

**NORTH CAROLINA STATE PLAN
HEALTH-CARE ASSOCIATED INFECTIONS**
Original December 31, 2009
Review/1st Revision September 20, 2010

1. Develop or Enhance HAI program infrastructure

Successful HAI prevention requires close integration and collaboration with state and local infection prevention activities and systems. Consistency and compatibility of HAI data collected across facilities will allow for greater success in reaching state and national goals. Please select areas for development or enhancement of state HAI surveillance, prevention and control efforts.

Table 1: State infrastructure planning for HAI surveillance, prevention and control.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation and Current Status
Level I	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Establish statewide HAI prevention leadership through the formation of multidisciplinary group or state HAI advisory council i. Collaborate with local and regional partners (e.g., state hospital associations, professional societies for infection control and healthcare epidemiology, academic organizations, laboratorians and networks of acute care hospitals and long term care facilities (LTCFs))	<i>January 2010 Completed</i>
	<input checked="" type="checkbox"/>	<input type="checkbox"/> ii.	ii. Identify specific HAI prevention targets consistent with HHS priorities	<i>September 2009 Completed</i>
			<i>NC Division of Public Health hosted the first meeting of the STATE HAI ADVISORY GROUP on January 14, 2010. The State Health Director and State Epidemiologist together with key partners - the NC Center for Hospital Quality and Patient Safety (NC Quality Center) and the Statewide Program for Infection Control and Epidemiology (SPICE) - extended invitations to selected state legislators, as well as representatives from the NC Chapter of the Association for Professionals in Infection Control and Epidemiology (APIC-NC), The Society for Healthcare Epidemiology of America(SHEA), the NC Association of Local Health Directors, Duke Infection Control Outreach Network (DICON), The Carolinas Center for Medical Excellence (CCME), NC</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation and Current Status
			<p><i>Division of Health Service Regulation, consumer advocates and others. The Advisory Group held conference calls on a monthly basis from February 2010 thru September 2010 to review and revise the STATE HAI Plan. The Advisory Group has been expanded to include representation from Indian Health Services, Federally Funded Health Care, Blue Cross Blue Shield of North Carolina, NC Medical Society, Perinatal Quality Collaborative of NC, and the NC Laboratory Response Forum. Sub-Groups were formed to examine questions surrounding Laboratory Surveillance, Economic Impact of HAI, Reporting of Surveillance Data and Outbreak Reporting. Advisory Group conference calls will continue on a quarterly basis, or more often as needed</i></p> <p><i>NC DPH and its partners have elected to focus on two HAI Prevention targets: Central Line-Associated Bloodstream Infections (CLABSI) and Catheter Associated Urinary Tract Infections (CAUTI). The CLABSI collaborative is not funded by ARRA; however the NC Quality Center will make available to NC DPH CLABSI data from the North Carolina System for Hospital Infections Management (NCSHIM) for analysis. The CAUTI collaborative is supported entirely by ARRA funds.</i></p>	
	<input checked="" type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<p>2. Establish an HAI surveillance prevention and control program</p> <p>i. Designate a State HAI Prevention Coordinator</p> <p>ii. Develop dedicated, trained HAI staff with at least one FTE (or contracted equivalent) to oversee the four major HAI activity areas (Integration, Collaboration, and Capacity Building; Reporting, Detection, Response and Surveillance; Prevention; Evaluation, Oversight and Communication)</p>	<p>January 2010 Completed</p> <p>March 2011 Completed</p>
			<p><i>A HAI Prevention Coordinator was hired and started work during March 2010. Primary responsibilities for this position include integration, collaboration, and capacity building; reporting, detection, response and surveillance; prevention; evaluation, oversight and communication. The State HAI Coordinator (a Nurse Epidemiologist/Infection Preventionist) receives programmatic direction from the State Advisory Group, the Medical Consultation Unit's Medical director, and the State epidemiologist.</i></p> <p><i>In addition to the HAI Prevention Coordinator, a Public Health Epidemiologist</i></p>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation and Current Status
			<p><i>and an administrative assistant were hired and began work during March 2010. These three DPH staff positions will work closely with its key partners</i></p> <p><i>Recommendations for permanent infrastructure for HAI surveillance and prevention will be made at the end of the ARRA HAI project.</i></p>	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>3. Integrate laboratory activities with HAI surveillance, prevention and control efforts.</p> <p>i. Improve laboratory capacity to confirm emerging resistance in HAI pathogens and perform typing where appropriate (e.g., outbreak investigation support, HL7 messaging of laboratory results)</p>	<p><i>December 2011</i> <i>Ongoing</i></p>
			<p><i>Selected laboratory activities for HAI are already part of NC DPH surveillance.</i></p> <p><i>The Laboratory Surveillance Sub-Group recommended that the Advisory Group should: 1) investigate how expand electronic reporting by laboratories and 2) develop a statewide antibiogram to determine statewide resistance patterns.</i></p> <p><i>NC DPH supports the integration of laboratory activities for HAI surveillance, prevention, and control, but does not intend to engage in laboratory surveillance except in the following circumstances:</i></p> <ul style="list-style-type: none"> <i>a. "Drug-Bug pairing"</i> <i>b. Reference testing through the NC State Laboratory of Public Health</i> <i>c. Collaboration with other states for typing.</i> 	
Level II	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>4. Improve coordination among government agencies or organizations that share responsibility for assuring or overseeing HAI surveillance, prevention and control (e.g., State Survey agencies, Communicable Disease Control, state licensing boards)</p>	<p><i>September 2009</i> <i>Ongoing</i></p>
			<p><i>ARRA funding offers an opportunity for NC DPH to better coordinate surveillance, prevention and control of HAI. The most immediate gains stem from collaboration with the North Carolina Hospital Association (NCHA) and</i></p>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation and Current Status
			<p><i>it's North Carolina Center for Hospital Quality and patient Safety (NC Quality Center) and the Statewide Program for Infection Control and Epidemiology (SPICE) at the University of North Carolina at Chapel Hill.</i></p> <ul style="list-style-type: none"> <i>• The NC Quality Center brings expertise and experience in educational, collaborative and performance measurement programs and services.</i> <i>• SPICE is charged with investigating and controlling healthcare-associated infections in hospitals, long-term care facilities, and other medical facilities in the state. The program provides training, education, and consultation to hospitals, long-term care facilities, and other medical facilities to prevent and control healthcare-associated infections.</i> <i>• The Epidemiology Section of the NC Division of Public Health and the North Carolina Division of Health Services Regulation worked together during 2008-2009 to do enhanced surveys of ambulatory surgical centers. Additional training in infection prevention practices was obtained for the surveyors through SPICE. Long Term Care surveyors and hospital surveyors have also received training in infection prevention practices and what they should be looking for when they enter a facility. Because of this collaboration and the findings of the investigation of an outbreak of Hepatitis C in an outpatient facility changes were made to the Administrative Code rule 10A NCAC 41A .0206 Infection Prevention – Health Care Settings, including in particular Safe Injection Practices among practices that should be covered in a required course on Infection Control. This rule includes other requirements such as implementing a written infection control policy in each health care organization performing invasive procedures, educating staff in infection prevention procedures, and designating one on-site staff member to direct infection prevention activities in each non-contiguous facility.</i> 	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>5. Facilitate use of standards-based formats (e.g., Clinical Document Architecture, electronic messages) by healthcare facilities for purposes of electronic reporting of HAI data. Providing technical assistance or other incentives for implementations of standards-based reporting can help develop capacity for HAI surveillance and other types of public health surveillance, such as for conditions deemed reportable to state and local health agencies using electronic</p>	<p>September 2009 Ongoing</p>

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation and Current Status
			<p>laboratory reporting (ELR). Facilitating use of standards-based solutions for external reporting also can strengthen relationships between healthcare facilities and regional nodes of healthcare information, such as Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs). These relationships, in turn, can yield broader benefits for public health by consolidating electronic reporting through regional nodes.</p>	
			<ul style="list-style-type: none"> • <i>NC DPH and the Advisory Group supports standards-based formats.</i> • <i>NC DPH and the Advisory Group supports the use of the National Healthcare Safety Network (NHSN) as a platform for voluntary reporting of HAI. Currently 28 of NC's 124 hospitals report data voluntarily to NHSN.</i> • <i>NC DPH has created a state users group within NHSN and is in the process of determining how best to request that healthcare facilities share data for as long as reporting is not mandatory (NC has a total of 34 registered NHSN users, but not all users submit data). Advantages to using NHSN include the availability of CDC training modules and standardization within NC and across states, allowing comparison of infection rates. Another advantage is that the Centers for Medicare & Medicaid Services recently released a new rule that lays out HAI reporting requirements for Medicare eligible hospitals that participate in CMS' pay-for-reporting program. More than 3,500 hospitals will soon use CDC's National Healthcare Safety Network (NHSN) to report central line-associated bloodstream infection (CLABSI) data to CMS.</i> • <i>NC DPH recently implemented the NC Electronic Disease Surveillance System (NC EDSS) that incorporates the capacity for Electronic Laboratory Reporting.</i> <p><i>Note: NC believes that surveillance is an important component of an effective infection prevention program; however, as per the APIC Position Paper, "manual methods to identify potential HAIs by laboratory results, chart reviews, data entry and looking for associations can be inefficient, labor intensive, and error prone." NC intends to move forward with standards-based solutions being careful not to "divert efforts away from prevention activities."</i></p>	

2. Surveillance, Detection, Reporting, and Response

Timely and accurate monitoring remains necessary to gauge progress towards HAI elimination. Public health surveillance has been defined as the ongoing, systematic collection, analysis, and interpretation of data essential to the planning, implementation, and evaluation of public health practice, and timely dissemination to those responsible for prevention and control.¹ Increased participation in systems such as the National Healthcare Safety Network (NHSN) has been demonstrated to promote HAI reduction. This, combined with improvements to simplify and enhance data collection, and improve dissemination of results to healthcare providers and the public are essential steps toward increasing HAI prevention capacity.

The HHS Action Plan identifies targets and metrics for five categories of HAIs and identified Ventilator-associated Pneumonia as an HAI under development for metrics and targets (Appendix 1):

- Central Line-associated Blood Stream Infections (CLABSI)
- *Clostridium difficile* Infections (CDI)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Infections
- Surgical Site Infections (SSI)
- Ventilator-associated Pneumonia (VAP)

Work is ongoing to identify optimal metrics and targets for VAP infection. However, detection and measurement with existing tools and methods can be combined with recognized prevention practices in states where an opportunity exists to pursue prevention activities on that topic.

State capacity for investigating and responding to outbreaks and emerging infections among patients and healthcare providers is central to HAI prevention. Investigation of outbreaks helps identify preventable causes of infections including issues with the improper use or handling of medical devices; contamination of medical products; and unsafe clinical practices. Please choose items to include in your plan at the planning levels desired.

¹ Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev* 1988;10:164-90.

¹ Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev* 1988;10:164-90.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>the outbreak investigation.</i></p> <ul style="list-style-type: none"> ○ <i>Because of the above decision to make healthcare associated outbreaks reportable, changes are needed in NC Statute and in NC Administrative Code rules, to include language commensurate to that decision. Work is currently underway to propose these changes.</i> ○ <i>NC provides training to local health department staff on outbreak investigations through a variety of educational opportunities including Preparedness Training and a required 60 hour Communicable Disease Course for all local health department nurses in charge of communicable disease control. If it is determined that a healthcare facility needs assistance with an outbreak investigation the local health director may request that the Communicable Disease Nurse be the one to provide the assistance.</i> ● <i>NC DPH has an established practice of disclosing information to the public on a need-to-know basis. Sometimes this means person-to person, institutional, or community disclosure.</i> ● <i>The NC Electronic Disease Surveillance System gives NC DPH more ability to analyze surveillance data in real-time. The system is new, however, and the reporting and analysis functionality is still under development.</i> ● <i>Use of NHSN will also help us analyze HAI surveillance data.</i> ● <i>The NC Division of Public Health worked with hospitals and the NC Hospital Association to install a public health surveillance system called Investigative Monitoring Capability in the larger facilities electing to be so equipped. It allows authorized public health officials to review the Electronic Health Record of patients of interest, usually identified through the syndromic surveillance system NC DETECT. IMC could be leveraged to have a role in HAI surveillance.</i> 	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues.	December 2011 Ongoing
			<i>Refer to Section 1 Develop or Enhance HAI program infrastructure 3i for information concerning HAI Advisory Sub-Group addressing laboratory issues. Of note, currently VISA/VRSA infections are reportable in NC.</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation	
Level II	<input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	3. Improve communication of HAI outbreaks and infection control breaches <ul style="list-style-type: none"> i. Develop standard reporting criteria including, number, size and type of HAI outbreak for health departments and CDC ii. Establish mechanisms or protocols for exchanging information about outbreaks or breaches among state and local governmental partners (e.g., State Survey agencies, Communicable Disease Control, state licensing boards) 	December 2011 Ongoing	
			<i>Refer to Section 2 Surveillance, Detection, Reporting and Response 1i for information concerning HAI Advisory Sub-Group addressing outbreak issues. NC DPH does use the NC Health Alert Network (HAN) System to report outbreaks rapidly. NC HAN has approximately 900 active users. Local/state health department staff is the primary users, but 81 of NC's 124 hospitals (161 users) also are users of this secure system.</i>		
<input checked="" type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4. Identify at least 2 priority prevention targets for surveillance in support of the HHS HAI Action Plan <ul style="list-style-type: none"> i. Central Line-associated Bloodstream Infections (CLABSI) ii. <i>Clostridium difficile</i> Infections (CDI) iii. Catheter-associated Urinary Tract Infections (CAUTI) iv. Methicillin-resistant Staphylococcus aureus (MRSA) Infections v. Surgical Site Infections (SSI) vi. Ventilator-associated Pneumonia (VAP) 	September 2009 Completed
			<i>HAI Advisory Group has selected Central Line-associated Bloodstream Infections (CLABSI) and Catheter-associated Urinary Tract Infections (CAUTI) as the priority prevention targets for surveillance in North Carolina. This allows NC DPH, the NC Quality</i>		

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<i>Center, and SPICE to review data from two prevention collaboratives.</i>	
	<input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	5. Adopt national standards for data and technology to track HAIs (e.g., NHSN). <ol style="list-style-type: none"> i. Develop metrics to measure progress towards national goals (align with targeted state goals). (See Appendix 1). ii. Establish baseline measurements for prevention targets 	December 2011 Completed
			<p><i>NC DPH and its partners have chosen the following metrics to measure progress towards the national goals:</i></p> <ul style="list-style-type: none"> • <i>CAUTI 2 (# of symptomatic UTI per 1000 urinary catheter days)</i> • <i>CLABSI 1 (CLABSI per 1000 device days by ICUs)</i> <p><i>The HAI Advisory Group's stated goals for NC are aligned with the national targets for CAUTI and CLABSI.</i></p> <p><i>As of October 2010 - The NC Quality Center has determined the collaboratives baseline CAUTI rate to be 4.11 per 1,000 catheter days [Apr-Jun 2010]. A 25% reduction would result in a target of 3.08. This should be obtained while maintaining or lowering the catheter utilization ratio (catheter days/total patient days).</i></p>	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Develop state surveillance training competencies <ol style="list-style-type: none"> i. Conduct local training for appropriate use of surveillance systems (e.g., NHSN) including facility and group enrollment, data collection, management, and analysis 	December 2011 Ongoing
			<p><i>SPICE provides technical assistance to hospital staff that wish to use NHSN as a reporting platform for ARRA funded HAI activities. SPICE provides information on NHSN to participants in their Infection Control Training Programs. They have also developed a webinar that was made available to all Infection Preventionists in the state on August 30, 2010. The webinar is in 2 parts: Getting Started in NHSN – The Enrollment Process and NHSN Enrollment Administrative Set-up. Rebroadcast of the Webinar is available through the SPICE website.</i></p>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p>shortcomings detected</p> <p><i>SPICE is currently conducting validation studies on CLABSI and CAUTI data entered into NHSN by NC hospitals. Specifically, staff is determining the sensitivity and specificity of the data provided to NHSN.</i></p> <p><i>To ensure that the NHSN definitions are appropriately applied IPs hired to perform validation duties have received intensive training which includes didactics and chart review at UNC Health Care/UNC.</i></p> <p><i>The following methods are being used to achieve the above aims:</i></p> <p><i>HAI's to be evaluated: CLABSI, CA-symptomatic UTI</i> <i>Sites: 23 participating NHSN hospitals</i> <i>Time frame: 2 years (sampling frame, each hospital sampled 4x).</i> <i>Study will begin 1 January 2010 and end 31 December 2011.</i> <i>Age: Only adult patients will be evaluated (i.e., age >18 years of age)</i> <i>Hospital sampling: Hospitals will be sampled during a six month period of time for infections in the previous 6 months</i> <i>Selection of Cases (patients reported to NHSN and/or IC Committee meeting NHSN criteria):</i></p> <ol style="list-style-type: none"> <i>1. Once list is provided (by facility IP) of all patients with reported CA-UTI, randomly select up to 25 (if that number is available and if there is a total of ≥50 patients at this facility with a positive culture); randomly select up to 20 (if that number is available and if there is a total of <50 patients at this facility with a positive culture). Limit only to inpatients >18 years of age.</i> <i>2. Once list is provided (by facility IP) of all patients with reported CLA-BSI, randomly select up to 25 (if that number is available and if there is a total of ≥50 patients at this facility with a positive culture); randomly select up to 20 (if that number is available and if there is a total of <50 patients at this facility with a positive culture). Limit only to inpatients >18 years of age.</i> <i>3. Denominator data: note the TOTAL number of cases (CAUTI, CL-BSI) on the selection list.</i> <p><i>Selection of Controls (patients with a positive culture):</i></p> <ol style="list-style-type: none"> <i>1. IP will request from lab a list of all patients with a positive urine culture (≥10³ CFU/mL, criteria includes: date of admission, location of surveillance) obtained during the previous 6 months (i.e., Phase I= 7/1/09-12/31/09) and</i> 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>exclude patients with a positive culture obtained in ED. Limit only to inpatients >18 years of age.</i></p> <ol style="list-style-type: none"> <i>2. IP will request from lab a list of all patients with a positive blood culture (criteria includes: date of admission, location of surveillance) obtained during the previous 6 months (i.e., Phase I= 7/1/09-12/31/09) and exclude patients with a positive culture obtained in ED. Limit only to inpatients >18 years of age.</i> <i>3. Once this list of positive urine cultures is obtained, randomly select up to 25 (if that number is available and if there is a total of ≥50 patients at this facility with a positive culture); randomly select up to 20 (if that number is available and if there is a total of <50 patients at this facility with a positive culture; even if there are <30 cases). Limit only to inpatients >18 years of age.</i> <p><i>NOTE: Controls should be selected ONLY from those units where surveillance is being done.</i></p> <ol style="list-style-type: none"> <i>4. Once this list of positive blood cultures is obtained, randomly select up to 25 (if that number is available and if there is a total of ≥50 patients at this facility with a positive culture); randomly select up to 20 (if that number is available and if there is a total of <50 patients at this facility with a positive culture; even if there are <30 cases). Limit only to inpatients >18 years of age.</i> <p><i>NOTE: Controls should be selected ONLY from those units where surveillance is being done.</i></p> <ol style="list-style-type: none"> <i>5. Denominator data: note the TOTAL number of controls (CAUTI, CL-BSI) on the selection list.</i> <p><i>Selection of charts for abstraction (Abstraction List CA-UTI; Abstraction List CLA-BSI)</i></p> <p><i>NOTE: the number of charts to be listed on the Abstraction List will depend on the number of patients with a positive culture (<50: 40 charts on abstraction list, >50: 50 charts on abstraction list).</i></p> <ol style="list-style-type: none"> <i>1. Once the 2 selection lists (cases and controls) for each site are completed by randomization, eliminate any duplicate charts, unless the duplicate charts have different dates of culture* or admission.</i> <i>2. Create the abstraction list by mixing the 2 selection lists. If there are less than 20 cases, add more controls so that the abstraction list has at least 30 total charts.</i> <i>3. On the final abstraction list (electronic and hard copy), please note which charts were from the reported cases</i> 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>(place an X in the column "Cases"). This information needs to be noted in the data but will be deleted in the lists sent to the blinded chart abstractors.</i></p> <p>4. The total number of cases and positive cultures for each site (denominator data) should be recorded on the Abstraction list.</p> <p><i>Data collected during the validation study will be analyzed to determine if healthcare facilities are using the correct CDC definitions for CLABSI and CAUTI and if all pertinent information is being entered into NSHN. This analysis will be used to determine if additional education is needed for the Infection Preventionist concerning definition use and appropriate entering of data. The state HAI team in collaboration with NC SPICE will review the results from this project once available and determine a future plan for data validation system.</i></p>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<p>9. Develop preparedness plans for improved response to HAI</p> <p>i. Define processes and tiered response criteria to handle increased reports of serious infection control breaches (e.g., syringe reuse), suspect cases/clusters, and outbreaks</p>	<p>December 2011 Ongoing</p>
			<p><i>As exemplified in several recent hepatitis outbreaks in health institutions associated with unsafe injection or blood glucose monitoring practices, response to HAI is multifaceted.</i></p> <p><i>The North Carolina Division of Public Health and the North Carolina Division of Health Services Regulation are working to define parameters for interagency notification regarding infection control breaches (e.g., syringe reuse) and suspect cases/clusters, and to clarify roles and responsibilities for investigation, response, and communication.</i></p> <p><i>The NC Health Alert Network (NC HAN) also provides a mechanism for statewide secure notification of outbreaks. It is widely used among state, regional, and local public health users, but hospitals also review and contribute.</i></p> <p><i>Discussion has been opened with Dr. Lana Deyneka (Epidemiologist supervising the Public Health Epidemiologist Program) to determine</i></p>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>the future role of hospital-based public health epidemiologists in reporting of healthcare-associated infection outbreaks.</i></p> <p><i>The HAI Advisory Group developed a sub-group to discuss this issue and how to best address outbreak reporting in the state of North Carolina. The sub-group determined that outbreaks of communicable disease occurring in a hospital that could be transmitted outside the hospital and impact the public health of the community should be made a part of mandatory reporting.</i></p>	
	☒	☐	10. Collaborate with professional licensing organizations to identify and investigate complaints related to provider infection control practice in non-hospital settings, and to set standards for continuing education and training	December 2011 Ongoing
			<p><i>NC DPH has addressed this issue in the past by providing testimony to the NC Medical Board and has worked closely with the NC Board of Pharmacy in situations involving individual practitioners and outbreaks of communicable disease.</i></p> <p><i>The Epidemiology Section of the NC Division of Public Health and the North Carolina Division of Health Services Regulation worked together during 2008-09 to do enhanced surveys of ambulatory surgical centers. Additional training in infection prevention practices was obtained for the surveyors through SPICE. Long Term Care surveyors and hospital surveyors have also received training in infection prevention practices and what they should be looking for when they enter a facility. Because of this collaboration and the findings of the investigation of an outbreak of Hepatitis C in an outpatient facility changes were made to the Administrative Code rule 10A NCAC 41A .0206 Infection Prevention – Health Care Settings, including in particular Safe Injection Practices among practices that should be covered in a required course on Infection Control. This rule includes other requirements such as implementing a written infection control policy in each health care organization performing invasive procedures, educating staff in infection prevention procedures, and designating one on-site staff member to direct infection prevention activities in each non-contiguous facility.</i></p>	
			11. Adopt integration and interoperability standards for HAI information systems and data sources	December 2011 Ongoing

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>Reporting of Surveillance Data Sub-Group met on September 13, 2010 and made the following suggestion to the HAI Advisory Group for consideration:</i></p> <ul style="list-style-type: none"> • <i>Change in general reporting by medical facilities in General statute 130A-137 from "may" to "shall" report communicable diseases.</i> ▪ <i>Change to 10A NCAC 41, 41A .0101 in making both outbreaks of communicable disease and CLABSI HAIs reportable.</i> ▪ <i>Change to 10A NCAC 41, 41A .0102 in making outbreaks reportable to local health departments and HAIs reportable to CDC through NHSN.</i> ▪ <i>Plan to add an HAI website through the DPH website where community members, healthcare providers and organization can access data on HAI in North Carolina.</i> ▪ <i>Emphasized the importance of making HAI information "consumer friendly", importance not to display complex statistical analysis which may mislead public understanding.</i> ▪ <i>Work with a consumer working panel to ensure HAI information meets the goal of consumer friendly.</i> ▪ <i>Reconsidering the CAUTI reporting objective and instead following the lead of CMS and requiring SSI as next HAI reporting goal.</i> 	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	13. Make available risk-adjusted HAI data that enables state agencies to make comparisons between hospitals.	December 2011 Ongoing
			<i>Risk adjustment of reported rates will be the primary responsibility of the state HAI epidemiologist. The Sub-Group on Reporting of Surveillance Data in collaboration with external advisors will serve in an advisory role to promote adjusted rates.</i>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	14. Enhance surveillance and detection of HAIs in nonhospital settings	December 2011 Ongoing
			<i>Per the 5 year plan towards HAI elimination in North Carolina, Long Term Care Facilities, Dialysis Centers, and other healthcare facilities will be contacted to determine if there are any infection prevention collaboratives in process or planned for the future. If not, NC-DPH with the NC Quality Center and SPICE will investigate what would be necessary in order for said collaboratives to be started. Several tool kits from the NC Quality Center are on line and can be used by</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>anyone wanting to start a collaborative. In order for the Quality Center to assist with setting up and running a collaborative, further assets and resources would be necessary. The North Carolina Division of Health Services may be able to assist in setting a collaborative for Nursing Homes. Resources are available from "Monitoring Penalties" that has been set aside to be used to help improve the quality of care and quality of life in Medicare Certified Nursing Homes of which is the vast majority of North Carolina Nursing Homes. The North Carolina Division of Health Services and the NC Quality Center will work together to determine if a collaborative can be set up.</i></p>	

3. Prevention

State implementation of HHS Healthcare Infection Control Practices Advisory Committee (HICPAC) recommendations is a critical step towards the elimination of HAIs. CDC with HICPAC has developed evidence-based HAI prevention guidelines cited in the HHS Action Plan for implementation. These guidelines are translated into practice and implemented by multiple groups in hospital settings for the prevention of HAIs. CDC guidelines have also served as the basis the Centers for Medicare and Medicaid Services (CMS) Surgical Care Improvement Project. These evidence-based recommendations have also been incorporated into Joint Commission standards for accreditation of U.S. hospitals and have been endorsed by the National Quality Forum. Please select areas for development or enhancement of state HAI prevention efforts.

Table 3: State planning for HAI prevention activities

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. Implement HICPAC recommendations. i. Develop strategies for implementation of HICPAC recommendations for at least 2 prevention targets specified by the state multidisciplinary group. <i>CLABSI and CAUTI have been chosen as the 2 HICPAC recommended prevention targets for North Carolina.</i>	01 Sept 2009 Completed
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. Establish prevention working group under the state HAI advisory council to coordinate state HAI collaboratives i. Assemble expertise to consult, advise, and coach inpatient healthcare facilities involved in HAI prevention collaboratives	31 Dec 2011 Completed
	<i>CLABSI and CAUTI collaborative have been established by the NC Quality Center. The Quality Center has the expertise to consult, advise, and coach inpatient healthcare facilities involved in the collaboratives.</i>			
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. Establish HAI collaboratives with at least 10 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions) i. Identify staff trained in project coordination, infection	31 Mar 2010 Completed

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	☒	☐	control, and collaborative coordination	
	☒	☐	ii. Develop a communication strategy to facilitate peer-to-peer learning and sharing of best practices iii. Establish and adhere to feedback of a clear and standardized outcome data to track progress	
			<i>The NC Quality Center a recognized leader in managing successful HAI collaborative, working with NC DPH and SPICE, has established a Catheter-associated Urinary Tract Infection prevention collaborative. The collaborative currently has 21 hospitals participating. Work continues to include more hospitals with the focus on Critical Access Hospitals – goal is to have at least 25 hospitals participate. Multiple teleconferences, phone consultations, and webinars have been provided and will continue to be provided to help guide the participating hospital in the collaborative process. Data has started to flow into the Quality Center from the CAUTI Collaborative -- first data entry date was April 15, 2010.</i>	
	☒	☐	4. Develop state HAI prevention training competencies i. Consider establishing requirements for education and training of healthcare professionals in HAI prevention (e.g., certification requirements, public education campaigns and targeted provider education) or work with healthcare partners to establish best practices for training and certification	December 2011 Completed
			<i>SPICE offers courses leading to certification as an Infection Preventionist (IPs) as well as continuing education courses for designated staff in outpatient healthcare settings. SPICE offers courses to meet the requirements of the North Carolina Infection Control law 10A NCAC 41A.0206 for hospitals and long-term care facilities. SPICE has developed the curriculum for .0206 Infection Control courses for healthcare workers in the Dental, Home Health and Hospice, and Out-Patient Settings. National and State APIC provides in person and webinars for IPs. IP Certification requires retesting every five years. IP Certification is written into many job descriptions and is highly recommended by The Joint Commission and other such agencies. SPICE and the Quality Center currently work with hospitals and other</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>enter a facility.</i></p> <p><i>Section 10A of the North Carolina Administrative Code 41A .0206 Infection Prevention – Health Care Settings was recently amended to state that in order to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens, each health care organization that performs invasive procedures shall implement a written infection control policy and shall designate one on-site staff member in each non-contiguous facility to direct these activities. Some of the more unusual "Health care organizations" included are podiatrist offices; local health departments; community health centers; ambulatory surgical facilities; urgent care centers; Emergency Medical Service (EMS) agencies; pharmacies where a health practitioner offers clinical services; or any other organization that provides clinical care.</i></p>	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Enhance prevention infrastructure by increasing joint collaboratives with at least 20 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions)	December 2011 Completed
			<p><i>The NC Quality Center, working with NC DPH and SPICE, has established a Catheter-associated Urinary Tract Infection prevention collaborative. The collaborative currently has 21 hospitals participating. Work continues to include more hospitals with an emphasis on Critical Access Hospitals – goal is to have at least 25 hospitals participate.</i></p>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7. Establish collaborative to prevent HAIs in nonhospital settings (e.g., long term care, dialysis)	December 2011 Ongoing
			<p><i>Per the 5 year plan towards eliminating HAI in North Carolina, Long Term Care Facilities, Dialysis Centers, and other healthcare facilities will be contacted to determine if there are any infection prevention collaboratives in process or planned for the future. If not, NC-DPH with the NC Quality Center and SPICE will investigate what would be necessary in order for said collaboratives to be started. Several tool kits from the NC Quality Center are on line and can be used by anyone wanting to start a collaborative. In order for the Quality Center to assist with setting up and running a collaborative, further assets and resources would be necessary.</i></p> <p><i>The North Carolina Division of Health Services may be able to assist in setting a collaborative for Nursing Homes. Resources are available from</i></p>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<p><i>"Monitoring Penalties" that have been set aside to be used to help improve the quality of care and quality of life in Medicare Certified Nursing Homes of which is the vast majority of North Carolina Nursing Homes. The North Carolina Division of Health Services and the NC Quality Center will work together to determine if a collaborative can be set up.</i></p>	

4. Evaluation and Communications

Program evaluation is an essential organizational practice in public health. Continuous evaluation and communication of practice findings integrates science as a basis for decision-making and action for the prevention of HAIs. Evaluation and communication allows for learning and ongoing improvement to occur. Routine, practical evaluations can inform strategies for the prevention and control of HAIs. Please select areas for development or enhancement of state HAI prevention efforts.

Table 4: State HAI communication and evaluation planning

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input type="checkbox"/>	<input checked="" type="checkbox"/>	1. Conduct needs assessment and/or evaluation of the state HAI program to learn how to increase impact <ul style="list-style-type: none"> i. Establish evaluation activity to measure progress towards targets and ii. Establish systems for refining approaches based on data gathered 	<i>December 2011</i> Future Activity
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>NC DPH will consider contracting with an external evaluator like the NC Institute for Public Health to conduct an evaluation of the state HAI program. NC DPH is currently working with the Institute which is conducting extended, multi-year evaluation for three Public Health systems.</i>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2. Develop and implement a communication plan about the state's HAI program and progress to meet public and private stakeholders needs Disseminate state priorities for HAI prevention to healthcare organizations, professional provider organizations, governmental agencies, non-profit public health organizations, and the public	<i>December 2011</i> Future Activity
			<i>Under the direction of the State Epidemiologist and the State HAI Coordinator, a communication plan will be developed detailing the state's priorities. The first step will be distribution of this document in narrative format to members of the State HAI Advisory Group.</i>	
Level II	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3. Provide consumers access to useful healthcare quality measures	<i>December 2011</i> Future Activity

			<i>The format for distributing useful healthcare quality data will be discussed and developed by the Reporting of Surveillance Data Sub-Group and reported to the State HAI Advisory Group for approval.</i>	
Level III	<input type="checkbox"/>	<input checked="" type="checkbox"/>	4. Identify priorities and provide input to partners to help guide patient safety initiatives and research aimed at reducing HAIs	December 2011 Future Activity
			<i>The State HAI Advisory Group has chosen CLABSI and CAUTI as the first two HHS (HICPAC) target priorities for North Carolina. CLABSI in ICUs will be the first HAI to required mandatory reporting.</i>	