MDRO Containment: From Data to Action

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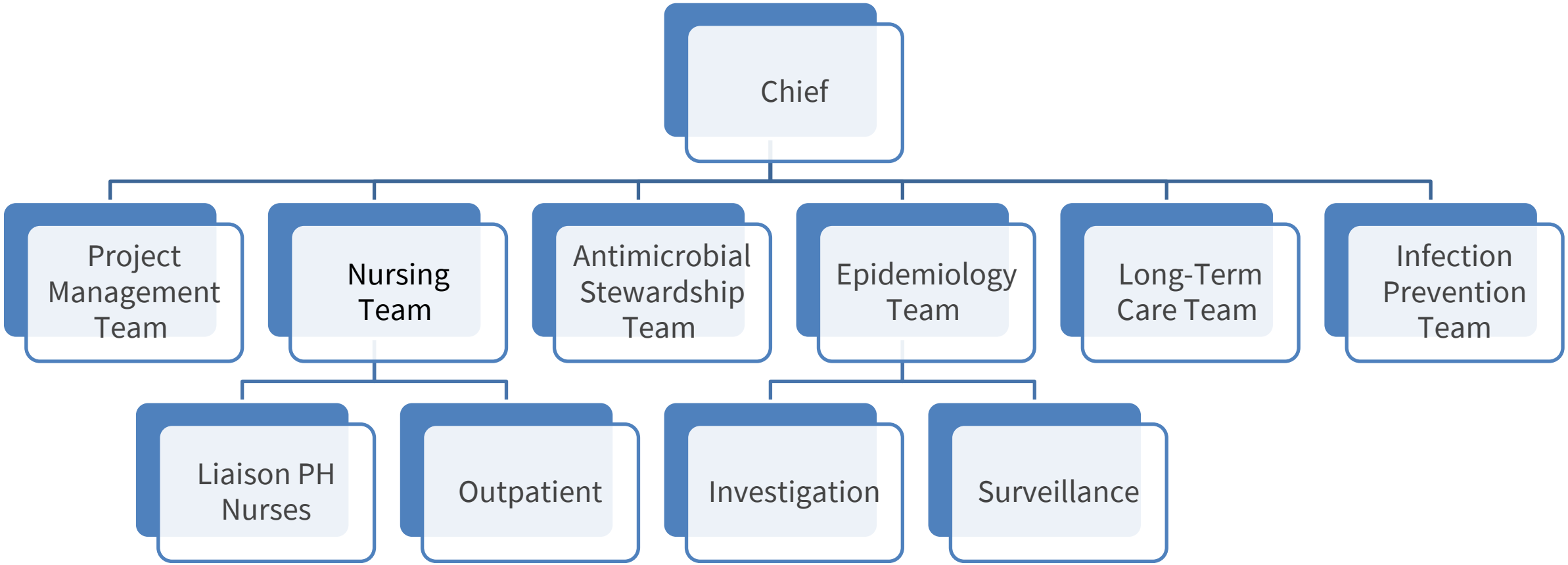
Acute Communicable Disease Control Program (ACDC)

August 12th, 2026

Objectives

- Understand how to investigate and prevent targeted MDROs
- Know where to access LACDPH MDRO resources
- Dismantle 5 common MDRO myths

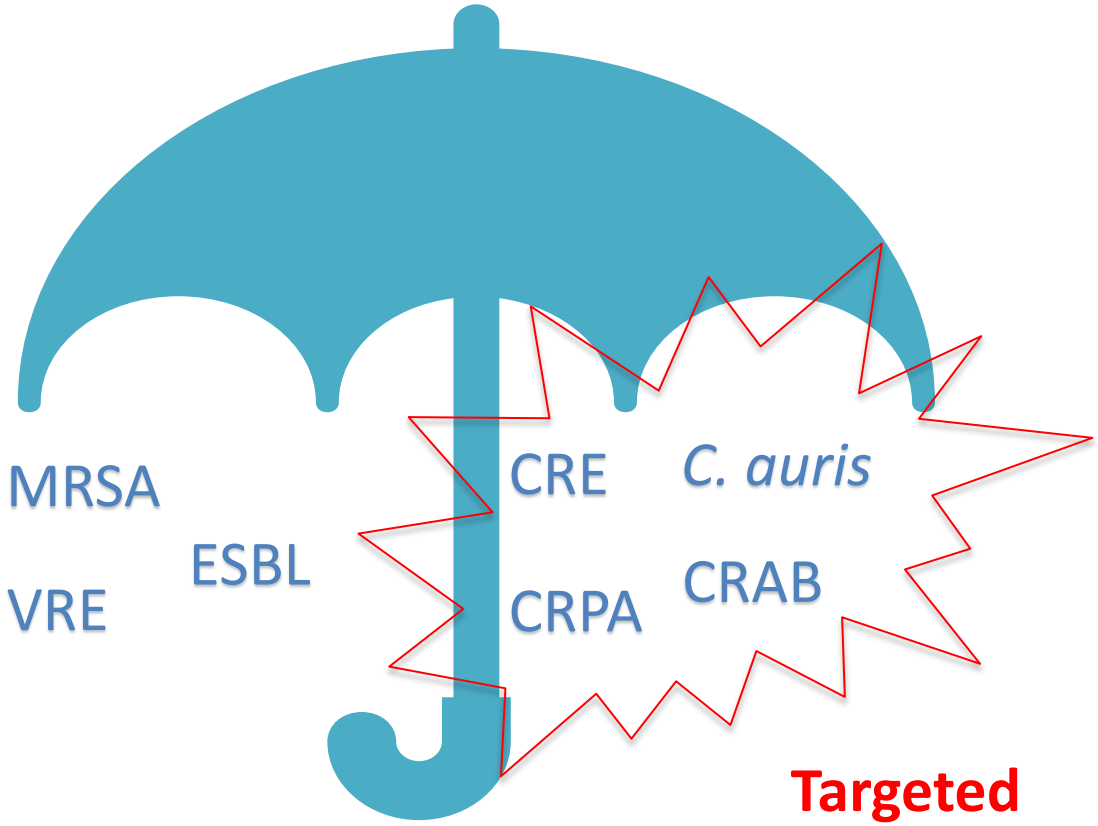
Healthcare Outreach Unit (HOU) Organization Chart



Introduction

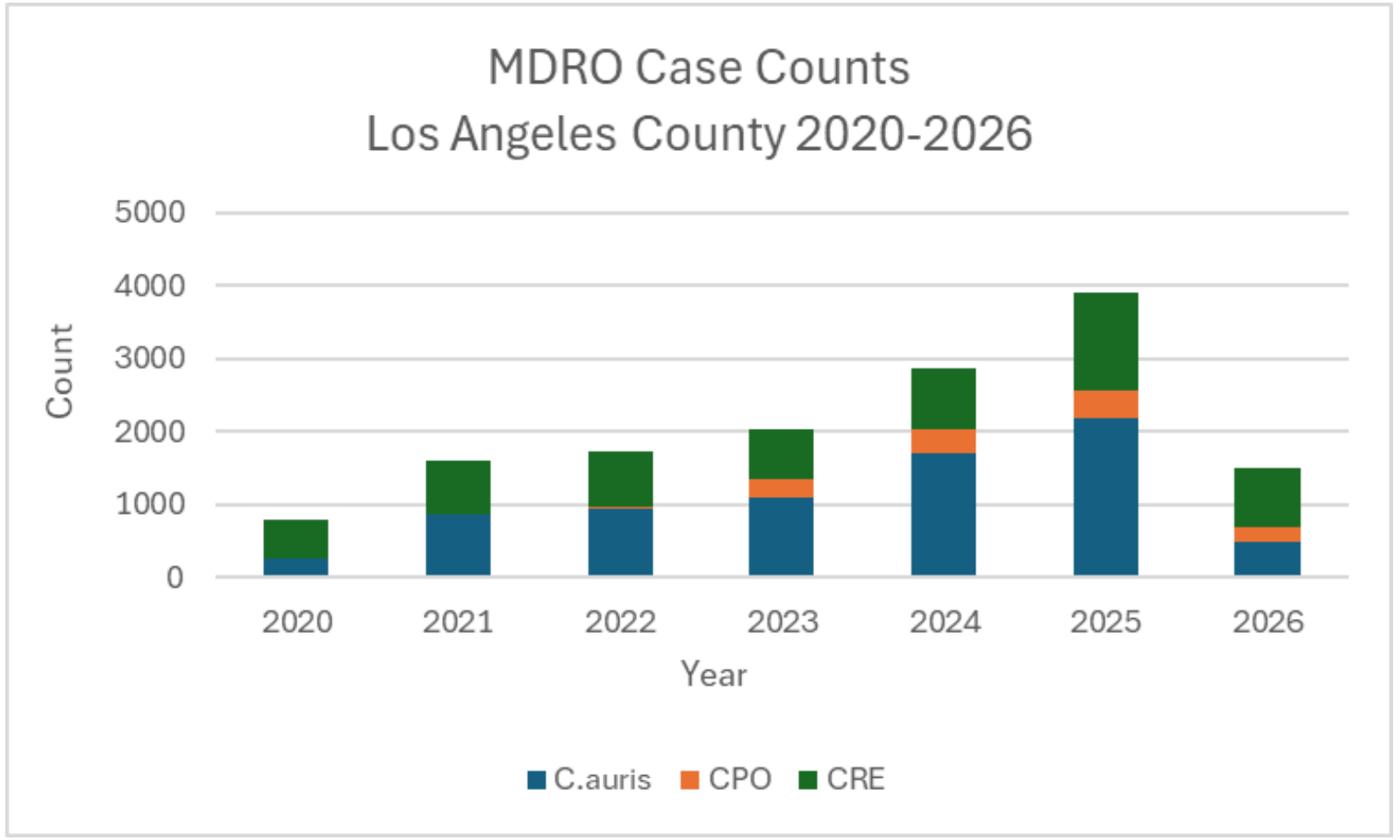
What "Novel" or "Targeted" MDROs Are

- Novel MDROs are:
  - Never/rarely detected in the US
  - Very difficult to treat
- Targeted MDROs are:
  - Pre-endemic
  - Difficult to treat
  - Easy to spread
- Varies by region/jurisdiction



https://www.cdc.gov/hai/pdfs/mdro-guides/Health-Response-Contain-MDRO-H.pdf

Los Angeles County MDRO Surveillance Data



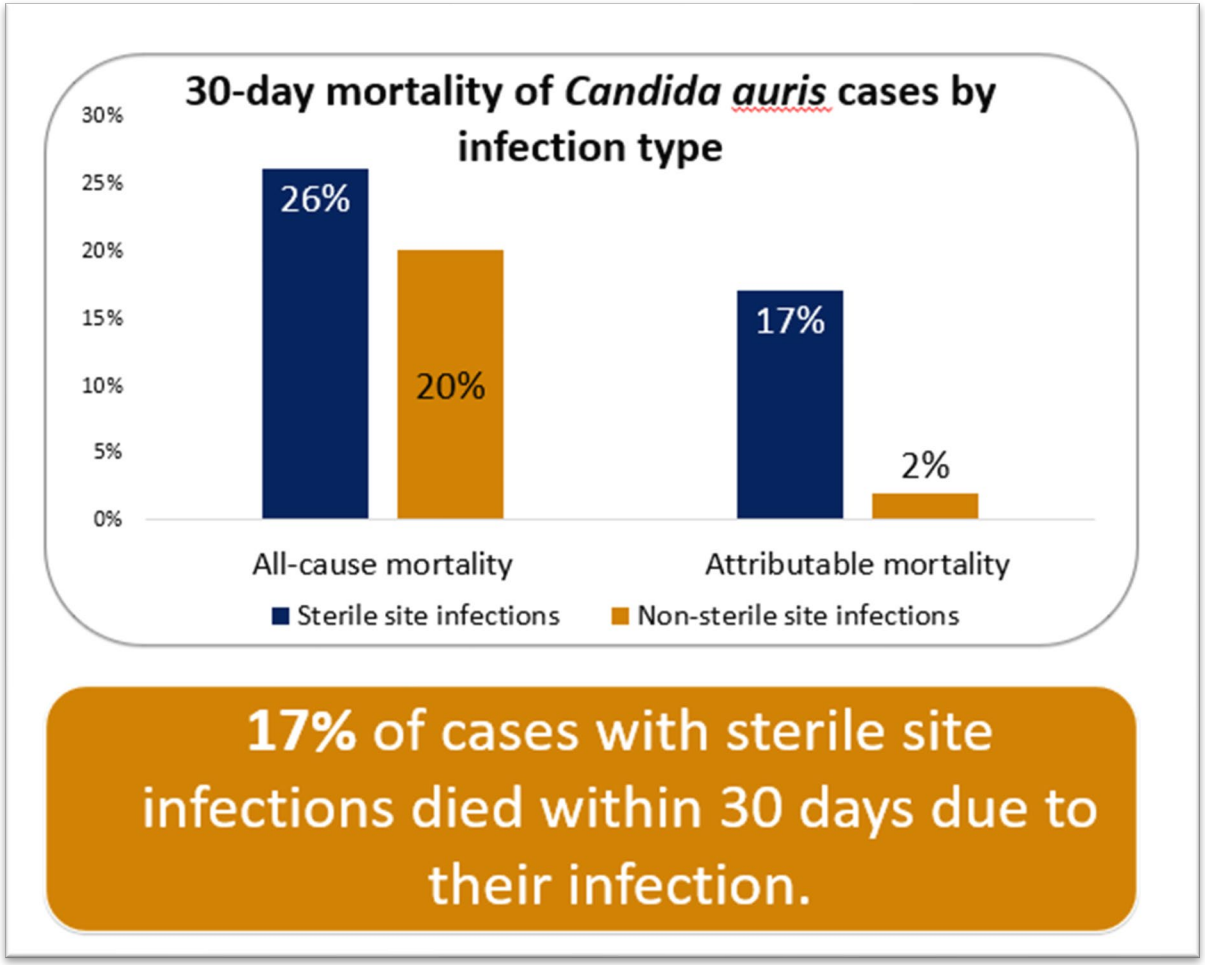
See the LACDPH Targeted MDRO Dashboard: http://publichealth.lacounty.gov/NMDROReportDashboard.htm

MYTH #1: *C. auris* is deadly

- Initial reports were of 45%+ mortality associated with *C. auris*.
- Likely due to fact that patients are at high risk of mortality, in general.
- Risk factors for *C. auris* colonization:
  - Presence of feeding tube (76%)
  - Presence of tracheostomy (57%)
  - Presence of wounds (55%)
  - Require mechanical ventilation (44%)

Attributable mortality and cause of death of *Candida auris* cases, Los Angeles County

- 2,055 total cases between January 2020 and March 2023
- 1080 cases (52%) had death certificate as of March 2023
- Attributing mortality to C. auris:
  - 70 deaths had sterile site cultures for *C. auris* (mortality rate 3% total cases)
  - 960 deaths had non-sterile site cultures (colonized)



Interactive Case Study: Containing an MDRO Cluster

MDRO

Shift Begins

- A new IP reviews the morning micro reports and spots 3 patients positive for carbapenem-resistant Enterobacterales (CRE) cultures in the subacute unit (SAU)
- She questions if this is just a coincidence because all the cases have different specimen sources.

Step 1

- How can she define the baseline for the unit?
- Where can she access past trends?

MDRO surveillance for Benchmarking

- Starting from admission, track all MDRO-positive lab reports and maintain a line list to monitor **healthcare-onset (HO)** versus **community-onset (CO)** infections/colonizations
  - General definition of HO = specimen collected 3 or more days after admission
  - Look at data from past 6-12 months at minimum to establish baseline rate

- Review regularly to identify trends that may require intervention, such as a cluster of a specific organism in a specific unit.
    - *Example: you usually see 1 HO-C. auris per month. This past month, you had 4 HO-C. auris in the same unit. This should be reported and investigated.*

Example of an MDRO Tracker

Date:							Unit:				
RESIDENT NAME/ MR Number	GENDER	ROOM	DATE OF ADMISSION	ADMITTED FROM (latest)	ORGANISM	SITE OF INFECTION/ COLONIZATION	DATE OF CULTURE	DATE OF RESULTS	DATE OF ISOLATION	ISOLATION/ PRECAUTION	Comment
XXX	F	211	6/2/2022	Hospital B	CRE	Sputum	6/6/2022	6/8/2022	6/6/2022	Contact	
XXXX	M	232-A	5/12/2022	SNF B	C.auris	urine	4/12/2021	4/15/2021	5/12/2022	ESP	
XXXXX	M	232-B	5/27/2022	Hospital A	C.auris	Sputum	5/5/2022	5/22/2022	5/27/2022	ESP	

You can find a downloable template here to use at your facility.

Updated Lab Results

New Details

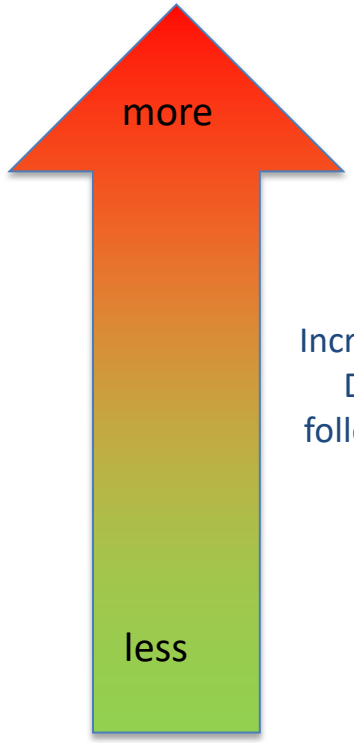
- IP determines there have been on average 1 CRE per month in the past.
- The lab updates that one of the CRE is positive for NDM.
- Upon review, the IP sees the NDM+ patient was admitted for 5 days prior to their first CRE culture.

Step 2

- How concerning is this pathogen?
- What steps, if any, does she need to take in response?

LACDPH MDRO Tier Designation

Tier	Description	Pathogens Included
1	Pathogens/resistance mechanisms never or very rarely detected in Los Angeles County (novel MDROs)	• Novel organism and/or resistance mechanism • Pan-resistant gram-negative organism[1]
2	Pathogens/resistance mechanisms not commonly detected in Los Angeles County (targeted MDROs)	• Concerning *C. auris*[2] • Uncommon carbapenemase-producing *Acinetobacter* spp.[3] • Uncommon carbapenemase-producing Enterobacterales[4]
3	Pathogens/resistance mechanisms commonly detected in Los Angeles County but not endemic	• Carbapenemase-producing *Pseudomonas* spp.[5] • NDM-producing Enterobacterales
4	Pathogens/resistance mechanisms endemic in Los Angeles County and/ or less epidemiologically concerning	• KPC-producing Enterobacterales • *C. auris* • OXA-23-like-producing *Acinetobacter* spp. • Vancomycin-resistant *Staphylococcus aureus* • Other MDROs not previously listed



Increasing DPH follow-up

1. *Resistant (R) to all drugs tested at public health laboratories (including CDC)*
2. *Including echinocandin- or pan-resistant* C. auris
3. *Incldlng NDM-, IMP-, VIM-, and KPC-producing* Acinetobacter *spp.*
4. *Including IMP-, VIM-, and OXA-like producing Enterobacterales*
5. *Including VIM-, IMP-, NDM-, KPC-, and OXA-like producing* Pseudomonas *spp.*

http://publichealth.lacounty.gov/acd/docs/LACDPH_MDRO_Tiers_ExternalGuidance.pdf

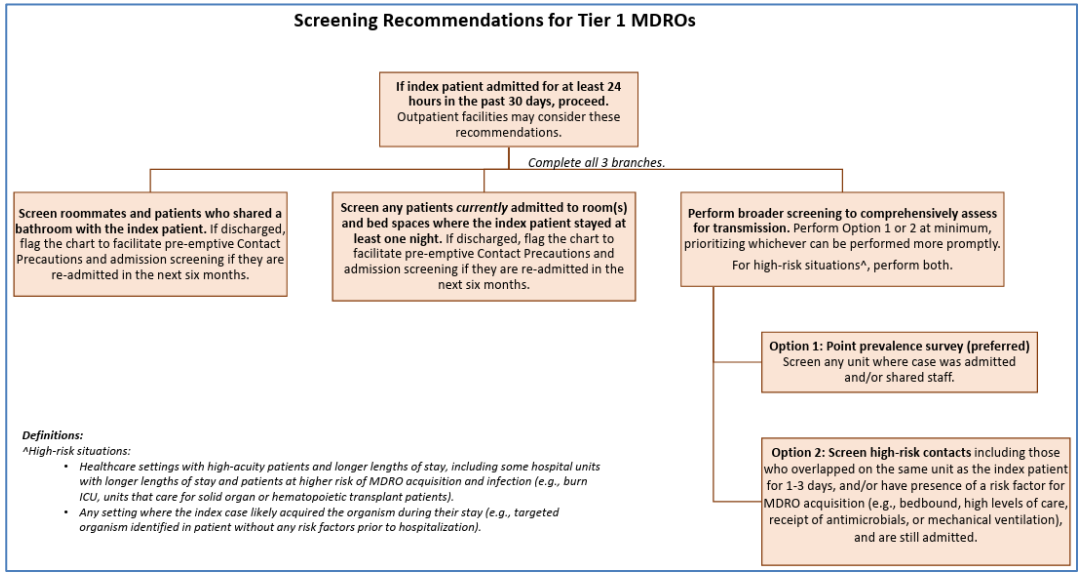
LAC Novel & Targeted MDRO Response

Upon receipt of a Tier 1-3* MDRO report, LACDPH will reach out to HCFs to:

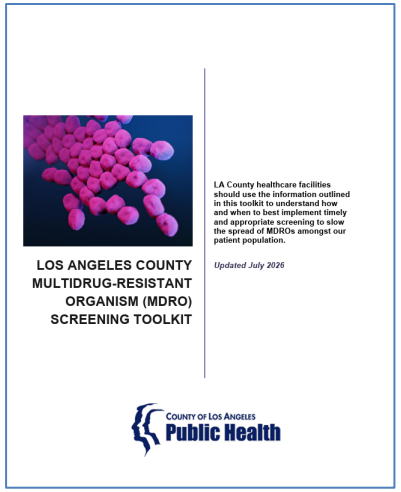
- Conduct assessment of affected facility(s) to ensure patient is/was on appropriate TBP
- Determine patient status and risk for transmission for unit(s)
- Identify whether transmission may have occurred
- Educate facility staff on how to prevent transmission
- Ensure communication of patient infection/colonization status

LACDPH MDRO Screening Guidance

- Screening should still occur even if the index patient was being managed with TBP
- DPH can assist with point prevalence surveys (PPS)
- Lists of reference labs that perform colonization screening are available
- New MDRO Screening Toolkit



http://publichealth.lacounty.gov/acd/docs/NMDROTierScreeningInterpretation.pdf



http://publichealth.lacounty.gov/acd/docs/MDROScreeningToolkit.pdf

Screening Recommendations for Tier 3 MDROs

At minimum, **screen roommates and patients who shared a bathroom with the index patient.**
In addition…

High-risk units should also perform broader screening if one or more of the following criteria met:
- Case acquired MDRO in house
- Case was on unit with a long length of stay
- Any evidence of transmission
- DPH identified a cluster

Low-risk units should also perform broader screening if one or more of the following criteria met:
- Any evidence of transmission
- DPH identified a cluster

Perform broader screening to comprehensively assess for transmission.
Perform Option 1 or 2 at minimum, prioritizing whichever can be performed more promptly.

Option 1: High-risk contacts including those who overlapped on the same unit as the index patient for 1-3 days, and have presence of a risk factor for MDRO acquisition (e.g., bedbound, high levels of care, receipt of antimicrobials, or mechanical ventilation), and are still admitted.

Option 2: Point prevalence survey (preferred)

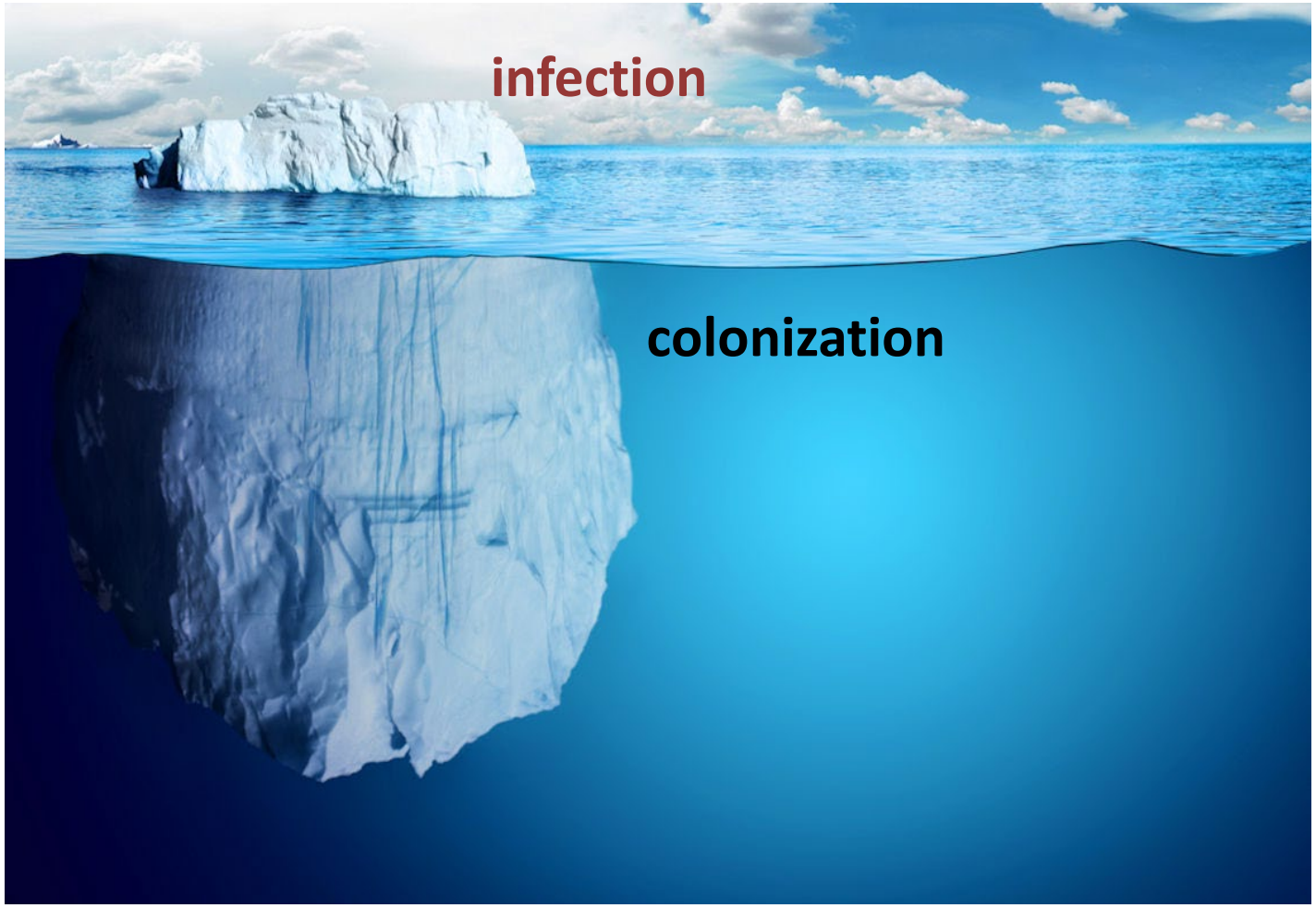
If it will take several days to identify higher risk contacts or if most higher risk contacts have been discharged, perform a unit-wide point prevalence survey promptly.

Definitions:

**Low-risk units: hospital units with a short average length of stay where patients are ambulatory and not mechanically ventilated or skilled nursing facilities.*

^High-risk units: 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 (e.g., burn ICU, units that care for solid organ or hematopoietic transplant patients), subacute units, long-term acute care hospitals.

Clinical cases are only the tip of the MDRO iceberg



Digging deeper: IPC

Active Fieldwork

- Facility conducts a PPS of the subacute unit (SAU), which includes 20 residents.
- While waiting for results, IP decides to audit IPC practices on the unit to identify any transmission routes, and assess any other areas to prevent future cases.

Step 3

- What practices should the IP consider auditing?
- What tools can she use?
- How can she integrate clinical prescribing patterns and antibiogram review into her fieldwork?

Basics of MDRO Prevention

Hand Hygiene

- Use of alcohol-based hand rub (ABHR) preferred
- Audit/feedback

Personal Protective Equipment

- Appropriate transmission-based precautions (TBP)
  - Hospitals: Contact Precautions
- Audit/feedback

Environmental Cleaning & Disinfection

- Use of EPA- approved disinfectants
- Shared devices/equipment
- Audit/feedback

Surveillance

- Tracking MDRO cases to detect possible clusters
- Intervening when audit/feedback shows areas of concern
- Screening

Inter-facility Communication

- Use of transfer form
- Use of LACDPH PSIE
- IP-to-IP communication

Education

- Staff
- Patients/visitors

Antimicrobial Stewardship

- Judicious use of antimicrobials Physician/family education

Reducing risk from water sources (CPOs)

- Conduct WICRA

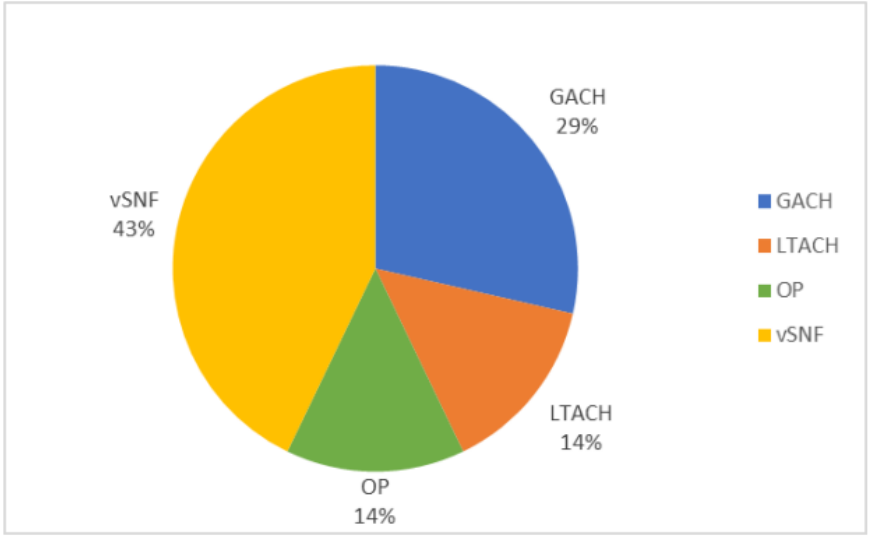
MYTH #2: *C. auris* is a "big" problem for SNFs

- In LAC, SNFs are considered low-risk settings for spread and infections
  - Subacutes, like ventilator-capable SNFs (vSNFs) are higher-risk

Table 8. MDRO outbreaks by disease, 2022 (n=7)

MDRO	No. of outbreak	No. of cases	Cases per outbreak (average)	Cases per outbreak (range)
C. auris	6	45	7.5	4-14
CPPA	1	4	4	4

Figure 2. MDRO Outbreaks by Setting Type, 2022 (n=7)



LACDPH 2022 MDRO Report: http://publichealth.lacounty.gov/acd/docs/LAC2022MDROReport.pdf

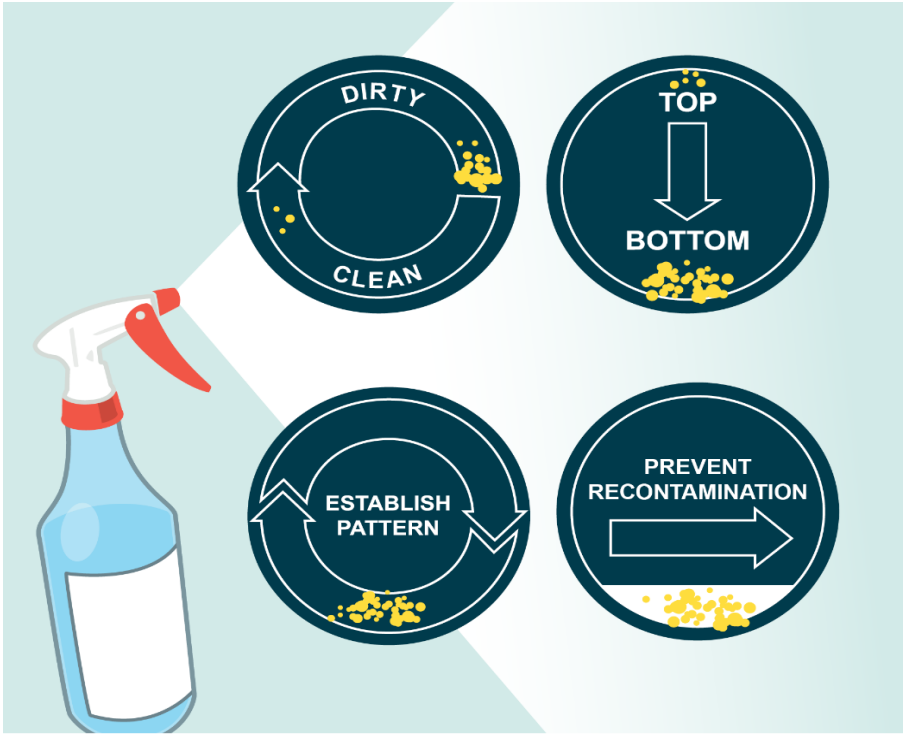
Common IC gaps identified during on-site visits

- **Cleaning & Disinfection**[1]
  - Lack of EVS workers training & knowledge to clean in proper sequence
  - Missed high-touch surfaces
  - Infrequent/unclear cleaning of shared equipment
- **HH**
  - Preference of soap & water over hand gel
    - Note: ABHR is preferred for MDROs, including *C. auris*
  - Missed opportunities upon entry and within room
- **PPE**
  - Not changing PPE between patients in same room
- **Cohorting**
  - Too complicated = unnecessary patient movement

1.

Environmental Cleaning: General Principles

- Establish a standard process that ensures consistency and prevents cross-contamination
- Pick EPA-registered disinfectants that have a realistic and effective contact time for the organism(s) of concern
- Clearly outline EVS vs Nursing Responsibilities
- See CDPH Environmental Cleaning in HCFs: https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/EnvironmentalCleaning.aspx



IPC Monitoring

CDPH California Department of Public Health

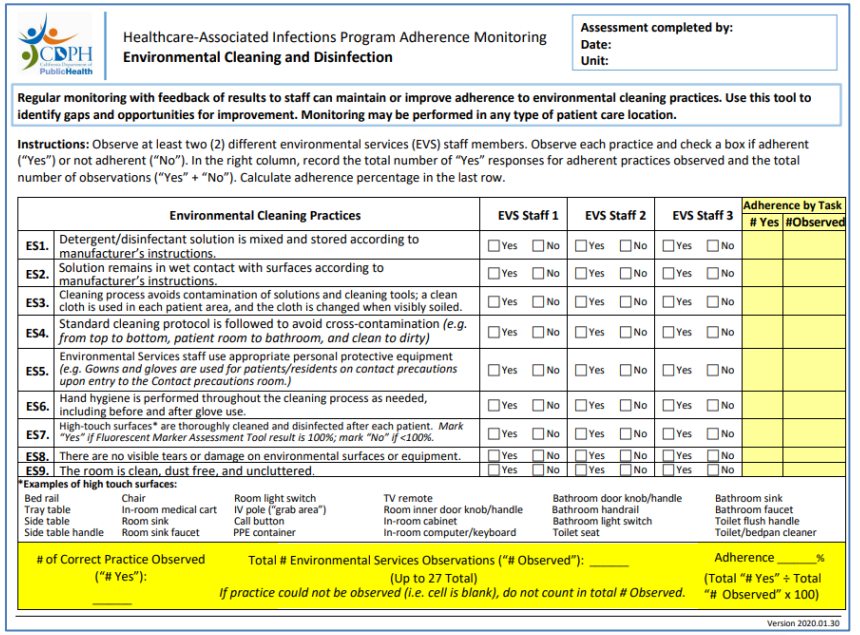
I am looking for | I am a | Programs | A-Z Index

Home | Programs | Center for Health Care Quality | Healthcare Associated Infections | Monitoring Adherence to Healthcare Practices that Prevent Infection

HEALTHCARE-ASSOCIATED INFECTIONS (HAI) PROGRAM

Monitoring Adherence to Health Care Practices that Prevent Infection

Healthcare facilities have infection control and prevention policies in place and are highly encouraged to develop a plan to regularly monitor staff adherence to evidence-based infection prevention practices. The following tools developed by the California Department of Public Health Healthcare-Associated Infections (HAI) Program may be used to measure healthcare worker adherence to care practices critical in preventing infections. Local public health may also use these tools to assist with healthcare facility infection prevention consultations. Select tool(s) based on type of infection control assessment to be conducted.



Healthcare-Associated Infections Program Adherence Monitoring
Environmental Cleaning and Disinfection

Assessment completed by:
Date:
Unit:

Regular monitoring with feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least two (2) different environmental services (EVS) staff members. Observe each practice and check a box if adherent ("Yes") or not adherent ("No"). In the right column, record the total number of "Yes" responses for adherent practices observed and the total number of observations ("Yes" + "No"). Calculate adherence percentage in the last row.

	Environmental Cleaning Practices	EVS Staff 1	EVS Staff 2	EVS Staff 3	Adherence by Task # Yes	Adherence by Task #Observed
ES1.	Detergent/disinfectant solution is mixed and stored according to manufacturer's instructions.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES2.	Solution remains in wet contact with surfaces according to manufacturer's instructions.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES3.	Cleaning process avoids contamination of solutions and cleaning tools; a clean cloth is used in each patient area, and the cloth is changed when visibly soiled.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES4.	Standard cleaning protocol is followed to avoid cross-contamination *(e.g. from top to bottom, patient room to bathroom, and clean to dirty)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES5.	Environmental Services staff use appropriate personal protective equipment *(e.g. Gowns and gloves are used for patients/residents on contact precautions upon entry to the Contact precautions room.)*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES6.	Hand hygiene is performed throughout the cleaning process as needed, including before and after glove use.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES7.	High-touch surfaces* are thoroughly cleaned and disinfected after each patient. *Mark "Yes" if Fluorescent Marker Assessment Tool result is 100%; mark "No" if <100%.*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES8.	There are no visible tears or damage on environmental surfaces or equipment.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
ES9.	The room is clean, dust free, and uncluttered.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

***Examples of high touch surfaces:**

Bed rail	Chair	Room light switch	TV remote	Bathroom door knob/handle	Bathroom sink
Tray table	In-room medical cart	IV pole ("grab area")	Room inner door knob/handle	Bathroom handrail	Bathroom faucet
Side table	Room sink	Call button	In-room cabinet	Bathroom light switch	Toilet flush handle
Side table handle	Room sink faucet	PPE container	In-room computer/keyboard	Toilet seat	Toilet/bedpan cleaner

# of Correct Practice Observed ("# Yes"): _____

Total # Environmental Services Observations ("# Observed"): _____ (Up to 27 Total)
If practice could not be observed (i.e. cell is blank), do not count in total # Observed.

Adherence _____% (Total "# Yes" ÷ Total "# Observed" x 100)

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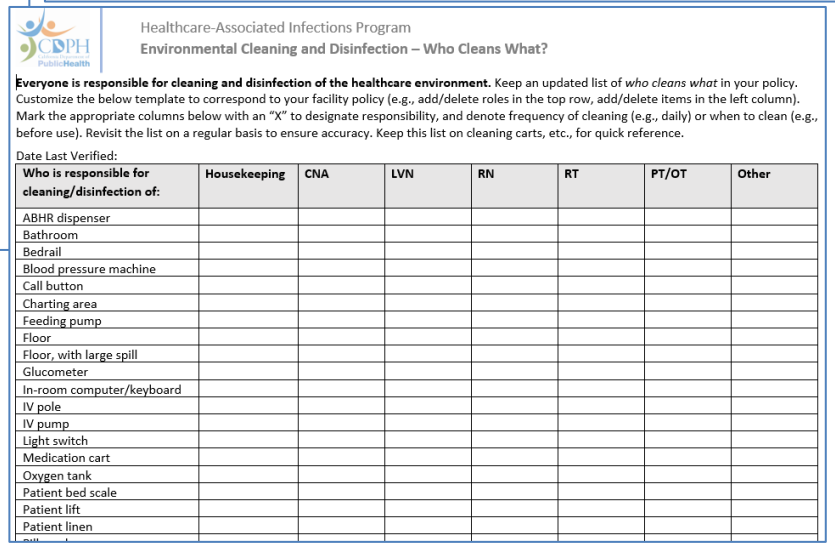


Healthcare-Associated Infections Program
Environmental Cleaning and Disinfection – Who Cleans What?

Everyone is responsible for cleaning and disinfection of the healthcare environment. Keep an updated list of *who cleans what* in your policy. Customize the below template to correspond to your facility policy (e.g., add/delete roles in the top row, add/delete items in the left column). Mark the appropriate columns below with an "X" to designate responsibility, and denote frequency of cleaning (e.g., daily) or when to clean (e.g., before use). Revisit the list on a regular basis to ensure accuracy. Keep this list on cleaning carts, etc., for quick reference.

Date Last Verified:

Who is responsible for cleaning/disinfection of:	Housekeeping	CNA	LVN	RN	RT	PT/OT	Other
ABHR dispenser							
Bathroom							
Bedrail							
Blood pressure machine							
Call button							
Charting area							
Feeding pump							
Floor							
Floor, with large spill							
Glucometer							
In-room computer/keyboard							
IV pole							
IV pump							
Light switch							
Medication cart							
Oxygen tank							
Patient bed scale							
Patient lift							
Patient linen							

https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPracticesThatPreventInfection.aspx

Premise plumbing can pose a risk

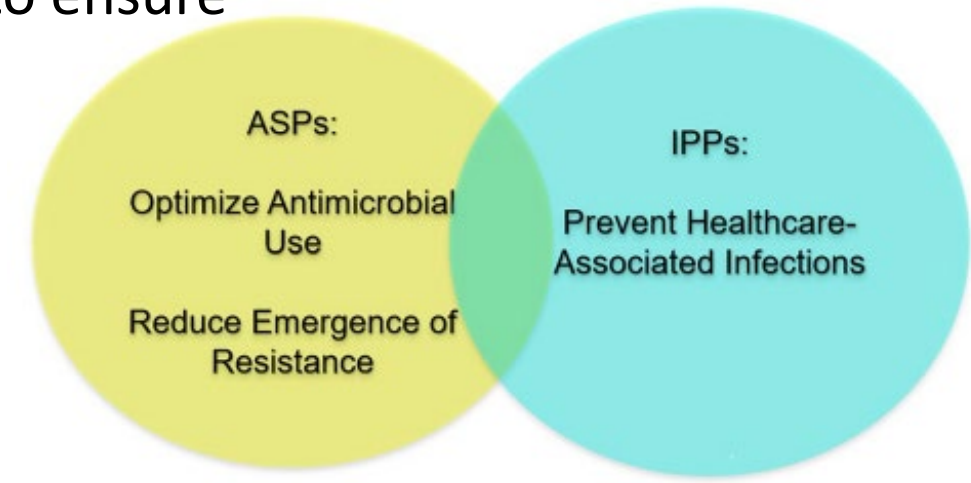
- Common water-loving CROs include:
  - *Pseudomonas aeruginosa*
  - *Enterobacterales*
- Reduce risk from sinks/drains, hoppers
  - Avoid placement of patient care supplies in splash zone of sinks
  - Ensure hoppers are fully covered when flushing
- Conduct a water infection control risk assessment (WICRA)[1]

1. https://www.cdc.gov/healthcare-associated-infections/media/pdfs/water-assessment-tool-508.pdf

https://www.cdc.gov/healthcare-associated-infections/php/toolkit/water-management.html

Antimicrobial stewardship

- Collaborate with your antimicrobial stewardship team
- Review antimicrobials provided to the case-patients to ensure they were appropriate
  - Did providers adhere to guidelines?
  - Did prospective audit and feedback occur?
  - Was appropriate pre-authorization completed?
- If any gaps identified, consider the following actions:
  - Educate provider(s) on adhering to facility policy/guidelines
  - Revise/update treatment guidelines
  - Review and re-assess areas of focus for prospective audit and feedback and which antibiotics require preauthorization



ASP resources

Welcome to the Antimicrobial Stewardship Program Home Page!

Information and tools for all healthcare settings

Please be sure to refresh your browser to see the latest updates and versions of this webpage. Page updated 5-22-26

Program Announcements

New!

Explore the new Los Angeles County DPH Antibiotic Use Dashboard.

Click to view countywide antibiotic use data to support stewardship efforts across healthcare facilities.

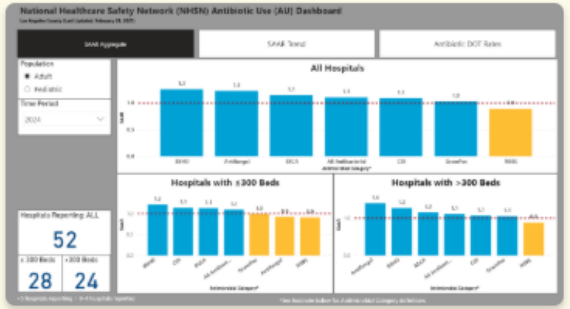


Table of Contents

- About Antibiotic Stewardship
- Our Programs, Guides and Toolkits
- Tracking Antibiotic Use and Resistance
- Resources

Contact Information

For further questions, please email us:

Stewardship@ph.lacounty.gov

http://publichealth.lacounty.gov/acd/antibioticstewardshipprogram/index.htm

Acting on Results

Turning Point

- A few days later, screening results start to arrive:
  - 1 positive for NDM
  - 1 positive for KPC
  - 16 negative
  - 2 pending

- IP now has to also determine precautions and cohorting.

Step 5

- What type of TBP do you apply?
- What is the best way to cohort?
- What resource(s) are available?

MYTH #3: MDROs require contact precautions in a single room

- **Indications:**
  - Targeted and endemic MDROs (Tier 2-4)[1]

    AND/OR
  - Indwelling device(s) and/or wound(s)
- **Implementation**
  - PPE during high contact care activities
- **Parameters:**
  - Residents are not restricted to their rooms
  - Do not require a private room

1. http://publichealth.lacounty.gov/acd/docs/SNFMDROGuidance.pdf

LACDPH MDRO TBP Recommendations

Organism*	Acute care hospitals	Nursing homes	Other long-term care facilities	Outpatient Dialysis^
C. auris	CP	**EBP**	SP	SP
CROs/CPOs	CP	**EBP**	SP	SP
C. difficile+	CP	**CP**	CP	CP
MRSA[1]	SP	**SP**	SP	SP
VRE[1]	SP	**SP**	SP	SP
ESBL[1]	SP	**SP**	SP	SP

Note these recommendations are for the MDRO alone. If resident meets other criteria for a higher level of precautions, follow appropriate guidance. For other organisms, see CDC Appendix A.

**Guidance does not differentiate between colonized and active infection as there is little evidence that the distinction is clinically stable. High risk conditions (diarrhea, draining wounds, etc). would be managed in contact-type precautions per CDC's standard precautions.*
^Inpatient dialysis centers in hospital usually follow hospital guidance.
+Contact precautions are for symptomatic C. diff or patients on active treatment.

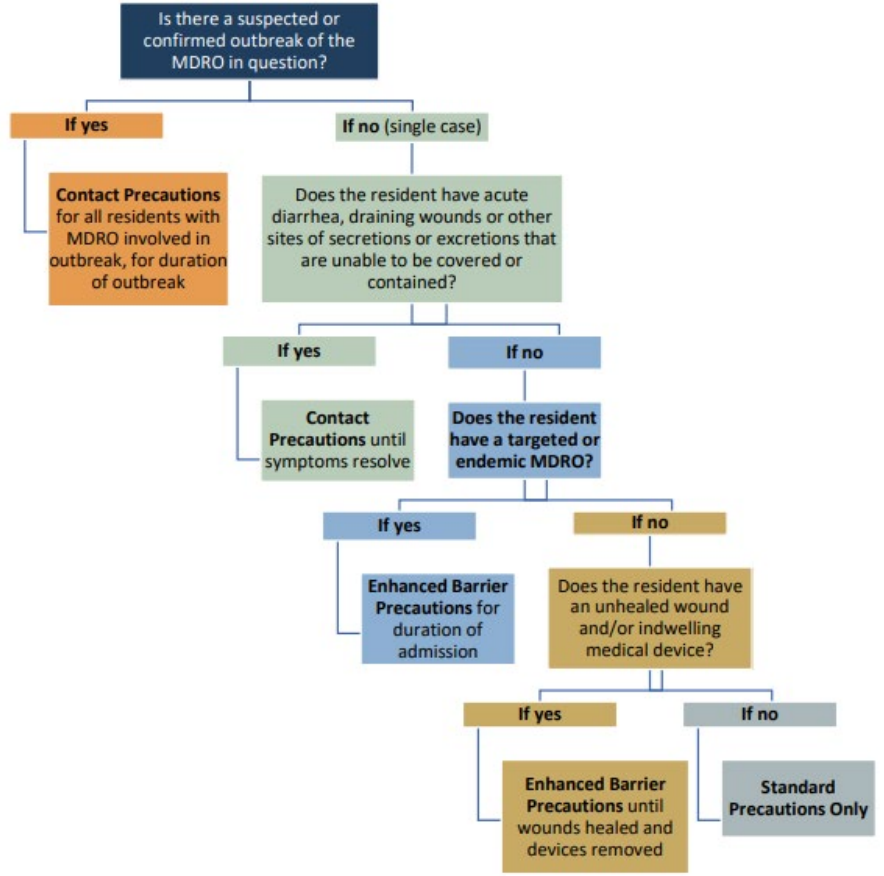
1. LACDPH Rethinking Contact Precautions for MRSA/VRE: http://publichealth.lacounty.gov/acd/RethinkingContactPrecautions/index.htm

Deciding what type of TBP to apply

- Ask yourself:
  - Is there transmission in the unit/facility?
  - What type of organism is it?
  - Does this patient have any risk factors?

- What should **not** be considered:
  - Current antibiotic use
  - Specimen source

Figure 1: Flowchart to determine appropriate TBP



see pages 10-11 of SNF MDRO guidance

Cohorting

- **Ideally, cohort "like with like" and keep it simple**
  - Consider other MDROs, COVID-19
  - *Can be flexible to reduce denials*
- **Avoid multiple room changes as much as possible**
  - Simplify cohorting policies
- **Implement strategies to limit transmission**
  - *Ensure staff treat each bed as a separate room*
  - Place patients in rooms that have beds at least 3-6 feet apart
- **Dedicate staff and equipment wherever possible**
  - If not possible, see *MDRO*-positive residents last

Example scenarios

Ideal situation

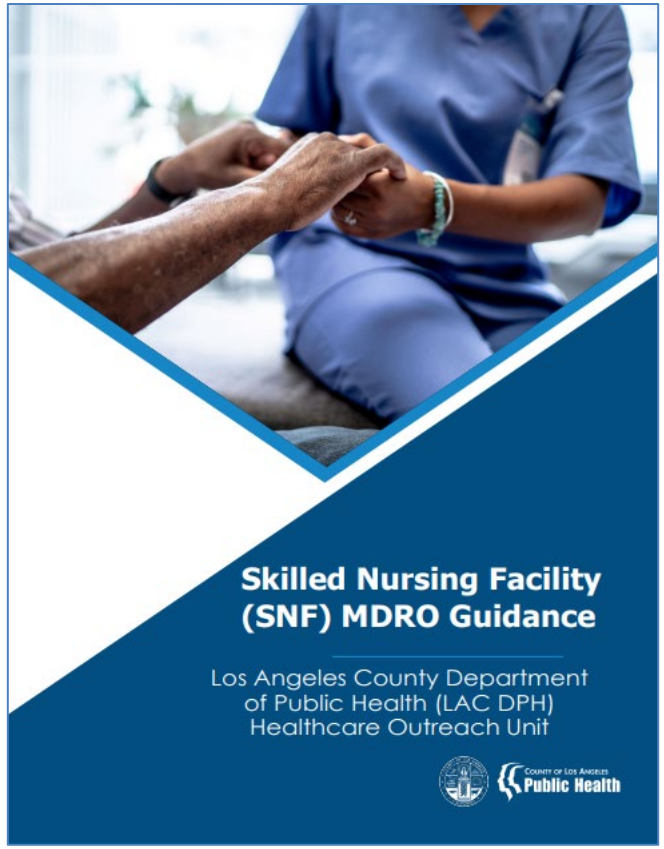
A resident with…	Can be cohorted with a resident with…
KPC-unknown rectal swab	KPC-CRE in urine
CRAB in urine, no signs/symptoms	CRAB in blood, with signs/symptoms
OXA-23 CRAB in urine and C. auris in urine	OXA-23 CRAB in wound and C. auris in axilla/groin swab

If needed situation

A resident with…	Can be cohorted with a resident with…
KPC-unknown organism rectal swab	CRE in urine
CRAB in urine, no signs/symptoms	A low-risk resident w/o CRAB
OXA-23 CRAB in urine and C. auris in urine	C. auris in axilla/groin swab

CDPH Best Practices for SNFs in Accepting Residents with MDROs webinar:
https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/SNFsBestPracticesAcceptingMDROResidentsWebinar_021524.pdf

LACDPH SNF MDRO Guidance



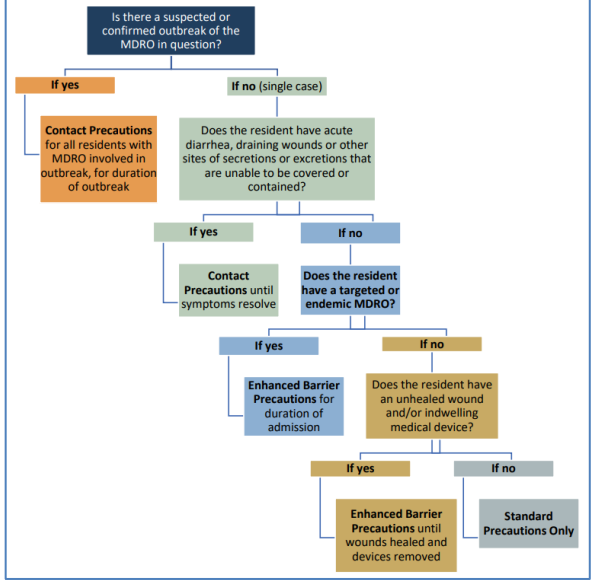
http://publichealth.lacounty.gov/acd/docs/SNFMDROGuidance.pdf

Table 4: TBP and Cohorting Recommendations by MDRO Type

Organism	TBP Type	How to cohort*
Common MDROs (MRSA, VRE, ESBL)	SP Only	Cohort with anyone (no need to cohort with another resident with the same organism), unless the facility is experiencing an outbreak for which cohorting needs to be prioritized. See LACDPH Rethinking Contact Precautions for MRSA and VRE for more guidance: http://publichealth.lacounty.gov/acd/RethinkingContactPrecautions/index.htm
CPOs	EBP	Cohort only with other residents with the same carbapenemase gene (KPC, IMP, NDM, OXA, VIM), unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate^, the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
CROs	EBP	Cohort only with other residents with the same organism, unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate^, the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
C. auris	EBP	Cohort only with other residents with the same organism unless there is an outbreak with a targeted MDRO for which cohorting needs to be prioritized. If a SNF is unable to admit or cohort a new MDRO-positive resident due to a lack of a compatible roommate^, the new resident can be placed in a room with a non-positive resident with the fewest risk factors for MDRO acquisition.*
VRSA	CP	Cohort only with other residents with the same organism.
Novel MDRO	CP	Cohort only with other residents with the same organism.

SCAN ME

Figure 1: Flowchart to determine appropriate TBP



see pages 10-11 of SNF MDRO guidance

Discharge Planning: SNF Transfer

Continuity of Containment

- Two residents are leaving the facility:
  - 1 pending is going to a hospital
  - 1 NDM+ is going to assisted living facility

Step 4

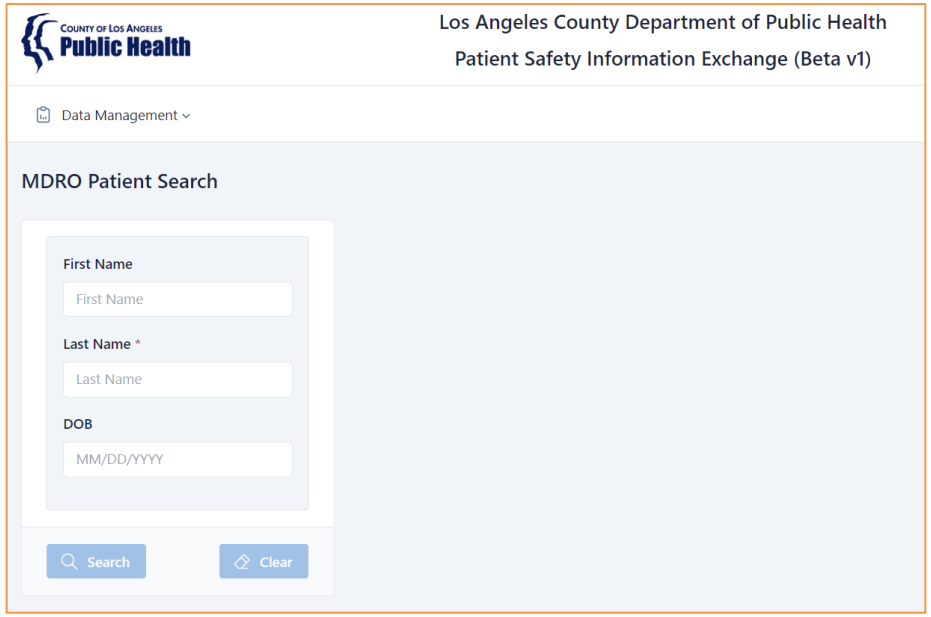
- Who needs to be notified about pending and/or positive results upon discharge/transfer?
- How do you communicate this?

Patient/Family Education

- Inform resident/caregivers of positive and pending test results
- See CDPH AR for Patients & Families for patient-specific educational materials: https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ARPatientsFamilies.aspx

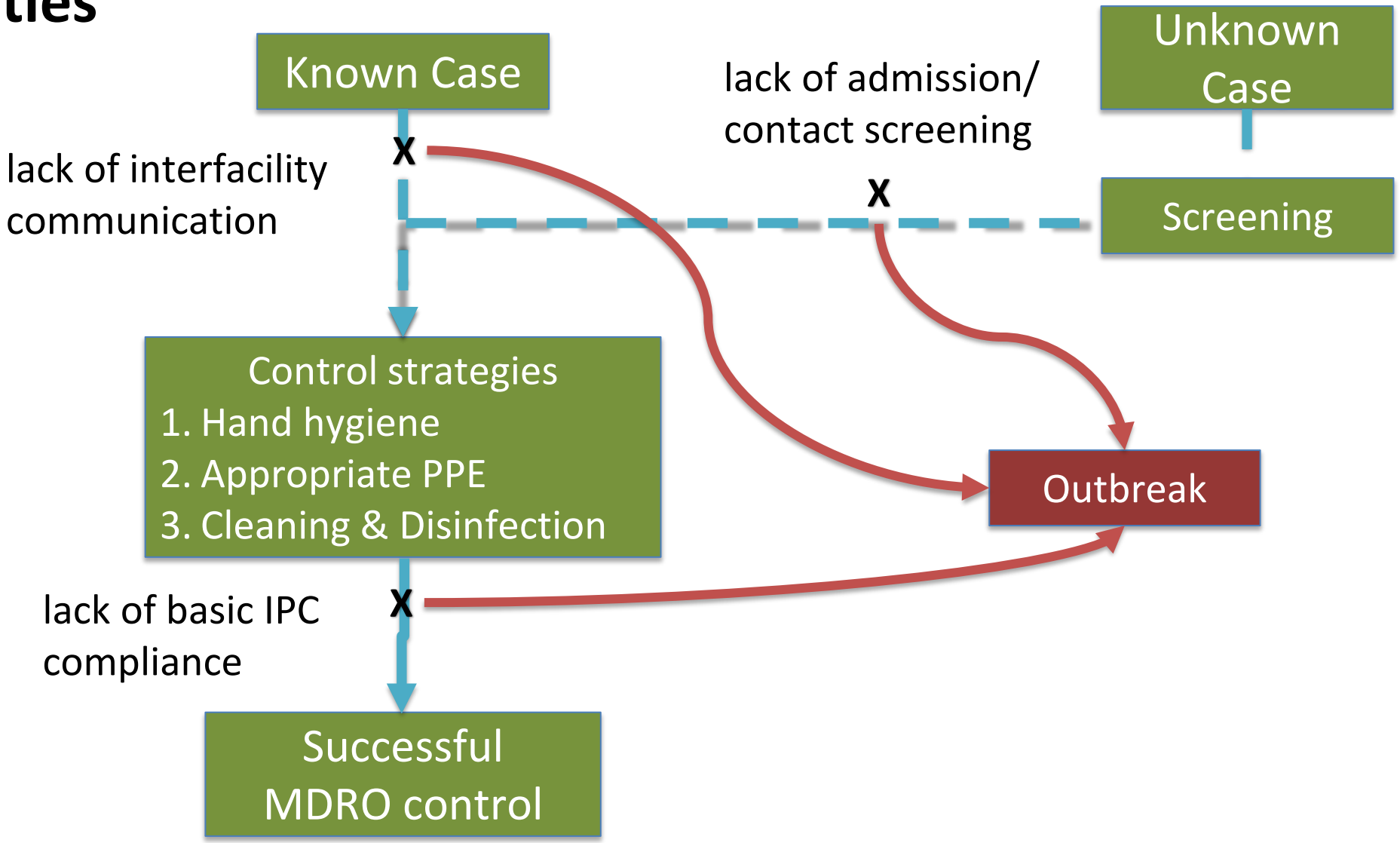
Interfacility Communication Options

- Communicate directly with facility IP
- Interfacility transfer form[1]
- LACDPH Patient Safety Information Exchange (PSIE)



[1] http://publichealth.lacounty.gov/acd/docs/FacilityTransferForm.pdf

Common causes of MDRO outbreaks in LA County healthcare facilities



MYTH #4: You can keep MDROs out of your facility

- There are thousands of MDRO-positive patients in Southern California
- Most are simply colonized – which means there's no signs/symptoms
- Unless you are doing admission screening **and** checking prior history, you likely are admitting *C. auris*-positive patients without knowing it
  - One study found that only 18% of MDRO status was known for SNF residents[1]

1. McKinnell et al. The SHIELD Orange County Project: Multidrug-resistant Organism Prevalence in 21 Nursing Homes and Long-term Acute Care Facilities in Southern California https://pmc.ncbi.nlm.nih.gov/articles/PMC7320073/

A new *C. auris* issue…

- The problem: More *C. auris* cases, less available beds

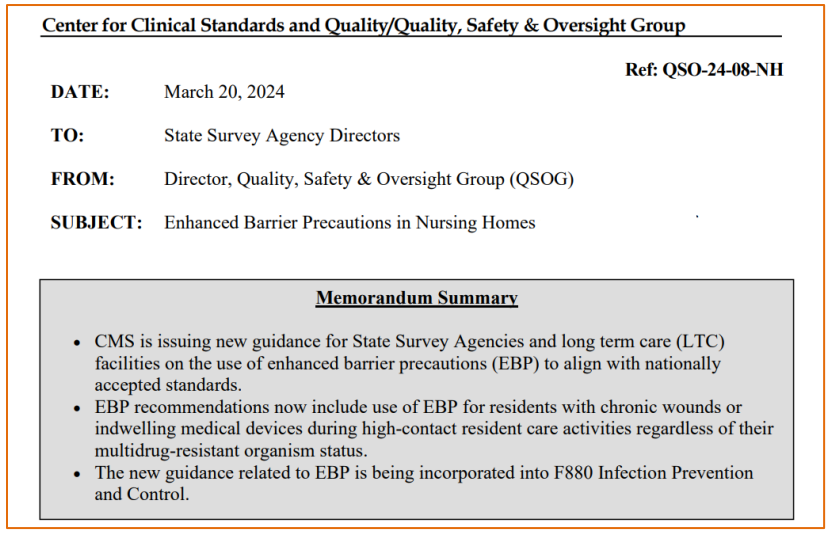
- The results:
  - Patients stuck in hospitals
  - Families and patients stressed
  - Hospitals and patients overwhelmed

Example: patient hospitalized for 225 days while awaiting SNF placement (was ready at day 30).

Example: "My dad is so sad, he just wants to go back to his nursing home. We're having to look and travel further just to find a SNF that's willing to accept him."

Example:
Patient care bill: $3.9 million dollars
Amount paid by insurance: $2.49 million
Cost incurred by healthcare institution: $1.41 million

CMS and CDPH Guidance



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-24-08-NH

DATE: March 20, 2024

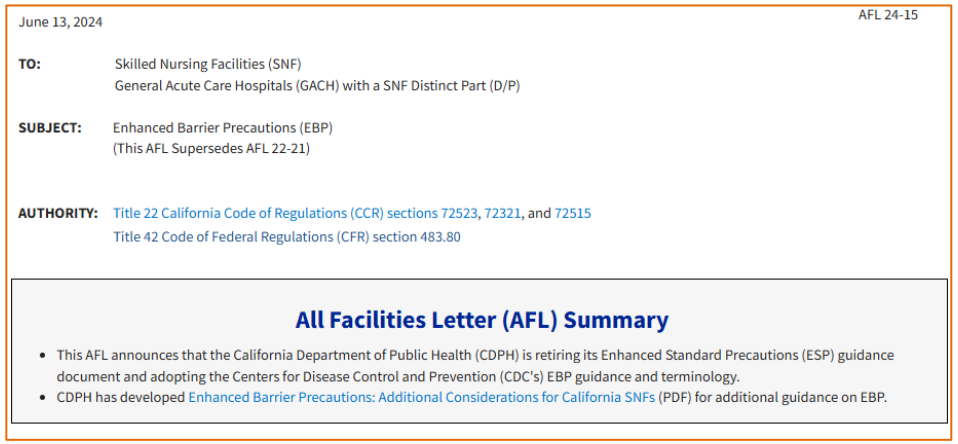
TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Enhanced Barrier Precautions in Nursing Homes

Memorandum Summary

- CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards.
- EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status.
- The new guidance related to EBP is being incorporated into F880 Infection Prevention and Control.



June 13, 2024

AFL 24-15

TO: Skilled Nursing Facilities (SNF)
General Acute Care Hospitals (GACH) with a SNF Distinct Part (D/P)

SUBJECT: Enhanced Barrier Precautions (EBP)
(This AFL Supersedes AFL 22-21)

AUTHORITY: Title 22 California Code of Regulations (CCR) sections 72523, 72321, and 72515
Title 42 Code of Federal Regulations (CFR) section 483.80

All Facilities Letter (AFL) Summary

- This AFL announces that the California Department of Public Health (CDPH) is retiring its Enhanced Standard Precautions (ESP) guidance document and adopting the Centers for Disease Control and Prevention (CDC's) EBP guidance and terminology.
- CDPH has developed Enhanced Barrier Precautions: Additional Considerations for California SNFs (PDF) for additional guidance on EBP.

"All SNFs in compliance with the CMS's EBP requirement are able to admit and provide care for residents with MDROs. Thus, **there is no basis for a SNF to refuse admission of a resident based on their need for EBP or MDRO status**."

Each SNF should develop an internal policy for how to admit and manage MDRO+ residents.

Escalating Care: Reaching out to DPH

Turning Point

- After reviewing the second NDM case, the IP learns this patient was in the adjacent SAU room for 10 days.
- IPC audits on SAU showed a HH adherence rate of 75%, PPE 65%, and EVS 87%.

Step 5

- What is the next step?
- When do you call DPH?
- What assistance and guidance can DPH provide?

When to Call DPH

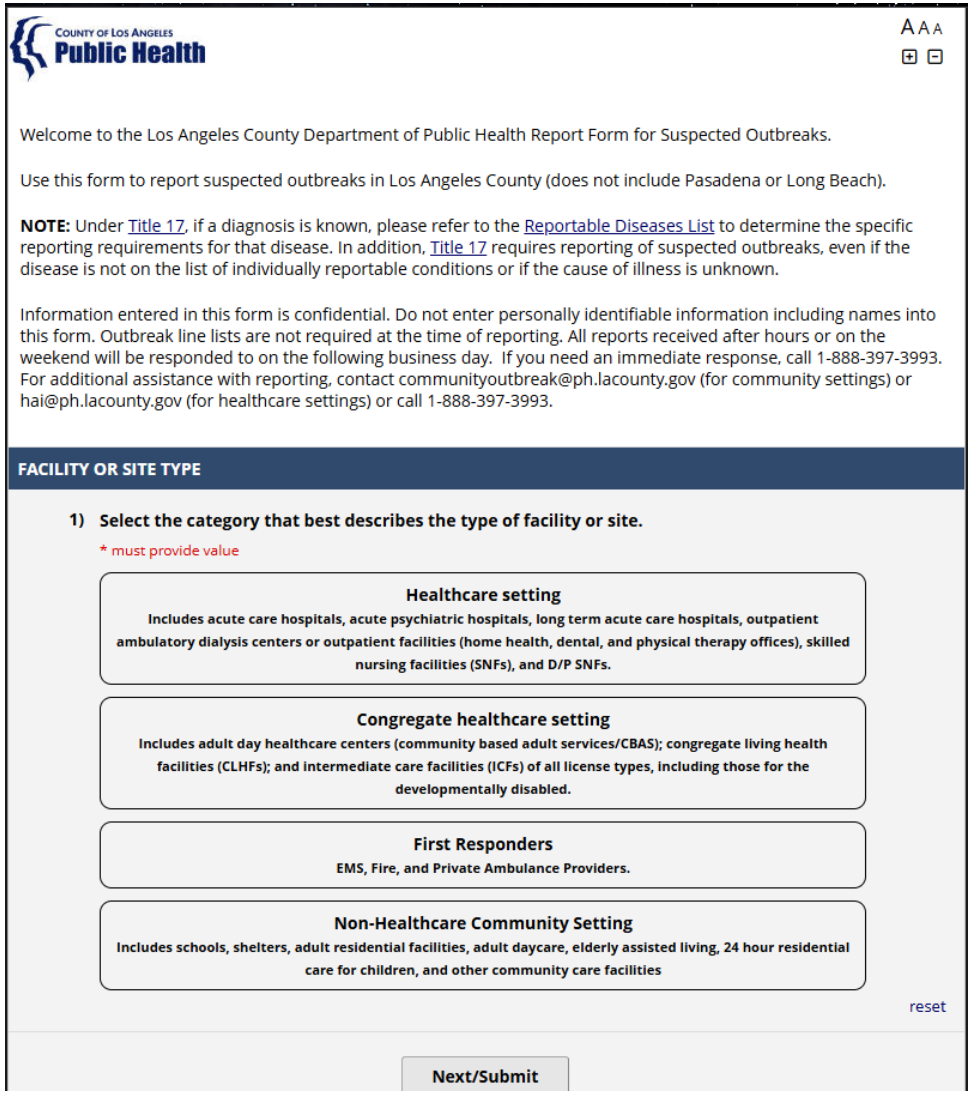
- Suspected MDRO Cluster/Outbreak
- Infection Prevention and Control Consultation
- Cohorting guidance of patient with significant MDROs
- MDRO testing guidance and support

New Cluster Reporting Tool

- Suspect and confirmed outbreaks are immediately reportable to LACDPH via our ACDC Suspect Outbreak Reporting Tool.

- Failure to report a suspect or confirmed outbreak in a timely fashion may result in citations.

https://acdcredcap.ph.lacounty.gov/surveys/?s=47PPTCKK8CYWWLM9

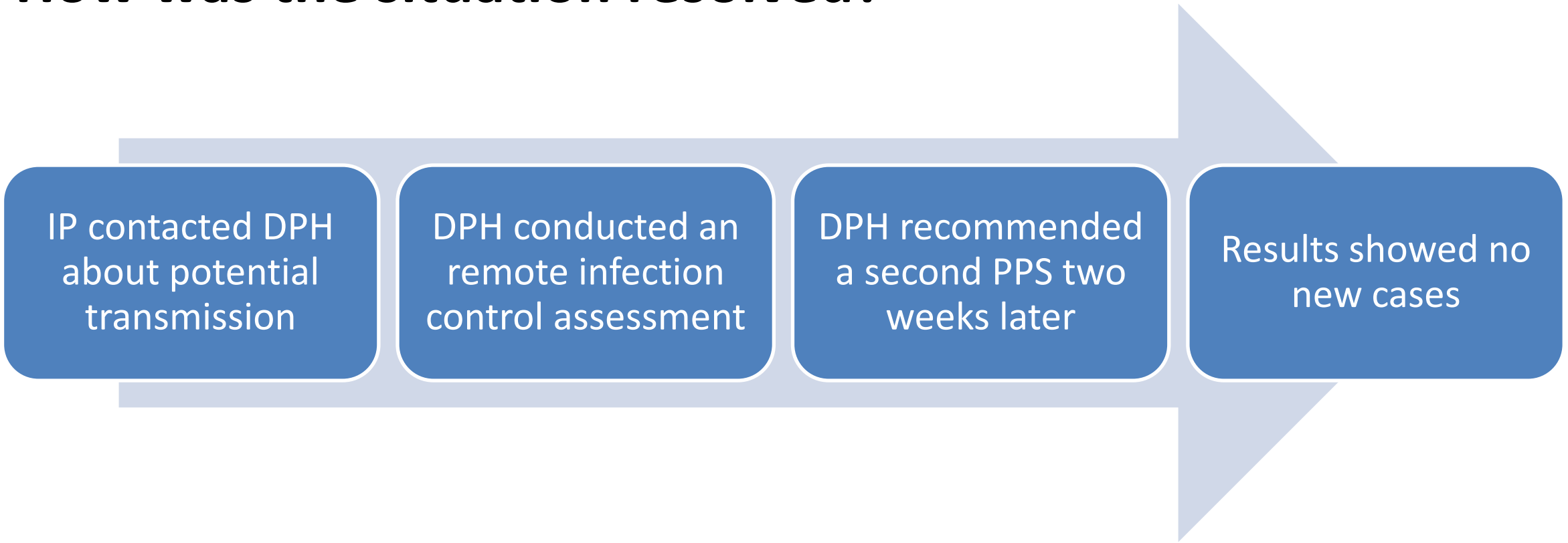


MYTH #5: *C. auris* will trigger visits from HFID

- Only confirmed outbreaks of MDROs should be reported to CDPH Health Facilities Inspection Division (HFID; also known as Licensing and Certification (L&C))
  - *C. auris* and most CPOs are no longer considered to be a novel MDRO
    - Do not need to report as unusual disease occurrences[1]
- Do in-house surveillance to detect and report clusters to your local DPH first

1. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx

How was the situation resolved?



IPC recommendations for “the big Cs”

	C. difficile	*C. auris*	CROs/CPOs	COVID-19
Good HH (ABHR preferred)	X (soap & water preferred, esp. during outbreaks)	X	X	X
Appropriate TBP	Contact Precautions	Enhanced Barrier Precautions	Enhanced Barrier Precautions	Contact Precautions + respirator + eye protection
Cohort appropriately	Single room, if possible	X	X	X
Environmental cleaning & disinfection	X (use List K agent)	X (use List P agent)	X	X (use List N agent)
Lab surveillance	X	X	X	X
Screen high-risk contacts	-	X	X	X
Antimicrobial stewardship	X	X	X	-
Interfacility communication	X	X	X	X

LACDPH Resources

Resource Category	Website / Tool	Key Utility
MDRO Dashboard	Website (Link)	Monitor County-wide trends.
SNF MDRO Guidance	Tool (Link)	Understand how to implement appropriate TBP, cohorting, and prevention strategies for MDROs.
MDRO Website	Website (Link)	Access key MDRO guidance, resources, laboratory, and reporting information.
MDRO Guidance for Containment & Prevention	Tool (Link)	Implement standardized approaches for MDRO surveillance, containment, and prevention.

Questions?

You can always email us at hai@ph.lacounty.gov

We want your feedback!

- What topic(s) should we cover at the in-person SNF Symposium on October 5th?