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

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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*

Containment Strategy/Guidance

Prevention Guidance

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https://www.cdc.gov/hai/mdro-guides/index.html

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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

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Virginia Tier Designation

Tier	CDC Definition	Virginia Organism Tiers
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

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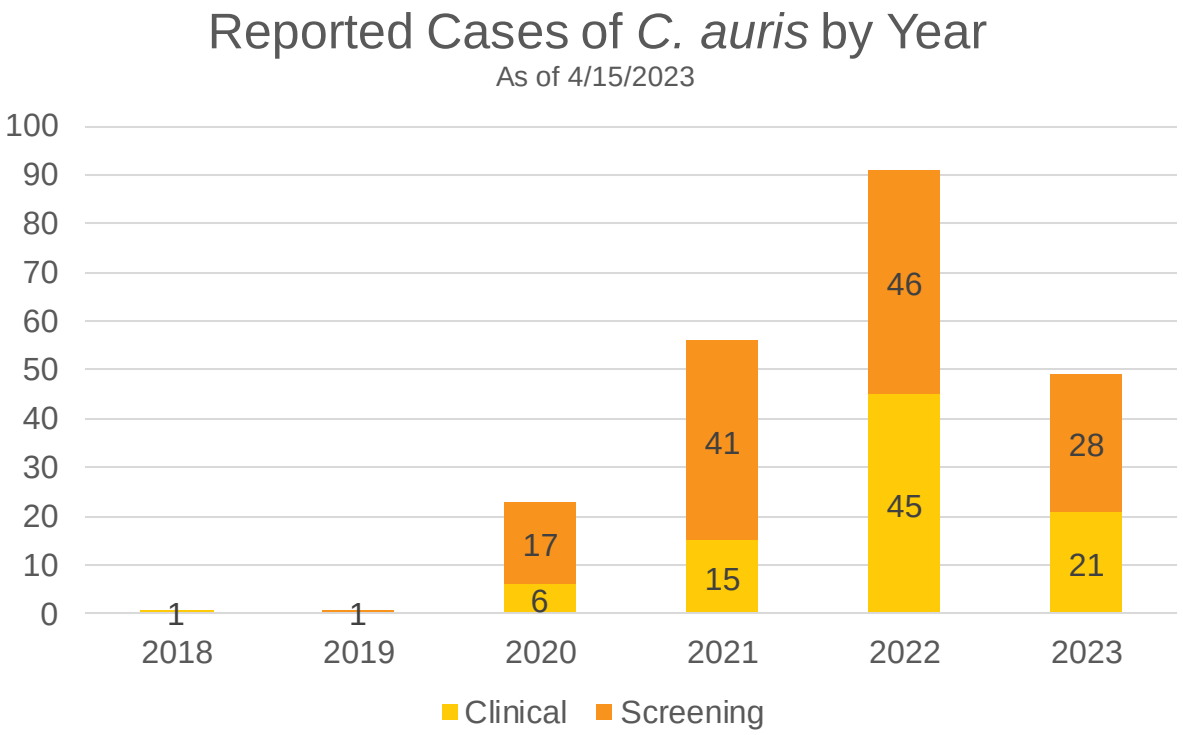
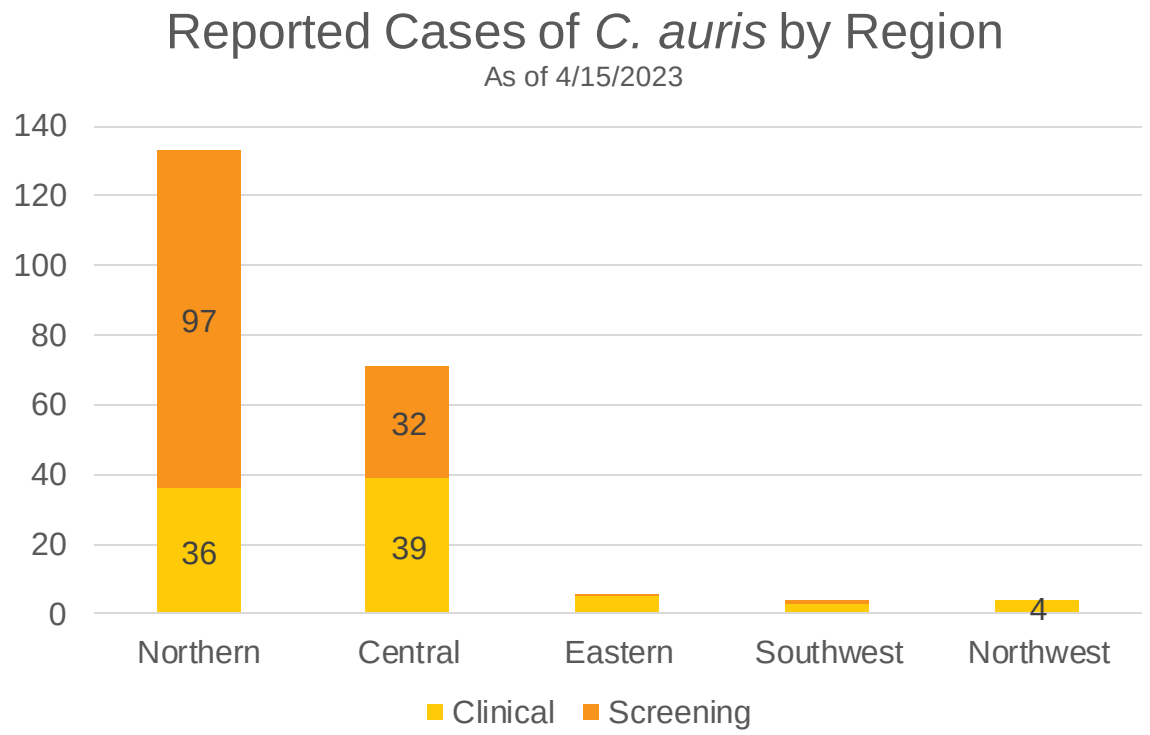
VRSA=Vancomycin-resistant *S. aureus;* CRE= Carbapenem-resistant Enterobacterales; IMP=Imipenemase Metallo-beta-lactamase ; NDM=New Delhi Metallo-beta-lactamase; OXA= Oxacillinase-like beta-lactamase; VIM= Verona Integron-encoded Metallo-beta-lactamase ;KPC= *Klebsiella pneumoniae* Carbapenemase; CRPA=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

Candida auris in Virginia

Clinical Case Count: 88
Screening Case Count: 133





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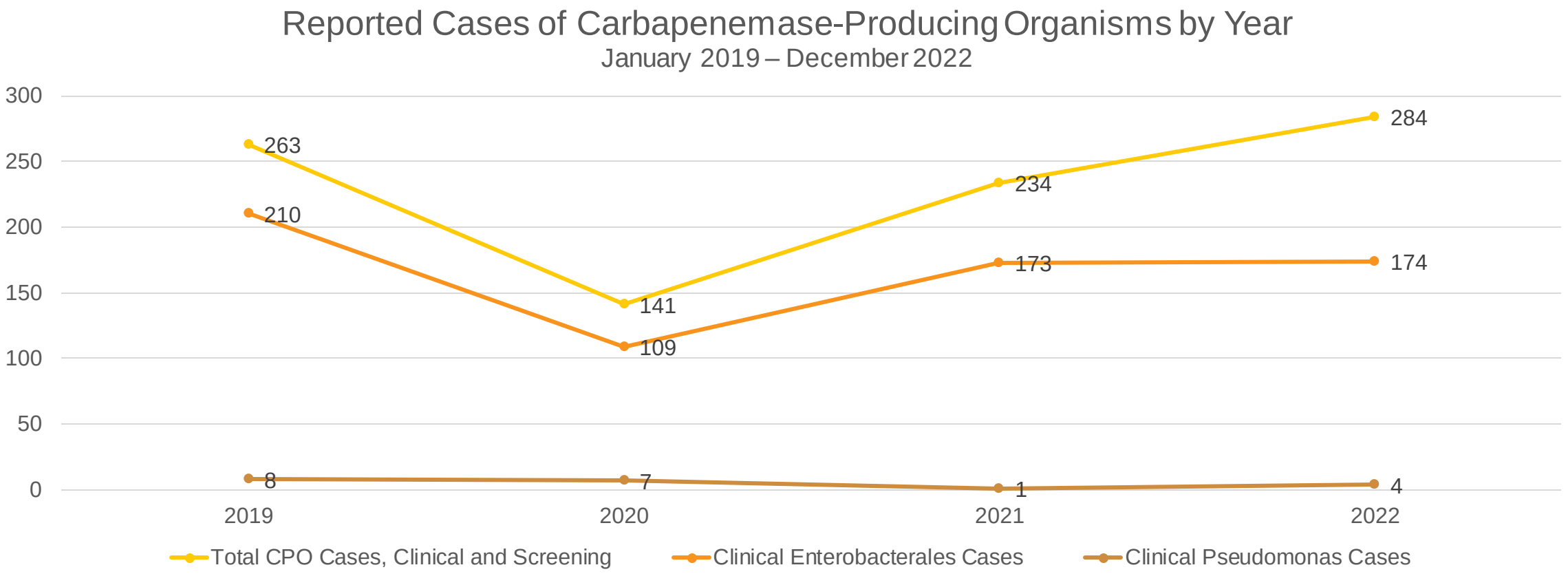
Data were collected from the Virginia Electronic Disease Surveillance System (VEDSS) on April 15 2023; data subject to change. For an individual to be considered a case they had to meet the case definition established by the Council of State and Territorial Epidemiologists (CSTE).

Carbapenemase-Producing Organisms (CPOs) in Virginia



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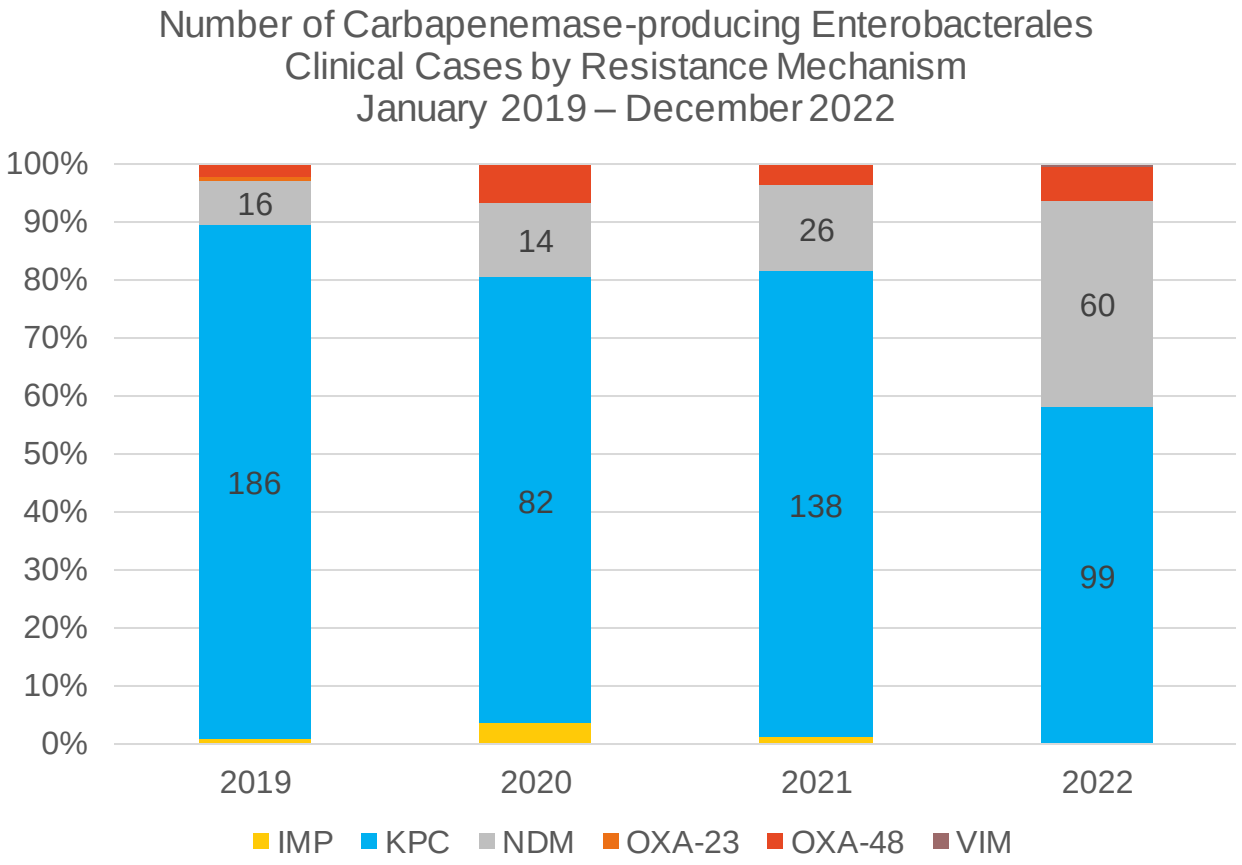
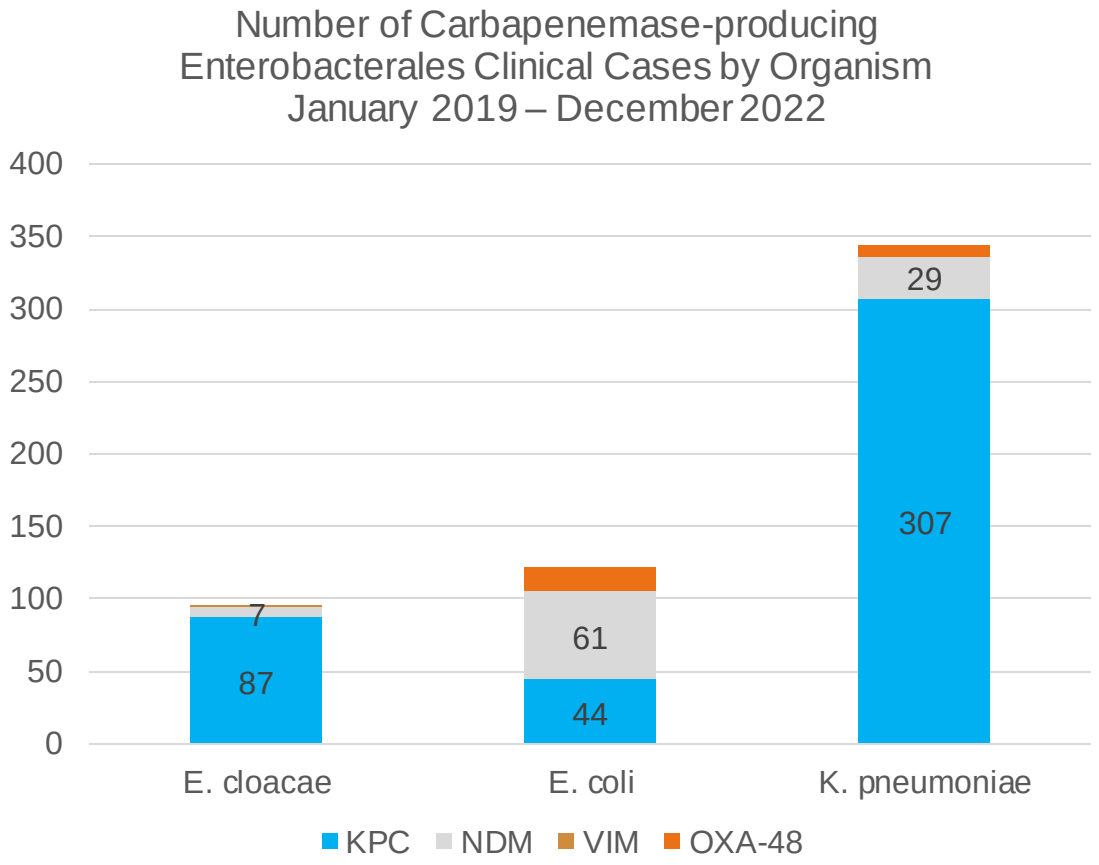
Data were collected from the Virginia Electronic Disease Surveillance System (VEDSS) on March 22, 2023; data subject to change. For an individual to be considered a case they had to meet the case definition established by the Council of State and Territorial Epidemiologists (CSTE).

Spotlight on Enterobacterales in Virginia





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Where do I find Virginia *C. auris* and CPO Case Counts?

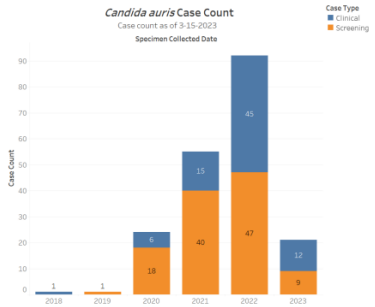
- VDH *C. auris* website https://www.vdh.virginia.gov/haiar/diseases-organisms/candida-auris/
- Monthly updates on static report, transitioning to Tableau

Virginia *Candida auris* Case Count

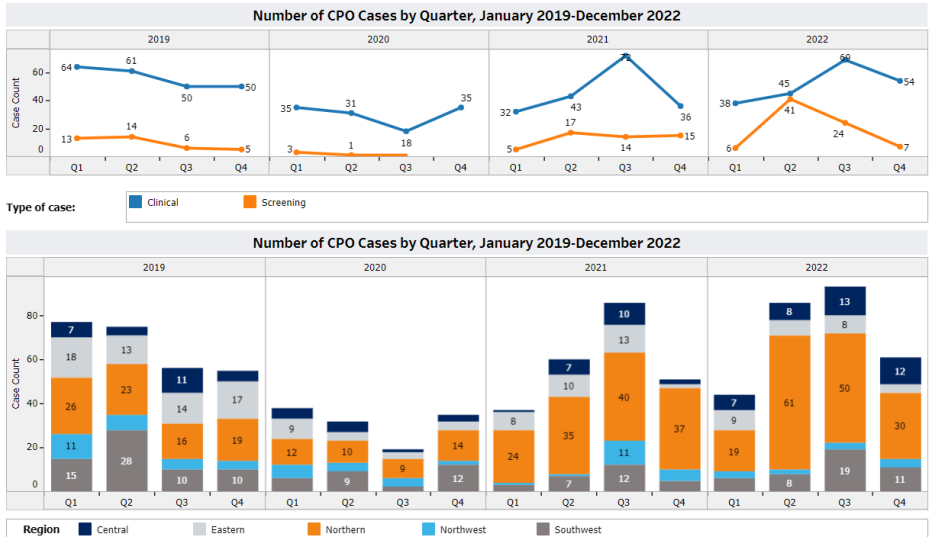
Clinical Case Count (as of March 1, 2023): 79

Colonized/Screening Case Count (as of March 1, 2023): 115

Figure 1.



- VDH CRO website https://www.vdh.virginia.gov/haiar/diseases-organisms/carbapenem-resistant-organisms-cro/
- Quarterly updates in Tableau



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Response Recommendations
Tiers 1-3

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Containment Response Goals for Targeted Organisms

Identify affected patients.

Ensure appropriate control measures are promptly implemented to limit further spread.

Determine if transmission within a healthcare facility and/or dissemination to other facilities are occurring (Tiers 1, 2).

Characterize novel organisms or mechanisms to guide further response actions, patient management, and future responses.

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.

Response Strategies

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)

Initial Response

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

Facility Responsibilities	Public Health Responsibilities
• Promptly notify the patient's primary healthcare provider, healthcare personnel caring for the patient, infection control department, and other healthcare staff per facility policies. • Notify LHD promptly. • Implement contact precautions or enhanced barrier precautions. • 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.	• Notify federal public health authorities. • Prioritize the facility for a rapid infection control assessment to identify and address any potential gaps in IPC (Tiers 1 and 2). • 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

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

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*Current CDC guidance is 30 days, however LHD may request information for the previous 90 days

Adherence to IPC: Healthcare Facility Responsibilities

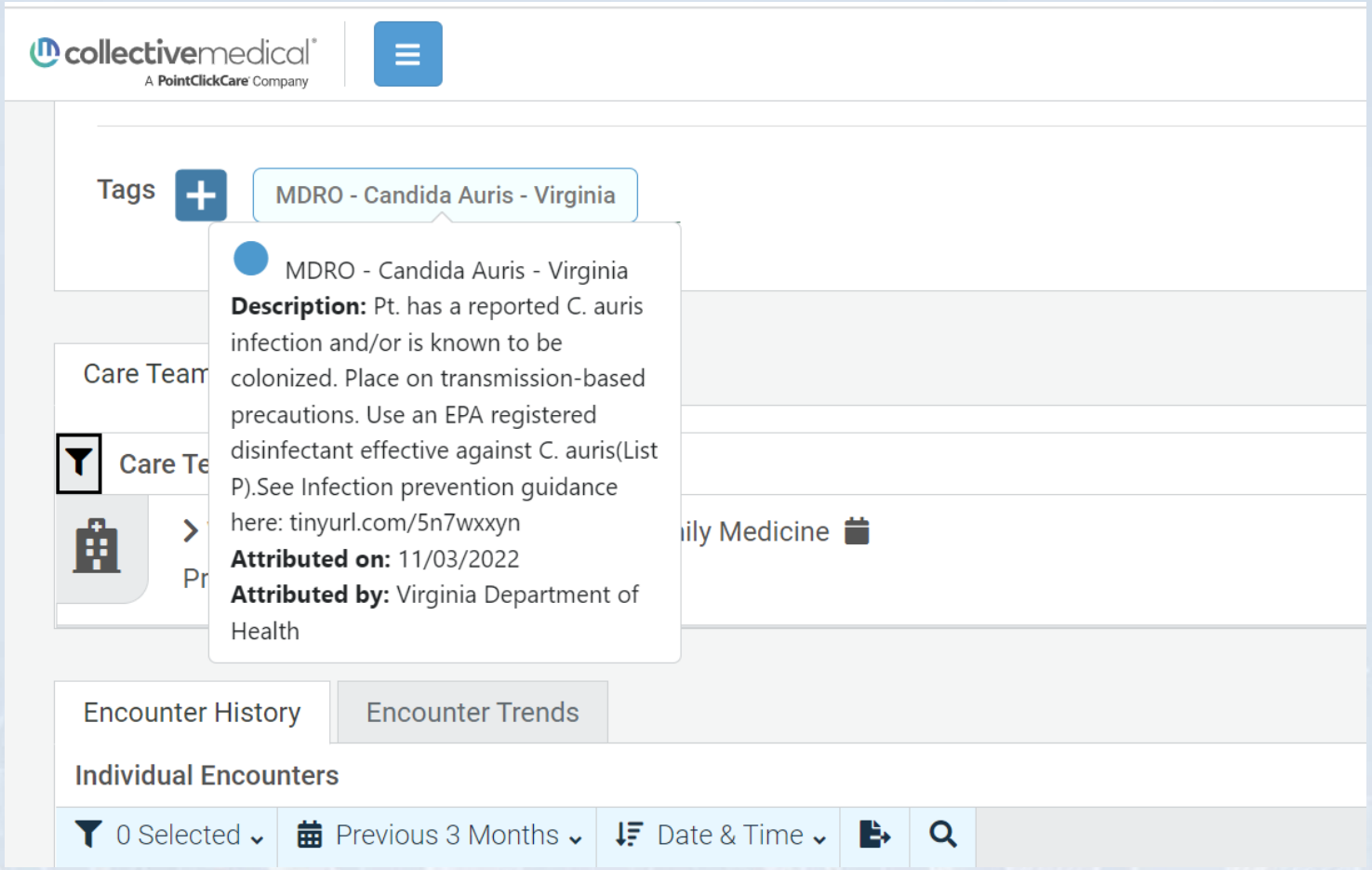
- Educate and inform the healthcare personnel (HCP) and visitors for the index patient about the organism and precautions indicated to prevent transmission
- Ensure that adequate supplies are available to implement Transmission-Based or Enhanced Barrier Precautions
- Conduct ongoing adherence monitoring 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
  - VDH, by facility type: https://www.vdh.virginia.gov/haiar/diseases-organisms/candida-auris/ *(recently updated)*
- CPOs
  - VDH, by facility type: https://www.vdh.virginia.gov/haiar/diseases-organisms/carbapenem-resistant-organisms-cro/ *(recently updated)*
- *Staphylococcus aureus*
  - https://www.vdh.virginia.gov/haiar/diseases-organisms/staphylococcus-aureus/
- Enhanced Barrier Precautions for Nursing Homes
  - CDC: https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html
  - VDH: https://www.vdh.virginia.gov/haiar/ip/ipc-by-healthcare-setting/
- General Infection Prevention and Control
  - https://www.vdh.virginia.gov/haiar/ip/

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)

Contact Screening: Tier 2, Broader Screening

- 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.

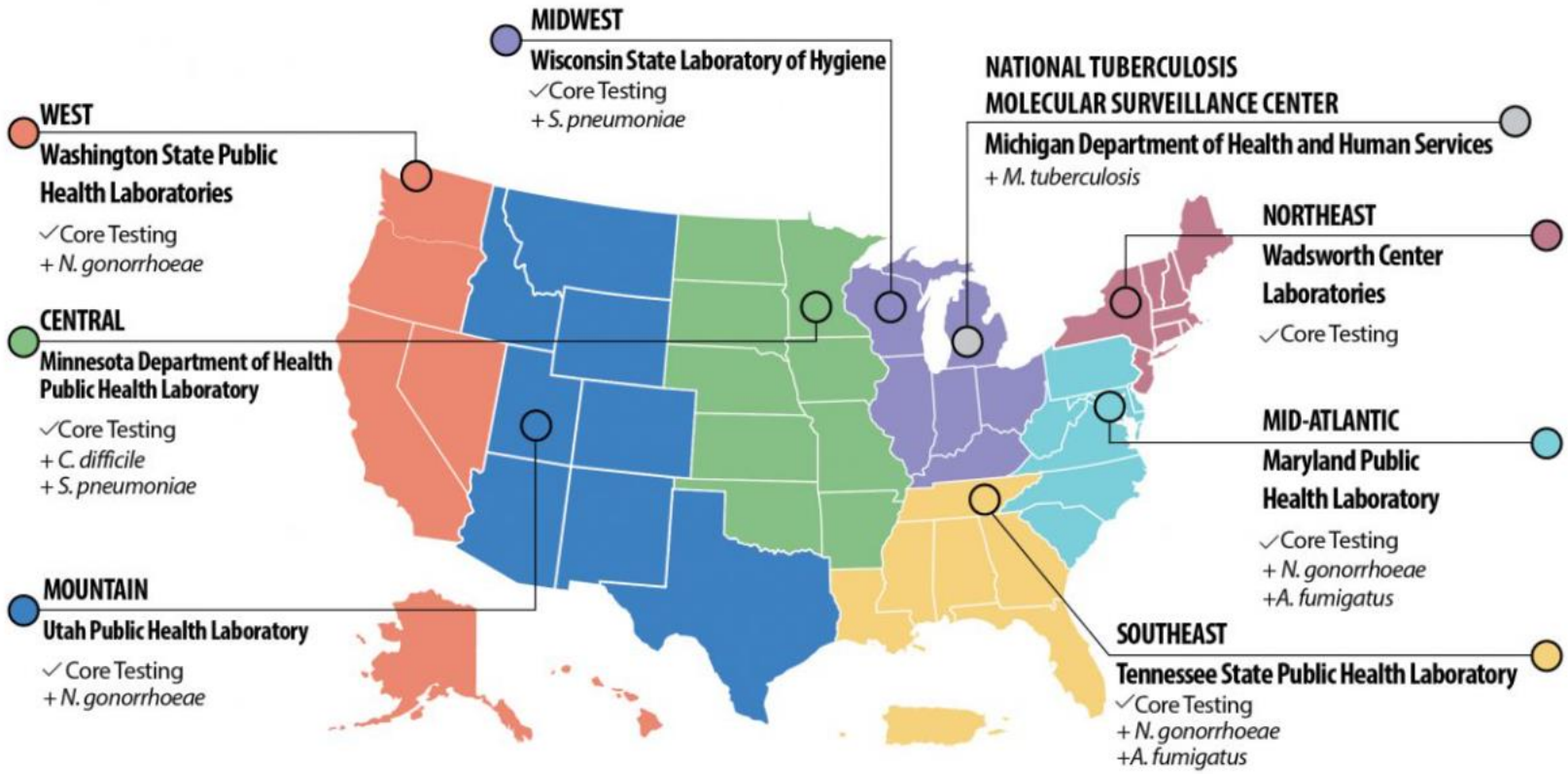
Household contact screening:

- 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

Clinical Laboratory Surveillance

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)

- 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

Virginia Reportable Disease List: Targeted MDROs

Physicians and Directors of Medical Care Facilities Report suspected or confirmed cases to the LHD within 3 days	Laboratories Forward Isolate to DCLS within 7 days
• *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 - 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

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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

Response Element	Recommendation	Tier 1	Tier 2	Tier 3
Healthcare investigation	Review the patient's healthcare exposures prior to and after the positive culture	At least 30 days	30-90 days	Current, sometimes prior admission
Ensure adherence to IPC	Infection control assessment w/observation of practices			
Contact Investigation	Screen healthcare roommates			
	Screen additional healthcare contacts			
	Screen household contacts			
	Screen healthcare personnel			
If transmission identified	Repeat PPS at regular intervals if cases identified			
	Evaluate potential for spread to linked facilities			
Clinical surveillance	Prospective laboratory surveillance			
	Retrospective laboratory surveillance			
Environmental cultures	Environmental Sampling			

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	Always		Sometimes
	Usually		Rarely

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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)

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https://www.cdc.gov/hai/mdro-guides/prevention-strategy.html

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

CDC MDRO Prevention Guidance

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"

Highly Recommended Activities for Influential Facilities

Strategy	Recommend Activities	VDH Resources for Facilities
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)

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Reach out to your local health department.

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Highly Recommended Activities for Highly Connected Facilities

Strategy	Recommend Activities	VDH Resources for Facilities
Education	• Provide MDRO and IPC-based education to healthcare facilities during planned onsite visits • Provide healthcare facilities with group educational opportunities	Trainings listed on VDH HAI/AR Education Website HAI 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)

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Interested in learning more about a prevention strategy?
Reach out to your local health department.

VDH VIRGINIA DEPARTMENT OF HEALTH

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

THANK YOU

Visit the VDH HAI/AR Website:
https://www.vdh.virginia.gov/haiar/

Contact Us:
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HAI&AR
Healthcare-Associated Infections & Antimicrobial Resistance Program

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