Healthcare Associated Infections Program
Special Meeting/Conference call notes
April 6, 2009

Attendees: Lauren Backman (DPH), Laurie Brentlinger (Danbury), Lillian Burns (Greenwich), Matt Cartter (DPH), Louise Dembry (Yale-New Haven Hospitals), Diane Dumigan and Cindy Kohan (Hospital of St. Raphael), Richard Garibaldi (John Dempsey/UConn) Brenda Grant (Stamford), Robin Herd (W. Backus), Alision Hong (CHA), Jennifer Martin (CCMC), Jim Meek (Yale EIP), Richard Melchreit (DPH), Jon Olson, (DPH), Mary Ann Pezkano (Day Kimball), Donna Prentiss (New Milford), Jean Rexford (Center for Patient Safety), Richard Rodriguez (DPH), Renee Savage (L&M), Joyce Suave (Hartford), Karen Traficante (Hospital of Central Connecticut)

Call to order: The conference call started at 12:00 p.m.

Background:

Committee members were given a brief background on the purpose of the meeting, the DHHS plan, the CDC Cooperative Agreement process, and state contracting requirements.

The purpose of the meeting was to update Committee members on the status of the American Recovery and Reinvestment Act (ARRA) funding for HAIs and to solicit ideas and recommendations from Committee members that will inform state planning to quickly and effectively respond to the ARRA HAI funding when it becomes available.

Of the $50 million total nationally, $10 million will go to CMS, and $40 million to states. The latter is the focus of this call. If the money were allocated per capita, Connecticut would get $440,000 but as we already report HAIs using the CDC's NHSN and we have the Connecticut Emerging Infections Program (EIP), we might anticipate getting more. As a range for discussion, assume the range for Connecticut would be $500,000 to $1 million over a two-year project period.

CDC usually distributes money through Cooperative Agreements with state health departments. The CDC's Cooperative Agreement guidance will set requirements for use and administration of the money and specify what the money can be used for. The guidance has not been published yet, but Acting CDC Director Dr. Richard Besser's testimony to Congress last week (sent out to members before the meeting) mentions some items. Once the money is received, contracts need to go through standard contracting processes that were summarized.

Recommendations:

The discussion at this preliminary stage was a brainstorming to consider possibilities for the funding and not to make final recommendations for future program direction or funding. No votes were taken. The following ideas were raised during discussion:

1. Workforce development in infection prevention for new and current infection prevention practitioners. This would include basic and more advanced refresher "classroom" training. It would also include more intensive and "hands on" training components. We would fund mentoring programs so that clinicians that are trained can get "internships" to spend time with experienced infection prevention staff and hospital epidemiologists to learn "hands on" and in more depth than is possible even in a several day training outside the facilities. This opportunity would be made available to practitioners in long-term care and other health care facilities in addition to acute care hospital staff. In addition to training, support and encouragement of current infection prevention staff to increase retention would be incorporated. Clinicians, such as nurses and physicians, would be trained.
2. Workforce development for (nursing) students – education for bachelors and master's level clinicians on infection prevention to ensure that enough new personnel are recruited into the field. Currently hospitals are having trouble recruiting enough interested and qualified candidates for open positions. With the aging of the current infection prevention workforce and the need to expand infection prevention activities, this is a critical need.
3. Data validation – additional staff (state durational) – would be hired at DPH to fulfill the data validation and chart-auditing role. The current Connecticut CLABSI validation is vital to ensure that the data is good enough to show the true scope of the program and to successfully guide prevention programs. This is a critical function, and needs to be continuous, not episodic (which is all that is possible with current DPH staffing levels). The validation would be tightly linked to training to improve the quality of the reported data and inform prevention activities.
4. Collaboratives – these might be statewide or regional, but would be based on the model of the current STOP BSI and MDRO prevention projects that are being lead by CHA and Qualidigm respectively. These involved facilities, technical assistance providers and experts sharing best practice protocols; planning by developing effective implementation strategies, fostering systems institutional support, and a culture of prevention; and tracking progress. A topic for such a collaborative or collaboratives might be "antibiotic stewardship" in a variety of healthcare facilities to ensure that antibiotics are being used correctly (this is often an element of MDRO prevention activities in hospitals).
5. Consider a model like the DPH Public Health Preparedness Epidemiologists – DPH employees that are sited in an outside entity in regions across the state.
6. A competitive funding/staffing pool - healthcare facilities would apply for medium sized grants for short-term assistance either with funds or trained infection control or grant writing staff for short-term assistance. (Might be combined with the following.)
7. Special demonstration projects similar to the New York State HAI competitively funded prevention projects. These included funding individual hospitals, hospital networks, and technical assistance organizations for targeted or innovative prevention training, prevention activities, or evaluation projects.

Adjournment:

The call was adjourned at 1:00 p.m.