Centers for Disease Control and Prevention: Healthcare-Associated Infections Program

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
State Health Department Efforts to Prevent Healthcare Associated Infections (CDC)	40.00	39.88	0.12
Improvement of State Survey Inspection Capability of Ambulatory Surgery Centers (CMS)	10.00	0.73	9.27
Total	50.00	40.61	9.39

B. Objectives

The American Recovery and Reinvestment Act (Recovery Act) appropriated $50 million to the Department of Health and Human Services (HHS) Office of the Secretary. These funds will be provided to states for the execution and implementation of healthcare-associated infection (HAI) reduction strategies. They will also be used for state prevention activities and enhancing oversight and accreditation at the state level.

This program is aligned to the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs), which represents a culmination of research, deliberation, and public comment to identify the key actions needed to achieve and sustain progress in protecting patients from the transmission of serious, and in some cases, deadly infections. For more information, visit: http://www.hhs.gov/ophs/initiatives/hai/infection.html.

Traditionally, state health departments have had limited activities or workforce to address HAIs. However, in recent years more than 20 states have passed laws requiring reporting of hospital-specific HAI data to state health departments with public disclosure of hospital infection rates. In 21 states thus far, the CDC's National Healthcare Safety Network (NHSN) has been identified as the tool for reporting and NHSN participation has grown from 300 hospitals nationally to approximately 2,100 hospitals in two and a half years. This program will assist in providing state health departments with the necessary workforce, training, and tools to rapidly scale up to meet this new effort to prevent HAIs, support the dissemination of HHS evidence-based practices within hospitals, support targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of new prevention collaboratives, and address overall HHS HAI prevention priorities.

This program provided funds for improvement of State Survey Agency (SA) inspection capability of Ambulatory Surgery Centers (ASCs) nationwide. This program will also assist

SAs, enabling them to identify and correct infection control deficiencies in ambulatory surgical centers.

Public Benefits

Healthcare-associated infections occur in all settings of care. It has been estimated that in 2002, 1.7 million infections and 99,000 associated deaths occurred in hospitals alone. The financial burden attributable to these infections is staggering with an estimated $33 billion in added healthcare costs (2009[1,2]). Recent research efforts supported by the CDC and the Agency for Healthcare Research Quality (AHRQ) have shown that implementation of CDC HAI prevention recommendations can reduce some healthcare-associated infections by as much as 70%. Broad implementation of HAI prevention guidelines can result in dramatic reductions in HAIs, which will not only save lives and reduce suffering, but will result in healthcare cost savings.

Investing in state health departments to promote HAI prevention is critical. States currently conduct limited activities on HAI surveillance and prevention activities. Recovery Act funding will fill an essential gap for state health departments and will build capacity for HAI prevention. This funding will allow states to better promote and coordinate HAI prevention activities in all hospitals in their states. States that currently have this leadership and coordination role (e.g. New York) have shown major decreases in HAIs. This funding will enable states to build a sustainable program to decrease HAIs which is expected to lead to a reduction in healthcare costs. Recovery Act funding is restricted to state health department efforts to track and prevent HAIs.

ASCs in the United States have been the fastest growing provider type participating in Medicare, increasing in number by more than 38% between 2002 and 2007. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various ASCs (potentially affecting more than 50,000 people). Follow-up surveys throughout Nevada found infection control deficiencies at more than 40% of the ASCs.

C. Activities

Centers for Disease Control and Prevention

CDC competitively awarded funding to eligible state health departments to support efforts to prevent HAIs as part of the HHS Action Plan to Prevent HAIs. Existing Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) and the Emerging Infections Programs (EIP) competitive cooperative agreement programs were utilized to make supplemental competitive awards to state health departments to carry out HAI activities as follows:

Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

- Coordinating and reporting of state HAI prevention efforts
- Reporting progress toward reductions on two or more of the targets in the HHS Action Plan To Prevent Healthcare-Associated Infections

[1] Scott, R. Douglas. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf

[2] Klevens RM, Edwards JR, Richards CL, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. Public Health Rep 2007;122:160-166.

- Developing sustainable state HAI reporting using the NHSN and to evaluate NHSN data
- Increasing awareness among healthcare providers
- Estimating the burden of HAI
- Monitoring the impact of prevention programs and reporting using NHSN metrics for progress toward HHS HAI Prevention Targets
- Establishing prevention collaborations with healthcare facilities, healthcare professionals, state Hospital associations, and state-based Medicare Quality Improvement Organizations

Emerging Infections Programs (EIP)
- Monitoring and investigating the changing epidemiology of HAIs in populations as a result of prevention collaboratives
- Quickly expanding the EIP infrastructure to address a broader array of HAI epidemiology
- Providing additional training for EIP state staff on HAI epidemiology and surveillance
- Developing and implementing enhanced surveillance tools and methods, and add staff for targeted two year projects

Centers for Medicare and Medicaid Services
This initiative will significantly expand the awareness of proper infection control technique among ASCs and SAs, increase the extent to which infection control deficiencies are both identified and remedied, and prevent future serious infections in ASCs by:
- Improving SA inspection capability and frequency for onsite surveys of ASCs nationwide,
- Using a new infection control survey tool developed by the CDC and CMS,
- Improving the survey process through the use of a CMS tracer methodology, and
- Using multi-person teams for ASCs over a certain size or complexity.

A CMS pilot program tested the above survey process improvements in three states in 2008 and demonstrated superior results in the identification and remedy of serious infection control deficiencies. The particular focus on ASCs for this funding was chosen because the available tool was developed and tested for ASCs, because ASCs have not been surveyed with the frequency and attentiveness to infection control that is needed (about once every ten years on average nationally), and because of the likely continuing infection control deficiencies in this setting. The Recovery Act funds will enable the application of the above four-component new survey process nationwide. For FY2009, 12 states participated in the ASC-HAI Initiative, utilizing the four-component survey process. For FY2010, 42 states are receiving Recovery Act funding to utilize the new survey process. The new survey process is mandatory for all state agencies as of October 1, 2009.

D. Characteristics

Centers for Disease Control and Prevention
Type of Financial Award: The Code of Federal Domestic Assistance number for HAI is 93.717. CDC utilized Code B – Project Grants to provide funding to state health departments using two existing competitive Cooperative Agreements:

1. **Epidemiology and Laboratory Capacity for Infectious Disease Program**
   - Coordination and Reporting of State HAI Prevention Efforts (Activity A)

Award Amount: up to $200,000 per funded state

- Detection and Reporting of Healthcare Associated Infection Data (Activity B)
  Award Range: $500,000 - $1,000,000 per funded state
- Establishing a Prevention Collaborative (Activity C)
  Award Range: $200,000 - $500,000 per funded state

States applied for ARRA funding to complete one, two, or three of the activities (A, B, C) listed above. If a State applied for A and another activity, they were required to justify in their application their ability to fully complete all requirements described in Activity A in a timely manner so that funds within Category B and C will be fully implemented within the ARRA allotted timeframes. State HAI funds were competitively awarded based on objective evaluation criteria, including sustainability. If a state applied for more than one activity, the state was required to describe how work done in each activity must be coordinated and complimentary. States will also need to discuss how funding supplements existing programs and does not supplant existing efforts. Spending under categories A, B, and/or C was contingent upon the States ability to sustain activities after Recovery Act funding has ceased.

2. Emerging Infections Program

- Resources will support targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of prevention collaboratives.
  Award Range: $200,000 -$500,000 per funded site
  Type of Recipient: States via the state health departments
  Type of Beneficiary: States

Centers for Medicare and Medicaid Services

Type of Financial Award: The Code of Federal Domestic Assistance number for HAI is 93.720. Payments are made to States separately from but in the same manner as they currently are made to operate the Survey and Certification program described under §1864 of the Social Security Act using funds from the Federal Hospital and Supplementary Medical Insurance Trust Funds. The SAs completed Form CMS-435, State Survey Agency Budget/Expenditure Report for current survey and certification requirements. Form CMS-435 is a multi-purpose form (budget request and approvals, expenditures reports, supplemental funding request, etc.) used in Medicare and Medicaid applications. The SA indicated the specific use of the form by checking the appropriate box. CMS internally assessed an allocation strategy based on the number of ASCs in the State, performance in meeting the prioritization of the objectives, and SA's capability to move forward expeditiously. The use of the funds are captured distinct from other Survey & Certification program funds using a modified version of the standard Form 435 – Expenditure form. Of the total funds, $8.375 million of the $9.95mil available has been allocated to States and $50,000 will be used for Federal administration (e.g., training of States). In both FY 2009 and FY 2010, the Recovery Act funds are separately tracked and monitored from the Federal Administration funds allocated for Survey and Certification program activities
Type of Recipient: State Survey Agencies
Type of Beneficiary: States

E. Delivery Schedule

Centers for Disease Control and Prevention
The table below shows the schedule of milestones for major phases (e.g. the procurement phase, planning phase, project execution phase, etc., or comparable) with planned delivery date(s):

Milestone	Completion Date
CDC Guidance issued for State HAI plans	May 2009
EIP Proposals Due to CDC	June 2009
Supplemental Awards for ELC	September 2009
Supplemental Awards to EIP	September 2009
State HAI plans submitted to CDC for review	January 2010
State Healthcare Collaboratives established	January 2010
State HAI Plans due by HHS	January 2010
States identify HAI coordinators	January 2010
Baseline State reporting measures in NHSN due	May 2010
Reporting of progress toward prevention targets using NHSN	Ongoing

Centers for Medicare and Medicaid Services
The table below shows the schedule of milestones for major phases (e.g. the procurement phase, planning phase, project execution phase, etc) with planned delivery date(s).

Milestone	Completion Date
First Training on new Evidence-based tool	May 2009
Notice to State Survey Agencies	June 2009
Selection of States for 2009 Implementation	July 2009
Implementation in 2009 Volunteer States	July 2009
Second Training – all States	October 2009
Implementation in Remaining States-FY 2010	November 2009
All ASC surveys completed	September 2010

F. Environmental Review Compliance

The grants and contracts addressed in this program are subject to a National Environmental Policy Act (NEPA) categorical exclusion reference 2d, 2e, 2g, 2i, 2j per HHS GAM 30-20-40 as promulgated by HHS [65 FR 10229 (2/25/2000)] and additional NEPA review is not required.

Categorical exclusions and other environmental reviews will be documented in writing and reported on the Section 1609(c) report.

G. Measures

Centers for Disease Control and Prevention

The investments for HAI prevention through December 2011, are historic both in helping states to address HAIs and in their potential for rapidly building capacity in state health departments for promoting HAI prevention long term. CDC provides technical assistance and support as necessary to ensure that states can effectively use these funds. With the successful implementation of this program, we anticipate some reductions in HAIs within two years, and potentially a greater than 50% reduction in HAIs within ten years of initiation of the program.

Table 1A. CDC – Healthcare-Associated Infections Recovery Act Performance Measures: Type, Polarity, Target, and Frequency

Goal/Objective	Measure	Type	Direction of Measure	Target	Frequency
Reduction in (targeted or selected) HAIs	% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable SIR) (CDC)	Outcome	Positive	FY09-Q3: -- FY09-Q4: -- FY10-Q1: -- FY10-Q2: -- FY10-Q3: 40% FY10-Q4: -- FY11-Q1: 50% FY11-Q2: -- FY11-Q3: 60% FY11-Q4: --	Annually
Detection and reporting of Healthcare Associated Infection data [selected states]: Number of new healthcare facilities participating in NHSN. .	% of all hospitals participating in NHSN, among states funded for detection and reporting of Healthcare Associated Infection data (CDC)	Output	Positive	FY09-Q4: 30% FY10-Q1: 40% FY10-Q2: 45% FY10-Q3: 45% FY10-Q4: 50% FY11-Q1: 50% FY11-Q2: 55% FY11-Q3: 60% FY11-Q4: 60%	Quarterly

Table 1B. CDC – Healthcare-Associated Infections Recovery Act Performance Measures: Data Source, Validation, and Reporting

Measure	Data Source	Validation	How Reported to Public
% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable (SIR) (CDC)	National Healthy Safety Network (NHSN) system	NHSN's web application has internal data validity and consistency checks. Data are entered in participating hospitals by trained infection prevention staff using standardized definitions and surveillance methods. Data are reviewed by CDC staff for consistency. ARRA funds will provide States resources to conduct validation studies of data submitted to NHSN; see (http://www.cdc.gov/nhsn/index.html)	Reported by participating hospitals to NHSN. Extracted by Project Officers and Program staff for reporting.
% of all hospitals participating in NHSN, among states funded for Detection and Reporting of Healthcare Associated Infection Data (CDC)			

Centers for Medicare and Medicaid Services

CMS will provide quarterly reporting on what work has been completed including milestones such as training, outreach efforts, allotments to SAs. Using data derived from the data base that supports survey operations, we are monitoring progress on the number of surveys and the survey results on a monthly basis internally, and reporting quarterly on the measure indicated in Table 1C below. To gauge effectiveness of the project overall, CMS will issue an evaluative report on the new ASC survey process. The report shall include SA & CDC input on the value from the enhanced survey infection control tool and other important aspects of the new survey process. CMS will post the report on its Web site at www.cms.hhs.gov.

Table 1C. CMS - Healthcare-Associated Infections Recovery Act Performance Measures: Type, Target, and Frequency

Goal/Objective	Measure	Type	Direction of Measure	Target	Frequency
Improve State Survey Agencies' ability to identify deficient infection control practices during inspection of Ambulatory Surgery Centers (ASCs) as a result of using an infection control surveyor tool.	Increase by 50%, when compared to the first three quarters of FY 2009, the percentage of all ASCs inspected by State Survey Agencies that are cited for an infection control deficiency. (CMS)	Outcome	Positive	FY10-Q1: -- FY10-Q2: -- FY10-Q3: -- FY10-Q4: 50%	Annually – at the end of FY 10

Department of Health and Human Services
American Recovery and Reinvestment Act
Healthcare-Associated Infections Program

Performance Reporting

Outcome / Measure	Unit	Type	9/30/09 09/Q4	12/31/09 10/Q1	3/31/10 10/Q2	6/30/10 10/Q3	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	6/30/11 11/Q3	9/30/11 11/Q4	Program End
% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable SIR) (CDC)[1]	%	Target				40%	-	50%	-	60%	-	60%
		Actual	-	-								
% of all hospitals participating in National Healthy Safety Network (NHSN), among states funded for Detection and Reporting of Healthcare Associated Infection Data (CDC)[2]	%	Target	30%	40%	45%	45%	50%	50%	55%	60%	60%	60%
		Actual	42.7%	43.4%								
Increase by 50%, when compared to the first three quarters of FY 2009, the percentage of all ASCs inspected by State Survey Agencies that are cited for an infection control deficiency.. (CMS)[3]	%	Target		-	-	-	50%					50%
		Actual		498%[4]								

[1] The SIR compares the actual number of the specific HAI type in a state with the baseline U.S. experience (i.e., standard population), adjusting for several risk factors that have been found to be associated with differences in infection rates. An SIR of less than 1.0 indicates that fewer HAI events (of that specific type) were observed than expected. The SIR is consistent with the HHS Action Plan to Eliminate HAIs, and is currently used by three states for public reporting. This measure will be reported for states receiving Activity C funding and have identified CLABSI as a prevention target.

[2] Thirty-two states are receiving funding for Activity B. This percentage is calculated by dividing the total number of hospitals participating in NHSN by the number of 2008 American Hospital Association (AHA) facilities. The denominator comes from the 2008 AHA national hospital survey. The numerator comes from the NHSN system and includes all hospital categories. This measure assumes that all NHSN facilities are included in the AHA facilities count. In actuality, NHSN facilities have not been matched to AHA data. There are some AHA facilities that are not participating in NHSN; also, there are some facilities within the NHSN system that are not included in the AHA list. **CDC is working to identify a more accurate denominator. If one can be found, it will be used in subsequent reports.**

[3] The numbers will change in the next reporting quarter as a result of lag time and enforcement activities. Also, as more surveys are uploaded, the performance measures will improve.

[4] The figure represents the percentage increase in the percentage of surveyed ASCs that had an infection control deficiency in the 1st quarter of FY09 versus the 1st quarter of FY10.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

CDC and CMS's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The CDC and CMS Senior Assessment Teams carry out comprehensive annual assessments of this Recovery Act program to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. They meet at least quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, CDC will present this program's high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Centers for Disease Control and Prevention
Understanding that funds allocated as part of Recovery Act require additional accountability, CDC has established a centralized oversight function, for agency-wide Recovery Act Coordination (RAC), to oversee and coordinate all Recovery Act-funded activities. Quarterly reviews of Recovery Act programs will be conducted by RAC in collaboration with CDC's Financial Management Office (FMO) and Procurement and Grant's Office (PGO), as well as program managers. Potential risks associated with executing Recovery Act funds have been identified and appropriate mitigation strategies have been instituted to ensure Recovery Act funding is effectively and efficiently utilized to achieve program goals. In addition, assurance of adequate staffing levels within FMO, PGO, and within the program has been addressed to provide appropriate oversight and monitoring of recipient activity.

To ensure Recovery Act grantee accountability and performance and to minimize risks associated with the misuse of Recovery Act funds, CDC will perform the following contract and grant management activities for Recovery Act-funded contractors and grantees:

- Coordinate with the Office of the Inspector General (OIG) to ensure that Recipient Capability Assessments are conducted on funded organizations as needed;

- Ensure ongoing technical assistance is provided to contractors and grantees who need assistance in meeting administrative and program requirements;
- Monitor the receipt of financial reports, and review those reports for the purpose of monitoring compliance with financial requirements;
- Monitor the receipt of recipient progress reports, and review those reports for the purpose of monitoring compliance with program requirements;
- Conduct vigorous post-award monitoring to include site visits to grantees;
- Ensure the unique identification of Recovery Act funds in contractual and grant agreements, to include the use of unique Recovery Act CFDA numbers for grants;
- Refer all known instances of suspected fraud, waste, or abuse to the OIG;
- Ensure that timely enforcement actions are taken on any non-performing contractor or grantee;
- Take appropriate enforcement action, such as the disallowance of costs, the recovery of funds, the referral of suspected fraud to the OIG, the implementation of administrative corrective actions by the contractor or grantee, or the termination of funding if CDC determines that a contractor or grantee has misused Recovery Act funds, CDC will; and
- Support the oversight of the Recovery Accountability and Transparency Board, the OIG, and General Accounting Office, to include taking timely action on inquires and recommendations.

There will be frequent communication between grant and contract recipients and program staff, including regular conference calls. Program staff will ensure site visits are conducted according to Recovery Act requirements, and that technical assistance is provided. Recipients may be allowed to charge increased administrative costs to support the frequent and extensive reporting required by the Recovery Act. Allowable and unallowable expenditures will be clearly communicated to recipients and appropriate penalties for misappropriation or misuse of funds will be enforced. The Office of Management and Budget (OMB) Circular A-133, “Audits of States, Local Governments and Non profit Organizations” will set the administrative requirements for these entities. OMB Circular A-87, “Cost Principles for State, Local and Indian Tribal Governments” will set the Federal principles for determining allowable costs.

Development and submission of grantee plans and quarterly updates on progress towards measures and targets will enhance recipient accountability. Specific financial and program performance measures and the frequency for their reporting have been enumerated regarding measures. These indicators will serve as an evaluation of progress in deploying funds and achieving the intended outcomes. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues. Monthly and quarterly reporting by recipients will be monitored by project and contract officers and failures to adhere to performance measures will be elevated to supervisory authorities immediately for troubleshooting.

Program Specific Risk Mitigation Strategies

EIP and ELC, funds were specifically awarded for HAI activities only. Recipients will outline a plan for reporting progress toward HHS Action Plan Prevention Targets using specified metrics compatible with NHSN. CDC will collaborate with AHRQ and work with grantees to eliminate duplication of effort, and the EIP and ELC supplemental funding opportunity announcements (FOAs) required details on how CDC-funded work will link into existing efforts funded by AHRQ.

HAI state applicants were required to describe state plans for sustaining Recovery Act impact beyond the federal funding provided and demonstrate a continued plan for progress toward meeting HHS Action Plan prevention targets as evidenced through reporting metrics outlined in the Plan.

Tables 2A and 2B includes a full presentation of the Agency specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections.

Development and submission of HAI grantee plans and quarterly updates on progress towards specific economic and performance measures and targets, enumerated in the preceding Measures section, will help minimize the risk of such abuse, These indicators,, including targets for reduction in HAIs will serve as an evaluation of progress, allowing for early intervention to ensure timely mitigation of issues. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues.

The HAI proposal was shared with the Office of Inspector General (OIG), and CDC successfully responded to all questions.

Table 2A. CDC-Specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Lack of program-direct support to hire the necessary staff within CDC to oversee grantee performance and reporting. *(High degree of risk)*	CDC is planning to use FY 2009 appropriations funding to hire additional FTE and contract staff.	At least half of the proposed FTEs and contract staff are in place by July 2009.	Inability to hire new staff, and/or to meet RA reporting requirements.	CDC: Joni Young
Potential for NHSN performance to degrade with rapid influx of new users. *(High degree of risk)*	CDC is planning to use FY 2009 appropriations funding to hire additional FTE and contract staff, purchase more servers, and related software.	Through continued monitoring of system performance and feedback from state users.	Unacceptable performance of NHSN	CDC: Dan Pollock

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Potential delay in the developing/ implementing prevention collaboratives and expansion of participation in NHSN due to lack of staff with HAI expertise in some states. *(Medium degree of risk)*	CDC will allow states to contract with outside entities (e.g. CSTE).	CDC will monitor states identifying and/or hiring of HAI coordinators through quarterly progress and financial reports.	State's inability to define needs and address barriers to implementation.	CDC: Joni Young
Potential impediments for state public health departments in hiring HAI Coordinator due to state hiring freezes and limitations of states to contract with out of state entities (e.g. Council of State and Territorial Epidemiologists). *(Medium degree of risk)*	CDC will work with states to define options; technical assistance to states with difficulty identifying a coordinator may receive additional technical assistance, but if an appropriate person is not readily identified, they may lose funding as per the ELC award conditions.	CDC will monitor states hiring of HAI coordinators through quarterly progress and financial reports.	State's inability to define needs and address barriers to implementation.	CDC: Mike Bell
Potential duplicative use of CDC's RA HAI funds for prevention collaboratives currently funded by the Agency for Healthcare Research and Quality (AHRQ). *(Medium degree of risk)*	The ELC supplemental FOA will require details on how CDC-funded work will link into existing efforts funded by AHRQ and reporting will be executed through CDC's systems. CDC will collaborate with AHRQ to ensure grantees are not duplicating efforts with OPDIV funds.	Through continued collaboration and discussion with AHRQ. Also through quarterly progress and financial reports.	State's inability to define their prevention collaboratives or how they complement any existing AHRQ efforts. If they cannot define their needs or address barriers to implementation.	CDC: Arjun Srinivasin

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Delays in EIP reporting due to need for OMB Paperwork Reduction Act (PRA) clearance *(Low to Medium degree of risk)*	Recipients will report via their customary progress reporting; hence we do not anticipate a need for PRA clearance. In the unlikely event PRA clearance is needed, many project milestones that can be completed while awaiting clearance and work can stay on schedule	Reporting of progress milestones is occurring in the first quarter	Judgment by CDC's PRA office that EIP reporting of milestones would require PRA	CDC: Susan Conner

Centers for Medicare and Medicaid Services

CMS will obtain detailed information on the ASC infection control deficiencies identified through onsite surveys. CMS will analyze such information to discern patterns and correlates of such deficient practices. CMS will also evaluate the extent to which States conduct the onsite surveys. Risk mitigation will focus primarily on issues related to addressing State across-the-board personnel restrictions (due to State budget deficits) and obtaining the necessary data on survey results in a timely manner and with sufficient detail.

Table 2B. CMS-Specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections

Risk Description & Degree	Mitigation Description	Assessment Measure	Contingency Plan Trigger	Responsible Official
1. Program Direction: Insufficient allocation of staff within CMS to provide proper direction and oversee grantee performance and reporting. *(High degree of risk)*	CMS examined workload priorities to redeploy FTE resources and to contract for certain support where necessary.	At least half of the proposed FTEs and contract staff are in place by July 2009.	Inability to hire new staff, and/or to meet Recovery Act reporting requirements.	CMS: Marilyn Dahl

Risk Description & Degree	Mitigation Description	Assessment Measure	Contingency Plan Trigger	Responsible Official
2. Training + Guidance: Potential for performance to be impaired if necessary training and guidance is not put in place effectively and timely. *(High degree of risk)*	CMS used webinars or satellite broadcasts to reach surveyors quickly in May 2009, sought assistance from CDC in training surveyors, conducted a second training (face-to-face) for surveyors in October 2009. ,	CMS will monitor system performance and obtain feedback from States and ASCs.	Unacceptable performance of States, lack of attendance at training.	CMS: Marilyn Dahl
3. State Surveyor Staffing: Potential impediments for State survey agencies due to State hiring freezes, furloughs, or other across-the-board limitations imposed due to the generalized budget deficits faced by States. *(High degree of risk)*	CMS communicated the importance and urgency of this infection control initiative to State Governors and Public Health Departments, and encouraged States to permit exceptions for State survey agencies from across-the-board personnel limitations. CMS worked with States to identify options and offer technical assistance.	CMS will monitor State hiring and personnel adjustments granted to State survey agencies.	State's inability to staff the ASC surveys.	CMS: Marilyn Dahl
4. **Evaluation**: Potential difficulties in obtaining results from surveys with the detail and timeliness required for an effective evaluation. *(Medium degree of risk)*	CMS will explore and implement stand-alone data collection strategies to improve the timeliness and detail of survey results, with possible contract assistance and collaboration with CDC.	Through continued collaboration and discussion with CDC. Also through quarterly progress and financial reports.	Delay or lack of necessary detail in survey findings reported.	CMS: Marilyn Dahl

I. Transparency

CDC and CMS is are open and transparent in all contracting and grant competitions that involve spending of Recovery Act funding consistent with statutory and OMB guidance and published on grants.gov and fbo.gov. CDC and CMS ensure that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CDC and CMS inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, CDC and CMS provide key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

CDC and CMS will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. CDC will ensure recipient cost and performance requirements are reported on a quarterly basis. All awards issued with Recovery Act will have special accounting numbers and codes to track the funds and awards.

Recipients will report economic indicators of job creation and/or preservation on a quarterly basis directly to a central reporting system in accordance with the provisions of Section 1512. These data will be available at the recipient level. All other indicators will be collected from existing databases, collated by the program staff and then reported to CDC RAC. The customary process for reporting progress on these measures to the Department of Health and Human Services (HHS) and the OMB will be employed. These measures will be reported in aggregate, however the recipient-by-recipient performance on which they are based will be available from the program and its project officers. A CDC point of contact has been established for federalreporting.gov and recovery.gov to receive and answer public inquiries regarding programmatic efforts with Recovery Act funds.

CDC shall ensure merit-based decision-making for Recovery Act grant and contract awards by:

- Promoting competition to the maximum extent practicable;
- Considering the weighting of selection criteria to favor applicants with demonstrated ability to deliver performance;
- Using award methods that allow grantees and contractors to commence activities as quickly as possible;
- Ensuring that receipt of funds is contingent on grantees and contractors agreeing to meet Recovery Act reporting requirements;
- Adapting current applicant evaluation and review processes to reflect Recovery Act needs; and
- Pursuing efforts to overcome impediments to Recovery Act awards.

CDC grant announcements and contract solicitations involving Recovery Act funds shall contain transparent merit-based selection criteria that allow CDC to evaluate an applicant's demonstrated or potential ability to:

- Deliver programmatic results;
- Create economic stimulus, to include the number of jobs created or saved in relation to Federal dollars obligated;
- Achieve long-term public health benefits; and
- Satisfy Recovery Act transparency and accountability objectives, to include all reporting requirements.

CDC shall avoid the funding of imprudent projects by:

- Exercising the formal approval of Agency, Program and Spend Plans;
- Identifying measurable Program and Recovery Act outcomes;
- Reviewing proposed activities and expenditures for imprudent projects; and

- Making the timely obligation of funds.

Centers for Disease Control and Prevention
The system central to HAI efforts is the National Healthcare Safety Network. Although data are entered by facilities, healthcare facility data are confidential at the federal level. However, some state public health department websites may provide access to specific facility data for facilities in their state. Per Tables 1A and 1B, the proposed performance measures track the number of states with a "threshold" percentage of healthcare facilities meeting the designated benchmark. This does not require reporting data for specific facilities.

The program will pull grantee expenditure data from the quarterly reports and performance data from the grantee progress reports submitted to their Project Officers. CDC will provide the necessary recipient performance and financial data at the aggregate and disaggregated levels for public access on the CDC Web site (www.cdc.gov).

As noted, the program and its project officers will collect and collate this information from databases and grantee progress reports. It will be reported in an existing system to CDC's FMO and PGO, which have can readily provide the recipient financial and performance information required for Recovery Act-funded programs.

Centers for Medicare and Medicaid Services
CMS published on the CMS Web site (www.cms.hhs.gov) the public communications with States (Survey and Certification memoranda) as well as the survey Guidance and protocol documents. Results from the quarterly reporting are available. CMS will also publish the results of the research completed at the end of the project based on results from the onsite surveys. There is frequent communication between grant recipients and program staff, including conference calls addressing costs, performance, and requirements with OMB, CMS, and other applicable guidance documents. All grant funds will be designated to State levels with consideration for the number of ASCs in that specific State.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CDC and CMS have built upon and strengthened existing processes. Senior CDC and CMS officials will regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Centers for Disease Control and Prevention
The HAI program has developed a CDC-approved Program Implementation Plan containing management and oversight processes. Additionally, a point of contact has been established for Recovery.gov to receive and answer public inquiry regarding programmatic efforts with Recovery Act funds.

CDC will conduct quarterly reviews between Division Directors/Management Officials and project officers prior to the end of the quarter to evaluate progress to date and discuss

grantee performance. This information will be provided to the National Center and ultimately CDC's Recovery Act Coordination unit for review. Additionally, National Center and Division Directors will have accountability and performance measurement objectives included in performance plans. Annual reviews will be conducted with CDC leadership to ensure programmatic objectives and grantee accountability measures are being executed and achieved as stated.

Centers for Medicare and Medicaid Services
CMS uses its existing internal control fiscal infrastructure to implement this Recovery Act initiative.

CMS also established additional procedures and practices, as necessary, to ensure proper transparency, accountability, and oversight. Training in the new survey process was mandatory for relevant State and federal surveyors, with attendance tracked. Completion of the expected ASC surveys are tracked through CMS' ASPEN surveyor information system. CMS incorporated the ASC-HAI performance expectations for States into CMS' State Performance Standards System (SPSS).

CMS communicated to the SAs the intent, purpose, and process for the State grants consistent with the funding and the requirements of the Recovery Act. CMS also communicated with State officials (such as State Governors) and leadership of state Departments within which the State Survey Agencies are organizationally located, in an effort to address any State gubernatorial or Department-level actions that may be taken to promote fulfillment of the goals of this initiative. SAs progress are monitored and the agencies are held accountable for outcomes through additions to the existing SPSS. CMS uses Regional Office environmental scanning to determine if States have applied the Recovery Act dollars consistent with this program's purpose. CMS will post on the CMS Web site the results of its pilot study as well as progress reports on the Recovery Act implementation and results.

K. Barriers to Effective Implementation

Barriers to effective implementation of Recovery Act-funded activities include: Circumstances that could impede the effective implementation of Recovery Act activities have been evaluated. In each of these circumstances, CDC has developed a strategy to identify and take actions to mediate appropriately.

Centers for Disease Control and Prevention

1. Potential delay in the development and implementation of prevention collaboratives and expansion of participation in NHSN due to lack of staff with HAI expertise in some states. Solution: The ELC supplemental FOA will allow states to use a portion of funds to contract with outside entities [e.g. the Council of State and Territorial Epidemiologists (CSTE)] to place fellows in states to address HAI prevention activities. Nine CSTE HAI fellows have been matched and are currently working with state health departments.

2. Potential impediments for state public health departments in hiring HAI Coordinator due to state hiring freezes and limitations of states to contract with out-of-state entities (e.g. Council of State and Territorial Epidemiologists). Solution: While the HAI program has

offered the use of ELC funding for hiring of an HAI coordinator, CDC is not able to affect state restrictions regarding procurement policies and procedures. CDC's HAI program and the ELC will provide technical assistance to the extent possible to help mitigate this risk. All grantees have identified current staff or hired new staff to serve in this role.

3. Potential impediments for state public health departments receiving activity B funding to enroll healthcare facilities into NHSN. States without mandates for the utilization of NHSN to report HAIs are having difficulty encouraging facilities to join NHSN and/or to share data with the state health department. CDC has encouraged all current NHSN-participating facilities to contact their state health departments to identify themselves and consider sharing their data. Facilities currently have the ability to make their data available to the state health department, but they have to manually identify all of the data that is to be shared. CDC is revising the current NHSN Assurance of Confidentiality parameters so that facilities can opt to share all of their data with the states upon joining NHSN, thus relieving some of the work of the facility. CDC is actively working with the Office of General Council to revise and implement the updated Assurance of Confidentiality. CDC is also partnering with other federal agencies to focus on opportunities to maximize NHSN utilization to everyone's benefit.

Centers for Medicare and Medicaid Services

1. State furloughs and hiring freezes may negatively affect State performance. Mitigation: CMS performed outreach to State officials to inform them of the project, its purpose, and engage them in this mutually beneficial endeavor. CMS communicated with State Governors, State Public Health Commissioners, and national State associations to stress the importance of this initiative and the need to address personnel barriers to enable success. States were able to hire additional surveyors – during FY10Q2, almost 20 surveyors were hired/retained through the Recovery Act dollars.

2. Ineffective staffing. Mitigation: We expect to be able to monitor this by examining the amount of surveyor time and the number of surveyors trained, and assigned to complete the work. We have some comparative data from the ASC pilot that we plan to apply in our analysis. We conducted specialized training to States and, through partnerships with other parties, seek to make physician consultants more readily available to State surveyors.

L. Federal Infrastructure

Not applicable.

Summary of Changes

- Updated all sections to reflect the current status of planned activities.
- Updated the **Delivery Schedule** with revised completion dates for all milestones
- Reduced **performance measures** in the Implementation Plan to highlight top-level measures that are core to the intent ARRA legislation specific to HAI. While CDC will continue to collect and monitor all measures, the two measures included for the purposes of presenting program progress to the American public maintain a good balance between the public health outcome and the process.
- Adjusted targets for performance measures.
- Updated mitigation strategy for each risk identified in the **Barriers to Effective Implementation** section.