



Illinois Action Plan to Prevent
Health Care-Associated Infections and
Antimicrobial Resistance

2025 - 2030

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Executive Summary

Infection and transmission of microorganisms acquired during health care remain a threat in all health care settings. The Centers for Disease Control and Prevention (CDC) reports that on a daily basis, 1 in 31 hospitalized individuals has a health care-associated infection (HAI).¹ Individuals residing in long-term care facilities (LTCFs) acquire an estimated 2 million infections yearly.² The CDC estimates that about 47 million unneeded antibiotic courses are prescribed annually in doctor's offices and emergency departments in the United States.³ While progress has been made to reduce HAIs and decrease transmission of multi-drug resistant organisms (MDROs) across the continuum of health care, the SARS-CoV-2 pandemic response resulted in a setback in HAI/antimicrobial-resistant (AR) organism prevention efforts.

The *Illinois Action Plan to Prevent Health Care-Associated Infections and Antimicrobial Resistance* (HAI/AR Plan) aims to provide a roadmap for refocused prevention and reduction efforts. It guides efforts for best practice dissemination, outbreak response preparedness, antimicrobial stewardship, and prevention of extensively drug-resistant organisms (XDROs), all with the lens of eliminating disparities and advancing equity throughout Illinois. Promoting quality care and improving health care safety are the top priorities of the HAI/AR Plan.

While prevention of all HAIs is essential, this action plan focuses on prevention, control, and containment of XDROs, such as carbapenem-resistant Enterobacteriales (CRE), *Candida auris*, and other emerging pathogens of public health concern across the continuum of care. Noting that emerging pathogens may first appear in the community, the plan establishes measures to collect data on such pathogens and prepares for responding to emerging pathogens. The plan has an additional focus on infections reported to the National Health Care Safety Network (NHSN).

It is important to note that supplemental funding from the CDC resulting from the pandemic response allowed the HAI/AR program to expand outreach, educational offerings, and response efforts. Sustained funding will be critical to achieving the goals outlined in the HAI/AR Plan.

Figure 1: Vision and Mission



The Illinois HAI/AR Prevention Advisory Council created the vision and mission at its first retreat in 2016 and has continued to use these statements to guide the drafting updated action plan's goals.

Priority Areas and Goals

In 2023, the Illinois Department of Public Health (IDPH) Division of Patient Safety and Quality (DPSQ) led a strategic planning process to update the HAI/AR Plan. This process involved gathering input from a diverse group

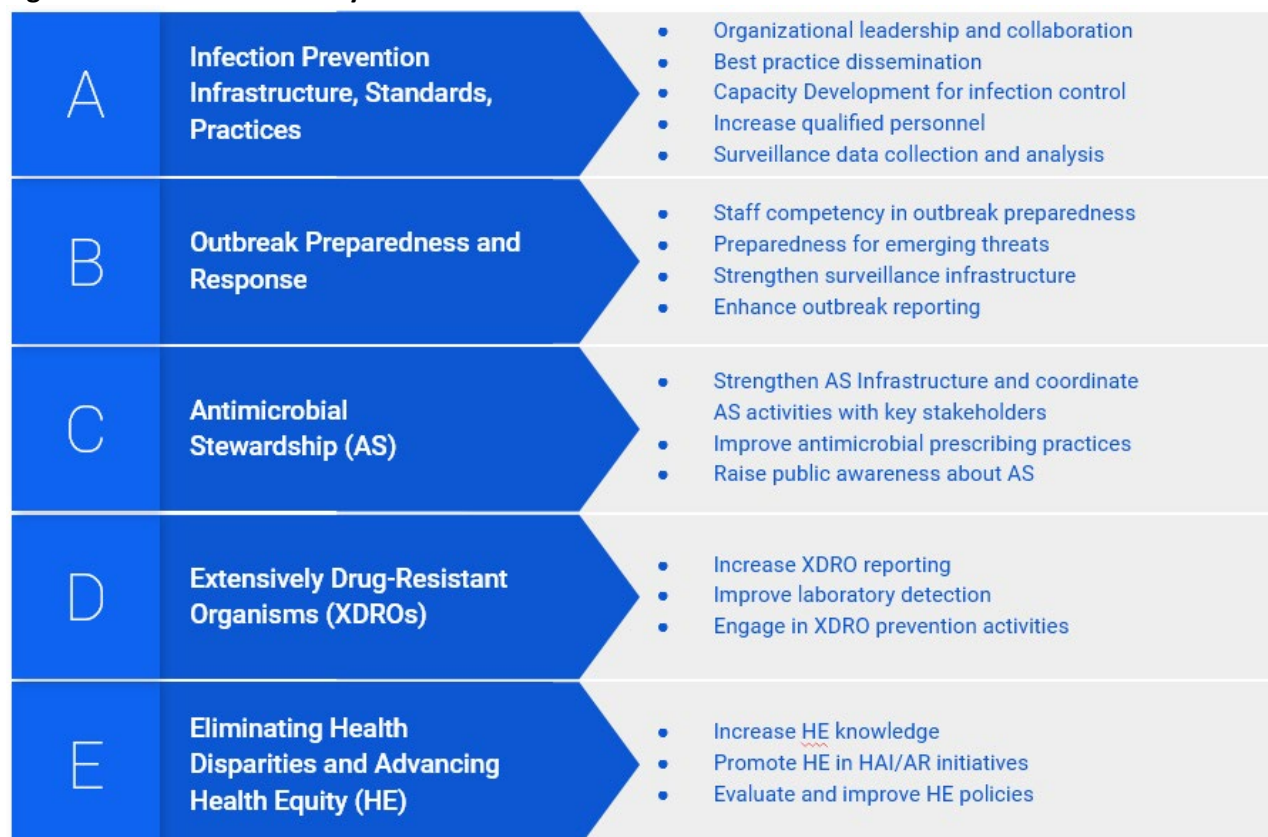
¹ Centers for Disease Control and Prevention. Health care Associated Infections. Health Department HAI/AR Programs. Available at: <https://www.cdc.gov/health-care-associated-infections/programs/index.html> Accessed June 19, 2024.

² Strausbaugh LJ, Joseph CL. The burden of infection in long-term care. *ICHE*. 2000;21:674–679.

³ Centers for Disease Control and Prevention. Health care Associated Infections. Health Department HAI/AR Programs. Available at: <https://www.cdc.gov/health-care-associated-infections/programs/index.html> Accessed June 19, 2024.

of more than 80 stakeholders and staff to assess the current state and future of IDPH’s efforts to prevent HAI/AR in Illinois. Two strategic planning workshops were convened in September and October of 2023 and were followed by workgroup calls. These resulted in five strategic priorities to drive statewide HAI/AR activities during 2025-2030. Figure 2 (below) outlines the five priority areas and the strategic goals for each major area. These priority areas were identified through an analysis of compiled data to understand the current landscape of HAI/AR in Illinois (summarized in the background section further below) and an exploration of IDPH’s strengths, weaknesses, opportunities, and threats. These priorities form a comprehensive strategy to fortify Illinois’ health care system against infectious threats while promoting equitable health outcomes statewide.

Figure 2: 2025 – 2030 Priority Areas



Priority Area A: Infection Prevention Infrastructure, Standards, Practices

- Goal #1: Implement a comprehensive and effective infection prevention and control system with standards, policies, and practices in place for all health care settings.
 - Objective 1.1: Provide organizational leadership for coordination and collaboration between public health and all health care settings across the continuum of care.
 - Objective 1.2: Develop sustainable capacities to assess and address infection prevention and control gaps throughout Illinois.
 - Objective 1.3: Increase the number of health care facilities with qualified personnel to implement effective infection prevention and control programs.
 - Objective 1.4: Collect, analyze, interpret, and report HAI/AR surveillance data to direct and inform actions.

Priority Area B: Outbreak Preparedness and Response

- Goal #2: Improve detection, investigation, and response to outbreaks of AR organisms in health care settings and the general community.
 - Objective 2.1: Increase knowledge and competency of relevant health care facilities and public health staff about outbreak preparedness, definitions, containment, and resolutions.

- Objective 2.2: Prepare for emerging communicable disease threats that may enter health care settings.
- Objective 2.3: Strengthen and expand the surveillance system infrastructure for detecting infectious outbreaks across acute care and non-acute care settings and emerging pathogens in the general community.
- Objective 2.4: Improve HAI and AR outbreak reporting across all health care settings.

Priority Area C: Antimicrobial Stewardship

- Goal #3: Strengthen public health and health care facility infrastructure to facilitate antimicrobial stewardship (AS) work.
 - Objective 3.1. Identify designated personnel and key stakeholders to coordinate and support state and local health department AS initiatives.
- Goal #4: Improve antimicrobial prescribing practices across all health care settings
 - Objective 4.1. Enhance AS implementation across health care settings.
 - Objective 4.2. Evaluate AS practices and monitor antimicrobial prescribing and use.
 - Objective 4.3. Promote transparency and communication.
- Goal #5: Raise public awareness about appropriate antimicrobial use, incorporating the CDC One Health initiatives.
 - Objective 5.1. Provide education to the general public on antimicrobial resistance and appropriate antimicrobial use, incorporating CDC One Health initiatives.

Priority Area D: Extensively Drug-Resistant Organisms (XDROs)

- Goal #6: Slow the emergence of antimicrobial-resistant organisms and prevent their transmission.
 - Objective 6.1. Increase reporting of antimicrobial-resistant organisms to surveillance systems and enhance those systems.
 - Objective 6.2. Enhance laboratory testing and detection of antimicrobial-resistant organisms and mechanisms of resistance.
 - Objective 6.3. Engage health care facilities in prevention activities for XDROs.

Priority Area E: Eliminating Health Disparities and Advancing Health Equity

- Goal #7: Bring awareness of health equity to all partners in health care settings in Illinois and utilize data to address health inequities and disparities where they exist.
 - Objective 7.1. Increase knowledge and competency of health equity related to HAI/AR among external and internal partners.
 - Objective 7.2. Collaborate with and mobilize key partners to reduce health disparities related to HAI/AR in health care settings.
 - Objective 7.3. Evaluate current health equity policies and identify areas for improvement to reduce HAIs and AR health disparities.

HAI/AR and Antimicrobial Stewardship Background in Illinois

The advisory council discussed current and past efforts in Illinois to prevent and monitor AR and HAIs. The following was used to guide action planning.

COVID-19 Pandemic

CDC reported an increase in hospital-onset AR infections and deaths by at least 15% during the first year of the COVID-19 pandemic and that much of the pre-pandemic progress on HAI/AR and antimicrobial stewardship (AS) had been lost.⁴ The pandemic highlighted critical health care facility capacity gaps and infection prevention and control (IPC) capabilities. The pandemic response also spurred increased but time-limited funding to expand public health infrastructure and address these gaps. As a result, Illinois' governmental public health substantively increased engagement with congregate care facilities, where the greatest needs were identified.

Infection Prevention and Control

In 2015, IDPH received CDC funding to establish the Infection Prevention Liaison Program (IPLP). Initially spearheaded by IDPH grantees, the program provided health care facilities free onsite infection control assessment and response (ICAR) visits and consultation from IPC experts. The IPLP led to the development of the IDPH Division of Medical Services' Regional Infection Prevention Program (RIPP) in 2023, staffed by seven regional infection control coordinators and a medical advisor.

To set standards for IPC in long-term care (LTC), Illinois has mandated infection preventionist (IP) staffing in skilled nursing and intermediate care facilities. The mandate includes a requirement for IP training. To assist with the training requirement, IPLP provides LTC IP training sessions, ongoing education (e.g., biweekly IPC webinars), and resources (e.g., Enhanced Barrier Precautions toolkit).

Antimicrobial Stewardship

In recent years, there has been an overall increase in the implementation of crucial stewardship activities across health care settings, driven by facility leadership, resources, and priorities; statewide commitment to stewardship efforts; regional collaborations focused on improving antibiotic use; and accreditation requirements.

In 2022, nearly 98% of Illinois hospitals reported implementing all seven [CDC Core Elements of Hospital Antibiotic Stewardship Programs](#). To help enhance the quality and impact of existing antibiotic stewardship programs (ASPs), the CDC released the [Priorities for Hospital Core Element Implementation \(Priorities\)](#) in 2022. The priorities have been identified for six of the seven core elements and highlight highly effective implementation approaches supported by evidence and stewardship experts. In 2022, only 6.5% of Illinois hospitals reported uptake of all six Priorities for Hospital Core Element Implementation. Less than 40% of Illinois hospitals reported submitting antimicrobial use data to the NHSN Antimicrobial Use option compared to 47.8% nationwide. In 2022, 87% of Illinois long-term care facilities (LTCF) reporting to the NHSN LTCF Component reported implementing all seven [CDC Core Elements of Antibiotic Stewardship Programs for Nursing Homes](#), compared to 83% nationwide. In the outpatient setting, antibiotic prescribing in Illinois outpatient settings is similar to the national average (701 vs 709 per 1,000 population in 2022).

IDPH recognizes the importance of antimicrobial stewardship in improving patient outcomes and mitigating antimicrobial resistance in Illinois and has employed a multipronged approach to promote appropriate prescribing and use across all health care settings in Illinois. These efforts focus on assessing knowledge and

⁴ Centers for Disease Control and Prevention (CDC). COVID-19: U.S. Impact on Antimicrobial Resistance, Special Report 2022. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2022. Available at <https://www.cdc.gov/antimicrobial-resistance/data-research/threats/COVID-19.html>

practices related to antimicrobial prescribing, organizing activities, and educational resources to facilitate learning and professional development, and conducting communication activities to promote judicious antimicrobial use among health care professionals and the general public.

Since 2013, IDPH has partnered with various organizations to co-host the annual Illinois Summit on Antimicrobial Stewardship, a one-day in-person training and best practice-sharing event that consistently brings together more than 250 providers across health care settings. IDPH-organized U.S. Antibiotic Awareness Week (USAAW) webinars targeting health care professionals have been well attended, with nearly 200 attendees annually. In 2023, IDPH publicly recognized eight health care facilities, local health departments, and organizations as part of the USAAW “Spotlight on Antimicrobial Stewardship.” In the long-term care setting, since 2021, IDPH has engaged nearly 900 health care professionals from approximately 300 facilities statewide through regional workshops and educational webinars. In 2023, IDPH recruited 12 long-term care facilities and four hospitals to participate in the Partnering Acute and Long-Term Care to Advance Antimicrobial Stewardship Efforts (PALASE) Collaborative, a 1:1 hospital-nursing home partnership aimed to strengthen cross-setting partnerships and establish successful and sustainable ASPs in long-term care settings. Outpatient efforts have engaged 34 immediate care centers, 17 of which provide care in underserved communities. Engaging more outpatient facilities statewide remains a high priority.

Extensively Drug-Resistant Organisms

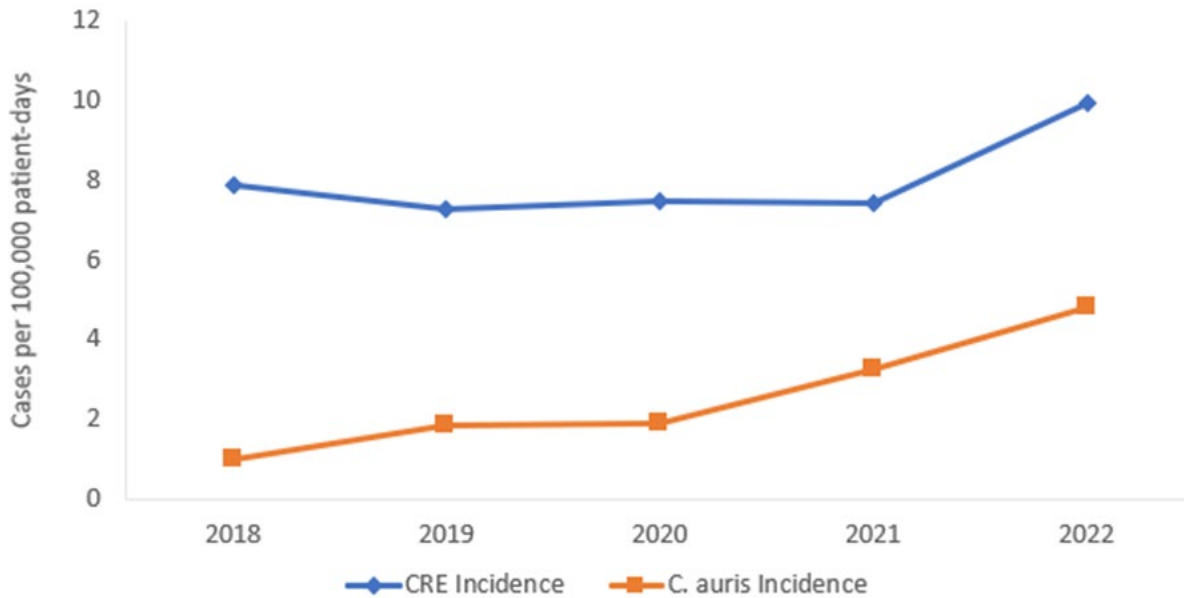
The [Extensively Drug-Resistant Organism \(XDRO\) registry](#) was created to improve surveillance and inter-facility communication of targeted XDROs; initially launched for CRE in 2013, *Candida auris*, carbapenemase-producing *Pseudomonas aeruginosa* (CP-CRPA), and carbapenem-resistant *Acinetobacter baumannii* (CRAB) were later added. Facilities can query or receive automated alerts from the XDRO registry when a patient is admitted to their facility. If the patient has a reported history of XDROs, appropriate infection control and prevention measures should be started. In 2023, alerting was available only for hospitals, but a pilot for long-term care alerts was launched in 2024 and will be completed in 2025. Querying or auto alerting became mandatory for hospitals, long-term acute care hospitals, skilled nursing and intermediate care facilities, and dialysis facilities as of February 2024. Reporting is also still a manual data entry process with no data flow to the Illinois-National Electronic Disease Surveillance System (I-NEDSS; later replaced by the Illinois Disease Surveillance System, IDSS).

In 2016, the CDC established the [Antimicrobial Resistance Laboratory Network](#) to provide MDRO testing at the state and regional levels. As of 2023, the IDPH Chicago laboratory had limited capacity to test CRE and CP-CRPA clinical isolates for the five major carbapenemases (KPC, NDM, VIM, IMP, OXA-48-like) and carbapenemase production. The Wisconsin State Laboratory of Hygiene, Illinois’ regional laboratory, can test CRE, CP-CRPA, CRAB, and *C. auris* clinical isolates and screening swabs.

IDPH referenced the CDC CRE Toolkit to inform CRE response and IPC activities. Since the last HAI/AR Action Plan, the CDC has published guidance for and provided funding to public health departments to implement [MDRO Containment](#) and [Prevention](#) strategies. IDPH now follows and structures prevention and response activities per these two guidance documents.

Using case data reported by Illinois acute care and critical access hospitals to the XDRO registry and patient days reported to NHSN, the CRE and *C. auris* incidence was assessed from 2018 to 2022. CRE incidence decreased or remained steady from 2018 – 2021, then increased by 34% from 2021 – 2022 (Figure 3). The *C. auris* incidence rate increased by 378%, from 1.01 per 100,000 patient days in 2018 to 4.83 per 100,000 patient days in 2022. Pilot surveillance of CRAB from 2019 – 2022 identified more than 1,100 clinical cases, with OXA-24/40 being the predominant carbapenemase detected. These numbers indicate the continued need for enhanced testing, surveillance, prevention, and response for XDROs.

Figure 3. Incidence of clinical CRE and *C. auris* cases among patients in Illinois acute care and critical access hospitals, 2018 – 2022



Health Care-Associated Infections as Reported to the National Health Care Safety Network (NHSN)

In Illinois, facilities’ HAIs are compared using the [standardized infection ratio](#) (SIR). The SIR adjusts for risk factors that are significant predictors of HAI infection incidence in a facility. It is a risk-adjusted summary statistic used to measure the relative difference in health care facility-onset (HO) events during a reporting period compared to a standard national referent period. Given the standard population, the SIR is the ratio of the actual number of HAIs reported to what would be expected.

If the SIR value exceeds 1.0, there are more infections than expected. If the SIR value is less than 1.0, then fewer infections occur than expected. If the facility SIR is 1.0, then the number of observed infections is the same or similar to the national infection rate. The three categories summarizing how a hospital compares to the national infection data for procedures performed are highlighted below:

- Statistically fewer (lower) infections than predicted based on national infection data,
- statistically similar (similar) infections as predicted based on the national infection data, or
- statistically more (higher) infections than predicted based on national infection data.

The SIRs for central line-associated bloodstream infections (CLABSI) in acute care hospitals and *Clostridioides difficile* infection (CDI) SIRs for critical access hospitals were notable.

Central line-associated bloodstream infection (CLABSI)

From 2019 to 2020, the standardized infection ratios (SIR) for CLABSI in acute care hospitals increased from ‘lower’ than to ‘similar’ to the national baseline (Table 1). Then, in 2022, the SIR for CLABSI was significantly higher than the national baseline. However, in 2023, the CLABSI SIR in acute care hospitals for the adult ICU was considerably lower than the national average (Table 1 and Figure 4).

When comparing Illinois' performance to itself over time, a statistically significant increase of 37% in CLABSI SIR was observed from 2019 to 2020 (Table 2). This increase may be due to the increased utilization of ICUs during the COVID-19 pandemic.

The years following the pandemic have seen a normalization of percentage.

Table 1. Summary of NHSN CLABSI in Illinois acute care hospitals – Adult ICU, 2018 – 2023

Reporting Year	# of Units Reporting Any Data	Number of CLABSI Infections		Standardized Infection Ratio (SIR)	95% Confidence Interval (SIR)		Statistical Interpretation (Comparison to National Baseline)
		Observed	Predicted		Lower	Upper	
2018	124	233	336	0.69	0.609	0.787	Lower
2019	123	255	337	0.76	0.668	0.854	Lower
2020	123	375	361	1.04	0.937	1.147	Similar
2021	206	437	400	1.09	0.995	1.200	Similar
2022	198	411	364	1.13	1.023	1.241	Higher
2023	194	269	329	0.82	0.724	0.920	Lower

Figure 4. Trend of NHSN CLABSI in Illinois acute care hospitals – Adult ICU, 2018 – 2023

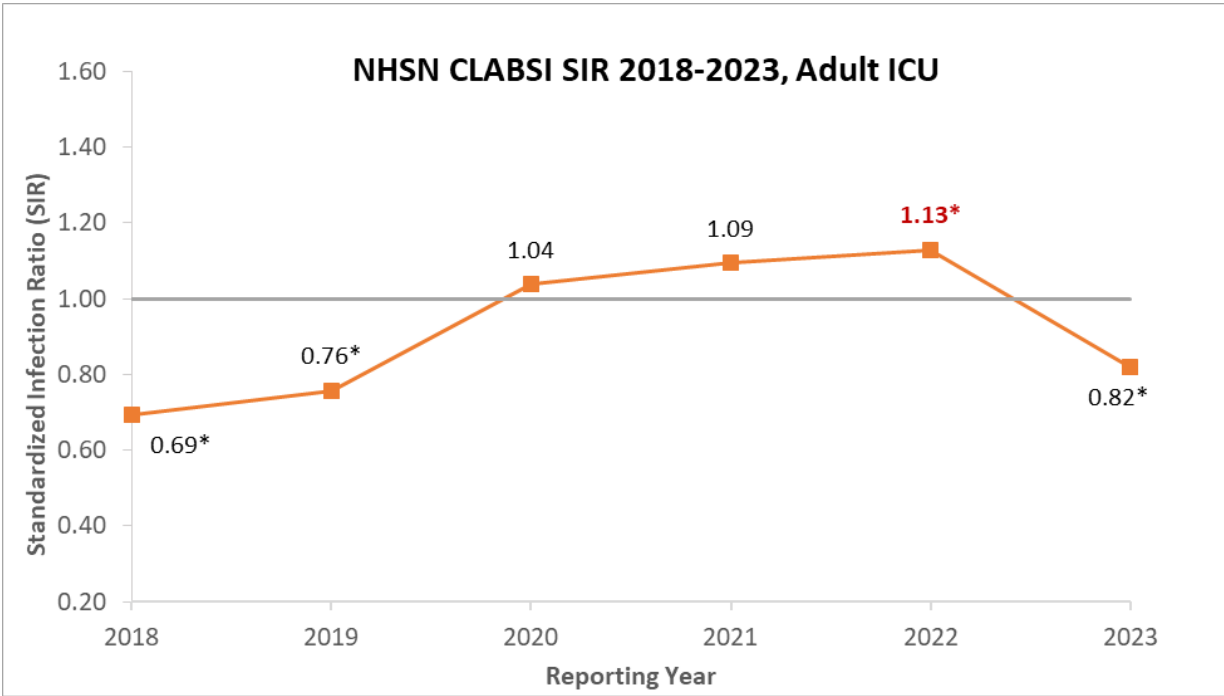


Table 2. Summary of CLABSI SIR percent change in Illinois acute care hospitals – Adult ICU, 2018 – 2023

Trend Range (Reporting Year)	% Change (SIR) 95% Confidence Interval	p-value (SIR)	Statistical Interpretation
2018 vs. 2019	9% (0.914, 1.304)	0.336	Increase/Not Significant
2019 vs. 2020	37% (1.171, 1.611)	<0.001[^]	Significant Increase
2020 vs. 2021	5% (0.916, 1.208)	0.474	Increase/Not Significant
2021 vs. 2022	3% (0.903, 1.183)	0.631	Increase/Not Significant
2022 vs. 2023	-28% (0.62, 0.844)	<0.001 [^]	Significant Decrease

[^] denotes a statistically significant change

C. difficile Infection

The SIR for *C. difficile* infections in Illinois critical access hospitals was similar to the national baseline in 2018, 2020, 2021, and 2023. In 2019 and 2022, the SIRs were 35% and 38% higher than the national baseline (Table 3 and Figure 5).

When comparing Illinois performance to itself over time, a statistically significant decrease of 44% of CDI was observed from 2019 to 2020 (Table 4). This decrease may be due to the pause in reporting CDI and the escalating COVID-19 pandemic. The years following the pandemic saw a fluctuation of percent change; however, they were not statistically significant.

Table 3. Summary of CDI in Illinois critical access hospitals, 2018 – 2023

Reporting Year	# of Facilities Reported	Number of CDIs		Standardized Infection Ratio (SIR)	95% Confidence Interval (SIR)		Statistical Interpretation (Compared to National Baseline)
		Observed	Predicted		Lower	Upper	
2018	49	41	40	1.02	0.739	1.365	Similar
2019	49	50	37	1.35	1.015	1.770	Higher
2020	48	27	36	0.75	0.504	1.075	Similar
2021	48	39	35	1.10	0.793	1.489	Similar
2022	51	54	39	1.38	1.048	1.788	Higher
2023	50	41	39	1.05	0.762	1.409	Similar

Figure 5. Trend of CDI SIRs in Illinois critical access hospitals, 2018 – 2023

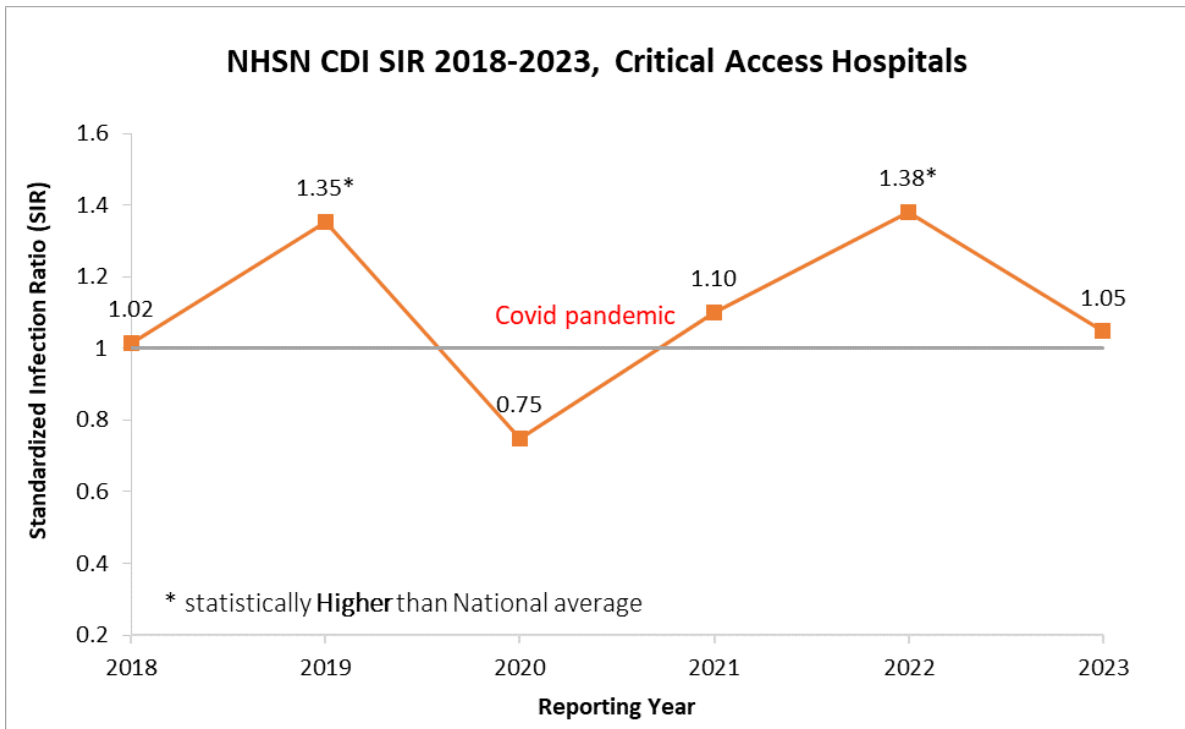


Table 4. Summary of CDI percent change in Illinois critical access hospitals, 2018 – 2023

Trend Range (Reporting Year)	% Change (SIR) 95% Confidence Interval	p-value (SIR)	Statistical Interpretation
2018 vs. 2019	32% (0.872, 2.002)	0.191	Increase/Not Significant
2019 vs. 2020	-44% (0.343, 0.882)	0.012[^]	Significant Decrease
2020 vs. 2021	49% (0.911, 2.451)	0.137	Increase/Not Significant
2021 vs. 2022	24% (0.824, 1.887)	0.303	Increase/Not Significant
2022 vs. 2023	-24% (0.503, 1.139)	0.184	Decrease/Not Significant

[^] denotes a statistically significant change

Health Equity

Health equity is a new priority area in Illinois's HAI/AR Strategic Plan. The HAI/AR program plays a crucial role in raising awareness of health equity among all partners in health care settings across Illinois and utilizing data to identify health inequities and disparities where they exist. The new priority will focus on addressing HAI/AR-related health disparities and implementing activities and programs to promote health equity throughout the state.

HAI/AR Action Plan

Priority Area A: Infection Prevention Infrastructure, Standards, and Practices		
Goal #1: Implement a comprehensive and effective infection prevention and control system with standards, policies, and practices in place for all health care settings.		
Objective 1.1: Provide organizational leadership for coordination and collaboration between public health and health care settings across the continuum of care.		
Strategy/Task	Performance Indicator	Targets/Dates
1.1.1 Engage multiple partners from across the health care continuum and other stakeholders in HAI/AR prevention in the HAI/AR Prevention Advisory Council.	<ul style="list-style-type: none"> Number of meetings of the Illinois HAI/AR Prevention Advisory Council. Publicly posted (online) HAI/AR Prevention Advisory Council membership list that reflects representation from at least four different health care settings and at least four other HAI/AR stakeholder groups. 	<ul style="list-style-type: none"> Thrice a year Annually by January 31
1.1.2 Evaluate progress toward achieving goals set forth in the HAI/AR Action plan; revise the plan as needed to reflect emerging needs and priorities.	<ul style="list-style-type: none"> Publicly posted (online) Illinois HAI/AR Progress reports summarizing progress on the HAI/AR Action Plan targets. 	<ul style="list-style-type: none"> Annually by March 1
1.1.3 Establish consistent communication between IDPH, HAI/AR Prevention Advisory Council, and infection preventionists across health care settings.	<ul style="list-style-type: none"> An HAI/AR Partner Engagement and Communication Plan developed, shared with, and approved by the HAI/AR Prevention Advisory Council related to IDPH infection prevention and control. 	<ul style="list-style-type: none"> January 31, 2026
1.1.4 Monitor and inform HAI/AR policies at the state level.	<ul style="list-style-type: none"> Internally maintained lists of (a) Illinois' proposed bills related to HAI/AR and IDPH position and (b) IDPH rulemaking related to HAI/AR. HAI/AR partner newsletter that includes policy updates. 	<ul style="list-style-type: none"> Ongoing; annually by December 31 Bi-annually (i.e., 2x/year)

Objective 1.2: Develop sustainable capacities to assess and address gaps in infection control throughout Illinois.		
Strategy/Task	Performance Indicator	Targets/Dates
<p>1.2.1 Provide infection prevention and control (IPC) resources and evidence-based practices to health care facilities, including facilities in communities with the highest social vulnerability indices (SVI).</p>	<ul style="list-style-type: none"> • Suite of IPC resources and implementation toolkits on IDPH website. • Number of IPC quality improvement initiatives implemented annually. • Number and percent of the health care facilities that participate in IPC quality improvement initiatives that represent high SVI communities. 	<ul style="list-style-type: none"> • January 31, 2026 • At least one IDPH-sponsored IPC quality improvement initiative annually, beginning in 2026. <ul style="list-style-type: none"> ○ At least 10% of acute care, 10% of critical access, and 10% of post-acute care facilities participate in IDPH-sponsored IPC quality improvement initiatives annually. • At least 10% of health care facilities participating in IDPH-sponsored IPC quality improvement initiatives represent high SVI communities.
<p>1.2.2 Engage selected health care facilities to perform onsite assessments, identify strengths and gaps, provide expert consultation on mitigating gaps, and follow up to ensure mitigation strategies are implemented.</p>	<ul style="list-style-type: none"> • Number of onsite and remote assessments and gap analyses of health care facility infection prevention and control (IPC) programs Improvement in health care facility IPC programs, as measured by pre- and post-assessments. • Report summarizing health care facility IPC assessments. 	<ul style="list-style-type: none"> • At least 240 assessments annually <ul style="list-style-type: none"> ○ At least 20% of assessments conducted annually include dialysis and critical access hospitals. • Annually by March 31, beginning in 2027.
<p>1.2.3 Develop and implement an honor roll system to incentivize and encourage health long-term care facility participation in HAI/AR prevention activities.</p>	<ul style="list-style-type: none"> • “Best in Class” criteria developed for public recognition of long-term care facilities. Final program name is to be determined. • Public announcement of award recipients. 	<ul style="list-style-type: none"> • January 31, 2026 • Annually by October 31 beginning in 2027.

Objective 1.3: Increase number of health care facilities with qualified personnel to implement effective infection control programs.		
Strategy/Task	Performance Indicator	Targets/Dates
1.3.1 Expand availability of the IDPH competency-based infection control training program for infection preventionists in long-term care (LTC) settings with emphasis on facilities with the highest social vulnerability indices (SVI). Provide mentoring support for IPs in skilled nursing facilities.	<ul style="list-style-type: none"> • Number of educational programs held annually for LTC IPs. • Number and percent of participants in the educational programs that represent health care facilities in high SVI communities. Number and percent of skilled nursing facilities provided with consultation or other technical support for IPC. • At least one LTC Tele-mentoring Program was implemented. 	<ul style="list-style-type: none"> • 10% of health care facilities representing high SVI communities that participate in educational IPC trainings. • December 31, 2025
1.3.2 Provide education and training on various infection prevention and control and HAI/AR topics.	<ul style="list-style-type: none"> • Number of educational programs (e.g., webinars, in-person trainings) held for IPs in non-LTC settings. • Number and percent of critical access hospitals, local health departments, and ambulatory care facilities participating in the educational programs. 	<ul style="list-style-type: none"> • At least 12 educational webinars annually from 2026-2030. • Evaluate performance indicators annually to establish an annual target.
1.3.3 Explore and evaluate policy options to incentivize health care facility retention of adequate staffing levels of qualified personnel to implement IPC programs.	<ul style="list-style-type: none"> • Evaluation of annual hospital/facility survey responses addressing staffing levels of qualified personnel for IPC .. 	<ul style="list-style-type: none"> • Annually by December 31, beginning in 2025.

Objective 1.4: Collect, analyze, interpret, and report HAI/AR surveillance data to direct and inform actions.		
Strategy/Task	Performance Indicator	Targets/Dates
1.4.1 Determine the threshold for appropriate outreach from IDPH and the local health department (LHD).	<ul style="list-style-type: none"> Subcommittee of IDPH and LHDs established to develop an algorithm for various levels of response. Algorithm posted on the IDPH website indicating multiple levels of response from IDPH to LHD and LHD to the facility. 	<ul style="list-style-type: none"> January 31, 2026 January 31, 2027
1.4.2 Align and leverage existing data sources to promote situational awareness, inform action, and evaluate the effectiveness of prevention efforts.	<ul style="list-style-type: none"> Statewide HAI/AR trend reports issued 	<ul style="list-style-type: none"> Annually by March 31.

Priority Area B: Outbreak Preparedness and Response

Goal #2: Improve detection, investigation, and response to outbreaks of AR organisms in health care settings and the general community.

Objective 2.1: Increase knowledge and competency of relevant health care facilities and public health staff related to outbreak preparedness, definition protocols, containment, and resolutions of HAI/AR outbreaks in health care settings.

Strategy/Task	Performance Indicator/Data Source	Targets/Dates
2.1.1 Educate and train relevant staff in health care facilities across the care continuum on outbreak preparedness and response for emerging and urgent infectious diseases.	<ul style="list-style-type: none"> Standardized training and training schedule developed for detection, investigation, and response to infectious outbreaks in health care settings. Number of training courses provided. Number of attendees from each health care setting. Number and percent of each health care facility type participating in training courses. 	<ul style="list-style-type: none"> December 31, 2026 March 31, 2027, and annually thereafter.

<p>2.1.2 Review existing legislation and consider policy options necessary to establish standards and requirements for training individuals responsible for coordinating HAI/AR outbreak detection and response activities.</p>	<ul style="list-style-type: none"> • Proposal drafted addressing/enhancing training requirements for outbreak detection in health care settings, including who the training requirement would apply to. 	<ul style="list-style-type: none"> • December 31, 2026
<p>Objective 2.2: Prepare for emerging communicable disease threats that may enter health care facilities.</p>		
<p>Strategy/Task</p>	<p>Performance Indicator</p>	<p>Targets/Dates</p>
<p>2.2.1 Grow partnerships between and coordinate efforts among HAI/AR prevention programs, communicable disease programs, IDPH Division of Laboratories, and emergency preparedness programs at the state and local health departments, particularly to prepare regional response plans for emerging infectious disease threats.</p>	<ul style="list-style-type: none"> • Regional response plans for emerging/special infectious disease threats • Requirement for facility specific response plans for emerging/special infectious disease threats • Report summarizing feasibility of facility readiness assessments • Number of continuum of care drills completed 	<ul style="list-style-type: none"> • June 30, 2028 • June 30, 2030 • December 31, 2026 • Annually, beginning in 2028.
<p>2.2.2. Administer the CDC standardized outbreak assessment tool for facility self-assessment of detection, reporting, and response to infectious disease outbreaks and emerging threats.</p>	<ul style="list-style-type: none"> • Report summarizing gaps in the overall outbreak response. • Outbreak/emerging threat toolkit to address the gaps and improve outbreak detection and response. 	<ul style="list-style-type: none"> • December 31, 2027 • December 31, 2027
<p>2.2.3. Evaluate and implement strategies to increase vaccination rates of health care workers as a means to prevent vaccine-preventable infections among health care workers, patients, and residents.</p>	<ul style="list-style-type: none"> • Summary of current health care-related vaccination requirements and supporting regulatory language. • Analyze the feasibility of mandating health care worker vaccination beyond influenza. 	<ul style="list-style-type: none"> • December 31, 2026 • December 31, 2028

	<ul style="list-style-type: none"> • Expansion of the vaccination database Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) to require providers to submit immunization information for health care personnel, patients, and residents. • Number of vaccination education and administration clinics held in communities with low access to vaccinations and low vaccination rates. 	<ul style="list-style-type: none"> • December 31, 2030 • Annually, beginning in 2028.
Objective 2.3: Strengthen and expand surveillance system infrastructure to detect infectious outbreaks across acute care and non-acute care settings as well as emerging pathogens in the general community.		
Strategy/Task	Performance Indicator	Targets/Dates
2.3.1 Evaluate current surveillance system infrastructure for (1) opportunities and (2) convergence of outbreak reporting/case investigation reporting in the XDRO Registry, I-NEDSS, ORS, REDCap, and NHSN.	<ul style="list-style-type: none"> • Evaluation of electronic/paper HAI/AR outbreak and surveillance reporting systems • Process map of all HAI/AR outbreak, surveillance, and regulatory reporting systems to identify redundancies and opportunities to streamline the process 	<ul style="list-style-type: none"> • June 30, 2028 • June 30, 2027
2.3.2 Enhance capacity to detect HAI/AR clusters of XDROs, emerging pathogens, and NHSN reported HAIs among health care service or “social” networks of facilities that share patients/residents rather than just geographic location.	<ul style="list-style-type: none"> • Number and percent of local health departments participating in IDPH-sponsored trainings on SaTScan, its uses/limitations, and how to use the information. • Publicity of the CDC-developed training materials/toolkit for accessing and utilizing the CDC MDRO Dashboard. • Presentation to the HAI/AR Prevention Advisory Council on feasibility of expanding the use of SaTScan for <i>Candida auris</i>. 	<ul style="list-style-type: none"> • At least 70% of LHDs by December 2027. • June 30, 2026 • December 31, 2026

<p>2.3.3 Utilize hospital emergency department data (from Illinois' Syndromic Surveillance System) to monitor widespread outbreaks and assess trends of antimicrobial-resistant infection and colonization in the community.</p>	<ul style="list-style-type: none"> • Presentation to the HAI/AR Prevention Advisory Council on plans to leverage syndromic surveillance data for HAI/AR tracking across the health care continuum. • System developed that uses established thresholds combined with syndromic surveillance data to trigger notifications and responses. • Assessment of the usefulness of a wastewater metric as additional information about wastewater monitoring becomes available. 	<ul style="list-style-type: none"> • December 31, 2030 • December 31, 2030 • December 31, 2030
<p>Objective 2.4: Improve HAI and AR outbreak reporting across all health care facilities.</p>		
<p>Strategy/Task</p>	<p>Performance Indicator</p>	<p>Targets/Dates</p>
<p>2.4.1. Establish protocols for exchanging information among state and local governmental partners (e.g., state survey agencies, licensing boards, infectious diseases authorities) about outbreaks related to breaches in practice.</p>	<ul style="list-style-type: none"> • Presentation to the HAI/AR Prevention Advisory Council on the possibility of a push notification from the Outbreak Reporting System (ORS), particularly when cases cross jurisdictions. • Presentation to the HAI/AR Prevention Advisory Council on the feasibility of a state-based system similar to Epi-X. • Tiered response criteria for infection control breaches, suspect cases/clusters, and outbreaks. • Maintain a regular cadence for sharing calls with surrounding state health departments. 	<ul style="list-style-type: none"> • December 31, 2026 • December 31, 2028 • December 31, 2030 • Within one year from plan approval.
<p>2.4.2. Develop a communicable disease "Critical Call List" and reporting process for laboratories to notify facilities, infection preventionists, hospital epidemiologists, and local health departments.</p>	<ul style="list-style-type: none"> • Workgroup established to develop a critical call list • Critical call list disseminated to labs, health care facilities, and local health departments 	<ul style="list-style-type: none"> • December 31, 2026 • June 30, 2028

Priority Area C: Antimicrobial Stewardship		
Goal #3: Strengthen public health and health care facility infrastructure to facilitate antimicrobial stewardship (AS) work.		
Objective 3.1. Identify designated personnel and key partners to coordinate and support state health department AS initiatives.		
Strategy/Task	Performance Indicator	Targets/Dates
3.1.1 Appoint designated IDPH personnel to coordinate state health department AS initiatives.	<ul style="list-style-type: none"> At least one qualified individual designated for AS coordination at IDPH. 	<ul style="list-style-type: none"> December 31, 2026
3.1.2 Expand and sustain collaboration with local health departments (LHD), health care facilities, professional organizations, and other key partners to facilitate and support AS efforts across health settings.	<ul style="list-style-type: none"> Number and types of partners that facilitate implementing AS activities and outreach to stakeholders and the general public. 	<ul style="list-style-type: none"> December 31, 2026, with annual review thereafter.
3.1.3 Identify and engage with community interest groups to facilitate outreach to the general public.		
Goal #4: Improve antimicrobial prescribing practices across all health care settings.		
Objective 4.1. Enhance AS implementation across health settings.		
Strategy/Task	Performance Indicator	Targets/Dates
4.1.1 Provide technical assistance, education, and tools to health care facilities	<ul style="list-style-type: none"> Number and types of health care facilities receiving direct technical assistance. Access to AS expertise established for health care facilities in resource-limited settings. Number of health care professionals participating in AS educational webinars, workshops, and other initiatives. Number of health care facilities enrolled in AS Recognition Program. An up-to-date AS resource page has been established on the IDPH website. 	<ul style="list-style-type: none"> December 31, 2026, with annual review thereafter. December 31, 2030 December 31, 2026, with annual review thereafter. December 31, 2026, with annual review thereafter. November 30, 2026, with annual review and update thereafter.

<p>4.1.2 Form and foster AS collaboratives.</p> <p>4.1.3 Explore strategies, including policy options, to strengthen AS practice.</p>	<ul style="list-style-type: none"> • Number and types of health care facilities participating in an acute care-long-term care AS collaborative focused on improving antimicrobial prescribing practices across the health care continuum. • Partnership established with a cohort of health systems to monitor and improve outpatient antimicrobial prescribing practices. • Number of clinician and public health training program curriculums (e.g., epidemiology, dentistry, veterinary, medical, pharmacy, nursing, and residency/fellowship programs) incorporating AS education. 	<ul style="list-style-type: none"> • July 31, 2026, with annual review thereafter. • December 31, 2030 • December 31, 2030
<p>Objective 4.2. Evaluate AS practices and monitor antimicrobial prescribing and use.</p>		
<p>Strategy/Task</p>	<p>Performance Indicator</p>	<p>Targets/Dates</p>
<p>4.2.1 Assess AS practices and implementation of Core Elements of Antibiotic Stewardship.</p> <p>4.2.2 Monitor trends in antimicrobial prescribing and use.</p>	<ul style="list-style-type: none"> • Percent of health care facilities reporting uptake of CDC Core Elements of AS. • Percent of hospitals that report uptake of Priorities for Core Elements Implementation. • Number and percent of hospitals reporting to the NHSN AUR Module. • Access and analyze data from at least one non-NHSN data source to monitor antimicrobial prescribing practices. 	<ul style="list-style-type: none"> • December 31, 2026, with annual review thereafter. • December 31, 2026, with annual review thereafter. • December 31, 2027, with annual review thereafter. • December 31, 2027

Objective 4.3. Promote transparency and communication.		
Strategy/Task	Performance Indicator	Targets/Dates
<p>4.3.1 Report information on antimicrobial use and AS practices to state health department leadership.</p> <p>4.3.2 Communicate information on antimicrobial use and AS practices to local health departments, health care facility leadership, payers, policymakers, and other key partners.</p>	<ul style="list-style-type: none"> • Summary report and presentation on antimicrobial use and AS practices provided to health department leadership and key external partners. 	<ul style="list-style-type: none"> • December 31, 2026, with annual update thereafter.
Goal #5: Raise public awareness about appropriate antimicrobial use.		
Objective 5.1. Provide education to the general public on antimicrobial resistance and appropriate antimicrobial use.		
Strategy/Task	Performance Indicator	Targets/Dates
<p>5.1.1 Participate in U.S. Antibiotic Awareness Week (USA AW) activities and events and disseminate Be Antibiotics Aware patient resources.</p> <p>5.1.2 Evaluate changes in the public’s knowledge, attitudes, and practices related to antimicrobial use.</p>	<ul style="list-style-type: none"> • Number of likes and reposts of IDPH USA AW social media posts. • Number of health care professionals participating in IDPH USA AW activities. • Number and types of health care facilities participating in IDPH USA AW activities. 	<ul style="list-style-type: none"> • November 30, 2026, with annual review thereafter.
<p>5.1.3 Develop, implement, and monitor AS initiatives to target the general public.</p>	<ul style="list-style-type: none"> • Development of a public communication strategy including engaging with local news channels and social media posts. • Number of partners participating in efforts to amplify public messaging on improving antimicrobial use. 	<ul style="list-style-type: none"> • December 31, 2030

Priority Area D: Extensively Drug-Resistant Organisms (XDROs)

Goal #6: Slow the emergence of antimicrobial-resistant organisms and prevent their transmission.

Objective 6.1. Increase reporting of antimicrobial-resistant organisms to surveillance systems and enhance those systems.

Strategy/Task	Performance Indicator	Targets/Dates
<p>6.1.1 Expand reporting of XDRO data to various systems used to monitor antimicrobial resistance, including XDRO Registry and NHSN Antimicrobial Use and Resistance (AUR) Module.</p>	<ul style="list-style-type: none"> • Annual summary of XDRO reporting requirements to these systems. • Number and percent of facilities, by facility type, reporting to these systems. 	<ul style="list-style-type: none"> • December 31, 2026, with annual update thereafter.
<p>6.1.2 Enhance the quality of reporting by providing case reporting procedures for XDROs and evaluating data accuracy in the XDRO Registry.</p>	<ul style="list-style-type: none"> • Creation and dissemination of guidance documents for case reporting of XDROs. • Quarterly evaluation of XDRO data quality (including demographics) for timeliness of reporting, completeness, and correctness. 	<ul style="list-style-type: none"> • December 31, 2026, with annual review thereafter. • Initial evaluation by April 30, 2026, with quarterly evaluation thereafter.
<p>6.1.3 Enhance the XDRO Registry to streamline reporting and notification features.</p>	<ul style="list-style-type: none"> • Number of facilities, by facility type, that receive automated alerts from the XDRO Registry. • Incorporation of ELR capability and integration of the Illinois Disease Surveillance System with the XDRO Registry. 	<ul style="list-style-type: none"> • March 31, 2026, with quarterly tracking thereafter. • December 31, 2029
<p>6.1.4 Enhance public health surveillance of XDROs.</p>	<ul style="list-style-type: none"> • Development of XDRO data dashboard or other tools to support surveillance, more rapidly identify clusters and outbreaks, and incorporate emerging surveillance methods (e.g., wastewater surveillance). • Percent of local health departments that use the data dashboards or other tools for surveillance. 	<ul style="list-style-type: none"> • December 31, 2026, with annual review and update thereafter. • December 31, 2027. Annual evaluation thereafter.

Objective 6.2. Enhance laboratory testing and detection of antimicrobial resistant organisms and mechanisms of resistance.		
Strategy/Task	Performance Indicator	Targets/Dates
6.2.1 Expand testing capacity for XDROs.	<ul style="list-style-type: none"> Assessment of XDRO diagnostic testing needs and resources. List of laboratories with advanced testing capabilities for XDROs that are willing to perform testing for other facilities. Number of specimens tested by IDPH laboratory, by XDRO type and location. Implementation of <i>Candida auris</i> testing at the IDPH Chicago and Springfield labs. BD Phoenix incorporated in the IDPH lab to expand AST testing for carbapenem-resistance. 	<ul style="list-style-type: none"> December 31, 2026, with annual review and update thereafter. January 31, 2026, with annual update thereafter. June 30, 2027 December 31, 2027
6.2.2 Improve XDRO testing practices at clinical laboratories.	<ul style="list-style-type: none"> Development of laboratory guidance and resources (e.g., laboratory testing methods for identifying and characterizing targeted XDROs and specimen submission) posted to the IDPH website. Percent of labs that can identify CRE according to updated CLSI criteria. 	<ul style="list-style-type: none"> December 31, 2026, with annual update thereafter. December 31, 2026, with annual update thereafter.
Objective 6.3. Engage health care facilities in prevention activities for targeted XDROs.		
Strategy/Task	Performance Indicator	Targets/Dates
6.3.1 Use existing data sources and methods to prioritize outreach to facilities on specific prevention initiatives.	<ul style="list-style-type: none"> Prioritization scheme created for outreach. 	<ul style="list-style-type: none"> June 30, 2027, with annual update thereafter or as needed.
6.3.2 Work with subject matter experts and stakeholders on best approaches for implementing CDC's MDRO containment and prevention strategies.	<ul style="list-style-type: none"> Development of Illinois-specific XDRO guidance for local health departments and facilities. Percent annual change in incidence and burden of XDROs. 	<ul style="list-style-type: none"> December 31, 2027, with annual review and update thereafter. Evaluate percent change by March 31, 2027, with annual evaluation thereafter.

Priority Area E: Eliminating Health Disparities and Advancing Health Equity		
Goal #7: Bring awareness of health equity to all partners in health care settings and utilize data to address health inequities and disparities where they exist.		
Objective 7.1. Increase knowledge and competency of health equity related to HAI/AR among external and internal partners.		
Strategy/Task	Performance Indicator	Targets/Dates
7.1.1 Educate and train LHD staff on health equity (HE) related to HAI/AR.	<ul style="list-style-type: none"> HAI/AR health equity toolkit developed for LHDs. Number of trainings held for LHDs on HAI/AR HE topics. Number and percent of LHDs participating in HAI/AR HE training. 	<ul style="list-style-type: none"> June 30, 2028 Annually, beginning in 2027.
Objective 7.2. Collaborate with and mobilize key partners to reduce health disparities related to HAI/AR in health care settings.		
Strategy/Task	Performance Indicator	Targets/Dates
7.2.1 Grow internal partnerships between and coordinate efforts among HAI/AR Prevention Programs and IDPH’s Health Equity Task Force.	<ul style="list-style-type: none"> At least one IDPH HAI/AR Prevention Program staff member will be present at IDPH Health Equity Task Force meetings. Number of Health Equity Task Force meetings attended by HAI/AR Prevention Program Staff, including workgroups. 	<ul style="list-style-type: none"> Monthly, beginning in 2025.
7.2.2 Establish a framework for exchanging information about health equity among IDPH and LHDs.	<ul style="list-style-type: none"> Online forum established to share HAI/AR HE information with LHDs. 	<ul style="list-style-type: none"> December 31, 2026
7.2.3 Pilot with LHD on the provision or utilization of patient-level data linked from multiple data sources to epidemiologically describe patients infected with HAI and MDROs and their geographic distribution (burden of infection).	<ul style="list-style-type: none"> Number of LHDs engaged in the pilot and analyzing potential association of health equity indicators and patients infected with HAI and MDROs. 	<ul style="list-style-type: none"> December 31, 2030

Objective 7.3. Evaluate current health equity policies and identify areas for improvement to reduce HAIs and AR health disparities.		
Strategy/Task	Performance Indicator	Targets/Dates
<p>7.3.1 Identify policy options to address disparities in HAI/AR burden among high-risk and underserved populations, including minorities and rural residents.</p>	<ul style="list-style-type: none"> • Number of LHDs that integrate health equity policies into their HAI/AR prevention activities to reduce health inequities and disparities. • Presentation to the HAI/AR Prevention Advisory Council on how the “Health in All Policies” framework has been integrated into IDPH HAI/AR program activities. 	<ul style="list-style-type: none"> • December 31, 2030 • December 31, 2026

Appendix: Strategic Planning Contributors

Strategic Planning Committee

Name	Role/Job Title	Organization
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Note: The list above reflects the individuals and affiliated organizations at the time of participation in the strategic planning meetings and work groups.

