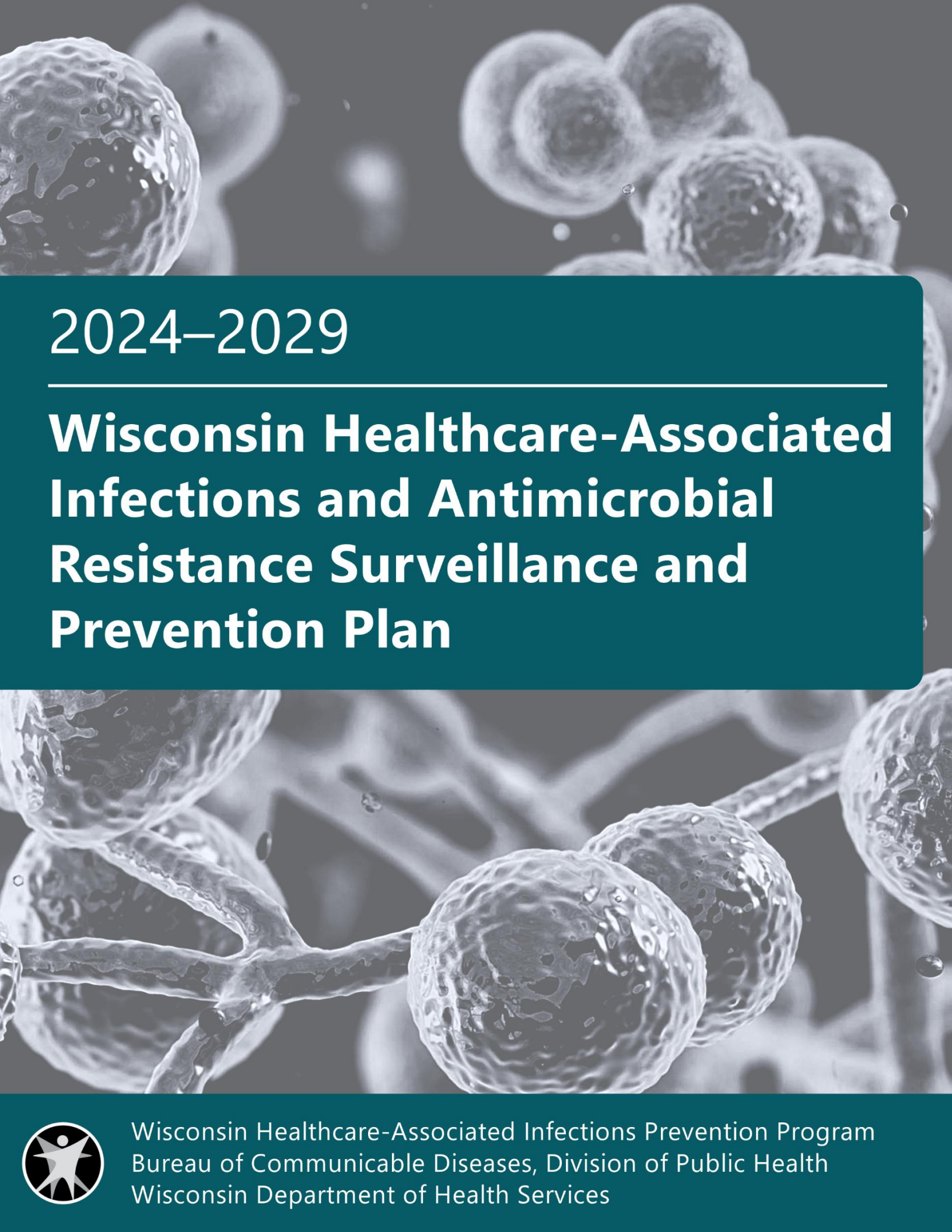


A grayscale, high-magnification microscopic image of bacteria. In the foreground, several spherical bacteria with a textured, almost crystalline surface are visible. Some are connected by thin, branching filaments. The background is filled with more out-of-focus spherical bacteria, creating a sense of depth and a dense microbial environment.

2024–2029

Wisconsin Healthcare-Associated Infections and Antimicrobial Resistance Surveillance and Prevention Plan



Wisconsin Healthcare-Associated Infections Prevention Program
Bureau of Communicable Diseases, Division of Public Health
Wisconsin Department of Health Services

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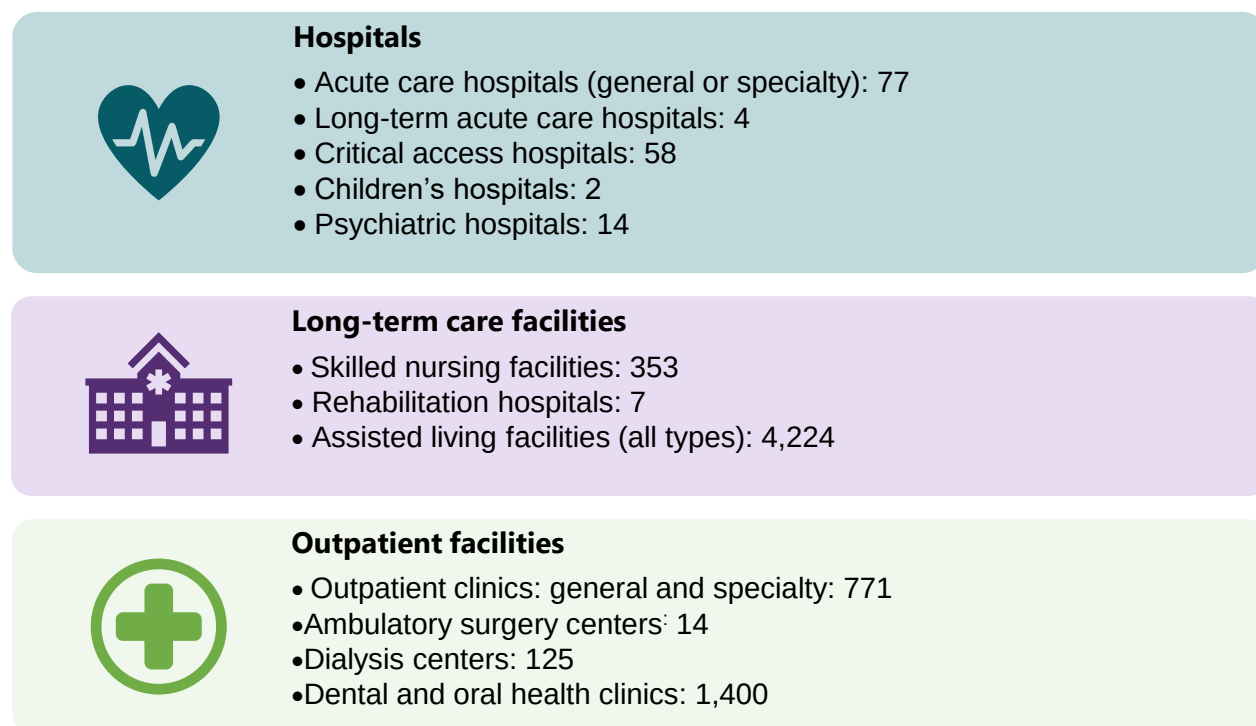
Executive Summary

Introduction

Wisconsin has a vast health care infrastructure (Figure 1) that supports and provides health care services in settings such as hospitals, long-term care facilities, outpatient facilities, and home health and hospice. However, like in many other states, healthcare-associated infections (HAIs), and antimicrobial resistance (AR) are a growing threat. Within 2024 alone, the Wisconsin HAI Prevention Program responded to 49 HAI outbreaks or infection prevention and control (IPC) breaches in a number of different health care setting types. Multidrug-resistant organism (MDRO) infections, such as *Candida auris* (*C. auris*), have also been increasing in the state. HAIs and AR negatively impact a person's health, drive up health care costs, increase the burden on public health, and can prevent Wisconsinites from living their best lives.

FIGURE 1

Wisconsin's health care infrastructure is comprised of nearly 7,000 health care facilities across various setting types.



Notes: Data is from internal lists supported by information from the [Division of Quality Assurance \(DQA\)](#), [Wisconsin Hospital Association \(WHA\)](#), National Healthcare Safety Network, and [Dentagraphics](#).

Purpose

The *2024–2029 HAI and AR Surveillance and Prevention Plan* provides background on Wisconsin’s HAI Prevention Program and outlines key program goals and strategies for addressing HAIs and AR threats across the state. Updates on progress made towards achieving goals and activities outlined in this plan will be provided via annual progress reports.

Wisconsin HAI Prevention Program

Program background

The Wisconsin HAI Prevention Program was established in 2009 through federal funding. Initially, the program primarily focused on acute care and inpatient settings. However, in response to shifts in health care delivery models from acute care settings to ambulatory and long-term care settings, the HAI Prevention Program broadened its infection prevention efforts. The program recognized that a multifaceted approach to infection prevention was crucial due to the interconnectedness of health care settings and individuals’ movement through the health care continuum.



Over time, the program has built a foundation rooted in education and relationship building with health care facilities, local and Tribal health departments (LTHDs), and other partners. Furthermore, the HAI Prevention Program has increased its capacity to conduct statewide HAI and AR surveillance, response, prevention, intervention, and coordination.

Program structure

The HAI Prevention Program’s capacity to provide infection prevention guidance, surveillance, and education support has grown substantially since it was first established. From 2019 to 2024, in response to a growing need for statewide infection prevention support, program IP staffing increased significantly. Program IPs provide free, non-regulatory infection prevention and control support to LTHDs and health care facilities across all settings including, but not limited to, hospitals, clinics, long-term care, dialysis, and oral health. The program’s ability to provide statewide HAI/AR surveillance and education has also grown to include staff specializing in health education, antimicrobial resistance and stewardship, and HAI/AR surveillance and epidemiology to support health care and public health partners.

HAI Advisory Committee

The HAI Prevention Program closely collaborates with partners across the state, many of whom serve on the HAI Advisory Committee. The advisory committee was established in 2009 to help guide development of the 2009 Wisconsin HAI Prevention Plan.

Since then, the HAI Advisory Committee has continued to meet with the charge to:

- Advise the program on subsequent Wisconsin HAI Prevention Plans.
- Prioritize HAI reduction efforts.
- Promote statewide HAI surveillance and prevention activities.
- Help coordinate activities among statewide HAI prevention partners.
- Propose methods to help ensure sustainability of HAI reduction efforts.

Current membership (Figure 2) of the committee includes a multidisciplinary network comprised of representatives from private health care and public health organizations.

FIGURE 2

The HAI Advisory Committee membership is multidisciplinary, with representation from both private and public health sectors.

Association for Professionals in Infection Control and Epidemiology (APIC)	Health care facility associations	LeadingAge Wisconsin
Rural Wisconsin Health Cooperative	Wisconsin Center for Assisted Living	Wisconsin Health Care Association
Wisconsin Hospital Association	Health care facility providers across settings	Ambulatory surgery centers
Hospitals	Long-term care facilities	Outpatient dialysis centers
Hospital epidemiologists and researchers	Local and Tribal health departments (LTHDs)	Patient representatives

Program vision, mission, and values

Vision

Improve outcomes across Wisconsin by reducing healthcare-associated infections and antimicrobial resistance.

Mission

To prevent, detect, and respond to healthcare-associated infections and antimicrobial resistance by collaborating with partners, conducting surveillance, and providing trusted guidance and education.

Values

The HAI Prevention Program's values include collaboration, innovation, responsiveness, and trust (Figure 4).

FIGURE 3

The HAI Prevention Program values collaboration, innovation, responsiveness, and trust in their work within public health and with health care partners.

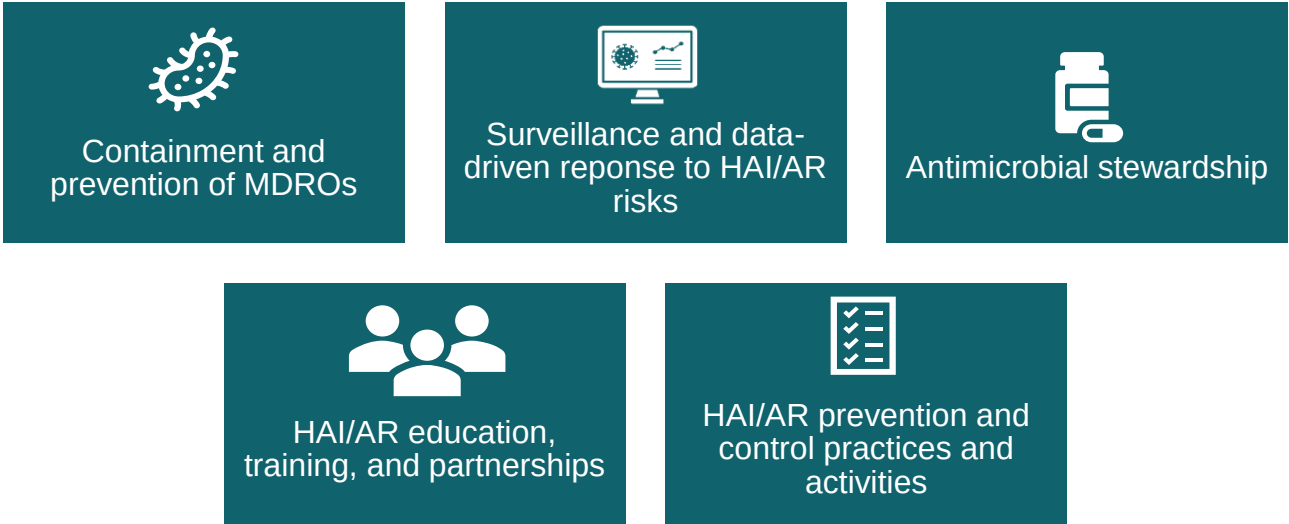
Collaboration	Innovation	Responsiveness	Trust
• Working with internal and external partners • Learning and listening empathetically	• Creative and dynamic • Courageous • Flexible	• Anticipate and adapt to change • Timely • Supportive • Recognizes and eliminates barriers	• Experienced and reliable • Evidence-based • Thoughtful • Inclusive • Builds relationships

Program priorities areas

The HAI Prevention Program will focus on the following priority areas while adapting to emerging trends and issues. The subsequent sections of this *2024–2029 HAI and AR Surveillance and Prevention Plan* will summarize HAI and AR activity across the state as well as detail the Wisconsin action plan that will guide efforts for the next four years.

FIGURE 4

HAI Prevention Program work is divided into five program priority areas.



Data and Trends

HAI and AR trends are tracked by the HAI Prevention Program using a variety of surveillance methods. Surveillance data is crucial in understanding the prevalence of HAIs and MDROs across the state.

HAI surveillance data and trends

Overview

Developed and maintained by the CDC, the National Healthcare Safety Network (NHSN), is the most widely used system for identifying and tracking HAIs in the United States. A wide range of health care facility types utilize NHSN, including hospitals, dialysis facilities, ambulatory surgery centers, and skilled nursing facilities.

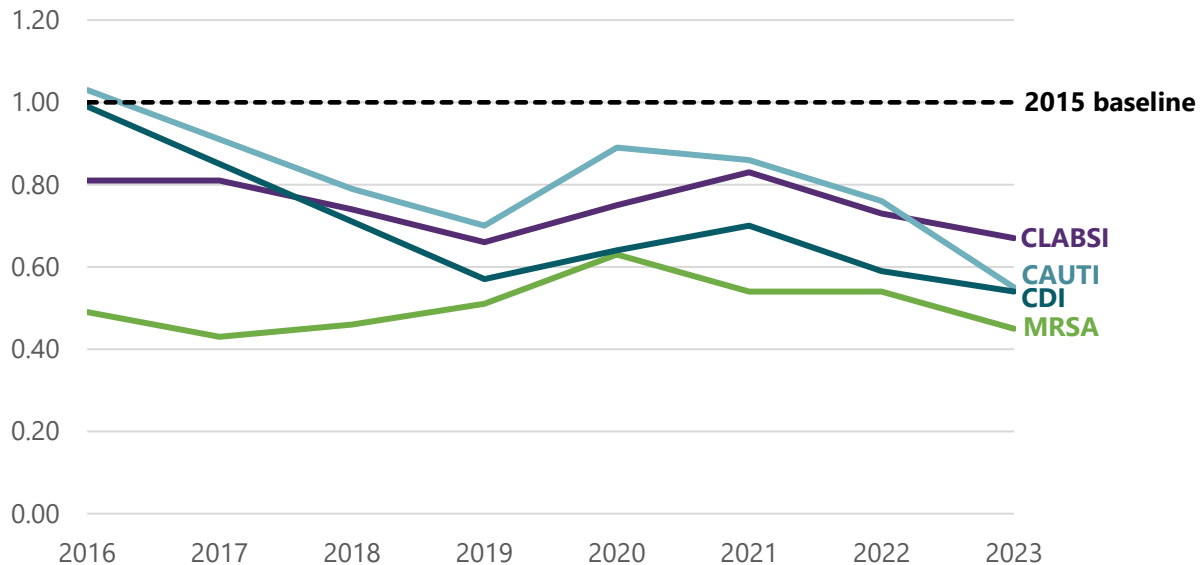
The primary outcome measure in NHSN is the standardized infection ratio (SIR), which is the ratio of the number of observed HAIs to the number of predicted HAIs. The SIR is risk-adjusted to account for facility-level, and in some cases patient-level, factors associated with the incidence of each HAI type. The SIR enables “apples to apples” comparisons of HAI data across facilities and hospital unit types, as well as with state and national data.

Historical data

Similar to [national trends](#), state-level SIRs for several HAI types were trending downward prior to the COVID-19 pandemic. As shown in figure 5, state-level SIRs in Wisconsin acute care hospitals for central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and hospital-onset *C. difficile* infections (CDI) were trending downward from 2016–2019. Since 2018, annual state-level SIRs for CLABSI, CAUTI, MRSA bacteremia, and CDI have all been statistically significantly lower than the 2015 national baseline.

FIGURE 5

State-level SIR values for Wisconsin acute care hospitals have been significantly below the 2015 national baseline for four HAI types since 2018.



Historical trends for **surgical site infections (SSIs)** in Wisconsin vary by procedure type. As shown in Table 1, state-level SIRs for SSIs following colon procedures and hip replacement procedures were significantly lower than the 2015 national baseline for most years between 2018 and 2023. State-level SIRs for SSIs following abdominal hysterectomies and knee replacement procedures were not significantly different from the 2015 national baseline for most years shown in the table. However, Wisconsin's SIR for SSIs following abdominal hysterectomies was significantly higher than the 2015 baseline in 2019.

Note that the data shown in Table 1 includes SSI data for both acute care and critical access hospitals. Also note that the SSI data in Table 1 reflects [NHSN's "Complex Admission/Readmission" SSI SIR model](#), which means that only adult, inpatient surgical procedures are included, and only those SSIs occurring at the deep or organ/space level that are detected during the same hospital admission as the surgical procedure or upon readmission to the facility where the procedure was performed are included.

TABLE 1

State-level SSI SIRs were significantly lower than the 2015 baseline for infections following colon surgeries and hip replacements for most years during this period.

Procedure type	2018	2019	2020	2021	2022	2023
Colon surgery	0.78	0.80	0.72	0.83	0.90	0.92
Abdominal hysterectomy	1.24	1.36	0.92	0.85	1.08	1.22
Hip replacement	0.93	0.73	0.70	0.55	0.83	0.73
Knee replacement	0.64	0.80	0.87	0.84	0.84	1.11

Notes: Green shading shows SIR values that are statistically significantly **lower** than the 2015 national baseline. Red shading shows SIR values that are statistically significantly **higher** than the 2015 national baseline. Data shown is based on the [Complex Admission/Readmission SSI SIR model](#).

Current data

In 2024, NHSN embarked on the process to recalibrate and update national SIR baseline values for all HAI types, based on data submitted by U.S. hospitals for calendar year 2022. The new baselines reflect updated risk-adjustment models and provide a much more current benchmark against which facilities and states can assess their continued progress in preventing HAIs.

NHSN's 2022 SIR rebaseline process is ongoing at this time, and data under the 2022 national baseline is not yet available for all HAI types or facility types. Also, it is important to note that **SIR values calculated under different national baselines are not directly comparable**. In other words, historical SIR values shown above (which were calculated under the 2015 national baseline) should not be directly compared to SIR values in this section, which are based on the 2022 national SIR baseline.

Available data to date show that for several HAI types, state-level SIRs for acute care hospitals are already below the new baseline.

FIGURE 6

State-level acute-care hospital SIRs are significantly lower than the 2022 baseline for several HAI types *apart from* CDI.

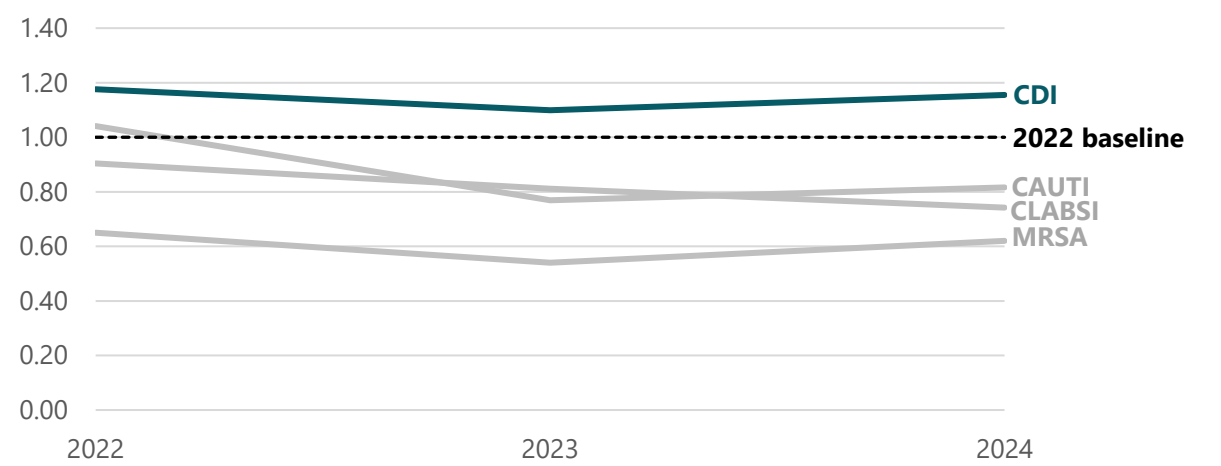


Table 2 shows state-level acute care hospital SIR values under the updated baseline for CAUTI, CLABSI, MRSA bacteremia and CDI. For CAUTI and CLABSI, state-level SIRs were significantly lower than the 2022 baseline for 2023 and 2024. For MRSA bacteremia, state-level SIRs were significantly lower than the 2022 baseline for all three years. Updated data for CDI paint a different picture, with state-level acute care hospital SIRs significantly higher than the 2022 baseline for all three years. Further investigation and conversations with acute care partners will be needed to better understand what may be contributing to these higher SIR values.

TABLE 2.

State-level acute care hospital SIR values are significantly lower than the 2022 SIR baseline for several HAI types, *apart from* CDI.

HAI Type	2022	2023	2024
CAUTI	1.04	0.77	0.82
CLABSI	0.90	0.81	0.74
MRSA bacteremia	0.65	0.54	0.62
CDI	1.18	1.10	1.16

Notes: Green shading shows SIR values that are statistically significantly **lower** than the 2022 national baseline. Red shading shows SIR values that are statistically significantly **higher** than the 2022 national baseline.

SSI data under the updated baseline is currently only available for the [Complex 30-day SSI model](#), which includes only adult, inpatient colon and abdominal hysterectomy procedures, and SSIs occurring at the deep and organ/space level. It includes SSIs that are detected on admission or re-admission to the hospital where the procedure was performed and those identified via post-discharge surveillance. Data shown in Table 3 includes acute care and critical access hospitals.

State-level SIRs for acute care and critical access hospitals for SSIs following colon surgeries were not significantly different from the updated baseline for 2022, 2023, or 2024. State-level SIRs for SSIs following abdominal hysterectomies were significantly higher than the new baseline for all three years. While these higher SIRs for infections following abdominal hysterectomies also warrant further investigation, a more complete picture of Wisconsin's progress in preventing SSIs will only be possible once NHSN's rebaseline process has been completed and data under additional SSI SIR models is available.

TABLE 3.

Currently available SSI data suggest the need for further investigation into infections following abdominal hysterectomies.

Procedure type	2022	2023	2024
Colon surgery	1.09	1.14	1.14
Abdominal hysterectomy	1.43	1.43	1.48

Notes: Green shading shows SIR values that are statistically significantly **lower** than the 2015 national baseline. Red shading shows SIR values that are statistically significantly **higher** than the 2015 national baseline. Data shown is based on the [Complex Admission/Readmission SSI SIR model](#).

Summary

Newly available NHSN data for Wisconsin hospitals suggest that Wisconsin hospitals continue to do well in preventing several types of HAIs. State-level SIRs for Wisconsin acute care hospitals were below the 2022 national SIR baseline for CAUTIs, CLABSIs, and MRSA bacteremia for 2023 and 2024. At the same time, state-level SIRs for CDI and SSIs following abdominal hysterectomies were significantly higher than the updated baseline for 2022, 2023 and 2024, and warrant further investigation.

The Wisconsin HAI Prevention Program will continue to actively monitor state-level data as NHSN releases the remaining 2022 baseline report templates (for additional HAI types and SIR models, and for other facility types) in the coming months. The Wisconsin HAI Prevention Program looks forward to engaging with partners and stakeholders to delve into our state's updated NHSN data and fully utilizing this resource to guide HAI prevention efforts going forward.

Antimicrobial resistance and multidrug-resistant organism trends

The Wisconsin HAI Prevention Program has been dedicated to preventing, detecting, and responding to MDROs since its inception. Through its partnership with the Wisconsin State Lab of Hygiene (WSLH), which also serves as the Midwest Antimicrobial Resistance Regional Laboratory (ARLN), the program has been able to incrementally surveil targeted MDROs (Figure 8) and collaborate with LTHDs and key stakeholders from health care facilities across the state to respond to identified cases.

FIGURE 7

Some MDROs are considered reportable diseases in Wisconsin.

Organism	Notes and considerations
Carbapenemase-producing carbapenem-resistant Enterobacterales (CP-CRE)	- This order of bacteria is commonly found in the human gastrointestinal system as part of the normal flora. - CP-CRE can cause serious infections if introduced to a sterile site, but people can also be colonized with CP-CRE without illness.
Carbapenemase-producing carbapenem-resistant <i>Acinetobacter baumannii</i> (CP-CRAB)	<i>Acinetobacter baumannii</i> is commonly found in soil and water. - This organism can survive for a long time on surfaces, colonize the skin, and cause severe infections. - CRAB can be highly resistant to antibiotics. Pan-resistant CRAB isolates have been detected in Wisconsin.
Carbapenemase-producing carbapenem-resistant <i>Pseudomonas aeruginosa</i> (CP-CRPA)	<i>Pseudomonas aeruginosa</i> is a bacterium commonly found in soil and water. <i>Pseudomonas aeruginosa</i> is naturally drug-resistant and can cause severe wound, burn, and respiratory infections. - While only a small proportion of CRPA isolates are carbapenemase-producing (CP), CP-CRPA can cause very serious and hard-to-treat infections.
<i>Candida auris</i> (<i>C. auris</i>)	<i>C. auris</i> is a rare but potentially life-threatening type of fungus that is resistant to most antifungal medications. <i>C. auris</i> can colonize the skin and is difficult to eliminate from the resident environment. <i>C. auris</i> infections have a high mortality rate.
Vancomycin- intermediate <i>Staphylococcus aureus</i> (VISA) and Vancomycin-resistant <i>Staphylococcus aureus</i> (VRSA)	<i>Staphylococcus aureus</i> is a bacterium commonly found in the nose or on the skin. VISA and VRSA are staphylococcal bacteria that has developed resistance to vancomycin antibiotics. - Sometimes staphylococcal bacteria can cause more serious infections such as sepsis, pneumonia, endocarditis, or osteomyelitis.

History of AR and MDROs in Wisconsin

Conducting surveillance for AR and MDROs in Wisconsin has been important for understanding the prevalence of the organisms statewide.

FIGURE 8

Wisconsin HAI Prevention Program, in collaboration with the Wisconsin State Laboratory of Hygiene (WSLH), has expanded MDRO surveillance over time.

2007	In an effort to accurately track resistant organisms in Wisconsin, VISA and VRSA became reportable conditions.
2010	WSLH expanded testing capabilities for CRE in clinical isolates. This included testing for several carbapenemases such as <i>Klebsiella pneumoniae</i> carbapenemase (KPC), New Delhi metallo-beta-lactamase-1 (NDM-1), and OXA-48 as well as culture-base testing of rectal swabs for CP-CRE. WHAIPP initiated surveillance for specific species of CRE, including <i>Klebsiella</i> spp. and <i>Escherichia coli</i> (<i>E.coli</i>) among hospital patients.
2017	WSLH expanded testing for additional carbapenemases to include impenemase (IMP) and Verona integron-encoded metallo-beta-lactamase (VIM). Culture-independent method of detecting carbapenemases from rectal swabs also became available.
2018	CP-CRE became a category I reportable condition in Wisconsin.
2019	The HAI Prevention Program began advocating for other MDROs of concern to become reportable in Wisconsin to enhance surveillance and response.
2022	All carbapenemase-producing organisms (CPOs) were made category II reportable conditions in Wisconsin, this included CP-CRE which was already reportable and added carbapenemase-producing carbapenem-resistant CP-CRAB and CP-CRPA. Also added to the list of reportable diseases was <i>C. auris</i> , a newly emerged fungal pathogen. WSLH also added clinical isolate and colonization testing of <i>C. auris</i> , CP-CRAB, and CP-CRPA.

Wisconsin MDRO data

The following data illustrates trends in reportable MDRO activity in Wisconsin from the year 2020 through 2024.

TABLE 2
Wisconsin cases of CP-CRAB, CP-CRE, and *C. auris* have increased in recent years.

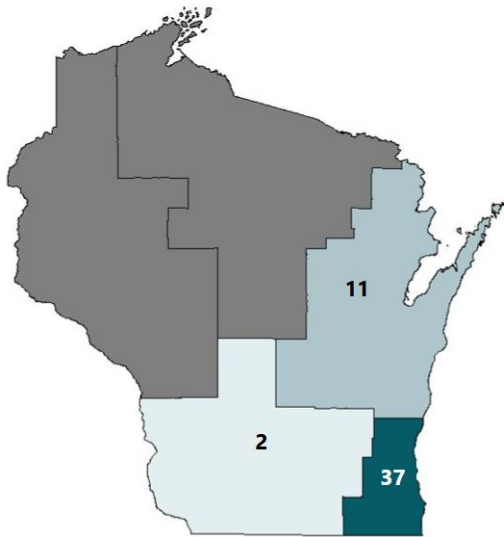
Reported cases of CP-CRAB, CP-CRE, CP-CRPA, and *C. auris* in Wisconsin, 2020–2024

	2020	2021	2022	2023	2024
CP-CRAB	41	153	112	153	139
CP-CRE	30	42	45	37	69
CP-CRPA	2	2	4	3	1
<i>C. auris</i>	0	1	5	21	23
VISA	1	1	2	4	0

Notes: Case counts listed are deduplicated and include both clinical and colonization screening isolates, besides VISA. Colonization screenings for VISA are not conducted at this time.

While the prevalence of these cases may appear low compared to other reportable diseases and conditions, systematic surveillance and one-on-one follow up on each case is an essential part of controlling their spread. Timely public health response and intervention helps prevent the potential for rapid increases of MDRO cases, which have been seen in other areas of the country.

FIGURE 9
Most Wisconsin *C. auris* cases have been detected in the Southeastern region.
 Reported cases of *C. auris* by Wisconsin public health region, 2020–2024



Notes: Case counts listed are deduplicated and include both clinical and colonization screening isolates.

After the first Wisconsin case of *C. auris* was detected in January 2022, cases have continued to rise. In 2024, 37 of the 50 cases of *C. auris* reported were detected in the Southeastern region of the state. *C. auris* cases were also detected in the Southern and Northeastern regions.

Summary

Surveillance data continues to play an important role in detecting, preventing, and responding to HAIs and MDROs in Wisconsin. Wisconsin HAI Prevention Program surveillance has shown that state-level SIRs for Wisconsin acute care hospitals were below the 2022 national SIR baseline for CAUTIs, CLABSIs, and MRSA bacteremia for 2023 and 2024. However, the state-level SIR for CDI was significantly higher than the updated baseline for 2022, 2023, and 2024, warranting further investigation. In addition, currently available SSI data also suggest the need for further investigation into infections following abdominal hysterectomies, which were significantly higher than the 2015 national baseline in 2022, 2023, and 2024.

Data also shows a steady increase of MDROs, in particular *C. auris*. The potential for rapid spread and difficulty in treating infections caused by these organisms, underscores the need for a timely response to the presence of MDROs.

The priority areas, goals, and activities of the Wisconsin HAI Prevention Program are and will continue to be driven by the landscape of HAIs and MDROs in all types of health care facilities. The above data showcases the need to continue to support health care facilities and public health in addressing HAIs and AR in Wisconsin.

Wisconsin Action Plan

The action plan below is organized by HAI Prevention Program priority area. The action plan outlines programmatic goals, subgoals, and activities. Updates on progress made towards achieving goals and activities outlined in this plan will be provided via annual progress reports.

Priority area 1: Containment and prevention of MDROs	
Goal: Prevent the emergence and contain the spread of novel and targeted health care-related MDROs.	
Subgoal	Activities
Implement MDRO containment strategies for timely MDRO detection and response.	• Track containment and response activities including onsite infection control assessments (ICARs). • Review state MDRO surveillance data. • Work with Wisconsin Wastewater Surveillance Program to detect MDROs in health care wastewater.
Maintain an MDRO prevention program.	• Execute MDRO prevention workplan. • Develop and distribute MDRO prevention-focused educational materials in various health care settings. • Establish admission screening programs for CRAB and <i>C. auris</i> in various health care settings.
Conduct activities to prevent the spread of	• Implement a transfer communication tool.

novel and targeted MDROs.	• Pilot an Antimicrobial Resistance Information Exchange (ARIE) program. • Conduct preventative ICARs. • Host monthly MDRO Office Hours.
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Priority area 2: Surveillance and data-driven response to HAI/AR risks

Goal: Use data-driven prevention strategies to improve infection prevention and control in health care settings.

Subgoal	Activity
Provide NHSN support to health care facilities.	• Maintain HAI Surveillance Coordinator position. • Maintain monthly NHSN support calls.
Understand and address factors that influence health related to HAI/AR.	• Develop and disseminate education materials that address differences that influence health. • Identify and implement focused strategies to connect with health care workforce trainees who train or work in priority areas throughout the state.

Priority area 3: Antimicrobial stewardship

Goal: Promote antibiotic stewardship (AS), the practice of measuring and improving how providers prescribe antibiotics and patients use them.

Subgoal	Activity
Provide antimicrobial stewardship expertise.	Maintain an Antibiotic Stewardship Coordinator to lead program AS activities.
Assess uptake of CDC's Core AS Elements to identify antibiotic stewards, clinicians, facilities, or health systems that need additional support to improve implementation of stewardship activities in different health care settings.	• Distribute outpatient AS core elements assessment surveys to outpatient health care organizations. • Monitor inpatient facility reported stewardship activities to guide further statewide stewardship efforts. • Monitor nursing home reported stewardship activities to support future stewardship efforts in long-term care. • Finalize and distribute dental-focused survey to measure core element use and prescribing practices.
Track antibiotic use to inform interventions to include high risk and underserved populations.	• Provide educational materials and trainings on AS to LTCFs. • Analyze antibiotic prescribing data for differences using key demographics such as area deprivation index, payor, and rurality.

	• Establish learning collaboratives for participating nursing homes enrolled in AS Learning Collaboratives. • Establish and distribute AUR data reports that can be distributed statewide for inpatient program education. • Release annual updates of the statewide outpatient medical and dental AU reports and semi-annual updates of the provider-specific online platform reports.
Collaborate with institutions and partners to form stewardship collaboratives.	Participate and lead meetings with partners where AS topics are discussed.
Coordinate and maintain antibiotic stewardship education and communication activities.	• Conduct at least semi-annual reviews of AS communications and education strategies to incorporate new ideas and initiatives. • Develop and release statewide educational content aimed at specific settings, including the link to targeted MDROs. • Release AS-related messaging for the general public via DHS communications channels. • Maintain Department of Health Services AS webpages.

Priority area 4: HAI/AR Education, training, and partnerships

Goal: Conduct needs assessment and coordinate infection prevention and control education for LTHDs, academics institutions and other partners, and provide training to address knowledge gaps.

Subgoal	Activity
Provide infection prevention and control education and training for health care facilities and personnel.	• Adapt and execute the CDC Project Firstline (PFL) Infection Prevention and Control Escape Room training for different staff types and health care setting types. • Continue to develop and execute year-long WHAIPP communications and education plans. • Incorporate CDC PFL materials into education and communications as applicable.
Identify and engage with key partners to advance and assess program goals.	• Participate in meetings with internal and external partners. • Meet with HAI Advisory Committee.

Priority area 5: HAI/AR prevention and control practices

Goal: Detect, prevent, and respond to HAI/AR risks.

Subgoal	Activity
Collaborate in outbreak and infection control breach investigations.	• Maintain an HAI Outbreak Lead to assist in HAI outbreak response. • Improve local capacity for HAI outbreak response: a. Provide focused education for LTHDs. b. Provide technical assistance and resources to LTHDs. • Assist health care facilities in investigations by providing: a. Onsite assistance. b. Guidance and resources. • Track all outbreak responses and infection control breaches.
Promote HAI/AR prevention in all health care settings including: • Hospitals. • Long-term care facilities. • Clinics. • Surgery centers. • Dialysis facilities. • Oral health clinics. • Congregate living facilities. • Home health and hospice.	• Develop and conduct related trainings and educational resources. • Participate in CDC trainings and forums. • Conduct responsive and proactive ICARs. • Track all consultations and ICARs.
Support infection prevention infrastructure.	• Support and onboard new facility infection preventionists. • Develop educational materials and toolkits to assist facility infection preventionists and health care staff.
Maintain partnerships.	• Participate in LTC-focused committees (including HAI in LTC coalition, DON council, and state survey agency webinars). • Participate in regional coalitions. • Maintain relationships with health care-focused associations.
Provide public health HAI/AR response and	• Maintain financial stewardship to drive completion of program goals.

prevention expertise through workforce capacity and development.	• Ensure staff review key resources from agencies such as CDC, Society for Healthcare Epidemiology of America (SHEA), and the Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA), the Association for Professionals in Infection Control and Epidemiology (APIC) as they are released. • Encourage personal and professional development opportunities to maintain staff expertise.
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