Voice for Infection Prevention

2018 Public Policy Agenda

Public Policy Agenda Contents

From the President

Be a Voice for Infection Prevention

Dear Advocate:

This year, with the midterm elections coming up, there will be a lot of distractions and noise coming from the many different campaigns. Unfortunately, the rhetoric of the campaigns could affect policies that support infection prevention and control. In order to be heard this election season, APIC members will need to coordinate and speak with one voice. A critical role of our organization is to magnify the voices of our more than 15,000 members to make sure our issues come before legislative and regulatory bodies; to create a safer world through prevention of infection.

The purpose of this Public Policy Agenda is three-fold, (1) to provide easy access to the key advocacy areas advanced by APIC; (2) to provide access to short downloadable documents created for use with policymakers; and (3) to build awareness of, and support for, APIC's current public policy agenda. Take a look at the brief policy position documents referenced in this guide to get informed and enrich your advocacy voice.

We also include "spotlight" sidebars in this document, featuring the advocacy journeys of some infection preventionists. Read testimonials on how these APIC members became involved in this important work; some entering the policy arena cautiously, but subsequently realizing that their advocacy work enriched their professional lives and improved the field of infection prevention for IPs and the patients we serve. These stories highlight the power of your input and how it can make a difference with policymakers.

We hope you will review this Public Policy Agenda, utilize the brief position papers to learn about APIC's positions, and envision what your role can be in advancing this agenda with policymakers. As an infection preventionist with real-world expertise in advancing safe patient care, policymakers need your help to understand infection prevention and control policies.

What will your input be? Here are some ideas:

- serve as a Chapter Legislative Representative or help them advance policy initiatives with your chapter;
- stay current on policy issues that influence our work as infection preventionists by subscribing to **APIC's Action eList** which provides updates on infection-related public policy developments;
- send letters to Congress through APIC's Voice for Infection Prevention **Action Alert system** and encourage others to do the same;
- urge your chapter to host an advocacy day with your state legislature;
- apply to serve on APIC's Public Policy Committee.

It is my sincere hope that you will connect with this public policy agenda, utilize it, and get excited about being a powerful voice for infection prevention.

Sincerely,

Janet Haas PhD, RN, CIC, FAPIC, FSHEA

2018 APIC President

About APIC

The mission of the Association for Professionals in Infection Control and Epidemiology (APIC) is to create a safer world through prevention of infection. The association's more than 15,000 members direct infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities. APIC advances its mission through patient safety, implementation science, competencies and certification, advocacy, and data standardization.

What do infection preventionists do?

Infection preventionists play a significant role in:

- Developing proven policies to ensure a safe environment for patients;
- Ensuring compliance with standards and regulations designed to protect patients and healthcare personnel;
- Tracking and monitoring activities to identify and prevent healthcare-associated infections (HAIs) and other infectious agents;
- Leading and participating in healthcare quality improvement efforts designed to protect patients;
- Educating the public and healthcare personnel about infectious diseases and how to limit their spread;
- Serving as leaders in preparing healthcare facilities and personnel to be ready for events such as an influenza pandemic; infectious diseases such as Ebola; and acts of bioterrorism;
- Reporting communicable diseases to the Centers for Disease Control and Prevention (CDC).

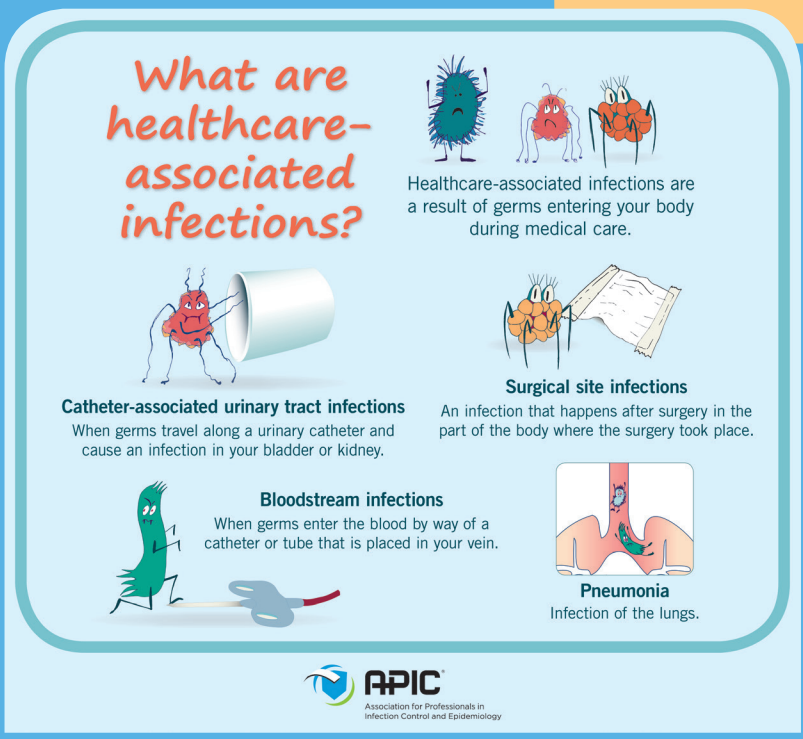
Visit APIC online at www.apic.org. Follow APIC on Twitter: www.twitter.com/apic and Facebook: www.facebook.com/APICInfectionPreventionandYou.

For information on what patients and families can do, visit APIC's **Infection Prevention and You** website at www.apic.org/infectionpreventionandyou.

KEY POINTS

Communicating with Policymakers

It can be a challenge to communicate exactly who infection preventionists are, what they do, and the issues facing the profession. Remember policymakers generally are not familiar with acronyms or other clinical jargon. Sharing your story of why infection prevention is critical may resonate more with a policymaker than technical explanations.



These images from APIC's **Infection Prevention and You** campaign are a perfect example of how to effectively communicate with policymakers and their staff.

Mission, vision, and strategic priorities

Our vision and mission

Vision:

Healthcare without infection

Mission:

Create a safer world through prevention of infection

APIC Strategic Goals: 2020

Patient safety:

Demonstrate and support effective infection prevention and control as a key component of patient safety.

Implementation science:

Promote and facilitate the development and implementation of scientific research to prevent infection.

IP competencies and certification:

Define, develop, strengthen, and sustain competencies of the IP across the career span and support board certification in infection prevention and control (CIC®) to obtain widespread adoption.

Advocacy:

Influence and facilitate legislative, accreditation, and regulatory agenda for infection prevention with consumers, policymakers, healthcare leaders, and personnel across the care continuum.

Data standardization:

Promote and advocate for standardized, quality, and comparable HAI data.

APIC policy development

The APIC Voice for Infection Prevention Public Policy Agenda is based on our vision and mission and is intended to help carry out APIC's Strategic Goals. It is developed by the infection preventionists (IPs) who serve on the APIC Public Policy Committee, with the approval of the APIC Board of Directors.

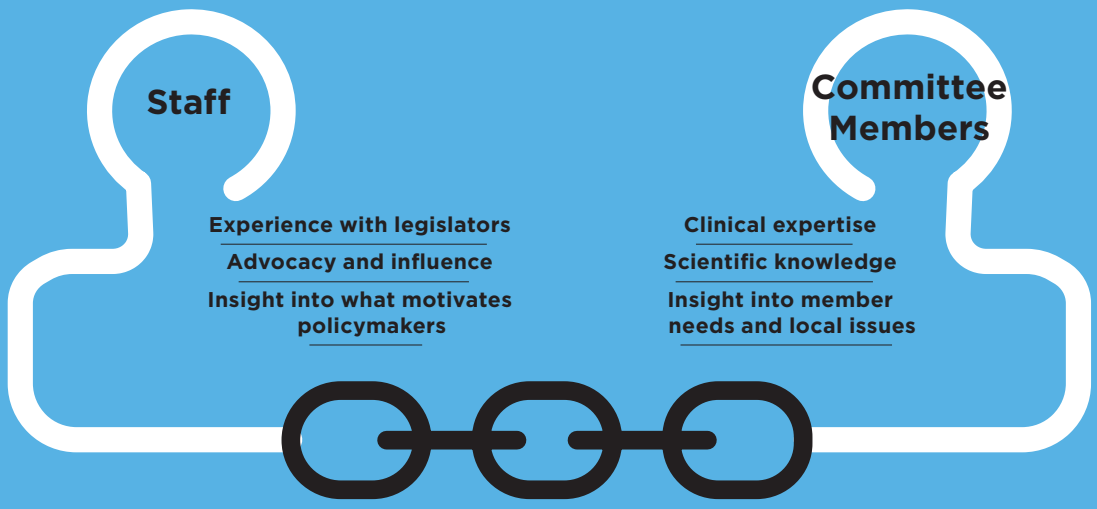
Because IPs are the ones putting infection prevention policies into practice, they are the best equipped to inform regulatory agencies and policymakers on practices related to protecting patients from HAIs. Our formula for informing policymakers and regulators is straightforward. It combines the clinical and practical expertise of IPs and the government affairs know-how of APIC staff to determine how we can best serve APIC's mission and vision.

The APIC Public Policy Committee (PPC), made up of ten IPs and a senior advisor from the APIC Board of Directors, works with APIC government affairs staff supplemented by a panel of IPs with regulatory expertise, to determine what proposed legislation and regulation APIC should weigh in on, and what the organization should say (see page 25). These judgments are based on both clinical and governmental considerations.

To determine what issues to address, APIC considers three questions:

1. Would it impact infection prevention?
2. Would it impact the work of IPs?
3. Would it contribute to APIC's strategic plan?

As partners, APIC members and staff determine our association's public policy agenda, draft Congressional testimony, write comments to federal agencies on proposed rules, and inform state legislators about preventing HAIs.



Support $21 million for the CDC National Healthcare Safety Network in FY 2019

Healthcare-associated infections and the National Healthcare Safety Network

Healthcare-associated infections (HAIs) are among the leading causes of preventable harm and death in the United States. One in 25 patients will contract an HAI on any given day, totaling approximately 722,000 infections and 75,000 deaths annually. An increasing number of these infections are resistant to antibiotics. APIC members, known as infection preventionists, work to prevent HAIs by isolating sources of infections and educating healthcare personnel on how to limit their spread.

HAIs are tracked and monitored on a national level using the U.S. Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). NHSN data:

- Provide means to evaluate progress towards national HAI elimination goals;
- Allow CDC and health facilities to target HAI prevention initiatives;
- Provide critical answers regarding the prevalence of HAIs in the U.S.

Continued support of NHSN would:

- Expand critical user support for NHSN to additional facilities across the spectrum of care;
- Enable expansion of NHSN's Antibiotic Use and Resistance (AUR) module reporting options. The AUR data will be used to guide local and regional efforts to reduce resistance and provide national benchmarks to promote safer use of antibiotics.

DID YOU KNOW?

According to the Centers for Disease Control and Prevention, the number of hospital patients that die with HAIs is nearly equal to the number of deaths from motor vehicle traffic accidents and breast cancer combined?

Public health issue	Deaths per year
HAIs	75,000
Opioids	72,000
Breast Cancer	41,523
Motor Vehicle Traffic Accidents	36,161

Support $200 million for CDC's Antibiotic Resistance Solutions Initiative in FY 2019

Antibiotic Resistance and Stewardship

Antibiotic resistance is a growing public health concern. Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections. Investments in the Antibiotic Resistance (AR) Solutions Initiative would:

- Continue efforts to expand HAI and antibiotic resistance prevention efforts to cover all 50 states, six large cities, and Puerto Rico;
- Sustain the Antimicrobial Resistance Laboratory Network of seven AR Regional Labs to serve as a national resource for cutting-edge lab support to states and characterize emerging resistance;
- Implement antibiotic stewardship programs that align with CDC's Core Elements for Antibiotic Stewardship in inpatient, outpatient, and long-term care settings;

- Drive innovation through the CDC's collaboration with academic research centers to conduct applied research on a variety of issues including: the microbiome, human and veterinary antibiotic use, infection prevention and control, and antibiotic resistance.
- Incorporate NHSN antibiotic use data to improve prescribing practices.

APIC recognizes that successful efforts to combat antibiotic resistance must also include protecting the effectiveness of all antibiotics through antibiotic stewardship.

Support $454 million for the Agency for Healthcare Research and Quality in FY 2019

Agency for Healthcare Research and Quality (AHRQ)

AHRQ is a key federal agency that generates reliable research on the delivery of quality care and creates materials to assist healthcare professionals put research into practice. The $454 million request is consistent with the FY 2010 level adjusted for inflation. This funding level will allow AHRQ to rebuild portfolios terminated after the last seven years of cuts, and will help the agency avoid a funding cliff that will result in more than a 25 percent cut to its program level budget if the Patient-Centered Outcomes Research (PCOR) Trust Fund expires in FY 2019.

AHRQ is an important ally in efforts to eliminate HAIs and prevent the spread of antibiotic resistant infections. As part of this funding request, APIC requests funding for AHRQ's HAI Research Activity of $36 million.

IP ADVOCACY SPOTLIGHT

Rachel Stricof, MPH, CIC,

2008 Carole DeMille Award recipient

Rachel Stricof got involved in public policy after noting the lack of scientific knowledge that went into government decision-making. Although she knew nothing about advocacy, she was mentored by other APIC PPC members and by APIC staff. Now Rachel is the person that many IPs look to as an advocacy mentor. She wishes that more IPs understood the impact they can have by speaking up to policymakers. Rachel noted that **"serving on the APIC Public Policy Committee was a constant learning and mentoring experience. We all need to understand that, as individuals working toward a common goal, we can have an impact not only for ourselves, but also for our facilities, communities, and our coworkers. The important thing is to get involved."**

Federal funding, continued

An example of AHRQ's work is the Comprehensive Unit-based Safety Program (CUSP), a highly effective method of preventing HAIs. Facilities that implemented CUSP methods and tools were able to reduce bloodstream infections by 41 percent, preventing over 2,100 central line-associated bloodstream infections, saving more than 500 lives, and avoiding more than $36 million in excess healthcare costs.

Continued support of AHRQ will allow them to work on priority healthcare issues including:

- reducing antibiotic overuse and eliminating healthcare-associated infections;
- improving care for people with multiple chronic conditions;
- incorporating the latest research findings into electronic health records to facilitate clinical decision making.
- discovering how to better provide opioid addiction treatment services in rural communities.

Federal Funding Priorities

Click or scan for a brief summary of APIC's position on Federal Funding Priorities.

APIC Public Policy Committee members Rebecca Fitzpatrick and Sarah Smathers visiting Capitol Hill.

President-Elect Karen K. Hoffmann, meeting with Senator Thom Tillis's (R-NC) office.

APIC Directors Sharon A. Williamson and Pat Metcalf Jackson meeting with Senator Ted Cruz (R-TX).

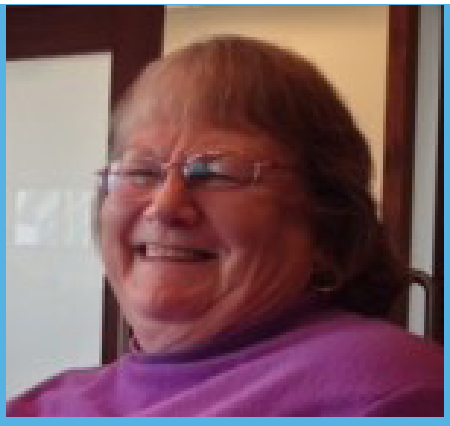
Outbreaks and emerging infectious diseases

The threat of SARS, H1N1, MERS, Ebola, and Zika have reinforced the need for strong public health infrastructure with protocols and procedures to prevent the spread of infection within U.S. healthcare facilities. IPs are an essential link to understanding and addressing risks that can contribute to serious public health threats; however, hospital infection control departments lack adequate funding and staffing to meet this need in addition to current HAI prevention and reporting requirements. An APIC survey found that 50% of hospitals had one or less than one full-time equivalent infection preventionist on staff. The lack of adequate staff in many facilities means that in a public health crisis, such as Ebola, IPs will likely be diverted from their ongoing work of preventing the spread of infectious organisms such as the "nightmare bacteria" Carbapenem-resistant Enterobacteriacaea (CRE).

APIC believes in order to have a robust infection prevention program that is capable of preventing infections day to day, and scaling up operations during a public health emergency, the following three elements are necessary:

- appropriate personnel staffing;
- ample training to ensure that guidelines are followed precisely;
- technology and equipment to maximize efficiencies and provide real-time data to detect and prevent infection.

IP ADVOCACY SPOTLIGHT



Susan Kraska, RN, CIC

Susan Kraska, RN, CIC, (Indiana CLR, previous PPC member) passed away in October 2016, after having left a lasting impact on infection prevention policy during her time as an APIC member. Although Susan did not know how to work with policymakers when she got started, she relied on APIC staff to help her learn the art of advocacy and how best to communicate her message. After many years helping shape HAI legislation and regulation, Susan was appointed to a state health department antibiotic advisory group.

Her ethos was simple, **"state decisions should not be made as knee-jerk reactions to today's problems, but instead should look at the big picture and make decisions based on scientific evidence. My role is to educate about the evidence and speak up for patients. That is the case in my facility and also in my state."**

FREQUENTLY ASKED QUESTIONS ABOUT HAIs

Q: What are healthcare-associated infections (HAIs)?

A: Any infection that develops while a patient is being treated in a healthcare facility, or within a prescribed amount of time after exposure to a healthcare setting, is considered healthcare-associated.

Q: How are these infections spread?

A: There are various modes of transmission. Most commonly, HAIs are spread by person-to-person contact or by touching a contaminated surface. Some infections can also be spread through the air via the breath of an infected person or through respiratory droplets produced by sneezing and /or coughing.

Q: What are some examples of HAIs?

A: You may already be familiar with some of the more commonly acquired HAIs, such as MRSA, *Clostridium difficile*, or catheter-associated urinary tract infections, central line-associated bloodstream infections, surgical site infections, and influenza.

Q: How does a patient acquire an infection while hospitalized?

A: Depending on the specific type of microorganism causing the infection, the patient could have gotten an infection from the unclean hands of healthcare workers, contact with non-sanitized medical equipment, unsafe surgical practices, exposure to other patients with an infectious disease, organisms on their body, or unsafe construction practices, just to name a few.

Q: Does this happen often?

A: The CDC estimates that one out of every 25 hospitalized patients will contract an HAI (www.cdc.gov/hai/surveillance). Some of these infections will be minor and easy to treat, while others will be life threatening.

Q: Can these infections be prevented?

A: In most cases, yes. Many HAIs are preventable through the implementation of proven, evidence-based infection prevention protocols and procedures. That is why tracking, monitoring, and reporting infections represent only the beginning. For infection prevention programs to be successful, they must have staff and funds to implement and support them.

Healthcare-Associated Infections (HAIs)

HAIs are an increasingly recognized problem by the healthcare community. The number of people who are sickened and the financial impact from HAIs are unacceptably high. In 2014, results of a project known as the HAI Prevalence Survey described the burden of HAIs in U.S. hospitals, and reported that there were an estimated 722,000 HAIs in U.S. acute care hospitals. Additionally, about 75,000 patients with HAIs died during their hospitalizations. Intrinsic to the problem is the inconsistent implementation of proven preventive measures. In addition, there is little information about the burden of infections outside hospitals, particularly in long-term care facilities, ambulatory surgical centers, and other outpatient settings. With the emergence of HAIs caused by multidrug-resistant microorganisms, there is an increasing concern about these types of infections across the continuum of care.

Requirements for the Elimination of HAIs

APIC believes the public policy recommendations needed to move in the direction of HAI elimination were succinctly outlined in **Moving toward elimination of healthcare-associated infections: A call to action**. They include:

- increasing sustainability through the alignment of financial incentives and reinvesting in successful strategies;
- collecting data to target prevention efforts;
- promoting adherence to evidence-based practices through partnering, educating, implementing, and investing;
- filling knowledge gaps to respond to emerging threats through basic, translational, and epidemiological research.

Align Financial Incentives

A thoughtful integration of payment incentives that focuses on prevention is critical in moving toward elimination of HAIs. Payment policies should provide sufficiently broad incentives to catalyze the development of systems of care that are prevention-oriented. In such systems, prevention of HAIs would not be an added requirement, but would be completely embedded in the processes of care delivery. A broad, strategic approach toward prevention-oriented healthcare payment is likely to shift the focus from strategies based on individual healthcare encounters (i.e. reduced payment for individual HAIs) to performance-modeled payment to providers or groups of providers based on the population-based results (i.e. numbers or rates of HAIs among all hospital admissions, all providers' patients, or particular groups of patients).

Collect Data to Target Prevention Efforts

Timely and accurate data on HAI occurrences are necessary to define the scope of the problem, its variability across locations, and to assess progress toward elimination. Incidence data allows healthcare epidemiologists and IPs to detect HAI trends, to inform clinicians about how best to prioritize prevention interventions, and assess the impact of those interventions. Data also allows public health officials to identify local and regional facilities in need of improvement. Measurement provides institutions and the public with information for comparisons across facilities and regions to better understand current risks for HAIs as well as risks over time.

Excerpted from **Moving toward elimination of healthcare-associated infections: A call to action**

Investments for timely and high-quality data should be focused on:

- Reshaping standard definitions and surveillance methods to fit the new, emerging information system paradigms (e.g. electronic health information records and data mining).
- Creating national and global data standards for key HAI prevention metrics.
- Creating or refining the data analysis and presentation tools available to prevention experts, clinicians, and policymakers at the local, state, national, and international levels.

APIC Public Policy Committee member Barbara Goss-Bottorff meeting with Congressman Dana Rohrabacher.

Adherence to Evidence-Based Prevention Practices

The cornerstone of HAI elimination is to increase adherence to what is already known to be effectively implemented, on the basis of scientific evidence. These recommendations are based on research conducted by experts in prevention and are included in several clinical guidelines.** Adherence to evidence-based practices will require flexibility to respond to the changing healthcare environment. Below are two areas where changes can be made to help the elimination of HAIs:

- Successful HAI prevention strategies have primarily targeted infections in ICUs.

  Prevention efforts must move increasingly into non–critical care hospital settings and nonhospital healthcare settings to achieve the best possible outcomes.

- Collaboration between competing facilities is key to HAI elimination.

  Partnerships among healthcare facilities and health departments have allowed sharing of best practices and strategies. Partnering with payers can also create an incentive for facilities to prevent HAIs by rewarding progress toward elimination.

APIC Board member Patricia J. Metcalf Jackson meeting with Senator Ted Cruz.

Address Gaps in Knowledge

Healthcare professionals need to better understand how and why HAIs occur. Although there are successful prevention initiatives for some device-associated infections in ICUs, research is still needed to develop evidence-based prevention recommendations for many other HAIs. In some cases, additional research is needed to augment a limited understanding of the basic epidemiology of healthcare-associated pathogens (e.g. colonization and transmission dynamics), to inform development of rational prevention strategies.

Excerpted from **Moving toward elimination of healthcare-associated infections: A call to action**

Policymakers and infection preventionists must continue to work together to increase adherence to practices supported by the body of knowledge on existing prevention interventions and toward the alignment of incentives to accelerate the elimination of HAIs. We must invest in research to find innovative solutions to combat challenges, such as antimicrobial resistance, the increasing burden of HAIs outside of traditional hospital settings, and the refinement of existing intervention bundles to be the safest and most cost-effective. We must be flexible and responsive to emerging challenges and the changing healthcare environment. Most of all, we must focus on the patient and must challenge ourselves to no longer accept the unacceptable. HAIs are preventable. We must work together to eliminate HAIs for the generations to come.

***Note:** APIC collaborated with the Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE), and the Pediatric Infectious Diseases Society (PIDS) on **Moving toward elimination of healthcare-associated infections: A call to action**, 2010. The recommendations in this document are detailed in that paper.

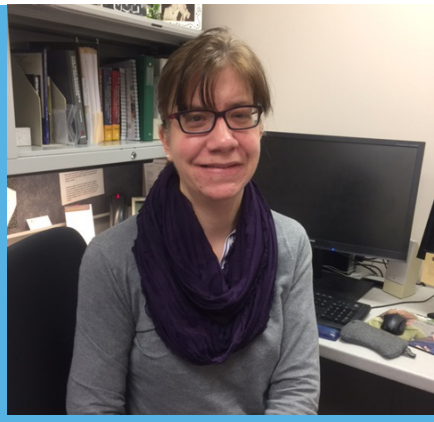
**Source documents include Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee [HICPAC] infection control guidelines, Society for Healthcare Epidemiology of America and Infection Diseases Society of America's Compendium of Practical Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, and APIC's Elimination Guides.

Elimination of Healthcare-associated infections

Click or scan for a brief summary of APIC's position on Elimination of HAIs.

IP ADVOCACY SPOTLIGHT

Theresa Cain, RN, CIC



Theresa Cain, RN, CIC (2008-2009 PPC Chair) first got involved in public policy in her home state of Minnesota. Theresa was a crucial voice for patients and IPs when the state legislature was considering HAI reporting legislation. She led efforts to meet with state legislators to educate them about HAIs and suggested legislative language to make sure the bill did what was actually intended. After her meetings, Theresa started a letter-writing campaign in her chapter to support the APIC-drafted legislation. To her surprise, the letters made a difference!

"During my first few years of involvement in public policy, I was simply inspired and awed by APIC members with more experience. I now realize that the time I invested in APIC public policy activities has paid off ten-fold. I use the advocacy skills I developed every day in my own facility, by improving my writing skills, learning how to organize my arguments, and talking to hospital administrators who do not understand specifics of what I do but make daily decisions about how I do it."

Antibiotic resistance

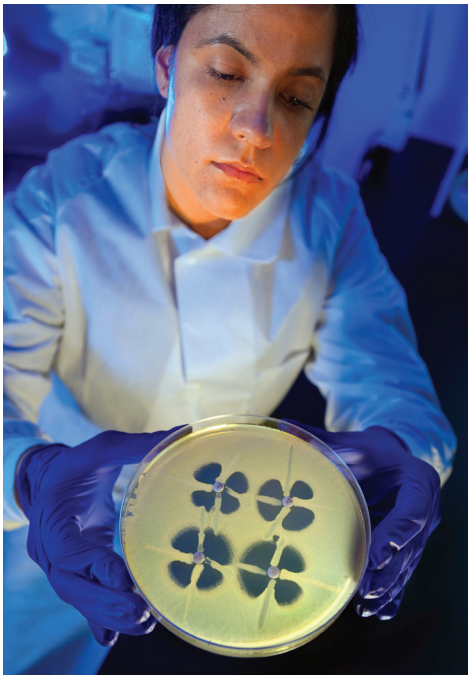
Since their introduction into medicine in 1941, antibiotics have saved millions of lives and transformed modern medicine. As a result, bacterial infections have become easily treatable, and the horizons for surgeries, transplants, and more complicated life-saving procedures have expanded. But increasing antibiotic resistance is leading to higher treatment costs, longer hospital stays, and unnecessary deaths. The more we use antibiotics, the more we contribute to the pool of antibiotic-resistant microbes. The development of resistance is an inevitable byproduct of exposure to antibiotics. All antibiotic use, whether warranted or not, places selection pressure on bacteria, and some organisms that possess genetic mutations will survive antibiotic treatment. Over time, resistance threatens to return us to an era where simple bacterial infections will once again be deadly. **As representatives from a range of fields concerned with human health, we jointly recognize our collective responsibility to protect the effectiveness of all antibiotics – those we have today, and those yet to be developed. We also recognize the potential for these life-saving drugs to be overused in both the human and agricultural sectors. Antibiotics are a shared resource, and every individual should consider how each prescription or use of antibiotics affects the overall effectiveness of the antibiotic arsenal. The problem is defined by challenges on both the demand and supply sides of the equation – just as antibiotics are frequently overused, there are few new drugs in the development pipeline. Understanding this situation, we jointly* commit to the following principles to both conserve and replenish our antibiotic resources:**

- to seek greater coordination among all stakeholders in antibiotic effectiveness, including healthcare personnel, hospital administrators, policymakers, patients, and individuals working in medical centers, universities, and pharmaceutical companies to promote knowledge sharing and a mutual commitment to improving antibiotic use, a practice referred to as antibiotic stewardship;
- to work towards optimizing antibiotic use through antibiotic stewardship programs and interventions, which help ensure that patients get the right antibiotics at the right time for the right duration;
- to identify the most effective examples of antimicrobial stewardship and to replicate these strategies and best practices, while also taking into account local context;
- to support research that deepens our understanding of the current situation and trends in antibiotic resistance and use;
- to use information about the drivers of antibiotic use to contribute to the evolving definition of "appropriate antibiotic use," and to use this definition to guide stewardship efforts, including the education of the general public and healthcare personnel at all levels;
- to improve surveillance for drug-resistant infections and to encourage reporting activities in a way that supports both positive outcomes and accuracy;
- to encourage the development of pharmaceutical products to combat antibiotic resistance, including new antibiotics or novel therapies, compounds to boost antibiotic effectiveness, diagnostics to better diagnose infections and their resistance characteristics, and vaccines to prevent infections from occurring;
- to recognize that antibiotic resistance is one of the world's most pressing public health threats and that global collective action is

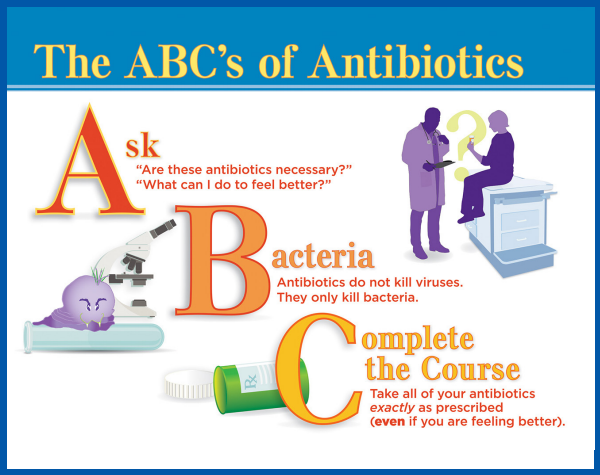
**Note:* *APIC joined with the Alliance for the Prudent Use of Antibiotics, American Academy of Pediatrics, American Academy of Physician Assistants, American Academy of Urgent Care Medicine, American Medical Directors Association, American Public Health Association, American Society of Health System Pharmacists, Association of State and Territorial Health Officials, Center for Disease Dynamics, Economics & Policy, Centers for Disease Control and Prevention, Consumers Union, Council of State and Territorial Epidemiologists, Infectious Diseases Society of America, Institute of Healthcare Improvement, National Association of County and City Health Officials, National Association of Directors of Nursing Administration in Long Term Care, National Association of Public Hospitals, Pediatric Infectious Disease Society, Public Health Foundation, Robert Wood Johnson Foundation, Society of Hospital Medicine, The Pew Charitable Trusts, The Society for Healthcare Epidemiology of America, The Society of Infectious Diseases Pharmacists, and Trust for America's Health on this Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention. The recommendations in this document are detailed in that paper.*

required to effectively address the challenge of managing our scarce supply of effective antibiotics;

- to acknowledge that the way we use antibiotics today in patients impacts how effective they will be in the future in other patients;
- to communicate that antibiotic resistance is an infectious disease and public health concern: some resistant bacteria have the potential to spread rapidly from person to person, which increases the threat of resistant infections;
- to work with regulatory, veterinary and industry partners to promote the judicious use of antibiotics in food animals;
- to reinforce the judicious use of antibiotics in agriculture by: limiting the use of medically important human antibiotics in food animals; supporting the use of such antibiotics in animals only for those uses that are considered necessary for assuring animal health; and having veterinary oversight for such antibiotics used in animals.



CDC microbiologist Johannetsy Avillan shows a modified Hodge test (MHT), which is used to identify bacteria that are resistant to carbapenems (Carbapenem-Resistant Enterobacteriaceae (CRE)), which are considered "last resort" antibiotics, produce a distinctive clover-leaf shaped growth pattern.
Photo Credit: CDC/Melissa Dankel



Excerpted from APIC's "The ABC's of Antibiotics" infographic, created as part of our consumer education efforts. The full graphic can be found on APIC's "Infection Protection and You" website at www.apic.org/infectionpreventionandyou.

Antibiotic Resistance

Click or scan for a brief summary of APIC's position on Antibiotic Resistance.

Antibiotic stewardship

APIC believes that successful efforts to combat antibiotic resistant bacteria must recognize the collective responsibility to protect the effectiveness of all antibiotics – those we have today, and those yet to be developed; recognize the potential for these life-saving drugs to be overused in both the human and agricultural sectors; and recognize that there are challenges on both the demand and supply side of the equation.

APIC has outlined the role of our members, infection preventionists, and how they benefit stewardship programs.

How infection preventionists benefit stewardship programs

Infection preventionists are an interdisciplinary profession, coming from a wide range of backgrounds, primarily in nursing, microbiology, and public health. They work across interdisciplinary lines and in varied care settings to learn, teach and promote infection prevention, patient safety, and healthcare quality improvement.

Because at its root, "Antibiotic Stewardship refers to collaborative, coordinated programs and interventions designed to improve antimicrobial prescribing (i.e., right drug, dose, duration, and route of administration when antibiotics are needed) to optimize clinical outcomes while minimizing unintended consequences of antimicrobial agent use such as toxicity, selection of pathogenic organisms, and emergence of resistance." To encourage facilities to adopt Antibiotic Stewardship programs the Centers for Disease Control and Prevention identified core elements for successful implementation in **hospitals and long-term care facilities** and **outpatient facilities.**

Infection preventionists, healthcare epidemiologists, and infectious disease pharmacists expanded on the CDC core elements to explain the essential role of microbiology laboratory staff and

CDC Core Elements of Antimicrobial Stewardship

HOSPITALS AND LONG-TERM CARE FACILITIES

Element	Description
Leadership commitment	Dedicating necessary human, financial, and information technology resources
Accountability	Appointing a single leader responsible for program outcomes
Drug expertise	Appointing a single pharmacist leader responsible for working to improve antibiotic agent use
Action	Implementing at least 1 recommended action with the goal of improving antimicrobial agent use
Tracking	Monitoring antibiotic prescribing and resistance patterns
Reporting	Regular reporting of information on antibiotic agent use and resistance to doctors, nurses, and relevant staff
Education	Educating clinicians about resistance and optimal prescribing

OUTPATIENT FACILITIES

Element	Description
Commitment	Demonstrate dedication to and accountability for optimizing antibiotic prescribing and patient
Action for policy and practice	Implement at least one policy or practice to improve antibiotic prescribing, assess whether it is working, and modify as needed
Tracking and reporting	Monitoring antibiotic prescribing practices and offer regular feedback to clinicians, or have clinicians assess their own antibiotic prescribing practices themselves
Education and expertise	Provide educational resources to clinicians and patients on antibiotic prescribing, and ensure access to needed expertise on optimizing antibiotic prescribing

clinical microbiologists. Their role includes:

- Assisting in timely and accurate diagnosis;
- Guidance in deciding the appropriate treatment of an ailment ; and,
- Advisement to effectively use molecular diagnostic technology for enhancement of infection prevention and control practices.

(**Manning M, Septimus E, Dodds E, et al. Antimicrobial stewardship and infection prevention-leveraging the synergy: A position paper update, Am J Infect Control 2018 April (46)4:364-368.**)

APIC efforts to promote antibiotic stewardship

APIC promotes antibiotic stewardship through the following activities, some of which overlap with recommendations included in the President's Council of Advisors on Science and Technology (PCAST) Report:

Clinician Education and training

We help healthcare facilities, policymakers and scientific experts better understand antibiotic use and resistance through educational webinars for clinicians and information provided in our practice resources and in-person infection prevention training.

We educate our membership on use of the Antimicrobial Use and Resistance (AUR) module of the National Healthcare Safety Network.

Consumer Education and Education

Through our consumer information network known as "Infection Prevention and You", we produce educational information for consumers such as our recent resource entitled "What is antimicrobial stewardship?" In addition, we have produced consumer-friendly infographics encouraging the proper use of antibiotics. These initiatives are developed to be suitable for clinician and consumer use via social media.

Public Policy initiatives:

- We support antibiotic stewardship efforts promoted by the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB).
- We support including antibiotic stewardship in the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoP).
- We lead and develop organizational support for a coalition to support increased resources for the National Healthcare Safety Network, which will be able to provide real time data on antibiotic use and trends through the AUR module.
- We collaborate on development of proposed meaningful measures that would discourage physicians from inappropriate antibiotic use.
- We support federal funding initiatives that promote antibiotic stewardship programs.
- We support policy recommendations that call for prizes for future development of rapid diagnostics.
- We work with stakeholder groups to continue to monitor the use of antibiotics in the animal agriculture industry and comment to regulatory agencies to promote stewardship when necessary.

For more information on the Centers for Disease Control and Prevention's investments in antibiotic stewardship visit the Antibiotic Resistance Solutions Initiative webpage.

Antibiotic Stewardship

Click or scan for a brief summary of APIC's position on Antibiotic Stewardship.

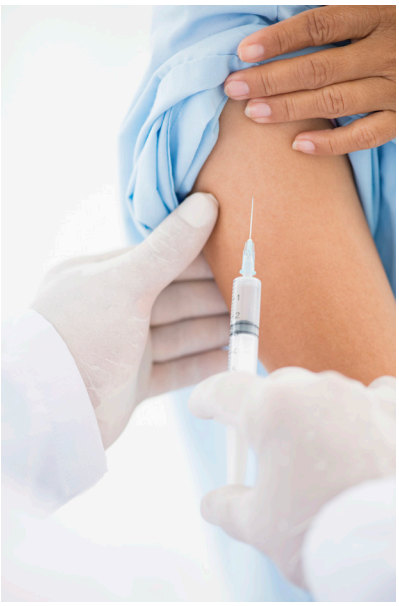
Mandatory influenza vaccination for healthcare personnel

Influenza and Patient Care

Influenza is a serious disease that is associated with high rates of morbidity and mortality. According to the World Health Organization (WHO), an estimated 5% to 15% of the U.S. population is affected by the virus each year. CDC reports that influenza infections result in more than 200,000 hospital admissions. In addition, annual influenza epidemics account for thousands of deaths each year, 3.1 million days of hospitalization, and 31.4 million outpatient visits.*

The most efficient method of preventing annual influenza epidemics and their associated morbidity and mortality, is through vaccination. Due to their exposure to patients, healthcare personnel (HCP) have an increased risk for acquiring influenza. Conversely, patients who are at greatest risk of developing severe complications of influenza are themselves more likely to be exposed through HCP contact. Therefore, one of the most important strategies to decrease influenza transmission to or from high risk persons is to immunize HCP.

To help reduce the spread of influenza in healthcare settings, the CDC has recommended annual influenza vaccinations for HCP since 1981. Despite this recommendation, a large minority of HCP avoid taking proper precautions such as participating in voluntary vaccination programs and not working while ill with influenza.



Public Policy Initiative

APIC believes annual influenza vaccination of HCP offers an important method for preventing transmission of influenza to patients, especially those that are high-risk. Evidence supports the fact that influenza vaccine is effective, cost efficient and successful in reducing morbidity and mortality. Evidence also demonstrates that the current policy of voluntary vaccination has not been effective in achieving acceptable vaccination rates.

APIC supports efforts by policymakers to encourage acute care hospitals, long-term care, and other facilities that employ HCP to require annual influenza immunization as a condition of employment unless there are evidence-based medical contraindications. Mandatory vaccination policies have proven successful in many ways including:

ACTIVE ON ADVOCACY ISSUES

Apply for an Advocacy Scholarship

The Judene Bartley Advocacy in Action Scholarship is an award established by APIC and SHEA for rising leaders in infection prevention and healthcare epidemiology. Awardees receive a scholarship of $1,500 to attend a conference or course dedicated to developing their advocacy skillset. Interested applicants should submit the following to **legislation@apic.org**:

- Curriculum vitae;
- Statement of 700 words or less on the importance of advocacy;
- Letter of reference from an APIC or SHEA member.

Mandatory influenza vaccination for healthcare personnel, continued

- Multifaceted mandatory influenza vaccination programs have been found to be the single most effective strategy to increase HCP vaccination rates, with multiple facilities and systems achieving vaccination coverage of more than 95%.
- Several studies demonstrate that HCP influenza vaccination reduces patient mortality.
- Institutions that have implemented a mandatory policy have dramatically reduced employee absenteeism as well as healthcare-associated influenza, thereby improving patient safety and reducing healthcare costs.
- Influenza vaccines are safe. The most common side effects of the injectable vaccine include temporary soreness, redness, or swelling at the site of injection.

**Depending on the severity and length of the flu season, annual deaths from influenza vary from 3,300-49,000.*

APIC efforts to promote HCP influenza vaccination

As a leader in infection prevention and patient safety, APIC is a vocal supporter of requiring HCP to receive an annual influenza vaccination as a condition of employment. APIC has:

- Issued a position statement outlining our support for mandatory influenza vaccination for HCP;
- Supported including HCP influenza vaccination as a measure for Medicare payment determination in CMS quality reporting programs for acute care hospitals, long-term care hospitals, inpatient rehabilitation facilities, ambulatory surgical centers, inpatient psychiatric facilities, and cancer hospitals;
- Prepared an HCP Immunization toolkit providing infection preventionists and their employee/occupational health colleagues with a full spectrum of tools to assist with the appropriate use of vaccines within an HCP immunization program;
- Presented a webinar explaining the "How To" of employee influenza vaccination programs;
- Promoted National Immunization Awareness Month;
- Offered educational programming at our Annual Conferences related to HCP influenza vaccinations.

For more information, access APIC's position statement on mandatory vaccination.

For more information in HCP influenza vaccination, access http://www.flu.gov/planning-preparedness/hospital/hcworkers_vaccine.html.

Mandatory influenza vaccination for HCP

Click or scan for a brief summary of APIC's position on Mandatory influenza vaccination for HCP.

APIC ADVOCACY TOOLKIT

Last year, APIC introduced a legislative advocacy toolkit that was developed with the help of APIC volunteers in Missouri and Minnesota to help guide chapters interested in planning visits to their state legislatures (The Voice for Infection Prevention (VIP) Advocacy Toolkit). If you still don't think you can do it, APIC Government affairs staff and volunteers have seen from firsthand evidence that you can and they want to partner with you.

To take the first step, contact **legislation@apic.org**.

What is infection prevention surveillance?

In the healthcare arena, infection prevention surveillance is a comprehensive method of measuring and analyzing data. Various healthcare quality outcomes, quality processes, and data are analyzed to provide information to members of the healthcare team to assist in preventing infections while improving outcomes and processes. In short, infection prevention surveillance is used to track and monitor systems within healthcare in order to prevent infections and keep patients well.

How are Healthcare-Associated Infection (HAI) data used?

Continuous monitoring of HAI rates provides the necessary data used to drive improvement initiatives, assess effectiveness of interventions, inform front line workers, and provide information which may be used for comparisons within and between facilities. Surveillance can also be used to quickly identify outbreaks, determine opportunities for clinical care improvement, and inform research studies and agendas.

Background and current state of HAI surveillance

Most organizations perform an annual risk assessment. The risk assessment allows organizations to target surveillance activities based on the needs of the population they serve as well as external regulatory requirements. A manual review of computerized microbiology reports, coupled with other laboratory and patient care information extracted from a variety of sources, both electronic and non-electronic, has historically been the primary method of finding HAIs.

In many cases, HAI data needs to be entered into electronic surveillance systems manually, a practice that can take hours each day. Time spent on manual data entry takes resources away from other important initiatives intended to improve patient safety and outcomes at the bedside hence automation can alleviate some of this burden.

Why standardized data collection is important?

- it is important to know the accurate number and type of infections so comparisons over time are meaningful.
- such information is useful only when it is believable, actionable and reliably used to decrease the number of patient infections by informing prevention efforts.
- it provides a platform for comparing facilities and accurately reporting data to the public.

Complications/difficulties

- The diverse and growing number of federal and state reporting requirements impacts the burden of HAI data collection. As the number of reporting requirements grows, increasing resources will be needed to not only

satisfy reporting requirements, but to assure high quality data and critical front-line infection prevention efforts. In addition, facilities spend a great deal of time and money reporting the same information individually to multiple outside organizations which may use these data for quality improvement programs, hospital ratings, government and/or private payment incentives, or federal/state public health initiatives.

- Collection of accurate data is essential. Despite evidence to the contrary, some continue to believe that existing data retrieved from administrative coding and billing systems (claims data) can be used to collect HAI data; however, this concept has been challenged by the concern that the sole use of administrative data cannot precisely, reliably, nor accurately determine HAIs. Billing data looks to maximize reimbursement based on provider documentation only. On the other hand, HAI surveillance methods use a particular set of evidence-based definitions utilizing the entire medical record to identify infections.
- We believe effective HAI surveillance requires the use of the full range of clinical data available to identify current or predicted HAIs. Effective and efficient surveillance and reporting require the use of standardized, validated definitions for any given HAI. APIC believes the logical choice for this is the National Healthcare Safety Network (NHSN) HAI definitions developed by the Centers for Disease Control and Prevention (CDC).

Automated (or Electronic) Surveillance technology would:

- Streamline and facilitate efficient review of relevant patient data, promoting rapid identification of infections, sentinel events and detection of outbreaks.
- Expand and better define the scope of infection prevention activities into areas beyond the intensive care units where many facilities currently focus their efforts, especially given more healthcare is being provided in outpatient and community-type settings.

Using data to prevent HAIs

Click or scan for a brief summary of APIC's position on Using data to prevent healthcare-associated infections.

IP ADVOCACY SPOTLIGHT

Patricia Gray, RN, BA, CIC, FAPIC

Patricia Gray (APIC's 2012-2013 PPC Chair) serves on APIC's regulatory review panel and is the APIC representative to the National Quality Forum. Patty got involved in advocacy accidentally, while serving as Grand Canyon Chapter President. When faced with the loss of her chapter's legislative representative (CLR) and pending state HAI reporting legislation at the same time Patty stepped forward and went to the legislature to talk about how preventing infections increases patient safety. Her 20 minute testimony before the Senate Health Subcommittee turned into nearly an hour of answering legislators' questions. The state passed a mandatory HAI reporting law with APIC-recommended language, and appointed Patty to the HAI Advisory Committee that was created by the law. **"You don't need an intense knowledge of the legislative process, only a desire to share your clinical knowledge and expertise to effect and improve the quality of care for your patients."**

- Reduce infection prevention department time spent on surveillance and clerical tasks and increase time spent with staff who provide care to patients.
- Improve rapid response to public health issues, for example, during outbreak investigations.
- Facilitate regulatory compliance.
- Enhance antibiotic stewardship programs through interfacing directly with pharmacy and laboratory databases, in order to decrease the transmission of multi-drug resistant organisms.
- Contribute to significant reductions in infections and subsequent cost savings through the utilization of electronic tools.

The Association for Professionals in Infection Control and Epidemiology (APIC) supports the following:

- The CDC/NHSN standardized definitions should be considered and utilized as the gold standard to identify, analyze, report and compare HAIs.
- The CDC/NHSN comparative database should be used to promote the reduction of and assess progress towards elimination of HAIs.
- The exclusive use of administrative coding and billing systems (claims data) data should not be used as a sole source for HAI identification as it is not a precise measure for identifying healthcare-associated infections. Further, it does not facilitate the real-time implementation of targeted prevention strategies.
- The need for and use of robust electronic surveillance technology systems is integral to swiftly informing infection prevention strategies and their effectiveness.
- Validation of findings from surveillance for HAIs is an essential component of the process that facilitates meaningful comparison of HAI findings in a standardized, unbiased manner.

For additional information:

The Use of Administrative Date for Identification of Healthcare-Associated Infections in US Hospitals

The Importance of Surveillance Technologies in the Prevention of Healthcare-Associated Infections

APIC Public Policy Committee member Linda Johnson meeting with a member staff from the Missouri delegation.

Maine Chapter Legislative Representative Troy Cutler meeting with Senator Susan Collins (R-ME).

APIC Public Policy Committee Chair Mary Alice Lavin meeting with a member of Jan Schakowsky's staff.

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Sitting (left to right): Ann Marie Pettis, Linda Greene, Katrina Crist, Janet Haas, Karen Hoffmann, Sharon Williamson

Public Policy Committee

Chair: Mary Alice Lavin, RN, MJ, CIC, FAPIC

Mary Alice Lavin

Mary Alice Lavin graduated from Marquette University with a Bachelor of Science in Nursing and Loyola University Chicago School of Law with a Master of Jurisprudence in Health Law. With more than 32 years of experience in infection prevention and control, she has worked in a variety of settings. Currently she is a consultant contracted with APIC Consulting Services, Inc. for the Chicago Department of Public Health Centers for Disease Control and Prevention grant funded infection prevention and control work. A member of APIC since 1983, Mary Alice has been Certified in Infection Control since 1984, and became a Fellow of the Association for Professionals in Infection Control and Epidemiology in 2016. She has served as the Nominating Chair, Chapter Legislative Representative, and President of the Chicago Chapter of APIC. Mary Alice has served on the Public Policy Committee since March 2013 and currently is the Chair.

She has presented on topics including infection control aspects of construction/renovation, ambulatory care, MRSA, CRE, influenza, regulatory issues, and *Candida auris*. Mary Alice has worked collaboratively for 16 years with the local and state health departments in the prevention and control of communicable diseases in healthcare organizations.

Vice Chair: Sarah Smathers, MPH, CIC, FAPIC

Sarah Smathers

Sarah Smathers, is the Senior Manager of Infection Prevention and Control at the Children's Hospital of Philadelphia (CHOP). She is the co-chair of the Infection Prevention and Control (IPC) Committee at CHOP, President-Elect for the Delaware Valley/Philadelphia Chapter of the Association for Professionals in Infection Control and Epidemiology (APIC) and the Vice Chair of the APIC Public Policy Committee. Sarah has conducted research in infectious diseases and infection prevention and control in the areas of Clostridium difficile, multi-drug resistant organisms, and healthcare-associated infection prevention and has a special interest in the professional development of infection preventionists and design of IPC programs. She has worked at CHOP since 2006 and has been certified in Infection Control since 2010, becoming an APIC Fellow in 2016. Sarah has presented at national conferences including APIC, SHEA and IDWeek and has published on the epidemiology and prevention of infectious diseases. Sarah has a biology degree from Kalamazoo College and earned her master in public health degree from the University of Michigan in Hospital and Molecular Epidemiology.

Committee Members:

Vicki Brinsko, MSN, RN, CIC, FAPIC
Lauren Fish, MPH, RN, CIC
Barbara Goss-Bottorff, RN, MPH, MSN, CNS, CIC, FAPIC
Linda Johnson, RN, MSN, CIC, FAPIC
Gwen Rogers, DBA, RN, CIC, FAPIC
Giovanna (Gio) Santovito-Carducci, RN, BSN, MPH, CIC
Cassandra (Casey) Sherman, BS, CIC
Boyd Wilson, MT(ASCP), MS, CIC, FAPIC
Annemarie Flood, RN, BSN, MPH, CIC, FAPIC – *Senior Advisor*

Interested in Serving on the Public Policy Committee?

As a member of the APIC Public Policy Committee, you will help monitor and prepare input into legislative and regulatory initiatives affecting the practice of infection prevention. If you are interested in serving on the Committee, download the volunteer application at **http://www.apic.org/About-APIC/Committees** and submit it to the APIC membership department at **membership@apic.org.**

Chapter Legislative Representatives (CLRs)

CLRs are the primary voice for communicating APIC policy positions and initiatives to members of their chapter. In addition, CLRs bring forward to APIC staff and the Public Policy Committee any public policy issues that arise in their chapter and state. These are the 2018 APIC CLRs:

NAME	CHAPTER
Alabama	Beth Goodall, RN, BSN, CIC
Arkansas	Amy Wilson, MLS(ASCP)CM, CIC
Badger	Heather Kloth, RN, BSN
Bay Area	Valerie J. Henderson, RN, CIC, MA
Blackhawk	Margaret A. Kochsmier, MSN, RN, CMSRN, CIC
Blue Grass	Emily E. Mills, CIC
Broward/Palm Beach Counties	Colette Klemenz, RN
California APIC Coordinating Council	Jessica L. Silvaggio, MPH, CIC
Central Florida	Melyssa M. Callahan, RN
Central Illinois	Amy L. Arnett, RN, MS, CPHQ
Central Iowa	Nancy Wilde
Central Ohio	William A. Pfeifer, RN, CIC
Chattahoochee Valley	Bonnie S. Norrick, MT(ASCP), EdM, CIC
Chicago Metropolitan Area	Anjali Bisht, MPH
Coastline	Jennifer M. Murray, RN, BSN, PHN, CIC
Corpus Christi	Dana Piatek, RN, MSN, CIC
Dacotah Plains	Shannon G. Hansen, MT(ASCP), CIC
Dallas-Fort Worth	Rachel Watson, MPH, CIC
Delaware Valley and Philadelphia	Sharon Marie Bradley, RN, CIC
East Central Pennsylvania	Theresa M. Haley, BS MT (ASCP) CIC
East Texas Chapter	Sandra A. Small, BS , MLT(ASCP), CIC
Eastern Iowa	Jennifer Ann VanderZee, MBA, BSN, RN, CIC
Eastern Ohio-Western Pennsylvania	Renee L. Rush, BSN
Grand Canyon	Pamela Anne Short, RN, MSN-Ed
Great Lakes	Amanda Marie Valyko, MPH, CIC
Greater Baltimore	Daphne Morgan, RN, MSN, CIC
Greater Buffalo	Ellen M. Eckhardt, RN, BSN, MS
Greater Chattanooga Area	Susan B. Berry, RN, BSN, CIC
Greater Jackson	Melinda L. Grubb, RN, CIC

CLRs, continued

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Greater Los Angeles	Alisa Ritea, RN, BSN
Greater New York	George D. Allen, PhD, CIC, FAPIC
Greater Omaha	Larry E. Krebsbach, CIC, REHS
Hawaii	Mary Wheaton, RN
Heart of America	Vivian L. Nutsch, RN
Heart of New York	Heather L. Bernard, DNP, RN, CIC, FAPIC
Heart of Texas	Pamela A. Douglas, MSN, RN, CIC
Houston	Jennifer M. McCarty, MPH, CIC
Inland Empire	Teresa A. Nelson, RN, BS CIC
Inland-Northwest	Georgia Ann Gauron, RN, BSN, MA, CIC
Kentuckiana	Sarah Marie Bishop, MSN, APRN, CCNS
Kern Rivers	Farrah J. Tehrani, RN
Long Island	Susan Bayh-Martino, RN, MBA, CIC
Memphis	Cindy York, RN, CIC
Middle Tennessee	Patrice J. Parrish, RN
Mile High Colorado	Christina L. Ewers, BSN, MSN
Mile High Colorado	Tara Janosz, MPH, CIC
Minnesota	Marsha M. Studer, RN, MPH
Mobile Bay Area	Hannah Beaton, RN
Montana	Jordan Zepeda, CIC
New England	Rob Taylor, RN, BS, IP
New Mexico	Kerry Flint, RN, MSN, CIC
North Carolina	Jodi West, LPN
North Central Wisconsin	Paul John Thomas, RN, BSN, CIC
Northeast Florida	Marilyn Middlebrooks, BSN,RN,CCRN, CIC
Northeast Ohio	Janine Journey, BSN,RN,CIC
Northeastern New York	Michelle Kaiser, CIC
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Northwest Ohio	Ann Keegan, BSN, RN, CIC
Northwestern Pennsylvania	Michele Welker, RN,BSN
Oklahoma O.K.	Lela L. Luper, RN, BS, CIC, FAPIC
Orange County	Damaris A. Torres, RN/PHN/BSN
Oregon and Southern Washington	Julie A. Koch, RN, MSN, CIC
Palmetto	Jan Boggs Lienau, CIC

CLRs, continued

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Pine Tree	Troy Cutler, RN, CIC
Puget Sound	Jamie Elizabeth Moran, MSN, RN, CIC
Rio Grande Valley	Belinda A. Medrano, MPH
River Region	Lisa D. Stamper, RN, BSN, CIC
Rochester Finger Lakes	Carol M. Tinoglio, RN
San Antonio	Marceau Julia Doze, MS MPH MSN IC CIC RN
San Diego & Imperial County	Christine S. Chapman, BSN, CIC
San Francisco Bay Area	Debra D. Johnson, RN, BSN, CIC, FAPIC
San Joaquin Valley	Tommie Clark, RN, MPH
Show-Me Central	Linda S. Johnson, RN, MSN, CIC, FAPIC
Sierra	Andree Sue Guest, RN,BSN,CIC
Smoky Mountain	Donald W. Chill, MSPH,SM(NRCM)&(ASCP)
Southeast Mississippi	Carlin Ann Necaise, BSN
Southeastern Wisconsin	Heather Kloth, RN, BSN
Southern Illinois	Kathryn Lynn Godsey, RN, CIC, CPHQ
Southwest Missouri	Bernadette Renee Meyer, BSN, RN
Southern Nevada	Mary Jo Foreman, RN, CIC
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Three Rivers/Pittsburgh	Suzanne Marie Mamrose-Hunt, MT (ASCP), MPH, CIC
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Virginia	Karen M. McGoldrick, MT(ASCP), CIC
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Wine Country	Carole Cole-Wandzilak, RN, MPA, CIC

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