

**Healthcare-Associated Infections (HAI)**  
**Levi Njord, MSc**  
**Constance D. Jones, RN,CIC**

**SLIDE 1**

Good afternoon, ladies and gentlemen. My name is Levi Njord and I am the Healthcare-associated Infections epidemiologist for the North Carolina Department of Health and Human Services, Division of Public Health. Today I will be speaking with you about healthcare-associated infections, their associated epidemiology, methods of prevention, and current state and federal movements to reduce such infections. Later on in this presentation, my colleague, Ms. Constance D. Jones, Healthcare-associated Infections Coordinator, will discuss how healthcare-associated infections fit into the larger public health mandate familiar to community or public health nurses. If, at the end of this presentation, you have comments or questions, please feel free to contact us at your leisure to discuss them. Contact information will be provided later on during the course of this presentation.

**SLIDE 2**

To begin, I would like to outline three basic objectives that we feel are important to understanding the public health nature of healthcare-associated infections. Although these three objectives cannot possibly encompass all that is necessary to become fully initiated in the world of healthcare-associated infections, they do provide a nice foundation from which to build as a public health practitioner. First, we will define healthcare-associated infections and briefly distinguish what separates this category of infections from more commonly known communicable diseases. Second, we will discuss the general epidemiology of healthcare-associated infections by their methods of transmission and preventative measures. Third, we will go over state and federal initiatives to control such infections, and finally, my colleague will discuss how healthcare-associated infections, a category of disease which has historically been relegated to healthcare facilities, relates or fits into the larger public health mandate, and make the connection between the community health nurse and the infection preventionist.

**SLIDE 3**

The National Healthcare Safety Network at the Centers for Disease Control and Prevention, or CDC, defines a healthcare-associated infection as follows: "A healthcare-associated infection is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or its toxins with no evidence that the infection was present or incubating at the time of admission to the healthcare setting." When describing a disease in general epidemiologic terms, we commonly define disease by person, place and time. This definition provided to us by the CDC clearly outlines each of these criteria. A healthcare-associated infection is an infectious agent or its toxin causing disease in a particular patient (the person), who was recently admitted or entered a healthcare setting (the place), and presented with said disease during or shortly after coming into contact with a healthcare facility, but the disease was not incubating at the time of admission (the time). The careful student of public health

will notice that it is not necessarily the infectious agent that uniquely characterizes a healthcare-associated infection, but it is the place and time which sets this unique category of infectious diseases apart from other infectious diseases.

#### **SLIDE 4**

To recap on the important components of the CDC definition previously explained; a healthcare-associated infection is 1) a localized or systemic condition, 2) which was caused by an infectious agent or its toxins, 3) which was not present or incubating at the time of admission to a healthcare setting.

#### **SLIDE 5**

Authors of public health literature always begin their articles with a brief discussion on the importance, or public health impact, of their specific disease. We too, would probably not be true public health practitioners if we didn't also try to communicate the importance or impact of healthcare-associated infections. The public health impact of healthcare-associated infections can be tremendous. Each year in the United States alone, 1.7 million healthcare-associated infections occur in healthcare settings nationwide. That equates to 1 infection every 18.6 seconds, which means that during the course of this presentation alone, about 100 patients across America will have acquired an infection in a healthcare setting. Of those 1.7 million infections occurring each year, 99,000 individuals will die because of those infections. This huge number equates to more deaths than are caused by automobile accidents and homicides combined. It is no wonder why federal and state law makers are calling for more to be done to reduce these preventable infections. Last but certainly not least, in an economy like ours, we need to consider the costs related to healthcare-associated infections. Estimates from the CDC list healthcare-associated infections as costing the American healthcare system an estimated 28 to 33 billion dollars. To put that figure in perspective, that amount would be enough money to purchase 191,823 homes at the average cost of a house here in the South. With the current economic climate, it becomes clear that reducing healthcare-associated infections not only becomes the right thing to do for patient safety, but also the right thing to do to help a struggling economy.

#### **SLIDE 6**

The pathogens that are commonly linked to healthcare-associated infections are not the bugs that more frequently grab our attention as public health professionals. The world of public health is much more comfortable with familiar friends like the human immunodeficiency virus, malaria, or tuberculosis, and many find infections such as acinetobacter or pseudomonas a bit less recognizable. Within the world of healthcare-associated infections, the most common pathogens are members of the staphylococci genus. Enterococcus and Candida species are also common and E. coli is also a top 5 favorite. Lesser known infections round off the top 10 list, but it should be noted that these infections listed only account for 85% of healthcare-associated infections nationwide. When we consider the definition of healthcare-associated infections we provided earlier, we can easily see that any pathogen has the potential to be spread in a healthcare setting when appropriate prevention practices are not being followed. Before leaving this slide, it may be of interest to some in the audience, the different frequencies

of these listed pathogens when stratified by various medical devices or procedures. Central line-associated bloodstream infections, or CLABSIs, closely mirror the total frequencies of healthcare-associated infections. Catheter-associated urinary tract infections, or CAUTIs, differ in most common etiology with *E. coli* being the most frequently associated pathogen. Surgical site infections and ventilator-associated pneumonia are both commonly associated with staph aureus, but share little commonality after that.

### **SLIDE 7**

Healthcare-associated infections only differ slightly from other infectious diseases in how they are communicated to infected patients. Common routes of transmission, such as airborne, foodborne, bloodborne, environmental, and direct contact, have all been documented in healthcare settings. A method of transmission unique to healthcare-associated infections is transmission of an infectious organism through a medical device or procedure. While airborne, foodborne, bloodborne, environmental, and direct contact each play an important role in infectious disease communication, device-associated transmission is associated with approximately 78% of all healthcare-associated infections. This Venn diagram indicates that although the potential methods of transmission are diverse, they are by no means independent of each other. For instance, improper hand hygiene has been associated with direct transmission of infection to patients, contamination of the healthcare environment, contamination of patients' food, and contamination of medical devices, all of which have caused disease in patients. As healthcare staff and public health practitioners look for ways to limit the spread of disease to patients, careful consideration needs to be given to each of these potential routes of transmission and their respective roles in healthcare-associated infections.

### **SLIDE 8**

Continuing our discussion on the methods of transmission for healthcare-associated infections, we can see, using this pie chart, that disease frequency differs greatly among the various transmission methods. Indwelling urinary catheters are associated with the greatest amount of transmission at 34% of identified, healthcare-associated infections. Following them in the device-associated category, are surgical site procedures with 17%, central catheters terminating near or at one of the major vessels with 14%, and mechanical ventilators with 13%. Additionally, 22% of healthcare-associated infections are due to other transmission routes than devices, such as foodborne, airborne or environmental. Outbreaks of *clostridium difficile* or norovirus, for example, would fall under this 22%. Quickly, we begin to realize the importance of encouraging healthcare personnel to abide by prevention bundles to limit the spread of healthcare-associated infections via medical devices and procedures.

### **SLIDE 9**

Our discussion on disease transmission is an excellent segue into our next topic; preventative measures. As public health professionals, it is probably without surprise when we learn that the number 1 way to prevent the spread of healthcare-associated infections is proper hand hygiene. Within the past several decades, public health and

medical research has concluded that many of the endemic and epidemic diseases found in healthcare settings can be almost completely eliminated by adherence to this basic preventative practice. Today, hand hygiene has taken on several definitions. Using gloves, alcohol-based hand gels, and standard soap and water, have all been grouped together under the hand hygiene umbrella. With all of these potential options, healthcare workers sometimes neglect standard practice which results in disease transmission to patients. With the emergence of bacterial drug resistance and limited efficacy of alcohol-based hand gels on some viral pathogens, the standard practice of using soap and water has proven to be the most efficacious method of hand hygiene and prevention of healthcare-associated infections. The next several slides summarize the other best practice methods and recommendations to prevent specific healthcare-associated infections provided by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Disease Society of America (IDSA). It should be noted before proceeding that, although hand hygiene will not be listed on every slide, it remains the most effective way to prevent transmission of infections in each of the categories.

#### **SLIDE 10**

First we will consider prevention of central-line associated bloodstream infections or CLABSIs. Some of the best practices to prevent these infections include 1) avoiding the femoral vein for central venous access in adults. This practice has been associated with higher rates of bloodborne infections in adults but is still recommended practice for children and neonates; 2) use of maximal sterile barrier precautions during insertion of the catheter to prevent peripheral contamination; and 3) use of a chlorhexidine-based antiseptic for skin preparation and decontamination in patients older than 2 months. Chlorhexidine is contraindicated for use in neonates because of potential tissue damage which may lead to a greater risk of infection.

#### **SLIDE 11**

Next we will consider prevention of indwelling catheter-associated urinary tract infections or CAUTIs. Increasingly, the single most recommended method to prevent this category of disease is to avoid the extended use of urinary catheters altogether. Other methods of urinary management should be actively considered, such as using condom catheters, or performing “in-and-out” or intermittent catheterization. Given the pathogens associated with urinary catheters, evidence has shown that frequent catheterization is much more preferable than extended methods. Where catheterization is necessary, the catheter should be removed at the earliest moment it is no longer necessary. Additionally, maintaining a sterile, continuously closed drainage system has proven to be an excellent way to limit the introduction of pathogens into an otherwise sterile field. It should be noted that introducing antibiotics or other antiseptic solutions into the urinary collection system has proven to be non-efficacious. Lastly, the use of silver-coated or other antibacterial catheters should not be routinely used. These devices have shown little benefit to infection control in individuals requiring catheterization.

## **SLIDE 12**

Surgical site infections are what many people think of when they consider healthcare-associated infections. The very nature of surgery makes it prone to the introduction of infectious agents which may cause disease. Over the decades, advances in disinfection, sterilization, surgical technique, and medical technology have dramatically reduced the amount of infections which were commonly associated with surgery. Although much progress has been made, we recently reviewed that surgical site infections continue to be associated with almost 1/5 of healthcare-associated infections. While specific recommendations exist for specific surgical procedures, the following three are either more general or have a stronger evidence base: first, the administration of antimicrobial prophylaxis in accordance with evidence-based standards and guidelines is crucial to preventing surgical site infections; second, removal of hair at the operation site should not be considered unless it will seriously interfere with the surgery. If hair must be removed for the surgery to be completed, then razors should not be used and instead substituted for by clippers; third, blood glucose levels should be maintained during the immediate postoperative period for patients undergoing cardiac surgery.

## **SLIDE 13**

Our last device-associated category of disease is ventilator-associated pneumonia. Some of the most effective ways to prevent pneumonia in patients on mechanical ventilation are, one, performing regular antiseptic oral care in accordance with product guidelines; second, medical staff should ensure that all patients on mechanical ventilation are maintained in a semi-recumbent position unless specifically contraindicated because of a comorbid condition; and lastly, healthcare facility policy should be altered to include standard practice for disinfection, sterilization, and care of respiratory equipment.

## **SLIDE 14**

The next two slides specifically refer to common pathogens associated with healthcare-associated infections. The first pathogen we will consider, and one commonly referenced in the popular media, is methicillin-resistant staphylococcus aureus or MRSA. MRSA is a very common healthcare-associated infection which ranks highly among central line-associated bloodstream infections, surgical site infections, and ventilator-associated pneumonia. This particular pathogen has created a headache for healthcare professionals nationwide and similarly created a scare in the general public. In the past several years, dynamics of MRSA have changed so that community-acquired MRSA infections are becoming more common. Some of the more prominent methods to prevent transmission of MRSA include appropriate hand hygiene (as I indicated earlier, proper hand hygiene is important in the prevention of all healthcare-associated infections but especially with MRSA); second, use of contact precautions with patients or healthcare workers who have been colonized or infected with MRSA (Decolonization efforts have been evaluated, but show limited efficacy and should be considered on a case-by-case basis); third, as a more public health-oriented recommendation, active surveillance of MRSA should be implemented if there is evidence of ongoing transmission within a facility.

## **SLIDE 15**

Our last set of prevention recommendations surround the area of clostridium difficile-associated disease, or CDAD, as it is affectionately referred to in healthcare and public health. It is a frequent culprit of many outbreaks of bacterial gastroenteritis in healthcare settings. CDAD is a unique pathogen and has many available routes of transmission to patients. The following three preventative measures are intended to address these various transmission routes: 1) The use of bleach-based products should be used for environmental decontamination. Clostridium difficile can persist in the environment for long periods of time and if these environments are not properly disinfected, outbreaks of disease can occur. 2) Symptomatic patients should be placed on contact precautions until tests for CDAD are confirmed. Clostridium difficile is easily transmitted via touch and therefore contact precautions are a necessary component to disrupt potential transmission. 3) Lastly, healthcare providers should routinely comply with hand hygiene, including disposable hand and gown use when handling patients. These preventative measures are more for the benefit of healthcare providers than they are for public health personnel, but they provide clues on what to investigate if clusters of healthcare-associated infections are presented to public health.

## **SLIDE 16**

Recently, the federal government and federal agencies have increased their participation in the prevention of healthcare-associated infections. Under the leadership of the US Department of Health and Human Services, public health agencies, national healthcare partners and advocacy groups developed the national HHS action plan to prevent healthcare-associated infections. The Centers for Disease Control and Prevention was identified as the primary agency to lead the national initiative to reduce healthcare-associated infections. As such, the CDC increased the capacity of the Division of Health Quality and Promotion to support states in their individual efforts to reduce healthcare-associated infections. As part of this capacity building, the CDC expanded the National Healthcare Safety Network, or NHSN, which is the current national surveillance system used to monitor healthcare-associated infections. In addition to expanding their supportive infrastructure, the CDC provided individual grants to states through the 2009 American Recovery and Reinvestment Act to develop or expand existing public health infrastructure to address healthcare-associated infections. In August, 2010, the Centers for Medicare and Medicaid Services likewise increased their involvement in surveillance of healthcare-associated infections through a rule requiring acute care hospitals to begin reporting central line-associated bloodstream infections in intensive care units in order to receive their annual inpatient prospective payment system payment.

## **SLIDE 17**

North Carolina has risen to the challenge to reduce healthcare-associated infections within the state. As part of the federal program to reduce healthcare-associated infections, the state of North Carolina has developed a 5 year plan outlining activities necessary to meet healthcare-associated infection targets. The North Carolina 5 year plan to reduce healthcare-associated infections is comprised of four key sections – expanding state healthcare-associated infection infrastructure, surveillance, prevention,

and communication. Recently, the North Carolina Healthcare-Associated Infections Advisory Group completed revision of the state plan which will be circulated for public use in the near future. Per requirements of the state plan, the Department of Health and Human Services, Division of Public Health hired 2 new staff members to establish and coordinate state HAI activities in cooperation with the state Healthcare-Associated Infections Advisory Group and associated partners. The expansion of personnel infrastructure is currently underway to include support staff and technical expertise. As part of the surveillance piece of the state plan, the Division of Public Health will begin surveying healthcare-associated infections using the National Healthcare Safety Network, or NHSN. Currently, healthcare facilities across the state are being assisted with enrollment in NHSN and we estimate that most facilities will be on track to begin reporting select healthcare-associated infections within a year. As the state's involvement in healthcare-associated infections expands, we are collaborating with key healthcare, academic, business, and governmental partners to promote activities focused on preventing healthcare-associated infections.

### **SLIDE 18**

“A plan without goals is like a ship without sails... it probably won't go anywhere”. With this in mind, North Carolina has set some modest goals to help direct healthcare-associated infection activities within the state. Given the immense scale of healthcare-associated infections, the healthcare-associated infections advisory group has decided, after much discussion, to focus on two specific device-associated infections – central line-associated bloodstream infections or CLABSIs, and catheter-associated urinary tract infections, or CAUTIs. For CLABSIs, goals have been set to reduce the CLABSI standardized infection ratio by 75%, reduce the laboratory detected bacteremia rate by 50%, and achieve 100% compliance with central line prevention bundles. For those who may not be familiar with it, the standardized infection ratio is a common metric used in healthcare epidemiology to evaluate rates of healthcare-associated infections. For CAUTIs, North Carolina has set goals to reduce the rate of bloodstream infections secondary to urinary tract infections by 50-75%, reduce the symptomatic urinary tract infection rate by 25%, and reduce the use of catheters in general by 50% (measured by the catheter utilization ratio). These goals represent important benchmarks for statewide partners as we constantly strive for the ultimate goal of zero infections.

### **SLIDE 19**

Finally, I would like to discuss some of the short-term future projections of the healthcare-associated infections program. First, modifications to the state General Statutes have been drafted and are currently under review to require reporting of select healthcare-associated infections by medical facilities. This proposed legislation will be submitted for this fiscal year 2011. If it is passed, the North Carolina Administrative Code will likewise be altered to include more precise language regarding which and how healthcare-associated infections shall be reported. In the interim period, the healthcare-associated infections program, in conjunction with state and federal partners, will work with hospitals on a voluntary basis to submit information on selected healthcare-associated infections within their facilities. Additionally, efforts to expand prevention activities are being coordinated with key partners working in healthcare-associated

infections throughout the state. I would now like to turn the time over to Ms. Constance D. Jones to elaborate on how healthcare-associated infections fit into the larger mandate of public health.

### **Constance Jones, RN, CIC**

Thank you Levi – now I would like to make this just a little more personal. I would like to share a story with you, one that I hope will help you view your job and the job of the infection preventionist a little differently than you do right now. The story is about my journey as an infection preventionist (IP) and a communicable disease nurse.

#### **SLIDE 20**

My story starts with a nationwide outbreak of “blood poisoning” from intravenous fluids manufactured in the mid-seventies by Abbott Laboratories. Because of this outbreak, many hospitals that did not have Infection Control programs, created one, and those that did have programs, enhanced them. At the time, I was working at a new hospital that did not have an Infection Control program. I was asked if I would like to lead the development of the program, along with developing an Employee Health program. I struggled to determine just exactly what the program should look like and where I could find the information I needed. I was very lucky that a group of infection control nurses were meeting in the area. I was surprised to find a public health nurse among the participants, which was really nice. The group’s main goal was to be a resource for each other. It was a very open group where all sorts of information was shared; thus began my membership in the Association for Practitioners in Infection Control (APIC). Many changes have taken place since those days. Our title has changed from Infection Control nurses to Infection Control Practitioners to Infection Control Professionals and today we are known as Infection Preventionists (IP). We have gone from desk telephones to beepers to cell phones to e-mails, from typewriters to desk top computers to personal compact computers, from fogging of isolation rooms to the use of ultra violet light, from infectious disease hospitals to isolation wards, to single isolation rooms, from everybody wearing absolutely everything they possibly could to cover themselves before entering an isolation room, to standard and transmission-based precautions. There have been many new emerging infectious diseases such as Human Immunodeficiency Virus (HIV), Methicillin-Resistant Staph Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Vancomycin Intermediate Staph Aureus (VISA), Vancomycin-Resistant Staph Aureus (VRSA), and Severe Acute Respiratory Syndrome (SARS) to the most recent H1N1 Influenza. There was also the name change of Hepatitis non-A non-B to Hepatitis C. Every time I thought I had hepatitis figured out they’d throw in a new letter.

#### **SLIDE 21**

I have seen many disease outbreaks throughout my career. I am reminded of one of the very first outbreaks that I was involved in. It started with a phone call from my hospital lab telling me that they were seeing an unusual number of positive stool cultures for Salmonella. I gathered some preliminary data and made a call to our local health department. By the time it was all over, approximately 120 persons had become ill. All of those affected had worked or eaten at a local International House of Pancakes

(IHOP). The culprit – Salmonella enteritidis in eggs used to make French toast that had not been cooked enough to kill the bacteria. I learned a lot about teamwork during this outbreak that was beneficial to me throughout my career.

## **SLIDE 22**

Another more recent outbreak that I was not personally involved in, but have been professionally affected by, was the outbreak of Hepatitis C at the New Hanover Community Health Center in Laurinburg, N.C. A technician infected seven patients with Hepatitis C during cardiac stress tests conducted at an outpatient clinic. The tests involve injecting a dye into a patient's vein. Because of this outbreak, Section 10A of the North Carolina Administrative Code 41A .0206 Infection Prevention, Health Care Settings, was 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 to direct these activities". Some of the more unusual "healthcare 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. Many ICPs or IPs have been affected by this because they are responsible for oversight and education of physician practices and/or outpatient facilities that are a part of their hospital system. Major educational sessions and revamping the way these offices are monitored has to take place. This may be a good time for me to share with you some of my duties and responsibilities as an Infection Preventionist. From a preventive perspective, I educated staff, physicians, patients, caregivers and visitors about infectious diseases, disease transmission, hand hygiene and other prevention measures. The control aspect involves identifying infections and taking steps to isolate patients so germs don't proliferate. Food safety and sharps injury prevention are also important concerns. I was responsible for surveillance to ensure that new infection prevention initiatives were effective and sustained. Microbiology reports, medical records and admitting diagnoses had to be reviewed and rounds had to be made to directly observe what was taking place on the units so that feedback could be given to the managers and staff. Gathering data and generating reports to share with the nursing department and medical staff were an important part of my job. Data entry and statistical analysis were my constant companions. As an Infection Preventionist, I was a champion of strategies to protect patients from potentially life-threatening infections. I was uniquely positioned to prevent infection by connecting the science of infection prevention to the people most deeply and personally affected – patients, visitors, volunteers, employees and healthcare workers. As an IP I wore many caps throughout the day – many times the caps were stacked on top of each other, one after another, I was an educator/teacher, an advocate, an observer, a construction advisor, an investigator, a consultant, a monitor, a mentor, a disciplinarian, a cheerleader, a mother-like figure, a data collector, a reporter, an enforcer, a meeting organizer, and an environmentalist. I guess you could say I was ubiquitous. Now let's look at my experience as a communicable disease nurse – the time I spent as a CD nurse was much shorter than the time I spent as an IP, so fewer changes took place. One big

change that occurred was the implementation of NC EDSS. Going from the small green card physicians and others used to report communicable diseases, to the full page report. I was still getting green cards over a year after we changed the system. Going from mailing all the reports to Raleigh to putting all the information into the computer and pushing the Send button. Some of us were more challenged than others by the whole process.

### **SLIDE 23**

I continued to encounter outbreaks. One of these outbreaks some of you may have been involved in. It started like they all do with an e-mail about several persons reporting gastrointestinal illness. The twist on this outbreak was that it occurred during an Introduction to Public Health Nursing course held at a Guilford County hotel. A list of all the participants with e-mail addresses was obtained, a case definition was written, an outbreak questionnaire was developed and sent to all 55 attendees. Thirty of the 55 attendees reported becoming ill with the main symptom being nausea and vomiting that lasted approximately 2 days. Since cultures were not obtained, we were unable to know exactly what caused the outbreak, but after reviewing all the results, we at Guilford County assumed it was a norovirus-like outbreak. My duties at the health department included investigation of all reportable communicable diseases, except for TB and HIV/STD. I think the most challenging was the Hepatitis B babies; man, did I have a lot of little guys that needed follow-up! I'm sure some of you can identify with that. I was on the phone from morning til night, asking questions of doctors, nurses, laboratories, and of course, the patient who was being reported. There were also calls from physicians, nurses, patients and just members of the general population with questions. This was non-stop, especially when an infection or outbreak hit the news. During the H1N1 months, my phone was constantly ringing. Speaking of H1N1, I gained a lot of knowledge on the workings of the Preparedness program of our county. What a great bunch of people I had to work with during that time of uncertainty. There were meetings upon meetings, and many early mornings and late, late evenings. There were television, radio and newspaper interviews. I didn't think that I would ever say this, but it got to be old hand. One thing that was started by my predecessor and I was able to continue, was a quarterly meeting with the TB nurses, the IPs from our county hospitals, and myself. It was a very useful meeting in that we were able to learn what was going on in the entire county, not just one little corner. What problems were we each having that the others may be able to help with? Communication issues could be addressed and corrected without having to involve others. Our Medical Director (who was also an Infectious Disease Physician) attended the meetings, which helped educate all of us on diseases and transmission issues that we may not have been familiar with. I invite you to consider forming an Infection Prevention team in your county. I could go on and on but I must bring this to an end. What I have tried to do today is to show you that your job as CD nurse is not all that much different from an IP. Both are educators/teachers, advocates, observers, investigators, consultants, monitors, data collectors, reporters, enforcers, and environmentalists. I guess you could say we are ubiquitous. One of the most recent changes we have seen is going from using "nosocomial" to using "healthcare-associated". "Nosocomial" referred to hospital-acquired infections while "healthcare-associated" can be in any healthcare

setting from hospital to nursing home to health department clinic. As we work toward the elimination of healthcare-associated infections in all forms of healthcare settings, we must recognize the importance of teamwork.

#### **SLIDE 24**

Today you and the IP are facing another change, one that you will face together as the state moves toward mandatory reporting of HAIs and in particular, the reporting of communicable diseases or conditions by the healthcare facility. Proposed changes to the General Statutes would require that “A medical facility, in which there is a patient reasonably suspected of having a communicable disease or condition declared by the Commission to be reported, shall report information specified by the Commission to a public health agency specified by the Commission”. This is a change in that previously, medical facilities have been given a choice as to report or not. If the proposed statute change is passed, medical facilities will be required to report. If the statute is changed, then the code/rule would be changed to include, not only the reportable communicable diseases, but also outbreaks of communicable diseases occurring in a hospital that could be transmitted outside the hospital and impact the public health of the community. This change would affect you in that you would be the one taking on the added responsibility of receiving reports and investigating communicable diseases, conditions and outbreaks that occur within healthcare facilities. It would affect the IP in that she/he would have to take on the added responsibility of reporting the communicable disease, condition or outbreak. The code/rule would also be changed to add HAI reporting by the hospital BUT this would be through the CDC’s National Healthcare Safety Network and would not involve the local health departments. Both you and the IP have experience in case finding, investigating and reporting. Separate, you are both good, but working together, you can be great. I encourage you to learn more about the IP in the hospital(s) in your county. If you don’t know her/him, now is the time to pick up that phone and introduce yourself. Start the conversation about infection prevention, reporting of communicable diseases, and outbreak investigation, and how you can work together for the betterment of the citizens of your county. We have all experienced change and will continue to experience it as we continue along our journey. We all adapt to change in our own ways but, we do adapt. It is said when you recognize the possibilities created by change, you’re more prepared to exploit them. You will find change as not something to fear, but as something to welcome and turn to your own advantage. Now is the time — you have no choice — you must prepare for the change!  
Thank you

#### **SLIDE 25**

Contact information