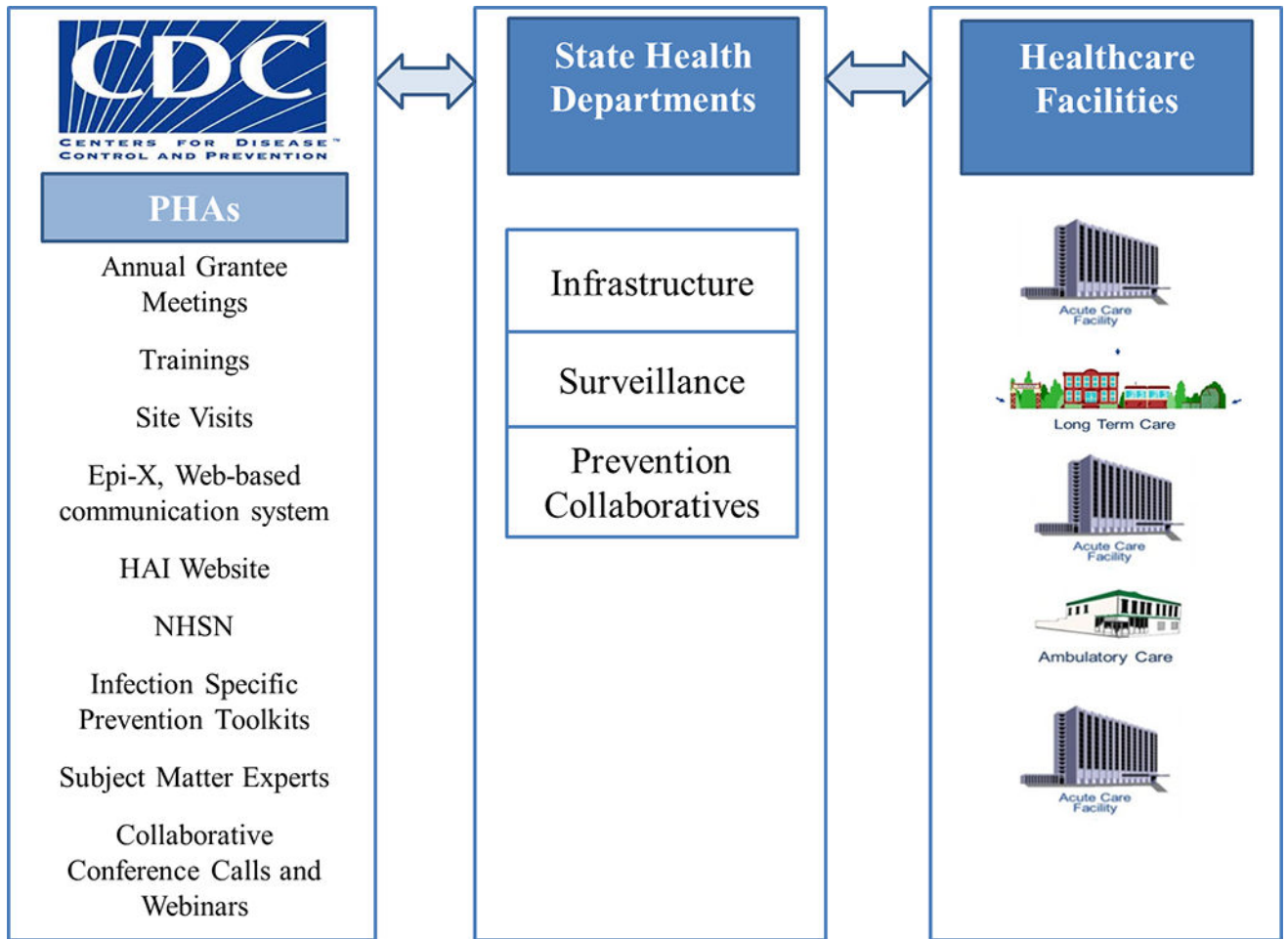
Figure.
Conceptualization of HAI Program Technical Assistance through the ELC cooperative agreement supported by ARRA

Table

Framework of four convergent types of technical assistance provided to states common across categories of HAI Program capacity-building with recommendations for future planning

TYPE of TA	RECOMMENDATIONS FOR TA PLANNING
1. Acting as a liaison	• Provide those delivering TA with access to subject matter experts (SMEs) and specific content information about their program area(s). • Prepare those delivering TA to be the principal source for triaging questions and requests as appropriate so to efficiently and effectively respond to inquiries. • Develop a resource book containing information about the program, program stakeholders and partners, as well as a listing of program-relevant guidelines, webinars, and toolkits.
2. Facilitating training	• Provide those delivering TA with resources to support the planning and coordination of trainings to ensure implementation of program aims and goals. • Offer a variety of training topics and modalities (e.g., in-person and/or web-based) noting the target audience(s) as appropriate. • Consider assessing training needs at start of program to determine areas of focus.
3. Providing administrative and program management support	• Train TA providers on all aspects of program management including grant administration, contracts, and funding redirections. • Provide support to those delivering TA for administrative matters such as a designated contact person in the department(s) that oversee funding awards and distributions. • Include TA providers at program inception in drafting of funding opportunity announcements to improve understanding and implementation of program conceptualization.
4. Sharing/disseminating information	• Equip those providing TA with materials and resources needed for mass-emails, conference calls, webinars, web-based tools, and other information-sharing platforms. • Share information and updates on a consistent basis with stakeholders, allowing for information exchange as needed. • Create a shared website and/or portal for centralized information exchange such as a listserv and/or website that allows for bidirectional posting of information while creating an enduring library of communications.