



**STRENGTHENING HAI/AR  
PROGRAM CAPACITY  
GUIDANCE  
10/1/2021**

Project E: Emerging Issues

Supported through the American Rescue Plan Act of 2021

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## STRENGTHENING HAI/AR PROGRAM CAPACITY

## GUIDANCE

## PROJECT E: EMERGING ISSUES

## BACKGROUND AND PURPOSE

As part of the *Coronavirus Aid, Relief and Economic Security (CARES) Act* (P.L. 116-136) and *Paycheck Protection Program and Health Care Enhancement Act* (P.L. 116-139) supplements, the ELC awarded over \$11 billion in 2020 and \$19.11 billion in 2021 to help address the domestic response to COVID-19. To provide additional critical support to recipients as they continue to address COVID-19 within their communities, a total of \$385 million dollars will be provided to ELC recipients through the *American Rescue Plan Act of 2021*, [P.L. 117-2](#) as program-initiated component funding under *Project E: Emerging Issues* of CK19-1904, henceforth, '*Strengthening HAI/AR Program Capacity*' supplement.

These funds are broadly intended to provide critical resources to state, local, and territorial health departments in support of a broad range of healthcare infection prevention and control (IPC) activities and epidemiologic surveillance related activities to detect, monitor, mitigate, and prevent the spread of SARS-CoV-2/COVID-19 in healthcare settings. These funds may also reasonably address other conditions in healthcare settings, such as healthcare associated infections (HAIs) and antimicrobial resistance (AR), which rely upon the same fundamental IPC and epidemiologic surveillance approaches that are used to detect, monitor, mitigate, and prevent the spread of SARS-CoV-2/COVID-19 in healthcare settings. Moreover, the prevention of AR pathogens and improving the appropriate use of antibiotics helps to protect COVID patients from complications and potential comorbidities. Recipients of this funding are limited to the existing 64 ELC recipients under CK19-1904. These resources should complement, not duplicate, existing funding provided to recipients under prior awards, including the *ELC CARES*, *ELC Enhancing Detection*, and *ELC Enhancing Detection Expansion* supplements, the *ELC Firstline IPC Training* supplement, and the *ELC Long-Term Care Facility Strike Team and Infrastructure* supplement. Additionally, recipients should leverage and build upon existing ELC infrastructure that emphasizes the coordination and critical integration of laboratory with epidemiology and health information systems in order to maximize the public health impact of available resources.

Ongoing monitoring of milestones and performance measures will be utilized to gauge progress toward successful completion of priority activities supported with these funds. Resources provided via this award mechanism should support necessary expenses to strengthen HAI/AR Programs and related public health infrastructure in a manner that ensures adequate resources are made available in an equitable fashion according to CDC priorities and the purposes of the funding, including but not limited to: timely and effective response to COVID-19 and other HAI/AR outbreaks; expanded laboratory capacity for early detection of and rapid response to drug-resistant pathogens; enhanced use of the National Healthcare Safety Network (NHSN) to augment surveillance and provide data for action; and improved infection control capacity and practices, implementation of antibiotic stewardship core elements, information sharing, and coordinated data-driven prevention efforts in all healthcare settings.

## FUNDING STRATEGY

The \$385 million, under the *Strengthening HAI/AR Program Capacity* supplement, will be awarded to the current 64 ELC recipients according to the factors below to address each recipient's projected needs in terms of epidemiology and laboratory support.

- A base award (i.e., \$86,340,000) consists of \$1.5 million for the 50 states, Puerto Rico, and six large local health departments (n=57); the base is \$120,000 for the remaining territorial jurisdictions (n=7).

## STRENGTHENING HAI/AR PROGRAM CAPACITY

- For recipients that serve as sites for AR Lab Network regional labs (n=7), \$10 million divided by regional population.
- The remaining funds (i.e., \$288,660,000) applied by the number of Centers for Medicare & Medicaid Services (CMS)-certified hospital, nursing home and dialysis facilities, and the proportion of U.S. population (n=64).

Financial expenditures will be monitored and assessed with recipients monthly.

### ALLOWABLE COSTS

Recipients should consider requesting the following when developing the *Strengthening HAI/AR Program Capacity* budgets.

1. Personnel (term, temporary, students, overtime, contract staff, etc.).
2. Laboratory equipment used for COVID-19 testing and necessary maintenance contracts.
3. Collection supplies, test kits, reagents, consumables, and other necessary supplies for existing or new screening testing or onboarding new platforms to support testing.
4. Personal Protective Equipment (PPE) (e.g., masks, gloves, gowns) for those collecting samples and/or conducting testing.
5. Courier service contracts (new or expansion of existing agreements).
6. Service contracts for provision of end-to-end services such as tests, collection, and reporting.
7. Hardware and software necessary for reporting to public health and communication and coordination of follow up on any positive cases detected.
8. Tools that assist in the rapid identification, electronic reporting, monitoring, analysis, and evaluation of control measures to reduce the spread of COVID-19, that may be translatable to other diseases (e.g., GIS software, visualization dashboards, cloud services).
9. Contracts with academic institutions, private laboratories, other non-commercial healthcare entities, and/or commercial entities that may provide all or part of the testing needs.
10. Software or systems to assist with laboratory resource management (e.g., software for inventory management, temperature notifications, etc.), quality management, biosafety, or training needs.
11. Expenses associated with outreach and assistance (e.g., support provided through education leaders, community-based organizations).
12. Direct financial support to facilities and/or local health departments to support activities described in this guidance.

The above list covers the anticipated, most relevant costs associated with achieving the activities in this guidance. This list does not represent a full list of allowable costs. Recipients are referred to the cost principles regulation found at [45 CFR Part 75 Subpart E – Cost Principles](#).

In determining if costs are allowable, consideration must be given to applicable regulations; the overall underlying cooperative agreement (CK19-1904); be considered necessary and reasonable; and be considered allocable (see: 45 [CFR 75.403](#)). Any questions about specific budget items should be directed to the OGS and the ELC Project Officer.

### COVID-19 TERMS AND CONDITIONS

**Coronavirus Disease 2019 (COVID-19) Funds:** A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the “CARES Act”) (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-

139); the Consolidated Appropriations Act and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 (P.L. 116-260) and/or the American Rescue Plan of 2021 (P.L. 117-2) agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation.

In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: <https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>.

Further, consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the recipient is expected to provide to CDC copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.

This award is contingent upon agreement by the recipient to comply with existing and future guidance from the HHS Secretary regarding control of the spread of COVID-19. In addition, recipient is expected to flow down these terms to any subaward, to the extent applicable to activities set out in such subaward.

To achieve the public health objectives of ensuring the health, safety, and welfare of all Americans, Recipient must distribute or administer vaccine without discriminating on non-public-health grounds within a prioritized group.

**Acknowledgement of Federal Funding:** When issuing statements, press releases, publications, requests for proposal, bid solicitations and other documents --such as toolkits, resource guides, websites, and presentations (hereafter "statements") --describing the projects or programs funded in whole or in part with U.S. Department of Health and Human Services (HHS) federal funds, the recipient must clearly state:

1. The percentage and dollar amount of the total costs of the program or project funded with federal money; and,
2. The percentage and dollar amount of the total costs of the project or program funded by non-governmental sources.

When issuing statements resulting from activities supported by HHS financial assistance, the recipient entity must include an acknowledgement of federal assistance using one of the following or a similar statement.

**If the HHS Grant or Cooperative Agreement is NOT funded with other non-governmental sources:**

This [project/publication/program/website, etc.] [is/was] supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$XX with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

The HHS Grant or Cooperative Agreement IS partially funded with other nongovernmental sources:

This [project/publication/program/website, etc.] [is/was] supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$XX with XX percentage funded by CDC/HHS and \$XX amount and XX percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

The federal award total must reflect total costs (direct and indirect) for all authorized funds (including supplements and carryover) for the total competitive segment up to the time of the public statement.

Any amendments by the recipient to the acknowledgement statement must be coordinated with the HHS Awarding Agency.

If the recipient plans to issue a press release concerning the outcome of activities supported by HHS financial assistance, it should notify the HHS Awarding Agency in advance to allow for coordination.

### Termination

This award may be terminated in whole or in part consistent with 45 CFR 75.372.

CDC may impose other enforcement actions in accordance with 45 CFR 75.371- Remedies for Noncompliance, as appropriate.

## PROCESS FOR WORKPLAN AND BUDGET SUBMISSION

Within five (5) business days of receipt of this guidance, the recipient's Authorized Official is required to acknowledge receipt of this guidance by submitting a Grant Note in GrantSolutions. The acknowledgement must be submitted on the recipient's official agency letterhead and utilize the 'Acknowledgement Letter for CK19-1904 – COVID Supplemental Funds' template provided at the end of this guidance document.

This funding will be awarded in the ELC Budget Period 3 (BP3) (i.e., August 1, 2021 – July 31, 2022) under CK19-1904. However, recipients should note that this supplemental funding is intended to support activities through BP5, which ends on July 31, 2024. Therefore, workplans and revised budgets should reflect activities and associated costs that will end on July 31, 2024.

Within 90 days of receipt of the Notice of Award (NOA), the recipient is required to submit a workplan and revised budget describing its proposed activities. Upon submission, budgets and workplans will be reviewed by CDC and feedback will be provided and discussed with the recipient. Any necessary or recommended changes must be agreed upon between the recipient and CDC and documented in REDCap; and any agreed upon changes must be captured in GrantSolutions, the system of record.

Additional workplan guidance will be provided to recipients post-award; they will be required to provide a clear and concise description of the time-bound strategies and activities they will use to achieve the project's outcomes.

To appropriately document workplans, budgets, and facilitate recipients meeting the 90-day requirement:

1. Workplan entries will be completed in the *Strengthening HAI/AR Program Capacity* page, under the 'DHQP: Strike Team & Strengthening HAI/AR Program Capacity Awards' portal, in REDCap; and
2. Revised budgets must be completed by using the Excel budget workbook template provided via GrantSolutions Grant Notes at time of NOA issuance. **Note:** If a recipient does not meet the 90-day submission requirement and has

not received written approval for an extension from CDC, then the Payment Management System (PMS) account associated with this award may be restricted. The restriction will result in a manual drawdown process that requires CDC approval of each PMS charge. This restriction will remain in effect until the recipient satisfactorily meets the workplan and budget submission requirement.

- a. Funds will be awarded under the 'Other' cost category and will be accessible in the Payment Management System (PMS) during the 90-day budget revision period for use in accomplishing activities outlined in this guidance;
  - b. Recipients will adjust the cost category allocations of awarded funds to reflect the areas where financial assistance is needed;
  - c. Recipients will upload the revised budget into GrantSolutions via a budget revision amendment, with a courtesy copy into REDCap *Strengthening HAI/AR Program Capacity* page of the 'DHQP: Strike Team & Strengthening HAI/AR Program Capacity Awards' portal, by the 90-day post award deadline; and
  - d. The ELC Project Officer and OGS will process the budget revision amendment in GrantSolutions, and the recipient will receive a revised NOA reflecting the requested cost category allocations.
3. A letter, indicating that all ELC Governance Team members (i.e., Project Director, Epidemiology Lead, Laboratory Lead, Health Information Systems Lead, Financial Lead, and HAI/AR Program Lead) have both contributed to and agreed upon the workplan and revised budget submitted, must be signed by all Governance Team Members (hard copy or digital signature), and submitted with the documents in the REDCap portal.

#### **GrantSolutions**

**Within 90 days of receipt of the NOA**, the recipient is required to submit a '**Budget Revision Amendment**' as part of the recipient's current award (CK19-1904), Budget Period 3.

The 'budget revision amendment' must consist of the following documents:

- 1. Budget Information: SF-424A**
  - a. Recipient can use the form generated by the ELC budget workbook;
  - b. Or, recipient can submit a PDF of this form.
  - c. Please do not use the **e-form in GrantSolutions** as it creates issues when processing the revised NOA.
- 2. Cover Letter** signed by the Authorized Official of record in GrantSolutions.
- 3. Completed revised budget** using the ELC budget workbook that was provided in GrantSolutions as a Grant Note.

**Note:** In a cooperative agreement, CDC staff is substantially involved in the program activities, above and beyond routine grant monitoring.

CDC responsibilities include but are not limited to:

1. Provide ongoing guidance, programmatic support (including guidance on evaluation, performance measurement, and workplan changes), technical assistance and subject matter expertise to the activities outlined in this supplemental funding announcement guidance.
2. Convene trainings, meetings, conference calls, and site visits with recipients.
3. Share best practices identified and provide national coordination of activities, where appropriate.

#### **REQUIRED TASKS**

**Note:** If a recipient does not meet the below required tasks and has not received written approval for an extension from CDC, recipient may have their funds restricted in the Payment Management System (PMS) for specific costs/activities. Recurring or repeat non-compliance may result in additional restrictions or other actions being taken, consistent with applicable grant regulations.

In addition to the programmatic activities noted below in further detail, recipient responsibilities include but are not limited to:

1. Within **five (5) business days** of receipt of this guidance the Authorized Official is required to acknowledge receipt of this guidance by submitting a Grant Note in GrantSolutions. The acknowledgement must be submitted on the recipient's official agency letterhead and utilize the 'Acknowledgement Letter for CK19-1904 – COVID Supplemental Funds' template provided at the end of this guidance document.
2. Regular participation in calls with CDC/HHS for technical assistance and monitoring of activities supported through this cooperative agreement.
3. On-time submission of all requisite reporting. This may include but is not limited to reporting of performance measures, progress on milestones, and/or financial updates within REDCap.
4. Report expenditures and unliquidated obligations (ULOs) on a monthly basis. On the 5<sup>th</sup> day of the month, the expenditures and ULOs from the prior month shall be reported in the REDCap *Strengthening HAI/AR Program Capacity* page.
5. Documentation of any necessary budget change/reallocation through GrantSolutions and REDCap.

## ACTIVITIES

### Overview

This supplement includes activities intended to further strengthen and expand (not duplicate) HAI/AR Programs funded through ELC (Program G1, G2, COVID-19 Supplements), including activities in 5 project areas:

[Project I. HAI/AR Program Network for Prevention and Response](#)

[Project II. Antibiotic Resistance Laboratory Network \(AR Lab Network\)](#)

[Project III. Antibiotic Stewardship](#)

[Project IV. Enhancing Use of NHSN](#)

[Project V. Project Firstline](#)

Each project area has a list of programmatic workplan activities supported by these funds and includes activities that are required to be addressed by the recipient, and other activities that are optional. This award has 27 required activities across the 5 project areas.

While the management and operations of each project and the overall supplement should be determined by the recipient, all project areas should, at a minimum, be managed in a manner that is collaborative and well-coordinated. As part of the **required** progress report, recipients will be asked to report, at the end of the period of performance, on the structures and processes established to promote coordination and collaboration among the 5 project areas.

### **Administration Considerations:**

The ELC Program Office and CDC's Division of Healthcare Quality Promotion (DHQP) strongly recommend that recipients ensure HAI/AR leadership staff at the recipient level are adequate for the management of this award and its integration with the recipient's overall portfolio of ELC funded activities. Depending on the recipient's current capacity for managing both existing ELC and COVID-19 funds, and the funds associated with this award, the recipient, consistent with its own policies and procedures, may identify a new HAI/AR Program Director or Deputy Director and additional full-time or part-time administrative, budget, or management program support positions to achieve the necessary monitoring and management requirements.



**Health Equity Considerations:**

Recipients are encouraged to identify, address, and monitor HAI/AR-related and COVID-19 related health disparities and health equity considerations in implementing required and optional activities, prioritizing activities and approaches that will advance health equity, and partnering with local health departments and organizations representing or serving disproportionately affected populations or underserved areas. A focus on addressing disparities and inequities should be intentionally incorporated into implementation of the strategies below.

**Partnership Considerations:**

Recipients are encouraged to increase communication and collaboration between public and private sector partners to form and expand networks across state and local levels. Collaborative engagement with partners can be facilitated by using the [CDC's Success Framework for HAI/AR Partner Networks](#). CDC technical assistance is available to support recipients' use of the Success Framework.

Recipients are encouraged to engage with local health departments (LHDs), where applicable, to build local capacity in HAI/AR and to expand HAI/AR infection prevention, control, COVID-19, and outbreak response activities. Support may take many forms, such as staff assigned to regions within the jurisdiction, staff assigned to multiple local health departments, direct funding to LHDs, some other arrangement (e.g., academic partner), or a combination of approaches. Regardless of the approach taken, recipients should establish clearly defined workforce roles, responsibilities, expectations, and oversight of HAI/AR activities and program priorities to assure the quality of services provided across the jurisdiction.

**Project I: HAI/AR Program Network for Prevention and Response**

Project I (P.I) aims to strengthen and expand public health capacity to prevent, detect, and respond to the threat of SARS-CoV-2/COVID-19 transmission in healthcare settings nationwide. The same fundamental activities used to prevent, detect, and respond to the threat of SARS-CoV-2/COVID-19 transmission in healthcare settings will also address the threat of other pathogens transmitted in healthcare settings, such as HAI and AR threats. The Project I guidance is organized around 4 strategies: A) strengthening existing HAI/AR Program infrastructure, B) enhancing multidrug-resistant organism (MDRO) prevention activities, C) supporting the HAI/AR response workforce, and D) implementing targeted HAI/AR prevention projects. Note that while activities related to long-term care (LTC) prevention and response activities are an essential part of HAI/AR Programs, these are primarily supported through core ELC (G1) and the ELC supplement, *Nursing Home & Long-term Care Facility Strike Team and Infrastructure Project*, and are not described in the following Project I guidance in a detailed manner.

**P.I Strategy A:** Building on existing HAI/AR Programs supported through core ELC (G1), Project I will help establish a national HAI/AR Program Network to sustain and expand existing capacity for epidemiology and infection prevention and control activities; effectively prevent, detect, and respond to SARS-CoV-2/COVID-19 and other HAI and AR threats in healthcare settings nationwide; and provide increased opportunities for support, coordination, and collaboration across programs.

1. **P.I Activity A1 (Required):** Recipients should specify their preferred HAI/AR Program designation (Core, Enhanced, Focal Point) within their workplan along with a brief rationale for selection. Details on each designation are provided below. Note that program designations can change over time as capacity and needs change and will not affect opportunities for future funding.
  - a. **Core HAI/AR Programs:** This designation is appropriate for HAI/AR Programs interested in focusing on strengthening and improving foundational HAI/AR response and prevention activities, including those required as part of their core G1 funding and the other COVID-19 supplements. Core HAI/AR Programs will focus on building the essential response and prevention activities to ensure that programs have a

strong foundation for future growth. Core HAI/AR Programs can pursue “optional” activities within Project I if they are priorities for the jurisdiction; however, required activities should be the primary focus.

- b. **Enhanced HAI/AR Programs:** This designation is appropriate for HAI/AR Programs interested in expanding beyond foundational HAI/AR response and prevention activities, assisting with development and piloting of new approaches and initiatives, or engaging in multijurisdictional projects. In addition to required activities, Enhanced HAI/AR Programs will focus on establishing a portfolio of enhanced response and prevention activities tailored to their jurisdiction. ***Enhanced HAI/AR Programs will pursue at least 3 optional activities from Project I, Strategies A–D.*** HAI/AR Programs that conduct high volumes of HAI/AR responses (including those involving novel or targeted MDROs), those engaged in large or complex prevention projects (e.g., G1 Tier 2 prevention projects), or who have historically served as a mentor to other HAI/AR Programs are strongly encouraged to consider this designation.
  - c. **HAI/AR Focal Points:** This designation is an option for recipients without an established HAI/AR Program (U.S. Affiliates and Territories). CDC will collaborate with these recipients to customize goals and priorities.
2. **P.I Activity A2 (Required):** Sustain and implement activities focused on workforce development and program strengthening. The sub-activities provide additional guidance to clarify the intent of activity.
- a. Identify or offer training and education opportunities for the public health workforce responsible for contributing to HAI/AR response and prevention activities at the state or local level. This workforce development should be complementary to *Project Firstline* activities. Options include, but are not limited to:
    - i. Facilitate participation in scheduled webinars and events (e.g., monthly AR containment webinar, Council of State and Territorial Epidemiologists (CSTE) HAI Subcommittee, and CDC-supported Communities of Practice) and with professional organizations that provide training and networking opportunities
    - ii. Provide access to formal training and certification in infection control
    - iii. Management and leadership training for HAI/AR staff who are new to these roles
    - iv. Utilize paid internships or fellowships within the HAI/AR Program
  - b. Identify opportunities to strengthen HAI/AR Program through partnerships and communicate the value of HAI/AR Programs to leadership and partners. Collaborative engagement with partners can be facilitated by using the [CDC’s Success Framework for HAI/AR Partner Networks](#). Options include, but are not limited to:
    - i. Engage in activities to help leadership or partners understand of the value of HAI/AR Programs, the benefit of expanding role/reach of new staff beyond COVID-19, and the importance of sustaining new positions after COVID-19 (e.g., building a business case)
    - ii. Contract or collaborate with external partners, including academic institutions and local chapters of professional societies
3. **P.I Activity A3 (Required):** Ensure that HAI/AR response and prevention expertise is widely and rapidly available to provide support across the entirety of the jurisdiction (i.e., at regional or local levels). The bulleted sub-activities provide additional guidance to clarify the intent of activity.
- a. At minimum, regionally or locally available HAI/AR expertise should include: (1) ability to perform onsite infection control assessments and provide onsite (or remote where appropriate) assistance until gaps have been addressed, and (2) specialized knowledge and skills to evaluate transmission risks and provide effective initial consultation with healthcare facilities to address MDROs, suspected outbreaks or infection control breaches.
  - b. Workforce might take the form of IPC, epidemiology, or other roles assigned to regions within the state (using existing organizational structures or based on jurisdiction need) and consideration for staff placed within a region to coordinate HAI/AR activities in that region), funded within LHDs, or some other

arrangements such as a partnership with academic institutions. This might also take the form of workforce (LHD or other) dedicated to underserved populations or facilities, from a health equity lens.

- c. Develop or reinforce mechanisms that enhance oversight, communication, and provision of direct technical assistance, training, and education across the jurisdiction.
  - d. Establish clearly defined workforce roles, responsibilities, and expectations for HAI/AR activities and program priorities across the jurisdiction as the workforce expands.
4. **P.I Activity A4 (Optional):** Participate in an HAI/AR Program Analytics & Evaluation Collaborative. In coordination with CDC, participating recipients will evaluate the effectiveness of HAI/AR prevention and response strategies. The bulleted items provide additional guidance to clarify the intent of this activity.
- a. CDC will convene this collaborative with participating recipients to develop priorities and implement selected evaluation priorities (e.g., evaluating the impact of HAI/AR Programs in nursing homes during the COVID-19 response).
  - b. Participating recipients will meet regularly (e.g., monthly) and take part in a minimum of 2 collaborative evaluation projects annually, which may include collecting and sharing standardized data. Participating recipients will also be encouraged to conduct additional evaluations of a prevention or response activity within their jurisdiction and share the findings with other sites through presentation, publication, or some other means.
  - c. Participating recipients may be called on to provide individual input on CDC performance measure development and evaluation efforts.
  - d. All recipients are eligible and should commit to participation for the full period of performance.
5. **P.I Activity A5 (Optional):** HAI/AR Outbreak Reporting System Pilot. In coordination with CDC, participating sites will routinely submit response data for MDRO and other HAI/AR response activities in an ongoing, prospective manner. Data elements in this pilot will mirror those requested as part of G1 performance measures, but frequency, timing, and mechanisms of reporting will be determined in coordination with the participating sites. At a minimum this will include initial and final submission of response activities, interim updates for prolonged responses, and data closeout activities. This pilot will provide insights into the information technology and systems needed to efficiently extract and transmit the data, and the feasibility of reporting, linking and harmonizing data sources (e.g., AR Lab Network, public health surveillance). Note that participating HAI/AR Programs will not have to enter data twice to fulfill performance measure requirements; CDC will import relevant data into the performance measure REDCap project.

**P.I Strategy B: Implement an intervention for prevention of novel and targeted multidrug-resistant organisms (MDROs).** A MDRO Prevention Strategy for novel (e.g., not previously identified in the United States) and targeted (e.g., carbapenemase-producing CRE, CRAB, or CRPA; or *C. auris*) MDROs is a cohesive and comprehensive approach, coordinated by public health, to prevent the spread of these organisms among a group of healthcare facilities in a geographic area (e.g., ELC recipient or region within the ELC recipient’s jurisdiction) or patient sharing network. The MDRO Prevention Strategy can cover an entire ELC recipient’s jurisdiction, a region within an ELC-funded recipient’s jurisdiction, or a cross-jurisdictional geographic area or network of healthcare facilities. For the latter, each participating recipient should describe activities complementary to other recipients they plan to work with.

1. **P.I Activity B1 (Required):** Conduct a needs assessment (CDC will provide a guide) for novel and targeted MDRO prevention activities and submit to CDC within 9 months of receipt of the needs assessment guide. This activity should assess state/local public health capacity, including facility-level considerations and laboratory and training needs, to implement novel and targeted MDRO prevention strategies.
2. **P.I Activity B2 (Required):** Develop and implement a written MDRO Prevention Workplan, using the needs assessment, and submit to CDC within 12 months of receipt of the needs assessment guide. This plan is distinct from the AR Containment plan that is currently required under the base G1 funding. MDRO Prevention Workplans (CDC will provide a template) should address **all** of the sub-activities.

- a. Proactive infection control assessments with observations of practice (e.g., ICAR) at high acuity post-acute care facilities (e.g., vSNF, LTACH) or other facilities determined by local epidemiology.
  - b. Follow-up assessments at facilities, prioritizing those with critical IPC gaps identified.
  - c. Establish or enhance local capacity and collaboration through:
    - i. Education, training, grants, or contracts.
    - ii. Facilitating improvements in communication practices between and among healthcare facilities and health departments (e.g., regional meetings, identification of Prevention Champions in healthcare facilities, development or enhancement of an AR information exchange/patient registry).
  - d. Facilitate connections with clinical laboratories to determine capacity to detect novel or targeted MDROs among clinical isolates and enhance reporting and isolate forwarding (where capacity allows) to the appropriate public health laboratory (PHL) for further characterization.
3. **P.I Activity B3 (Optional):** Establish an Enhanced MDRO Prevention Program. If including this activity in the workplan, address **all** of the sub-activities.
- a. Conduct intermittent, proactive point prevalence surveys at high acuity post-acute care facilities (e.g., vSNF, LTACH) or other facilities determined by local epidemiology.
  - b. Participate in a CDC-led Novel and Targeted MDRO Prevention Community of Practice.
  - c. Designate a MDRO Prevention Epidemiologist to work closely with laboratories, healthcare facilities, and other partners to develop, implement, monitor, and evaluate the MDRO Prevention Workplan.
  - d. Designate a MDRO Prevention Coordinator to work closely with healthcare facilities and public health laboratories to coordinate onsite visits and colonization screening sample submission and testing.
  - e. Develop and monitor process and outcome measures for the prevention intervention, beyond those describing required activities.
4. **P.I Activity B4 (Optional):** Evaluate novel and innovative strategies to monitor emergence and spread of novel and targeted MDROs. Describe plans to implement and evaluate **one or both** of the following.
- a. Evaluate correlation between National Wastewater Surveillance System community-level wastewater surveillance and/or facility-level (e.g., LTACH, SNF) wastewater surveillance for novel and targeted MDROs with case surveillance collected over the same space and time.
  - b. Assess feasibility of pooling colonization screening swabs from multiple patients to improve efficiency of screening.
5. **P.I Activity B5 (Optional):** Support multi-jurisdictional epidemiologic investigations to describe the epidemiology of novel and targeted MDROs in collaboration with CDC. If including this activity in the workplan, address **both** of the sub-activities.
- a. Collect and report epidemiologic data (e.g., location of specimen collection, patient risk factors, patient outcomes) for carbapenemase case investigations to CDC. CDC will work with interested recipients to determine reported elements and mechanisms of reporting.
  - b. Provide information on the health informatics systems needed to efficiently extract and transmit these data to CDC.

**P.I Strategy C: Expand and strengthen HAI response activities.**

1. **P.I Activity C1 (Required):** Establish a dedicated (e.g., full-time) HAI Outbreak Lead dedicated to coordinating and overseeing response to HAI (non-AR/MDRO) outbreaks including, but not limited to:
- a. Initial consultation with healthcare facility with suspected outbreak or infection control breach.
  - b. Focused onsite IPC assessment.
  - c. Environmental sampling as indicated.
  - d. Coordination with public health laboratory (PHL) for testing/typing of clinical and environmental specimens/isolates as indicated.
  - e. Assisting healthcare facility/provider with or conducting patient notification as indicated.

- f. Coordinating patient testing as part of patient notification as indicated.
  - g. Tracking all outbreak and infection control breach investigations in response tracking system.
  - h. Collaborating with regional/LHD staff.
  - i. Engaging with regional FDA office for medical product investigations as indicated.
  - j. Engaging with CDC (on medical product investigations or multi-jurisdictional outbreaks, at minimum).
2. **P.I Activity C2 (Required):** Ensure staff are adequately trained in HAI outbreak response. This may include review of The Council for Outbreak Response: HAI and AR Pathogens (CORHA) materials and participation in SHEA Outbreak Training Course, CDC HAI Outbreak Course (under development) or similar educational opportunities.
  3. **P.I Activity C3 (Optional):** Improve capacity for HAI outbreak response through activities such as those listed in the following sub-activities.
    - a. Participation of regional/LHD in remote consultations and focused onsite IPC assessments.
    - b. Providing HAI outbreak presentations to regional/LHD staff (e.g., didactic sessions, tabletop exercises).
    - c. Ensure adequate materials, supplies and expertise to conduct environmental sampling or help train staff on appropriate IPC practices.

#### **P.I Strategy D: Strengthening HAI/AR prevention activities in healthcare settings**

1. **P.I Activity D1 (Required):** Ensure capacity to assess and improve support for HAI/AR prevention in outpatient hemodialysis practices. *At minimum*, address sub-activities 'a' through 'f' in the workplan.
  - a. In line with P.I Activity A3, ensure that the HAI/AR Program has dialysis-specific expertise available.
  - b. Establish and maintain active relations with CMS-funded End Stage Renal Disease (ESRD) Network.
  - c. Improve IPC capacity and competency within outpatient hemodialysis facilities through education, prevention practices improvements, surveillance, outbreak reporting, and outbreak monitoring.
  - d. Use available data (e.g., NHSN data, survey data, and/or other facility characteristics) to target outpatient hemodialysis facilities for infection prevention assessments and response (ICAR).
  - e. Join and actively participate in CDC's Making Dialysis Safer (MDS) for Patients Coalition.
  - f. Perform landscape analysis of locations where outpatient dialysis services are being provided with a particular focus on home dialysis (including dialysis that occurs in nursing homes).
2. **P.I Activity D2 (Optional):** Enhance capacity to assess and improve support for HAI/AR prevention (for protection of patients or healthcare workers) in one or more of the following: acute care (short stay) hospitals, critical access hospitals, psychiatric hospitals, home health, emergency medical services, dental facilities, federally qualified health centers, urgent care facilities, or other setting(s). This activity can include HAI prevention workgroups that include representation of local facilities in a variety of settings or service lines within settings (e.g., acute care, surgical care, neonatal intensive care, long-term care, ambulatory surgery, rehabilitation). Workplans should describe the setting type(s), rationale, and description of proposed activities.
3. **P.I Activity D3 (Optional):** Implement a targeted prevention project or collaborative addressing: (a) MRSA bloodstream infections (BSI), (b) CDI, or (c) device- or procedure-associated infections (CAUTI, CLABSI, dialysis BSI, or surgical site infection). Workplans should specify selected HAI, setting(s), number of facilities (minimum expectation is typically 10 facilities), rationale, roles/responsibilities, reduction goals, interventions including TAP Strategy or other IPC assessment (e.g., ICAR), and process, progress, and outcome measurements.
4. **P.I Activity D4 (Optional):** Promote injection safety and basic infection control. Workplans should address: (a) collaboration between the HAI/AR Program, members of the state HAI advisory committee, and partners such as health care provider professional associations, the state survey agency, medical/nursing schools, professional boards, insurance providers, and liability carriers; and (b) leveraging currently available materials/tools relating to injection safety, which may include point of care testing, insulin administration, drug diversion and basic infection control or address specific outpatient settings (e.g., pain, orthopedics, podiatry, dental, oncology).
5. **P.I Activity D5 (Optional):** In addition to embedding a focus on equity and disparities in work as noted above in the Overview, develop one or more HAI/AR prevention projects focused specifically on health equity. Prevention

projects can include activities to better understand health disparities and health equity through collection, analysis, and reporting of data, paired with targeted prevention or response interventions to improve reach and benefit the population(s) or setting(s) identified as disproportionately affected or historically underserved. CDC will convene a Community of Practice to help identify approaches, challenges, lessons learned and best practices.

6. **P.I Activity D6 (Optional):** CDC will pilot a process and template for developing a HAI/AR strategic plan with interested recipients. CDC will provide assistance and support. The plans will define goals, objectives and strategies of programs; define organizational components and their roles and responsibilities; and network partners and their roles, including local public health departments where appropriate.

**Note:** Recipients not previously funded for all core ELC G1 activities (AS, FM, GU, MH, MP, PW, VI) are only required to conduct 2 of the 8 required activities from P.I Activity A through D. CDC will collaborate with these recipients to customize goals and priorities.

## **Project II: Antibiotic Resistance Laboratory Network (AR Lab Network)**

Project II (P.II) aims to use the existing structure of the AR Lab Network to expand laboratory capacity for early detection of drug-resistant pathogens and public health infrastructure for rapid response to stop transmission, which are critical components of effective strategies for preventing the spread of AR in the context of COVID-19. Project II guidance is divided into two sections according to current funding status under ELC G2. Recipients currently funded as AR Lab Network labs under G2 should write to the activities listed under Group A. Recipients currently funded as AR Lab Network Regional Laboratories should additionally write to the activities listed under Group B.

### **Group A: Current AR Lab Network labs (56 recipients)**

1. **P.II Activity A1 (Required):** Increase laboratory capacity to perform tier 1 CLIA-compliant organism identification, carbapenemase production testing, carbapenem-resistance mechanism testing, and routine confirmatory antimicrobial susceptibility testing (AST) on CRE/CRPA, as recommended by CDC. This includes **one or more** of the sub-activities.
  - a. Expanding CRE genera tested.
  - b. Applying the full AR Lab Network testing directory to every eligible isolate received.
  - c. Recruiting additional facilities to submit CRE/CRPA isolates.
2. **P.II Activity A2 (Required):** Increase laboratory capacity to perform CLIA-compliant organism identification, AST and molecular characterization of carbapenem-resistant *Acinetobacter baumannii* (CRAB). Facilitate connections with clinical laboratories in the state or jurisdiction to solicit submission of CRAB isolates for this activity.
3. **P.II Activity A3 (Required):** Identify a dedicated AR Coordinator to work with laboratory staff (including the AR Lab Expert), state or local HAI/AR epidemiologists, healthcare facilities, and the regional laboratory to recruit and coordinate sample submissions and testing, and facilitate the communication of data for containment and prevention activities, using elements and guidance provided by CDC. The AR Coordinator will also support clinical lab outreach for AR Lab Network activities.
4. **P.II Activity A4 (Required):** Advance electronic information exchange implementation. Address **all** of the sub-activities in the workplan.
  - a. Identify a dedicated AR Informatics Expert to ensure IT infrastructure for timely reporting to submitting facilities, state or local public health laboratories, epidemiologists, regional AR prevention partners, and CDC for all funded AR testing. This includes:
    - Implementing or improving LIMS systems in the jurisdiction lab to connect instruments to electronic databases.

- Ensuring adequate infrastructure for electronic reporting of test results to state and local HAI/AR Programs, submitters, and CDC.
  - b. Work with APHL to implement or sustain reporting using APHL Informatics Messaging Services (AIMS) platform and Lab Web Portal version 2 or higher for applicable testing. Timely reporting will include sharing results in acceptable manner as well as addressing special “alert” notification needs.
  - c. Work towards transitioning to HL7 messaging to CDC for all AR Lab Network Testing.
- 5. **P.II Activity A5 (Optional):** Provide laboratory support for state-led epidemiologic investigations and HAI/AR prevention efforts focused on screening for targeted AR threats (e.g., carbapenemase-producing organisms [CPOs], pan-resistant organisms) by performing CDC-recommended assay(s), including molecular tests to detect colonization with CPOs. Regional labs may use funding to expand capacity for this testing. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Work with state/local epidemiologists or HAI/AR Programs to facilitate collection and transportation of specimens for colonization testing to ensure timely testing of specimens.
  - b. Provide advice to healthcare facilities and personnel on the collection and transportation of specimens.
  - c. Test and report results to the jurisdictional public health department and submitting healthcare facility within two working days of specimen receipt.
  - d. Submit colonization testing data to CDC, via AIMS, at least monthly; submit reports of positive screening results as alerts within 1 day.
- 6. **P.II Activity A6 (Optional):** Perform whole-genome sequencing (WGS) for HAI/AR pathogens to support national AR containment priorities in the region. In coordination with CDC, laboratories will support AR Lab Network priorities and epidemiologic investigations in state or jurisdiction. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Demonstrate sequencing capacity in adherence with CDC guidance for minimum quality requirements.
  - b. Describe a plan to use bioinformatics tools to perform quality assessment and analyze sequence data.
  - c. Implement WGS for HAI/AR pathogens in adherence with CDC guidance for priorities.
  - d. Enhance computing/data management capacity by implementing LIMS for sequencing systems and/or utilizing cloud computing or a local server to supplement sequencing activities.
  - e. Submit sequencing data to National Center for Biotechnology Information (NCBI) for public posting and report sequencing IDs (per CDC guidance) and AR Lab Network isolate IDs to CDC.
- 7. **P.II Activity A7 (Optional):** Implement laboratory capacity to perform *C. auris* colonization testing to support surveillance activities and outbreak investigations occurring within the state or local jurisdiction in the context of COVID-19. Regional labs may use funding to expand capacity for this testing. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Coordinate with state or local HAI/AR Program to transport collection swabs to healthcare facilities where swabbing for colonization testing will take place.
  - b. Provide advice to healthcare facility laboratories on the collection and transportation of specimens.
  - c. Test and report results to the jurisdictional public health department and submitting healthcare facility in timeframe consistent with CDC guidance.
  - d. Submit colonization testing data to CDC, via AIMS, at least monthly.
- 8. **P.II Activity A8 (Optional):** Establish laboratory capacity for *N. gonorrhoeae* gradient strip AST using to monitor cases of concern (e.g., suspected treatment failures), cases with prevalent susceptibility and to expand the potential to capture emerging resistance. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Implement CLIA compliant procedures to recover GC isolates from genital and extragenital specimens (including pharyngeal specimens) and conduct Etest for azithromycin, ceftriaxone, cefixime on GC isolates recovered from these specimens in accordance with CDC guidance.
  - b. Provide specimen collection and/or transport materials to submitters and provide training to submitters for initial culture of *N. gonorrhoeae* based on the acceptable specimen types in their validated SOPs.

- c. Enroll in the semi-annual Proficiency Test program provided by the Wisconsin State Laboratory of Hygiene (WSLH).
- d. Send Etest AST results back to submitters with a turn-around-time of 7 to 10 days. Submit alert data to CDC within 48 hours and submit summary data to CDC quarterly.
- e. If concerning resistance is identified, conduct whole genome sequencing and molecular investigations of identified strains (optional) or send isolate to CDC or regional AR Laboratory.

#### Group B: AR Lab Network Regional Laboratories (7 jurisdictions)

1. **P.II Activity B1 (Required):** Implement reference AST to new **antifungal** agents and for an expanded panel of antibiotics as part of the Expanded Drug Antimicrobial Susceptibility Testing (ExAST) Program. Labs will work with CDC to identify drugs and methods for inclusion in testing and in accordance with guidance provided by CDC.
2. **P.II Activity B2 (Required):** Expand capacity to perform WGS and bioinformatic analyses for *C. auris* isolates, in accordance with CDC guidance, to identify new introductions and characterize transmission as a part of local and epidemiological investigations. Address **all** of the sub-activities in the workplan.
  - a. Labs will post raw sequence data to NCBI within timelines established by CDC.
  - b. Labs will provide support for onboarding of non-regional laboratories for *C. auris* WGS and bioinformatics analysis as needed.
3. **P.II Activity B3 (Optional):** Conduct molecular detection of FKS gene, in *C. auris*, as a determinant of echinocandin resistance, in conjunction with ongoing AFST. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Validation of a single molecular assay in accordance with CDC guidance.
  - b. Submit data to CDC alongside AFST data, via AIMS, at least monthly.
4. **P.II Activity B4 (Optional):** Regional laboratories with anaerobic culturing and whole genome sequencing (WGS) capabilities and bioinformatics expertise are eligible to incorporate *Clostridioides difficile* testing. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Provide outbreak investigation support at the request of healthcare facilities and laboratories located in any jurisdiction, in consultation with CDC, by performing *C. difficile* isolation, culturing and WGS to assess transmission.
  - b. Develop an inter-facility transmission index by determining the minimum number of genetically related *C. difficile* isolates that represent transmission between geographically proximate facilities (including inpatient and post-acute care facilities). This will involve collecting relevant geographic, patient and epidemiologic data; culturing stool specimens for *C. difficile*; performing WGS, bioinformatic processing and analyses to check sequence data quality; and performing single nucleotide variant (SNV) and other relevant (e.g., multilocus sequence typing [MLST], core genome MLST, whole genome MLST) analysis on all or a subset of randomly sampled clinical isolates from at least two or more facilities that share patients to develop an inter-facility transmission index based on the phylogenetic relationships of these isolates.
  - c. Submit sequencing data to NCBI for public posting and report relevant ID, including sequencing IDs (per CDC guidance) to CDC.
5. **P.II Activity B5 (Optional):** Implementation of molecular methods for *Neisseria gonorrhoeae* strain surveillance. If including this activity in the workplan, address **all** of the sub-activities.
  - a. Implement real-time PCR assays for selected AMR markers associated with susceptibility to ceftriaxone and potentially to ciprofloxacin in accordance with CDC guidance.
  - b. Conduct molecular testing of remnant NAAT specimens from GISP sites (up to 200 specimens per month).
  - c. Report PCR results to CDC within 4 weeks of specimen receipt.
  - d. Retain specimens for up to 1 year and ship selected specimens to CDC as requested.



### **Project III: Antibiotic Stewardship**

Project III (P.III) aims to provide access to stewardship expertise especially for settings where inequities in stewardship support exist. Antibiotic stewardship activities prioritize patient safety and quality improvement through engagement with a variety of partners. Stewardship expertise will be critical to support healthcare settings with the following activities in the context of COVID-19: implementing CDC *Core Elements*, tracking and reporting antibiotic use (AU), establishing and supporting antibiotic stewardship collaboratives and implementing stewardship activities to improve prescribing practices.

1. **P.III Activity 1 (Required):** Provide access to stewardship expertise by identifying an Antibiotic Stewardship Lead (and additional positions if resources are available). The Antibiotic Stewardship Lead will act as primary liaison between local and state health departments, HAI/AR Coordinator, healthcare facilities, CDC, professional societies and other community partners with regards to antibiotic stewardship. The Antibiotic Stewardship Lead should have expertise and experience leading and implementing stewardship activities and will be responsible for the development, implementation and evaluation of the required stewardship activities.
2. **P.III Activity 2 (Required):** Identify and engage antibiotic stewards, clinicians, facilities or health systems that need additional support to improve implementation of antibiotic stewardship *Core Elements* in different healthcare settings. For settings for which there are no core elements, Antibiotic Stewardship Leads can engage with CDC stewardship subject matter experts on appropriate strategies for that setting. Examples to identify targets for engagement can include, but are not limited to:
  - a. Inpatient: facility not meeting all core elements on NHSN annual hospital survey, NHSN AU option Standardized Antimicrobial Administration Ratio outlier or MDRO outbreak.
  - b. Outpatient: high antibiotic prescribing rates (by volume or other metric) at the level of individual provider, facility or system.
  - c. Long-term care (LTC): not meeting all core elements on NHSN facility survey or state administered survey, CMS stewardship citations, high antibiotic use identified through collaborative tracking antibiotic use or other data source, facilities with an MDRO outbreak or surveys.
  - d. Other settings: dialysis, dental settings, assisted living facilities, or other settings with an MDRO outbreak.
3. **P.III Activity 3 (Required):** Track antibiotic use in the recipient's jurisdiction to inform and assess the implementation of focused stewardship interventions in different healthcare settings in the context of COVID-19. Assess data sources for availability of equity-related variables that identify disparities in antibiotic prescribing (socioeconomic, insurance status, social vulnerability index, race/ethnicity, geographic), and incorporate in surveillance and analyses at the patient, facility and community level. Examples of antibiotic use data can include, but are not limited to:
  - a. Inpatient: NHSN Antimicrobial Use Option or other health system data.
  - b. Outpatient: CDC's Antibiotic Resistance Patient Safety Portal, Medicaid data, CMS Part D Public Use Files, or other proprietary data, All Payer All Claims or other claims data, overall or condition-specific antibiotic prescribing rates in partnership with local health system.
  - c. LTC: facility-level pharmacy transactions or electronic health record data, antibiotic use tracking collaborative.
4. **P.III Activity 4 (Required):** Partner with academic institutions, facilities and other partners to form stewardship collaboratives to implement and evaluate evidence-based, local-level interventions informed by antibiotic use data in different healthcare settings in the context of COVID-19. Examples of collaborative activities can include, but are not limited to:
  - a. Inpatient: Support NHSN AU Option enrollment, and leverage NHSN AU Option Standardized Antimicrobial Administration Ratio (SAAR) metrics to inform where to focus improvement activities.

Support discharge stewardship activities to improve antibiotic prescribing during transitions to outpatient and LTC settings.

- b. Outpatient: Providing feedback with peer comparison to prescribers (potential partners may include state Medicaid office or local health plans), partnership with local health systems to support the dissemination of communication training modules to prescribers.
  - c. LTC: Implementation of specific stewardship quality improvement initiatives to improve the diagnosis and treatment of infections, tracking and reporting of antibiotic use data.
  - d. In all settings: Optimizing the treatment of common infections (respiratory, urinary and skin/soft tissue infections) by promoting guideline-concordant care (e.g., diagnosis, antibiotic selection and duration).
  - e. In all settings:
    - i. Providing antibiotic stewardship mentorship and support (virtual or in-person) to settings where inequities in access to antibiotic stewardship expertise can create differences in quality of care (e.g., high social vulnerability index, rural locations, availability of pediatricians).
    - ii. Supporting One Health collaboratives to promote judicious antibiotic stewardship to reduce the impact of antibiotic-resistant pathogens on human, animal and environmental health. One Health collaboratives can facilitate communication and encourage identification of antibiotic stewardship best practices across settings and among multiple disciplines.
5. **P.III Activity 5 (Required):** Coordinate antibiotic stewardship activities with partners (health systems, professional societies, academic partners, regulatory/licensing entities, local health departments). Examples of coordination activities can include, but are not limited to:
- a. Report stewardship activities and outcomes to health department leadership and partners.
  - b. Create facility certificates (e.g., honor roll) to acknowledge success based on the implementation of priority activities outlined in the core elements checklist for all settings.
  - c. Publish information on health disparities related to antibiotic use identified in your jurisdiction.
  - d. Provide setting-specific antibiotic stewardship educational workshops (e.g., communication skills training, antibiotic use tracking, improving diagnosis and treatment of infections and sepsis).
  - e. Support the development of programs and/or policies that encourage antibiotic stewardship implementation and/or tracking of antibiotic use data (e.g., requirement for NHSN AU Option reporting).
6. **P.III Activity 6 (Optional):** Support collaboratives that implement electronic health record-based stewardship interventions in different health settings (e.g., clinical decision support tools, automated prescriber feedback reports).
7. **P.III Activity 7 (Optional):** Evaluate antibiotic prescribing in new or emerging healthcare delivery mechanisms (e.g., telehealth).
8. **P.III Activity 8 (Optional):** Identify opportunities to implement diagnostic stewardship to optimize antibiotic use, particularly for urinary and respiratory infections in different healthcare settings
9. **P.III Activity 9 (Optional):** Develop a targeted intervention to improve antibiotic prescribing based on individual, facility or community level disparities associated with antibiotic use identified.

**Note:** Recipients not previously funded for all core ELC G1 activities (AS, FM, GU, MH, MP, PW, VI) are only required to conduct 1 of the 9 required or optional activities from P.III Activity 1 through 9. CDC will collaborate with these recipients to customize goals and priorities.

#### **Project IV: Enhancing Use of NHSN**

Project IV (P.IV) aims to bolster HAI/AR Programs' use of NHSN to identify areas of improvement in patient safety and healthcare quality for emerging and enduring health threats including HAIs, AR infections, SARS-CoV-2, and other emerging patient safety threats. Funding will also be provided to HAI/AR Programs to designate financial support to

healthcare facilities that demonstrate commitment to implement antibiotic use and resistance reporting and/or leveraging electronic health record systems (EHRs) to automate reporting to NHSN. These additional resources are critical to improving surveillance to inform action.

1. **P.IV Activity 1 (Required):** Identify an NHSN Coordination Lead (and additional positions if resources are available). The NHSN Coordination Lead will:
  - a. Act as primary liaison between local and state health departments, HAI/AR Coordinator, Antibiotic Stewardship Coordinator, healthcare facilities, CDC, and other community partners with regards to NHSN.
  - b. Prioritize patient safety and quality improvement surveillance, have expertise and experience with HAI/AR surveillance patient safety surveillance, data analysis, data validation, and reporting.
  - c. Provide technical assistance to facilities regarding NHSN enrollment and reporting, particularly to long-term care facilities (LTCFs) and other facilities eligible to report to NHSN, such as Assisted Living Facilities and Intermediate Care Facilities.
2. **P.IV Activity 2 (Optional):** Establish new data use agreements (DUAs) or update existing agreements with NHSN to access Antimicrobial Use and Antimicrobial Resistance (AU/AR) data reported by facilities. Where appropriate, encourage local health departments (LHDs) to also establish and/or update DUAs including AU/AR data access. As examples of partnerships with LHDs in using NHSN data for action, programs should reference Project I (HAI/AR Program Network) Strategy D, “Strengthening HAI/AR prevention activities in specific healthcare settings,” and Project III (Stewardship), Activities 3 and 4.
3. **P.IV Activity 3 (Optional):** Partner with facilities and academic institutions to form sentinel sites for validation studies of inpatient HAI data and post-acute care HAI data.
4. **P.IV Activity 4 (Optional):** Conduct data validation to inform prevention. Recipients are expected to conduct some prior analysis of their state NHSN data to identify HAIs at priority need for external validation. Participating recipients are required to identify 2 HAIs that will be validated during a funding year. In addition to the inpatient facility-based HAI validation, recipients are strongly encouraged to conduct Dialysis Event validation and Long-Term Care Facility HAI validation at least once during the current cooperative agreement cycle. (Note: this activity was previously included in ELC G1 as a Tier 2 project.) If including this activity in the workplan, address **all** the sub-activities.
  - a. Conduct health department validator training to enhance workforce capacity for HAI.
  - b. Assure competency in data validation and NHSN methods and definitions via certificates of completion of in-person or online training.
  - c. Prior to data validation, conduct an analysis of jurisdiction's data to target the HAIs, facilities, and records to be validated.
  - d. During validation, assess local surveillance data quality, HAI surveillance data completeness, timeliness, sensitivity and specificity and identify reporter training needs.
  - e. After validating, produce a HAI validation report and an assessment of each guidance component, and provide feedback to facilities to have them correct their data in NHSN and provide user trainings to prevent future case misclassification.
  - f. After validating, produce a HAI validation report, an assessment of each guidance component, quantitative information, and recommended modifications.
  - g. Identify ongoing barriers among healthcare facilities to produce required line-listing information linking laboratory and admissions data. Provide recommendations for reducing barriers.
  - h. Identify ways to ensure secure transmission of spreadsheet data from healthcare systems to health department.
  - i. Build and foster data validation collaborations for improving upon tools and guidance. Strengthen partnerships with healthcare facilities by demonstrating transparency of validation processes.

5. **P.IV Activity 5 (Optional):** Identify and provide financial support to healthcare facilities who require additional resources to implement antibiotic use and resistance (AU/AR) surveillance and reporting in their facilities. Financial support should be distributed using fair and equitable methods of selection.
6. **P.IV Activity 6 (Optional):** Provide financial incentives to LTCFs that require additional resources and support implementing EHRs to leverage automated reporting to NHSN.

**Note:** Recipients not previously funded for all core ELC G1 activities (AS, FM, GU, MH, MP, PW, VI) are only required to conduct one of the following activities at minimum: P.IV Activity 1, 3, 4, 5 or 6. CDC will collaborate with these recipients to customize goals and priorities.

### **Project V: Project Firstline**

Project V (P.V) aims to increase the capacity of health departments to effectively engage, educate and train their healthcare workforce about infectious disease threats that spread in healthcare settings. This project complements, and does not duplicate, activities in the *ELC Firstline IPC Training* supplement.

#### **P.V Strategy A: Strengthen coordination of Project Firstline activities and partnerships with local health departments and healthcare organizations**

1. **P.V Activity A1 (Required):** Identify a Project Firstline (PFL) Lead who will be responsible and accountable for the coordination and/or implementation of Project Firstline activities and for communication with CDC on Project Firstline activities. The Project Firstline Lead will act as primary liaison between local and state health departments, HAI/AR Program, healthcare facilities, CDC, professional societies, and other community partners with regards to Project Firstline activities. The lead will also be responsible for ensuring the product/activity brief process is followed for their jurisdiction.
2. **P.V Activity A2 (Required):** Partner with local health departments to engage and train frontline healthcare workers. Consider prioritizing partnership with local health departments that have healthcare workers or healthcare facilities that serve communities experiencing health disparities.
3. **P.V Activity A3 (Required):** Identify and build partnerships with local healthcare organizations (e.g., with local hospital associations, health systems, and local chapters of professional associations) to raise awareness of Project Firstline materials and to disseminate information about healthcare-associated infections and infection control. Consider prioritizing partnerships with organizations that represent healthcare workers that are historically underserved (i.e., professions requiring lower levels of education, healthcare workers who speak English as a second language, healthcare workers from racial/ethnic minority groups, etc.).
4. **P.V Activity A.4 (Optional):** Partner with local academic institutions to educate and train rising healthcare workers on infection control, tailoring the PFL curriculum to local threats that rising healthcare workers may be more likely to encounter on the job. Consider partnering with academic institutions like community colleges that often train healthcare workers in non-clinical fields.

#### **P.V Strategy B: Provide data-informed infection control training, education, and targeted communications to a range of audiences**

1. **P.V Activity B1 (Required):** Analyze and leverage data from the learning needs assessment and an understanding of the healthcare workers in the jurisdiction, to frame, disseminate and adapt the PFL curriculum for local needs, experiences, etc. Consider how the learning needs identified may highlight broader health equity disparities in the healthcare workforce (linguistic accessibility, cultural appropriateness, etc.) and address these disparities within planned framing and dissemination activities.
2. **P.V Activity B2 (Required):** Conduct at least 2 training experiences/events for a target audience identified in a jurisdiction's learning needs assessment.

## STRENGTHENING HAI/AR PROGRAM CAPACITY

3. **P.V Activity B3 (Required):** Use existing PFL and health department dissemination channels (trainings, partners, social media, town halls, promotional campaigns, etc.) to communicate with frontline healthcare workers about local HAI threats, explaining where the threat tends to live (its reservoir), how it spreads, who is most at risk and actions healthcare workers can take to assess risk and stop spread, keeping in mind actions specific to certain healthcare professions and settings.
4. **P.V Activity B4 (Optional):** Participate in a CDC-PFL supported Community of Practice to obtain skills and share knowledge on how to more effectively engage and teach adult learners, and how to utilize/adapt PFL content.
5. **P.V Activity B5 (Optional):** Obtain and maintain capacity to provide continuing education credits relevant to the healthcare workforce (such as CME, CNE and CHES credits).

**Note:** Recipients not previously funded for all core ELC G1 activities (AS, FM, GU, MH, MP, PW, VI) are only required to conduct P.V Activity B3.

## PERFORMANCE MEASURES

In addition to the metrics and deliverables indicated above, performance measures specific to COVID-19-related activities will be finalized and provided to recipients within approximately 90 days. The Division of Healthcare Quality Promotion (DHQP) will utilize existing data sources whenever possible to reduce the reporting burden on recipients and, where appropriate, existing performance measures may be used. While more frequent reporting may be employed within the first year of this supplement, these requirements may be adjusted as circumstances allow. Reporting will utilize existing mechanisms (e.g., the HAI/AR Performance Measures project in REDCap), and where it is possible, will be aligned to current performance measure reporting timelines.

Consistent with current ELC practice, progress on workplan milestones will be reported on a quarterly basis utilizing REDCap. Recipients will be provided 2 weeks to update their progress and note any challenges encountered since the previous update. Financial reporting requirements shall be noted and, as necessary, updated in the Terms and Conditions of the award.

## SUMMARY OF REPORTING REQUIREMENTS

The following is a summary of the reporting requirements for the *Strengthening HAI/AR Program Capacity*.

1. Within five (5) business days of receipt of this guidance, the Authorized Official is required to acknowledge receipt of this guidance by submitting a Grant Note in GrantSolutions.
2. Quarterly progress reports on milestones in approved workplans via REDCap.
3. Monthly fiscal reports (beginning 30 days after NOAs are issued).
4. Performance measure data.
5. Annual progress reports (APRs). CDC will provide APR guidance and optional reporting templates.

Please also note: Data collected as a part of the activities supported with these funds shall be reported to CDC in a form and fashion to be determined and communicated at a later date.

**ACKNOWLEDGEMENT LETTER: DUE WITHIN FIVE (5) DAYS OF NOA RECEIPT**

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**Strengthening HAI/AR Program Capacity**

Date:

Organization Name:

Subject: Acknowledgement Letter for CK19-1904 – COVID-19 Supplemental Funds –Strengthening HAI/AR Program Capacity

Reference: Guidance for the use of supplemental funding for CK19-1904 Strengthening HAI/AR Program Capacity through the *American Rescue Plan Act of 2021*.

This is to acknowledge that I have received, reviewed, and understand the requirements in the attached programmatic guidance.

The federal funding received will be in support of the supplemental funding referenced herein and will be spent in accordance with the legislation and programmatic guidance.

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Authorized Official