Updated Public Health Response for Targeted Multidrug-resistant Organisms (MDROs)

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Antimicrobial Resistance Coordinator
May 5, 2023
What are targeted MDROs?

- MDROs that are in pre-endemic stages of spread, for which a coordinated public health response to identified cases is an important strategy to limit transmission.

- This includes the following organisms:
  1. Vancomycin-resistant *Staphylococcus aureus* (VRSA)
  2. Carbapenemase-Producing Organisms (CPO)
  3. *Candida auris*

Why Did CDC Update Containment Guidance?

• To reflect new findings from responses and performance measure data

• To reflect evolving practices by linking to targeted MDRO prevention activities

• To clarify points of confusion
Key Updates to the 2019 Interim Guidance

• Revised Tier definitions
  • Moved organisms that are not susceptible to any available antimicrobials from Tier 1 to Tier 2
  • Added Endemic (Tier 4) to describe actions that should be taken for targeted MDROs that are endemic in a jurisdiction/state

• Expanded response recommendations with more details
  • More information about infection control assessments
  • Added recommendation to screen patient currently in room
  • Strengthened recommendation to perform broader screening
Tier Designations and Virginia Case Counts
# Virginia Tier Designation

<table>
<thead>
<tr>
<th>Tier</th>
<th>CDC Definition</th>
<th>Virginia Organism Tiers</th>
</tr>
</thead>
</table>
| 1    | • Never (or very rarely) been identified in the United States and for which experience is limited | • VRSA  
• Novel resistant mechanisms |
| 2    | • Not commonly identified in the region OR  
• No current treatment options exist (pan-not susceptible) and have the potential to spread more widely within a region (e.g., have plasmid-mediated resistance mechanisms) | • CRE with NDM, VIM, OXA-48, IMP  
• CRPA with KPC, NDM, VIM, OXA-48, and IMP  
• CRAB with KPC, NDM, VIM, OXA-48, and IMP  
• *Candida auris*  
• Pan-resistant isolates |
| 3    | • Have been identified frequently across a region, but not considered endemic | • CRE with KPC  
• CRAB with OXA-23, -24/40, -58 mechanisms |
| 4    | • Endemic but have clinical significance and potential to spread rapidly | • Not applicable in Virginia |

*March 2023 Update – Moved Pan-resistant organisms to Tier 2 to align with updated guidelines*

VDH will periodically review tier designations to determine if changes should be made

VDH VIRGINIA DEPARTMENT OF HEALTH

HAI&AR Healthcare-Associated Infections & Antimicrobial Resistance Program

VRSA=Vancomycin-resistant S. aureus; CRE=Carbapenem-resistant Enterobacteriales; IMP=Imipenemase Metallo-beta-lactamase; NDM=New Delhi Metallo-beta-lactamase; OXA=Oxacillinase-like beta-lactamase; VIM=Verona Integron-encoded Metallo-beta-lactamase; KPC=Klebsiella pneumoniae Carbapenemase; CRPA=Carbapenem-resistant P. aeruginosa; CRAB=Carbapenem-resistant Acinetobacter
Candida auris in Virginia

Clinical Case Count: 88
Screening Case Count: 133

Reported Cases of C. auris by Year
As of 4/15/2023

Reported Cases of C. auris by Region
As of 4/15/2023

Data were collected from the Virginia Electronic Disease Surveillance System (VEDSS) on April 15, 2023; data subject to change. For an individual to be considered a case, they had to meet the case definition established by the Council of State and Territorial Epidemiologists (CSTE).
Carbapenemase-Producing Organisms (CPOs) in Virginia

Reported Cases of Carbapenemase-Producing Organisms by Year
January 2019 – December 2022

Data were collected from the Virginia Electronic Disease Surveillance System (VEDSS) on March 22, 2023; data subject to change. For an individual to be considered a case they had to meet the case definition established by the Council of State and Territorial Epidemiologists (CSTE).
Spotlight on Enterobacterales in Virginia

Number of Carbapenemase-producing Enterobacterales Clinical Cases by Resistance Mechanism January 2019 – December 2022

Number of Carbapenemase-producing Enterobacterales Clinical Cases by Organism January 2019 – December 2022
Where do I find Virginia C. auris and CPO Case Counts?

- Monthly updates on static report, transitioning to Tableau

- Quarterly updates in Tableau
Response Recommendations
Tiers 1-3
Containment Response Goals for Targeted Organisms

1. Identify affected patients.
2. Ensure appropriate control measures are promptly implemented to limit further spread.
3. Determine if transmission within a healthcare facility and/or dissemination to other facilities are occurring (Tiers 1, 2).
4. Characterize novel organisms or mechanisms to guide further response actions, patient management, and future responses.
5. Coordinate response with ongoing prevention activities (e.g., MDRO education, infection prevention and control improvement initiatives, routine colonization screening, and improved interfacility communication) in the region.
| Initial Response Measures | Conduct a healthcare investigation | Ensure Adherence to Infection Control Measures | Conduct a Contact Investigation | Clinical Laboratory Prospective and Retrospective Surveillance (Tiers 1, 2) | Environmental Cultures (not routinely performed for Tiers 1, 2) |

**Response Strategies**
## Initial Response

### Recommendations are similar for Tiers 1-3, except where noted

<table>
<thead>
<tr>
<th>Facility Responsibilities</th>
<th>Public Health Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Promptly notify the patient’s primary healthcare provider, healthcare personnel caring for the patient, infection control department, and other healthcare staff per facility policies.</td>
<td>- Notify federal public health authorities.</td>
</tr>
<tr>
<td>- Notify LHD promptly.</td>
<td>- Prioritize the facility for a rapid infection control assessment to identify and address any potential gaps in IPC (Tiers 1 and 2).</td>
</tr>
<tr>
<td>- Implement contact precautions or enhanced barrier precautions.</td>
<td>- Ensure implementation of appropriate infection control measures (e.g., Contact Precautions), which may vary depending on the healthcare setting, and adequate supplies to implement these measures.</td>
</tr>
<tr>
<td>- Notify the patient about the results and infection control measures being implemented.</td>
<td>- If the MDRO was present on admission, notify the transferring facility so appropriate investigation can occur at that facility.</td>
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<td>- Provide LHD with information as requested.</td>
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**Facility Responsibilities**

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- Notify LHD promptly.
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- Notify the patient about the results and infection control measures being implemented.
- If the MDRO was present on admission, notify the transferring facility so appropriate investigation can occur at that facility.
- Provide LHD with information as requested.

**Public Health Responsibilities**

- Notify federal public health authorities.
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- Ensure implementation of appropriate infection control measures (e.g., Contact Precautions), which may vary depending on the healthcare setting, and adequate supplies to implement these measures.
- If the MDRO was present on admission, notify the transferring facility so appropriate investigation can occur at that facility.
# Healthcare Investigation

<table>
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<tr>
<th>Objective</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate and define the risk for transmission and the extent of spread and</td>
<td>Identify the extent of spread and implement measures to prevent further</td>
<td>Identify patients and find and address gaps in detection or infection</td>
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<tr>
<td>implement measures to prevent transmission</td>
<td>transmission in affected facilities and in the region</td>
<td>control that could facilitate transmission</td>
<td></td>
</tr>
<tr>
<td>Timeframe</td>
<td>At least 30 days prior to the initial positive specimen collection up</td>
<td>30 days prior to the initial positive culture up to the present*</td>
<td>Limited to the current admission except if the admission immediately</td>
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<td></td>
<td>to the present</td>
<td></td>
<td>prior was within 30 days of specimen collection and occurred at a</td>
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<td>facility where the organism has never or rarely been identified</td>
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<td>Exposures of interest</td>
<td>Overnight stays in healthcare settings (both domestic and international),</td>
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<td></td>
<td>outpatient visits, and home health visits to identify facilities where</td>
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<tr>
<td></td>
<td>transmission could have occurred.</td>
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</tr>
<tr>
<td>Priority Information to collect</td>
<td>Index patient’s admission/discharge dates, care location(s) within a</td>
<td>Not addressed in guidance</td>
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<td>facility, presence and duration of roommates, types of care received</td>
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<td></td>
<td>(e.g., respiratory therapy, wound care, hemodialysis, invasive</td>
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<td>mechanical ventilation), functional status (e.g., bedbound, incontinent</td>
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<td></td>
<td>of stool), laboratory culture and screening results for organism of</td>
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<td></td>
<td>interest, timing of healthcare facility implementation of</td>
<td></td>
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<tr>
<td></td>
<td>transmission-based precautions (if any), and history of travel and/or</td>
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<tr>
<td></td>
<td>healthcare outside the U.S. in the prior 12 months.</td>
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</tr>
</tbody>
</table>

*Current CDC guidance is 30 days, however LHD may request information for the previous 90 days
Adherence to IPC: Healthcare Facility Responsibilities

• Educate and inform the healthcare personnel (HCP) and visitors for the index patient about the organism and precautions indicated to prevent transmission

• Ensure that adequate supplies are available to implement Transmission-Based or Enhanced Barrier Precautions

• Conduct ongoing adherence monitoring of infection control practices and provide feedback to HCP

• Flag affected patients’ medical records to initiate appropriate infection control precautions upon readmission

• Make plans for how receiving facilities will be notified of affected patients’ MDRO status

  • A decision to discharge a patient from one level of care to another (e.g., moving a patient from an intensive care unit to a medical ward) or to another healthcare facility should be based on clinical criteria and not colonization status.
MDRO Flags in the Emergency Department Care Coordination (EDCC) System

• The 2017 General Assembly established the Emergency Department Care Coordination (EDCC) Program within the Virginia Department of Health (VDH) to provide a single, statewide technology solution that connects healthcare facilities
  • ConnectVirginia, now a program of Virginia Health Information, was contracted by VDH to fulfill the requirements of this legislation
  • Collective Medical, now a PointClickCare company, was chosen as the EDCC Program technology partner
• CPO and C. auris cases entered in VEDSS are sent to Collective Medical twice a week and will show up in enrolled facility EHR when patients are admitted
MDRO Flags

MDRO results will display within the patient overview page.
MDRO Flags in the Emergency Department Care Coordination (EDCC) System

- All ACH and some LTC facilities are enrolled in the EDCC
  - Enrolled facilities need to turn on MDRO notifications
    - Facilities should email Sarah Watt (sarah.watt@pointclickcare.com) & Collective Medical Support (support@collectivemedical.com)
- LTC facilities that would like to onboard should contact Marcus Divers (marcus@vhi.org) & EDCC Support (edccsupport@vhi.org)
- Facilities should still communicate MDRO status on transfer; EDCC alerts are not a replacement, just an addition
Adherence to IPC- Public Health Responsibilities
What to Expect During a Visit

Policy Review
IPC Resources for Healthcare Facilities

• **C. auris**
  - [https://www.cdc.gov/fungal/candida-auris/index.html](https://www.cdc.gov/fungal/candida-auris/index.html)

• **CPOs**

• **Staphylococcus aureus**

• **Enhanced Barrier Precautions for Nursing Homes**
  - CDC: [https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html](https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html)

• **General Infection Prevention and Control**
Contact Screening Changes: Removed Contact Precautions as Exemption for Screening

- Isolation and Contact Precautions reduce transmission from infected or colonized patients to others
- Adherence highly variable, some differences by facility type
- CDC received feedback from health departments about existing language
  - Challenging to assess adherence in timely fashion
    - During this period, number of contacts available to screen dwindles
    - Did not address when patient on Contact Precautions but appropriate disinfectants not used
- **Recommendation**: Not necessary to evaluate Contact Precautions adherence to recommend broader screening
  - Consider context, including patient characteristics and facility practices
Contact Screening Changes: Screen patients who currently occupy the room

- **Rationale:** Due to the risk of persistent environmental contamination for some organisms (e.g., carbapenem-resistant *Acinetobacter baumannii* or *Candida auris*) and transmission through the premise plumbing for others (e.g., carbapenemase-producing Enterobacterales and *Pseudomonas*)

- **Recommendation (Tier 1 and 2):** Screen patient *currently* admitted to room(s) and bed spaces where the index patient stayed at least one night in healthcare facilities identified during the healthcare investigation
  - Consider time contact has been in room and time elapsed since index patient was present when planning screening
  - Either short time for contact in room or long time since index patient was present may make screening lower yield
Contact Screening Changes: Broader Screening (PPS and/or targeted contacts)

• Broad screening is now generally recommended
  • Prioritize extensive contact screening, such as a Point Prevalence Survey (PPS) and/or screening of targeted contacts for
    • Settings with high-acuity patients and longer lengths of stay
    • Any setting in which the index case likely acquired the organism during their stay
  • Exceptions include situations in which response is to single case and
    • Index patient has very short length of stay and facility is low acuity
    • Acute care hospital unit with a short average length of stay where patients are ambulatory and not mechanically ventilated and more than 7 days have passed since patient was discharged
Contact Screening: Tier 2 Recommendations

- Screen roommates and patients who shared a bathroom with the index patient
  - If discharged to another inpatient setting: screen patient
  - If discharged to home: facility should consider flagging patient charts and implement preemptive contact precautions and admission screening if readmitted in the next six months
- Screen the patient currently admitted to room(s) and bed spaces where the index patient stayed at least one night in healthcare facilities identified during the healthcare investigation
- In most situations, perform broader screening to comprehensively assess for transmission
  - Broader screening using PPS is preferred
  - Alternatively, broader screening may initially target contacts who are at higher risk due to overlap on the same ward as the index patient and presence of a risk factor for MDRO acquisition and who are still admitted (risk-factor)
When deciding whether to use a risk-factor-based approach, PPS, or a combination of both strategies, the following will be considered:

- If it will take several days to identify higher risk contacts or if most higher risk contacts have been discharged from a facility, perform a unit-wide point prevalence survey promptly.
  - Facility should consider flagging charts of contacts who have been discharged, to facilitate preemptive Contact Precautions and admission screening if they are readmitted in the next six months.
  - If these individuals have been discharged to high-acuity post-acute care, health departments should consider screening these individuals.
- Public health laboratory capacity, individual facility characteristics, and index patient characteristics

Prioritize broader screening for:

- Healthcare settings with high-acuity patients and longer lengths of stay, including some hospital units with longer lengths of stay and patients at higher risk of MDRO acquisition and infection
- Any setting where the index case likely acquired the organism during their stay
Contact Screening: Tier 2, Transmission Suspected or Identified

- Wider point prevalence surveys are indicated if there is evidence or suspicion for ongoing transmission (e.g., isolates from multiple patients) or if initial targeted screening of high-risk patients identifies new cases.

- If new cases are identified, periodic (e.g., every two weeks) point prevalence surveys are recommended until transmission is controlled. Control is generally defined as two consecutive point prevalence surveys with no new MDRO cases identified, or, in facilities with high colonization pressure (i.e., >30%), substantially decreased transmission.

- In healthcare facilities with high colonization pressure, consider continuing point prevalence surveys at increasing intervals (e.g., monthly and then quarterly) after transmission is controlled, to ensure transmission remains low.

- Health departments will assess whether facilities would benefit from proactive, prevention-focused point prevalence surveys and infection control assessments after response activities conclude.
Contact Screening: Tier 2, Admission Screening When Transmission is Occurring

• Admission screening can help distinguish importation from ongoing transmission within a healthcare facility, such as in situations where the Tier 2 organism or mechanism is believed to be present at other facilities in the region.

• Prioritize admission screening in settings with good adherence to recommended infection control practices, due to higher likelihood that identification on admission will reduce intra-facility transmission.
  • Public health laboratory-supported admission screening may be available for a time-limited period.
  • After an initial pilot period, the facility and public health should evaluate the utility of continuing admission screening as a long-term prevention strategy.
Contact Screening: Tier 2 – Regional Approach When Transmission is Occurring

• We are all in this together!
  • Avoid the blame game

• Implement measures to reduce the risk of further MDRO spread within the region at facilities known to regularly admit/receive patients from the facility where transmission occurred.
  • VDH might recommend an infection control assessment and admission screening and/or PPSs, particularly at high-acuity post-acute care facilities, especially if the facility is not engaged in prevention activities or there has been a long interval between the last infection control assessment or point prevalence survey.
Transmission Happens

• No healthcare facility wants to bring harm to their patients or residents
• No healthcare facility wants to bring harm to patients or residents in their transfer networks
• Most of us do our best under the circumstances and with the resources we have been given
• But sometimes transmission happens…and happens…and happens
• This can cause frustration, anxiety, anger, blame, $!*%
What to do?

• Don’t give up!
  • Infection control improvements take time... but are always worth the effort

• Don’t get too focused on the PPS results alone
  • Define other measures of success and celebrate them

• Don’t get too focused on where the patient/resident acquired the MDRO
  • If they are in your facility, it is up to you to limit transmission
Contact Screening: Tier 2 – Additional Recommendations

Healthcare personnel screening:
• In the absence of known or suspected transmission from HCP or other strong epidemiologic links, HCP screening is not recommended.

Household contact screening:
• Screen household contacts who have extensive contact (e.g., share a bed or assist with personal care) with the index patient if the household contact has frequent inpatient healthcare exposure to determine if transmission-based precautions are necessary for their subsequent admissions.
Contact Screening: Tier 3

- CDC allows for broad latitude in screening recommendations for Tier 3 organisms; recommendations may differ in intensity as we work through Tier 3 cases and implement prevention strategies; laboratory capacity will be taken into consideration
  - Lower yield: Short time for contact in room or long time since index patient was present
- Broader screening will be prioritized for the following:
  - Facilities with a long average length of stay (e.g., SNF, LTACH, some ACH units) and facility is not participating in targeted MDRO prevention activities
  - Index patient likely acquired the organism during their stay
  - There is evidence or suspicion for transmission on the unit (2 or more cases epi-linked)
- Generally, screening patient that is currently admitted to room occupied by index case would only be performed with epi link/suspicion of an outbreak
Virginia Screening: CDC AR Lab Network
Virginia Screening in a Nutshell

- Work with your local health department on identifying who to screen, when to collect, and what to collect
- Currently, specimens are sent to Maryland public health lab for *C. auris* and CPO colonization testing
- Screening sites
  - CRE and CRPA: rectal
  - CRAB: composite axilla/groin (and potentially rectal)
  - *C. auris*: composite axilla/groin
- Turn around time from specimen collection is about 3-7 days
  - Public health labs do not perform testing on weekends/holidays
• Laboratories should perform prospective surveillance for at least three months after identification of the index patient or, if transmission is identified through surveillance or screening, three months after the last case is identified.

• Perform retrospective surveillance (laboratory lookbacks) of results from these clinical laboratories to identify organisms with similar resistance patterns, extending three months prior to identification of the index case.

Due to Virginia isolate forwarding requirements, clinical laboratory surveillance might not be applicable as recommended in CDC guidance (exception: CRAB, or laboratories not following isolate submission requirements).
**Virginia Reportable Disease List: Targeted MDROs**

<table>
<thead>
<tr>
<th>Physicians and Directors of Medical Care Facilities Report suspected or confirmed cases to the LHD within 3 days</th>
<th>Laboratories Forward Isolate to DCLS within 7 days</th>
</tr>
</thead>
</table>
| • *Candida auris*, infection or colonization  
• Carbapenemase-producing organism, infection or colonization  
• Vancomycin-intermediate or vancomycin-resistant *Staphylococcus aureus* infection | - *Candida auris*  
- *Candida haemulonii*  
- Suspected *Candida auris* as indicated by [CDC algorithm](https://www.cdc.gov)  
- Carbapenem-resistant Enterobacterales  
- Carbapenem-resistant *Pseudomonas aeruginosa*  
- Vancomycin-intermediate *Staphylococcus aureus*  
- Vancomycin-resistant *Staphylococcus aureus* |

*CRAB isolates can be forwarded to DCLS on a voluntary basis for carbapenemase testing*
Environmental Cultures

Tier 1
• The threshold to do environmental cultures should generally be lower for Tier 1 organisms than for organisms for which the role of the environment in transmission (e.g., environmental persistence, effectiveness of disinfectants) is understood

Tier 2
• Environmental cultures are recommended only if transmission is identified or suspected and there is epidemiologic evidence implicating an environmental reservoir in ongoing transmission

Tier 3
• Environmental cultures are generally not recommended unless transmission is identified or suspected, and there is epidemiologic evidence implicating an environmental reservoir in ongoing transmission

Before environmental sampling takes place:
• Consult with a laboratory that has experience processing environmental samples
• Work with laboratory to develop an environmental sampling strategy
• Consult with experts to interpret results
# Containment Response Element Summary

<table>
<thead>
<tr>
<th>Response Element</th>
<th>Recommendation</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare investigation</td>
<td>Review the patient’s healthcare exposures prior to and after the positive culture</td>
<td>At least 30 days</td>
<td>30-90 days</td>
<td>Current, sometimes prior admission</td>
</tr>
<tr>
<td>Ensure adherence to IPC</td>
<td>Infection control assessment w/observation of practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Investigation</td>
<td>Screen healthcare roommates</td>
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<td></td>
<td>Screen additional healthcare contacts</td>
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<tr>
<td></td>
<td>Screen household contacts</td>
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<td></td>
<td>Screen healthcare personnel</td>
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<tr>
<td>If transmission identified</td>
<td>Repeat PPS at regular intervals if cases identified</td>
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<tr>
<td></td>
<td>Evaluate potential for spread to linked facilities</td>
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<tr>
<td>Clinical surveillance</td>
<td>Prospective laboratory surveillance</td>
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<td>Retrospective laboratory surveillance</td>
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<tr>
<td>Environmental cultures</td>
<td>Environmental Sampling</td>
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</tbody>
</table>
Tier 4 Guidance – Not Containment

• Ensure that healthcare facilities and providers promptly receive testing results, to facilitate implementation of appropriate infection prevention and control measures for the affected patient.

• Confirm measures are in place to ensure adherence to IPC, and communication of patient MDRO status at transfer.

• Prioritize prevention measures described in the Public Health Strategies to Prevent the Spread of Novel and Targeted Multidrug-resistant Organisms (MDROs) over a public health response to single cases, as is done for organisms in Tiers 1–3.

• Remain vigilant for outbreaks and changes in regional epidemiology that may suggest additional measures (e.g., enhanced screening, expansion of prevention activities) are needed.
MDRO Containment Webinar Series

• Adding this webinar and slides to the VDH website: https://www.vdh.virginia.gov/haiar/mdro-containment-webinar-series/

• Additional topics:
  • Role of Hand Hygiene
  • Healthcare Facility Environmental Cleaning and Disinfection
  • Enhanced Barrier Precautions in Nursing Homes
  • Simplifying Carbapenem Resistant Organisms
  • *C. auris* and CPO Colonization Screening
  • Outbreaks and Water Management
Public Health Strategies to Prevent the Spread of Novel and Targeted Multidrug-resistant Organisms (MDROs)

CDC MDRO Prevention Guidance formalizes proactive recommendations and helps prioritize public health resources

**Prevention Strategies**

**Strategy 1**
- Conduct education

**Strategy 2**
- Improve infection prevention and control (IPC) practices

**Strategy 3**
- Detect colonized individuals

**Strategy 4**
- Facilitate communication
Prevention Guidance: Who and What are We Targeting

Priority Organisms
Categorizing Facilities: Influential and Highly Connected

• Influential Facilities
  • Large overall influence on regional MDRO prevalence
  • Include all LTACHs and vSNFs
  • May also include facilities that have substantial transmission and are thought to impact regional prevalence; would be identified during containment response

• Highly Connected Facilities
  • Acute care hospitals and skilled nursing facilities that most frequently receive patients from influential facilities and are therefore likely to admit patients/residents with MDROs
  • LHDs might ask you about your transfer patterns

Facilities not categorized as influential or connected will be "other"
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Recommend Activities</th>
<th>VDH Resources for Facilities</th>
</tr>
</thead>
</table>
| **Education** | • Provide MDRO and IPC-based education to healthcare facilities during planned onsite visits  
• Schedule IPC demonstrations or in-services  
• Provide healthcare facilities with group educational opportunities | Trainings listed on VDH HAI/AR Education Website  
HAI and AR Navigator Newsletter                                                                                                                                 |
| **IPC**       | • Conduct prevention-driven, **recurring (at least yearly)** MDRO-focused infection control assessments  
• Provide follow-up and technical aid to mitigate identified gaps as needed | VDH Proactive Infection Prevention and Control Assessment Request Form                                                                                                                                               |
| **Screening** | • Prevention-driven, **recurring point prevalence surveys (PPSs) at a predetermined frequency**  
• Admission screening if early in epidemic stage, facility has performed PPS, and has good adherence to IPC as observed during IPC assessment | Reach out to your LHD – public health lab capacity is limited                                                                                                                                                     |
| **Communication** | • Understand when, what, and how MDRO-related information is communicated to the local health department and how the facility should be communicating within and between facilities  
• Issue health alerts for clinicians and laboratories  
• Support healthcare facilities to improve interfacility communication within a region | VDH Reportable Disease List  
VDH Clinician Letters  
CDC Transfer Form  
EDCC (see earlier slide)                                                                                                                                  |
## Highly Recommended Activities for Highly Connected Facilities

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• Provide healthcare facilities with group educational opportunities | Trainings listed on VDH HAI/AR Education Website  
VDH and AR Navigator Newsletter |
| **IPC**      | • Conduct prevention-driven *ad hoc* infection control assessments for facilities with limited IPC resources  
• Provide follow-up and technical aid to mitigate identified gaps as needed | VDH Proactive Infection Prevention and Control Assessment Request Form |
| **Screening**| • *Ad-hoc* PPS and admission screening only recommended | Reach out to your LHD – public health lab capacity is limited and will be prioritized for response actions |
| **Communication** | • Ensure all healthcare facilities and other providers understand when, what, and how MDRO-related information is communicated to the local health department and how they should be communicating within and between facilities  
• Issue health alerts for clinicians and laboratories  
• Support healthcare facilities to improve interfacility communication within a region | VDH Reportable Disease List  
VDH Clinician Letters  
CDC Transfer Form  
EDCC (see earlier slide) |

Interested in learning more about a prevention strategy? Reach out to your local health department.
What Should Facilities Do Now?

• Update any facility policies or protocols for targeted MDROs with the updated guidance

• Influential and highly connected facilities: consider prevention strategies
  • Request a proactive onsite assessment

• Continue to report cases and work with your local health department to prevent transmission
  • VDH is working on updating documents shared with facilities to reflect updated practice
  • Send questions regarding new guidance to local health departments
    • Will work with CDC to provide answers
      • VDH will create additional FAQs if deemed necessary
Visit the VDH HAI/AR Website:
https://www.vdh.virginia.gov/haiar/

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