



COVID-19 Chicago Long Term Care Roundtable

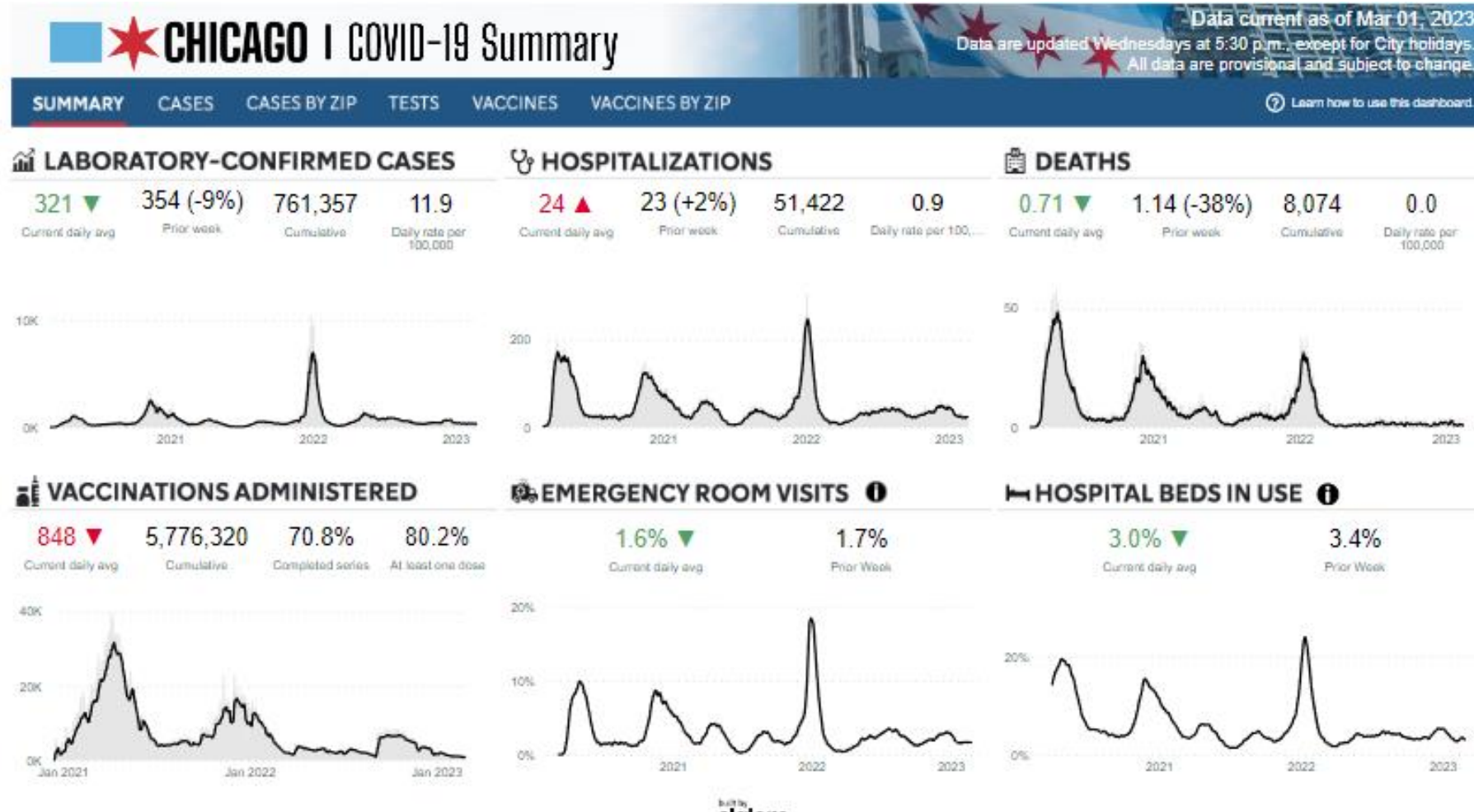
03-02-2023



Agenda

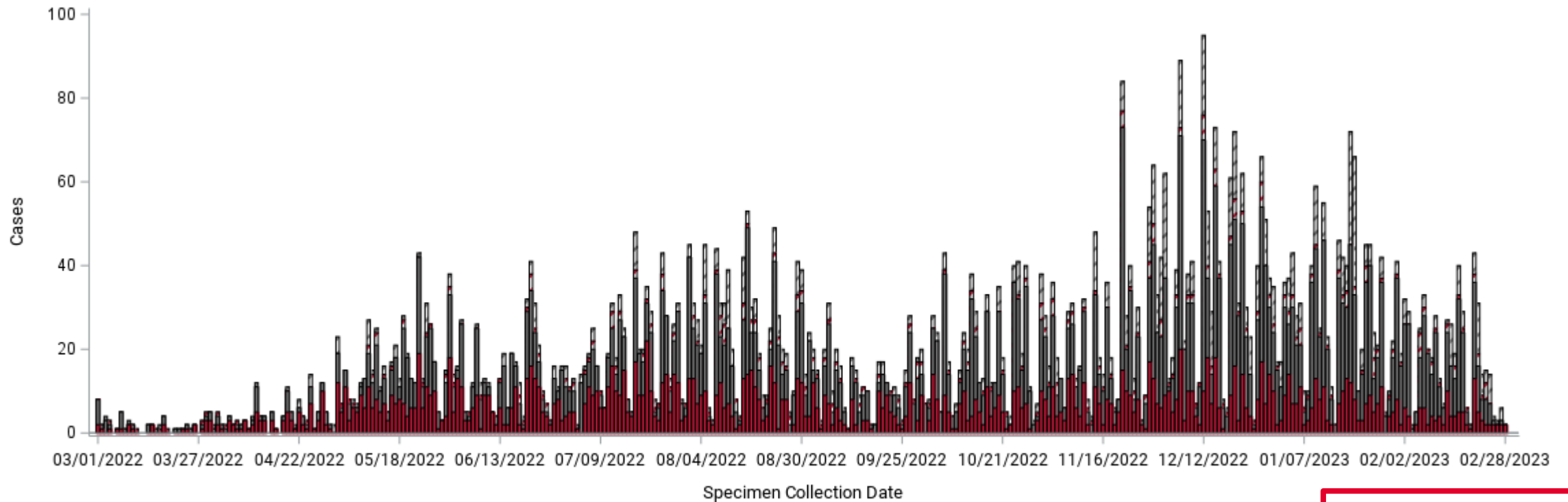
- COVID-19 Epidemiology
- COVID-19 Reminders, Updates, and FAQs
- LTC IP Resources
- Project Firstline
- Transfer Network
- Point Prevalence Survey Overview
- Transmission Based Precautions Scenarios
- Questions & Answers

Chicago Dashboard



SNF COVID-19 Cases

(Mar. 1, 2022 – Mar. 1, 2023)



Legend:
 / / Not Fully Vaccinated Resident
 / / Not Fully Vaccinated Staff
 ■ Fully Vaccinated Resident
 ■ Fully Vaccinated Staff

Data Sources: INEDSS (Illinois state) and REDCap (facility self report)

A fully vaccinated case occurs when the positive test specimen was collected at least 14 days after the individual completed their COVID vaccination

Fully vaccinated cases may be underestimated due to delayed reporting

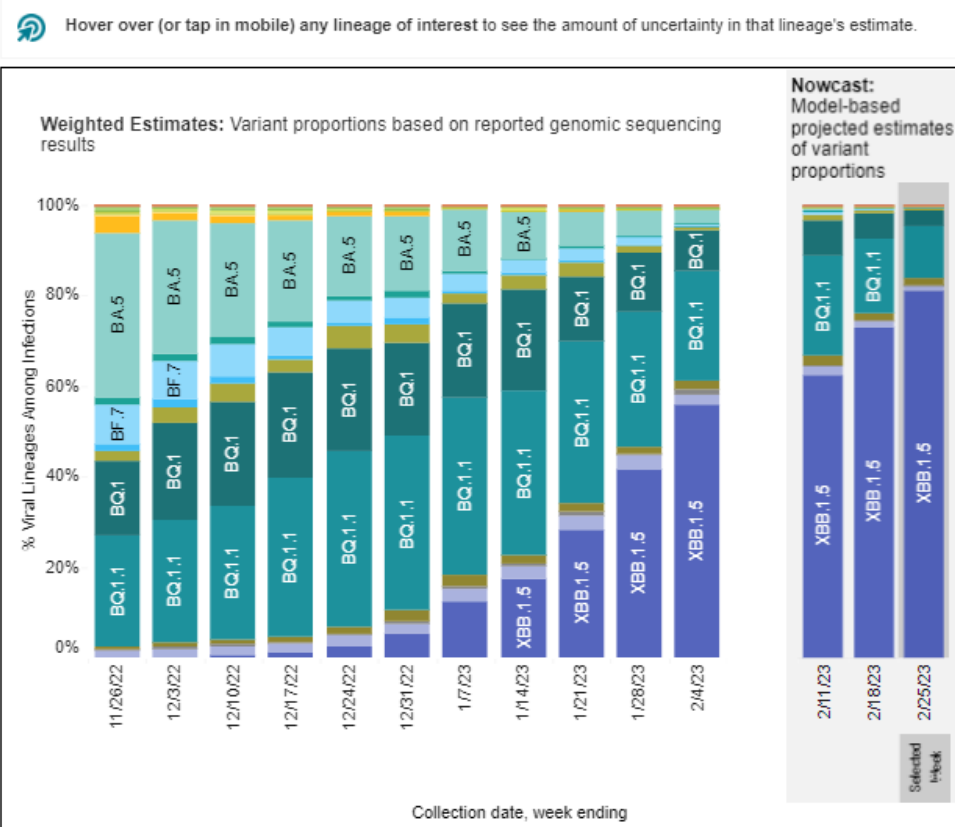
**53 (67%) SNFs
have active
outbreaks**

COVID-19 Variant Proportions



Weighted and Nowcast Estimates in HHS Region 5 for Weeks of 11/20/2022 – 2/25/2023

Nowcast Estimates in HHS Region 5 for 2/19/2023 – 2/25/2023



Region 5 - Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	XBB.1.5	VOC	81.2%	78.4-83.7%
	BQ.1.1	VOC	11.6%	10.0-13.4%
	BQ.1	VOC	3.5%	3.1-4.0%
	CH.1.1	VOC	1.5%	1.1-2.1%
	XBB	VOC	0.9%	0.7-1.2%
	BN.1	VOC	0.5%	0.4-0.7%
	BA.5	VOC	0.2%	0.2-0.3%
	BF.7	VOC	0.2%	0.1-0.2%
	BA.2	VOC	0.1%	0.0-0.1%
	BA.5.2.6	VOC	0.1%	0.0-0.1%
	BF.11	VOC	0.0%	0.0-0.1%
	BA.2.75	VOC	0.0%	0.0-0.0%
	BA.2.75.2	VOC	0.0%	0.0-0.0%
	BA.4.6	VOC	0.0%	0.0-0.0%
	B.1.1.529	VOC	0.0%	0.0-0.0%
	BA.2.12.1	VOC	0.0%	0.0-0.0%
BA.4	VOC	0.0%	0.0-0.0%	
BA.1.1	VOC	0.0%	0.0-0.0%	
Delta	B.1.617.2	VBM	0.0%	0.0-0.0%
Other	Other*		0.1%	0.1-0.3%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.

BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. Except BA.2.12.1, BA.2.75, XBB and their sublineages, BA.2 sublineages are aggregated with BA.2. Except BA.2.75.2, CH.1.1 and BN.1, BA.2.75 sublineages are aggregated with BA.2.75. Except BA.4.6, sublineages of BA.4 are aggregated to BA.4. Except BF.7, BF.11, BA.5.2.6, BQ.1 and BQ.1.1, sublineages of BA.5 are aggregated to BA.5. Except XBB.1.5, sublineages of XBB are aggregated to XBB. For all the other lineages listed, their sublineages are aggregated to the listed parental lineages respectively. Previously, CH.1.1 was aggregated to BA.2.75. Lineages BA.2.75.2, XBB, XBB.1.5, BN.1, BA.4.6, BF.7, BF.11, BA.5.2.6 and BQ.1.1 contain the spike substitution R346T.

★ Reminder: CDC COVID Data Tracker

Indicator - If the two indicators suggest different transmission levels, the higher level is selected	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days	0-9.99	10-49.99	50-99.99	≥100
Percentage of NAATs ¹ that are positive during the past 7 days	0-4.99%	5-7.99%	8-9.99%	≥10.0%

Note: Community transmission levels will now be updated weekly

CDC COVID Data Tracker: Cook County

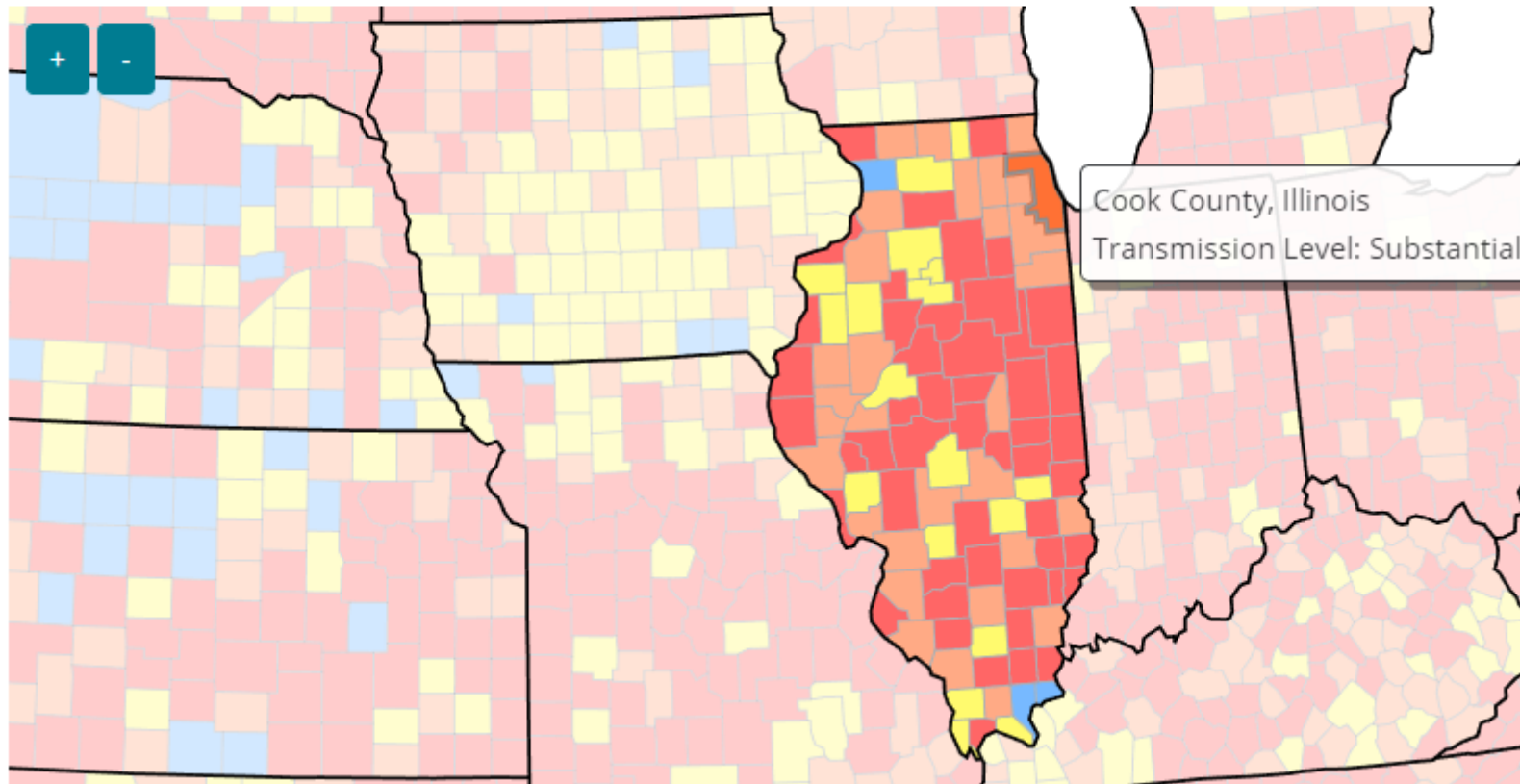


Data Type:

Community Transmission

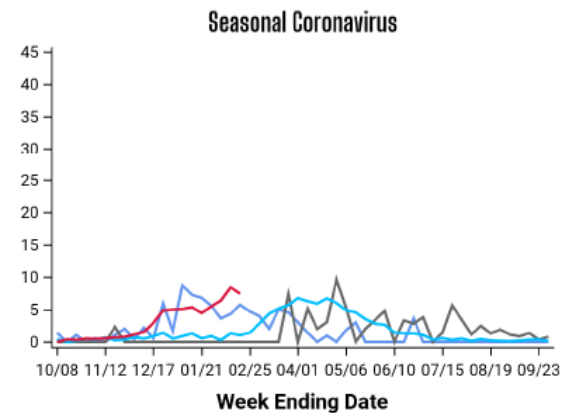
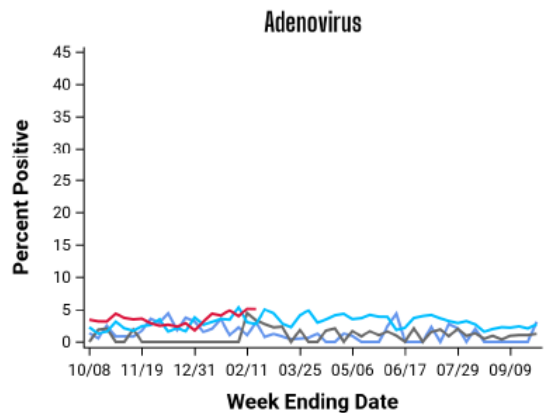
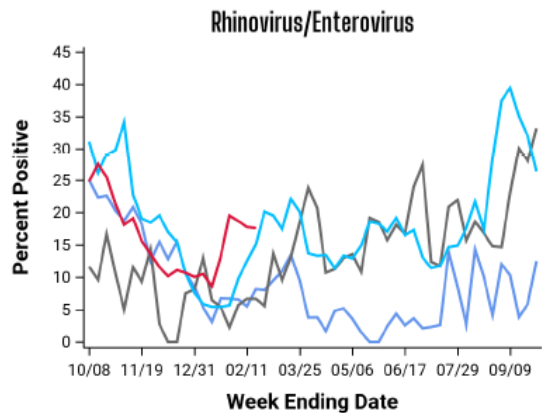
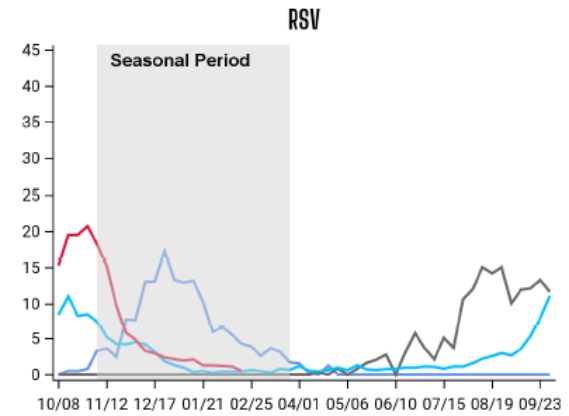
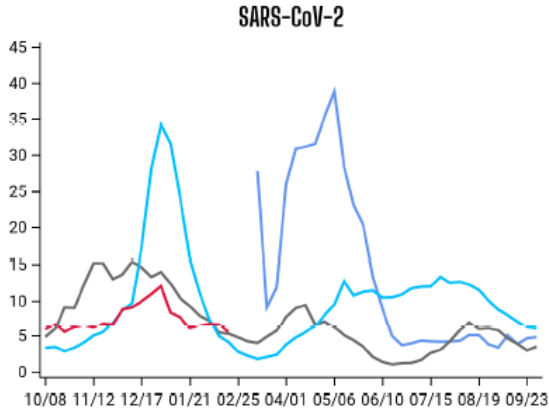
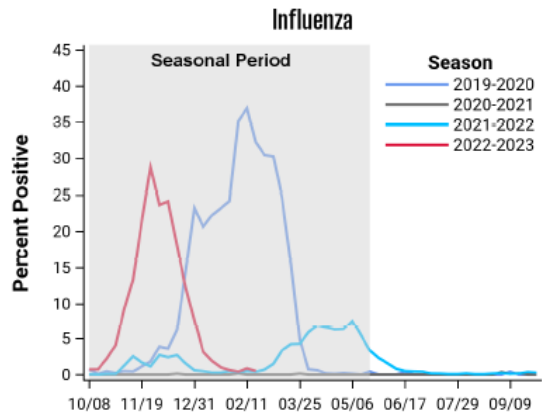
Map Metric:

Community Transmission





Chicago Respiratory Virus Surveillance Report – Seasonal Trends





Chicago Respiratory Virus Surveillance Report

Respiratory Pathogen	Week Ending February 18, 2023		Since October 2, 2022	
	# Tested	% Positive	# Tested	% Positive
Influenza*	3,921	0.5	112,434	10.8
RSV*	2,670	0.6	84,982	7.5
SARS-CoV-2*	4,130	5.5	139,457	7.5
Parainfluenza	1,516	1.5	34,652	2.8
Rhinovirus/Enterovirus	1,000	17.6	24,555	16.1
Adenovirus	1,000	5.1	24,258	3.5
Human Metapneumovirus	1,000	6.9	24,645	1.6
Seasonal Coronaviruses [†]	1,516	7.5	35,098	2.9

*Represents both dualplex and multiplex PCR data. All other data represents only multiplex panels that include the specified pathogens;† Four seasonal coronavirus strains include 229E, NL63, OC43, and HKU1.



Reminder: Minimum Routine Staff Testing Frequency

Vaccination Status	Community Transmission Level	Testing Frequency
Not up to date	All	No required routine testing*
Up to date**	All	No required routine testing*

* Unless symptomatic, had a high-risk exposure, or your facility is in outbreak and performing unit/broad-based testing.

** An individual has received all COVID-19 vaccinations for which they are eligible

★ Reminder: Minimum Routine Resident Testing Frequency

Vaccination Status	Community Transmission Level	Routine Testing Frequency
Not up to date*	All	No required routine testing**
Up to date*	All	No required routine testing**
New and readmissions, regardless of vaccination status	Low, Moderate, Substantial	No required routine testing**
New and readmissions, regardless of vaccination status***	High	Upon admission, 48 hours after 1st negative test, 48 hours after 2nd negative test (i.e., days 0, 2, 4)

*Excluding new/readmissions when community transmission is high

**Unless symptomatic, following a high-risk exposure, or your facility is in outbreak and performing broad-based testing.

***Unless COVID+ within the prior 30 days



FAQ: How do I know if a staff member's exposure to COVID was “higher risk”?

- As per the IDPH guidance, a higher risk exposure occurred when an HCP who had prolonged close contact (within 6 feet for 15 minutes or longer during a 24-hour period or for any duration during an aerosol generating procedure) with a resident, visitor, or HCP with a confirmed SARS-CoV-2 infection and:
 - HCP was not wearing a respirator (or, if wearing a face mask, the COVID+ individual was not wearing a cloth or face mask) **AND/OR**
 - HCP was wearing a surgical or procedure mask but the COVID+ individual was not wearing a face covering or mask **AND/OR**
 - HCP was not wearing eye protection and the COVID+ individual was not wearing a face covering or mask **AND/OR**
 - HCP was not wearing a gown, gloves, eye protection, and a respirator while performing an AGP with a COVID+ individual



Managing HCP with a Higher Risk Exposure

- In general, a HCP who had a higher-risk exposure does not need to be restricted from work, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2
 - Could consider work restriction if HCP is unable to be tested or wear source control, is moderately/severely immunocompromised or works with residents who are moderately/severely immunocompromised, and/or works on a unit with uncontrolled SARS-CoV-2 transmission
- Following a higher-risk exposure, HCP should:
 - Have a series of three SARS-CoV-2 tests (at day 1, 3, and 5)
 - Monitor for symptoms
 - Wear well-fitting source control for at least 10 days
- If the HCP develops symptoms and/or tests positive, they should be excluded from work until they meet return-to-work criteria



Long-Term Care Certification in Infection Prevention (LTC-CIP)

- Standardized measure of knowledge, skills, and abilities expected of professionals working in the field
- 150-question pass/fail exam
- \$410 examination application fee
- Must recertify every five years
- To apply, visit this [link](#)

LTC-CIP Attestation Form



LTC-CIP Attestation of Eligibility

To be completed by employer or supervisor

Employer:

Type of care setting (select one):

- Nursing home /skilled nursing facility
- Inpatient rehabilitation facility
- Assisted living facilities
- Hospice care
- Senior daycare services
- Long-term acute care hospitals
- Local Public Health with regulatory oversight (e.g. oversight of municipally owned nursing homes or adult day care centers)
- Other (please specify)

I verify that the candidate named below has responsibility for the infection prevention and control programs/activities in a long-term care setting as defined on the [LTC-CIP website](#).

The IP role should include direct **responsibility or collaboration** in the following areas, and I verify that the candidate's practice includes the elements below:

Select all that apply, practice must include all the following infection control elements to be eligible

- Identification of infectious disease process
- Surveillance and epidemiology
- Preventing and controlling the transmission of infectious agents
- Environment of care
- Cleaning, disinfection, sepsis and sterilization best practices

And at least 2 of the following additional activities:

- Employee and occupational health
- Management and communication
- Education and research

If you have questions, please contact CBIC at 202-454-2625 or info@cbic.org

Candidate Name
Candidate's Employment Start Date:
Employer/Supervisor's Name (please print)
Employer/Supervisor's Title
Employer/Supervisor's Work Phone
Employer/Supervisor's Signature
Date

★ Topic Areas: LTC – CIP Exam

- **Long-Term Care Settings**
 - Ethics, Communal Gatherings, Interdisciplinary Team, Normal Aging Process, Special Populations
- **Management and Communication of the Infection Prevention Program**
 - Infection Prevention Plan, Policies and Procedures, Education and Training, Research, Quality Assurance and Performance Improvement, Leadership
- **Identification of Infectious Diseases**
 - Clinical Signs, Symptoms, and Risk Factors to Identify Potential Infectious Diseases, Diagnostic, Radiologic, Procedural, and Laboratory Reports, Specimen Collection, Transportation, Handling, and Storage, Basic Microbiology, Epidemiologically Significant Organisms
- **Surveillance and Epidemiologic Investigation**
 - General Principles of Epidemiology, Surveillance Design, Outbreak Management, Collaboration with Internal and External Agencies, Reporting, Data Management, Analysis, and Interpretation

★ Topic Areas: LTC – CIP Exam

- **Prevention and Control of Infectious and Communicable Diseases**
 - Hand Hygiene, Standard and Transmission-Based Precautions, Personal Protective Equipment, Food Safety, Resident Immunizations, Ancillary Services
- **Environment of Care**
 - Environmental Safety, Construction and Maintenance
- **Cleaning, Disinfection, and Sterilization of Medical Devices and Equipment**
 - Cleaning, Disinfection, and Sterilization Practices
- **Antimicrobial Stewardship**
 - Core Elements of Antimicrobial Stewardship, Colonization, Infection, and Contamination
- **Employee/Occupational Health**
 - Occupational Exposure, Fitness for Duty, Employee Immunizations

LTC-CIP Sample Question

- Cleaning is defined as:
 - a) Removal of organic material
 - b) Applying sporicidal solutions to surfaces
 - c) Inactivation and killing of microorganisms
 - d) Activities that achieve the absence of pathogenic levels of microorganisms

New National Forum for LTC IPs

- The American Healthcare Association (ACHA) and the Association for Professionals in Infection Prevention and Control (APIC) are setting up a forum for LTC IPs and IPC champions to:
 - Rapidly disseminate updates, tools, and resources
 - Foster collaboration
 - Share experiences between IPs
- If you are interested in participating, complete [this](#) brief survey.

★ MRSA Prevention Collaborative

- The Agency for Healthcare Research and Quality (AHRQ) is launching a MRSA prevention collaborative for LTCFs
- Free 18-month program aimed at improving bathing and skincare techniques to reduce pressure injuries, wounds, MRSA, and other MDROs
- Can get CME/CEUs/NAB credits for participating
- Deadline for participation is May 31, 2023
- To learn more about the program, visit: <https://safetyprogram4mrsaprevention.org/page/join-the-program-ltc>



AHRQ Safety Program for MRSA Prevention

We are recruiting long-term care facilities to participate in the *Agency for Healthcare Research and Quality (AHRQ) Safety Program for MRSA Prevention*, a free 18-month program that seeks to improve bathing and skincare techniques to reduce pressure injuries, wounds, and methicillin-resistant *Staphylococcus aureus* (MRSA) and other Multidrug Resistant Organism (MDRO) transmission.

Beginning in June 2023, this program combines evidence-based guidance with implementation strategies to address the attitudes, beliefs, culture, and barriers that often pose challenges to improving infection prevention practices. This program can help you enhance your infection prevention program and prevent MRSA infection by utilizing evidence-based MRSA prevention strategies including improvement of hand hygiene, proper skin care, antibiotic stewardship, and environmental cleaning.

Participation in this AHRQ program will provide your long-term care facility with technical assistance, coaching, webinars, and tools to support your infection prevention program and resident safety.

Benefits of Participation Include—

- Reducing skin and soft tissue infections
- Reducing pressure injuries and skin tears
- Reducing MDRO infections
- Improving team-based infection prevention practices
- Enhancing communication and teamwork regarding proper skin care
- Increasing resident and family satisfaction

Eligible Long-Term Care Facilities (enrollment limited to adult populations)

- Nursing homes
- Skilled nursing facilities

This program is not designed for long-term acute care facilities (LTACHs), adult day care, home health programs, exclusive hospice facilities, dementia or memory care facilities, or facilities specializing in the care of developmentally disabled or pediatric patients.

How Can I Learn More?

Attend an informational webinar:

Date	Time (ET)	Registration Link
2/23/23	12 pm – 1 pm	https://norc.zoom.us/webinar/register/WN_4HFRAZPdRLyK0Yf0ROKBmA
3/7/23	11 am – 12 pm	https://norc.zoom.us/webinar/register/WN_XrMks0hrTg2OczREXBWSxQ
3/16/23	2 pm – 3 pm	https://norc.zoom.us/webinar/register/WN_SSVChv4DTMGM75loK3Jl3g
3/23/23	2 pm – 3 pm	https://norc.zoom.us/webinar/register/WN_EnHAe9s3TZyXoDVQd-U-tw

Visit <https://safetyprogram4mrsaprevention.org/> or email MRSAPrevention@norc.org for more information.

This program is funded and guided by the Agency for Healthcare Research and Quality and led by Johns Hopkins Armstrong Institute for Patient Safety and Quality and NORC at the University of Chicago.

Project Firstline

Alison VanDine, MPH

Infection Prevention Specialist I Project Firstline Lead

Healthcare Program

★ CDPH's Project Firstline 2023 Newsletter

- As a CDC Project Firstline Partner, the Chicago Department of Public Health is excited to share new infection control educational resources and training materials!
- These resources, developed with and for healthcare workers, provide you with the tools you need to guide your teams to prevent infection.
- Stay up to date on the latest Project Firstline resources and [register today](#) to receive the 2023 Infection Prevention Essentials Newsletter!



★ Questions & Answers

- Please contact the **PFL-Chicago team** at projectfirstline@cityofchicago.org:
 - To meet our education specialists
 - To schedule an onsite training tailored to your facility
- For additional PFL-Chicago upcoming events, please visit the [CDPH HAN page](#):
 - CDPH offers webinars, newsletters, and more!
- Reference the CDC's [Project Firstline](#) for:
 - Infection Control **Educational Materials**
 - CDC Promotional Resources
 - Explore Project Firstline Partnerships
 - Translated resources and more!



★ New At-Home Influenza/COVID Test

- FDA issued an EUA for an over-the-counter at-home test that simultaneously tests for SARS-CoV-2, influenza A, and influenza B



FDA Authorizes First Over-the-Counter At-Home Test to Detect Both Influenza and COVID-19 Viruses

Agency Continues Its Commitment to Increase Availability of Home Diagnostic Tests



For Immediate Release: February 24, 2023

[Español](#)

Today, the U.S. Food and Drug Administration issued an [emergency use authorization](#) (EUA) for the first over-the-counter (OTC) at-home diagnostic test that can differentiate and detect influenza A and B, commonly known as the flu, and SARS-CoV-2, the virus that causes COVID-19. The Lucira COVID-19 & Flu Home Test is a single-use at-home test kit that provides results from self-collected nasal swab samples in roughly 30 minutes.

New At-Home Influenza/COVID Test

- Residents or staff with positive at home flu tests should not be listed as lab-confirmed cases in the LTCF Outbreak Reporting Form; however, please include these individuals in the count of staff members or residents with influenza-like illness (ILI)
- Positive at-home tests would not trigger a new influenza outbreak for public health reporting purposes
- For residents with positive at-home tests (e.g., an Assisted Living resident), consider confirming with a PCR test.



Influenza Feedback

- What are the most common reasons that staff who decline the flu vaccine provide for their declination?
- CDPH is interested in developing and distributing influenza-related educational materials that would be helpful for facilities (e.g., posters encouraging staff uptake). What type of materials would be most beneficial to your facility?
- A HAN alert will go out when influenza/COVID tests are ready for distribution to the Chicago-based LTCFs



Crossroads of acute and long-term care: what can we do to help reduce MDRO burden in healthcare?

Kelly Walblay, MPH
Senior Epidemiologist

Epidemiology of Organisms by Location Type

- At the last roundtable, we discussed MDRO epidemiology in Chicago
- Prevalence/reporting of MDROs varies by location type:

Percentage of Chicago MDRO cases reported to XDRO by organism and reporting setting, 2022.

MDRO	Acute care hospital (ACH)	Long-term acute care hospital (LTACH)	Skilled nursing facility (SNF)	Ventilator-capable skilled nursing facility (vSNF)
C. auris	39%	42%	1%	18%
CRE	66%	14%	2%	19%
CP-CRPA*	11%	0%	0%	89%
CP-CRAB*	43%	27%	3%	27%

*Not reportable in IL

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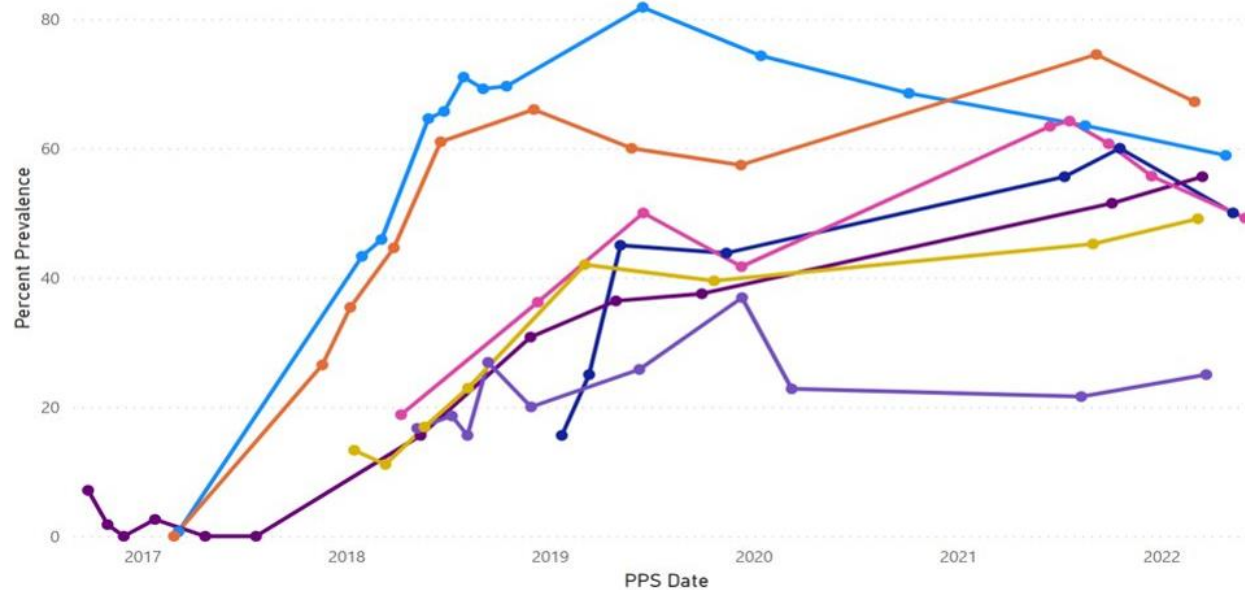
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Candida auris vSNF & LTACH point prevalence data by facility, 2017-2022

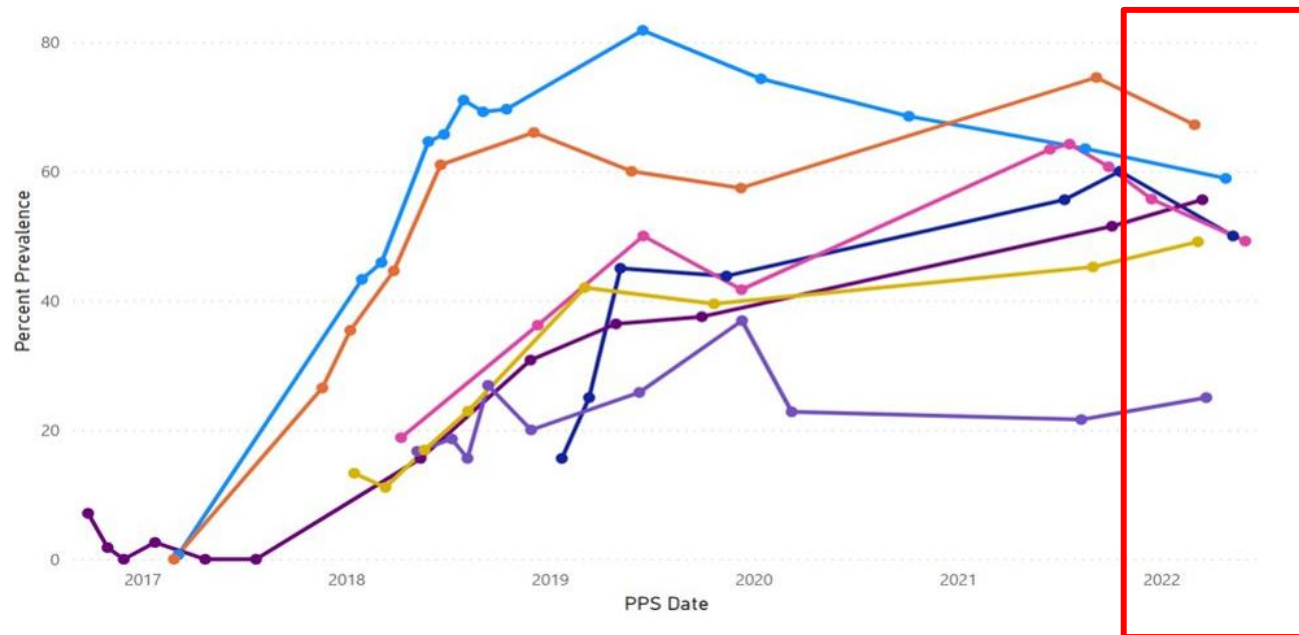


Compared to 0-1% in ACH ICUs

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Compared to 0-1% in ACH ICUs

★ Tier Approaches to MDRO Response

Tier 1

- Organisms for which no treatment options exist or have never or only rarely been detected in the U.S.

Tier 2

- Organisms not commonly detected in a geographic area

Tier 3

- Organisms that are known threats in a geographic area but not endemic

Table 1: Summary of Response Recommendations for MDRO Containment by Tier

Description	Tier 1 Resistance mechanisms never or very rarely identified in the United States; pan-resistant organisms with the potential for wider spread in a region	Tier 2 Mechanisms and organisms not regularly found in a region	Tier 3 Mechanisms and organisms regularly found in a region but not endemic
Healthcare Investigation¹			
Review the patient's healthcare exposures prior to and after the positive culture	Always	Always	Always
Contact Investigation¹			
Screening of healthcare roommates	Always	Always	Always
Broader screening of healthcare contacts ²	Always ³	Sometimes ⁴	Sometimes
Prospective lab surveillance ⁵	Always	Always	Always
Retrospective lab surveillance ⁶	Always	Always	Sometimes
Household contact screening	Sometimes	Rarely	Rarely
Environmental sampling	Sometimes	Rarely	Rarely
Healthcare personnel screening	Sometimes	Rarely	Rarely
Evaluate potential spread to healthcare facilities that regularly share patients with the index healthcare facility ⁷	Sometimes	Sometimes	Rarely
Infection Control Measures			
Prompt notification of healthcare providers and patient and implementation of appropriate transmission-based precautions	Always	Always	Always
Clear communication of patient status with transferring facilities	Always	Always	Always
On-site infection control assessment with observations of practice, such as Epidemiology and Laboratory Capacity (ELC) Infection Control Assessment and Response (ICAR)	Always	Always	Sometimes

¹ For Tier 1 and 2 organisms/mechanisms, healthcare exposures and healthcare contacts over the preceding 30 days should be investigated unless information is available about the time the organism was most likely acquired. This includes any healthcare facility where the patient had an overnight stay during that time period. In some investigations, outpatient facilities and emergency departments might also be included. For Tier 3 organisms, investigation of healthcare exposures and healthcare contacts is generally limited to the current and sometimes prior admission.

² This may include targeted screening of contacts at highest risk for acquisition and/or unit point prevalence surveys.

³ If the MDRO is a novel organism for which data on the frequency and modes of transmission are not known, or if the index patient was not on Contact Precautions during their entire stay in a healthcare facility, then additional screening (beyond roommates) is recommended. Broader screening, including patients on the same ward as the index patient and/or patients that shared healthcare personnel, might be particularly important for detecting novel MDROs when data on the frequency and modes of transmission are lacking.

⁴ If the index patient was not on Contact Precautions during their entire stay in a healthcare facility, then broader screening (beyond roommates) is recommended. Screening can initially be limited to the contacts at highest risk for acquisition, such as those still admitted who overlapped on the same ward as the index patient and who have a risk factor for MDRO acquisition (e.g., bedbound, high levels of care, receipt of antibiotics, or mechanical ventilation). Alternatively, facilities may choose to screen entire units using point prevalence surveys.

⁵ Prospective surveillance of clinical cultures should be conducted for three months after the last identified case.

⁶ Conduct a laboratory lookback covering at least 6 months prior to identification of index case.

⁷ A public health investigation should also be initiated at healthcare facilities known to regularly share patients with healthcare facilities where transmission has occurred, such as post-acute care facilities. At a minimum, this should include notification of the facility and a request to retrospectively and prospectively evaluate clinical cultures for the phenotype of interest. This could also include admission screening of patients at the facility (e.g., transfers from the index facility) and/or point prevalence surveys of high-risk patients or units.

<https://www.cdc.gov/hai/pdfs/containment/Health-Response-Contain-MDRO-H.pdf>



Proposed Chicago MDRO Tiers



Tier 1



TBD based on CDC national data



★ Proposed Chicago MDRO Tiers

Tier 1

TBD based on CDC national data

Tier 2

CP-CRAB non-OXA mechanism

CP-CRPA with mechanism

C. auris in non-vSNF/LTACH healthcare setting or other congregate setting

C. auris cluster* in ACH

CP-CRE – VIM, IMP, OXA-48

CP-CRE NDM in non-vSNF/LTACH healthcare setting or other congregate setting

CP-CRE NDM cluster* in ACH

Cluster of Pan-R organisms (e.g., *Elizabethkingia*)

**Cluster definitions still need to be determined*

★ Proposed Chicago MDRO Tiers

Tier 1

TBD based on CDC national data

Tier 2

CP-CRAB non-OXA mechanism

CP-CRPA with mechanism

C. auris in non-vSNF/LTACH healthcare setting or other congregate setting

C. auris cluster* in ACH

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CP-CRE NDM in non-vSNF/LTACH healthcare setting or other congregate setting

CP-CRE NDM cluster* in ACH

Cluster of Pan-R organisms (e.g., *Elizabethkingia*)

Tier 3

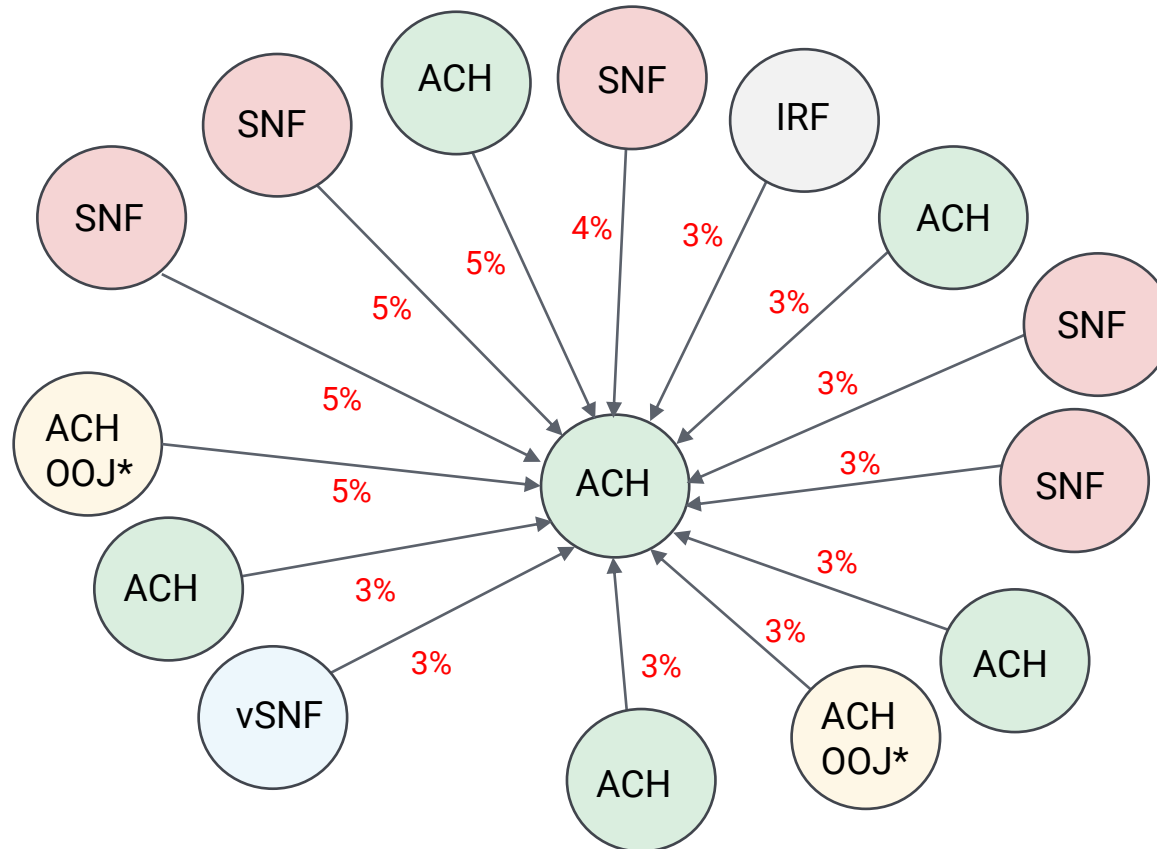
CP-CRE NDM: single cases in ACH, or clusters* in vSNF/LTACH

CP-CRAB (OXA or unknown mechanism) cluster*



Patients are transferred between setting types across the continuum of care

- Example of ACH patient transfer network – academic center



Not all facilities are pictured

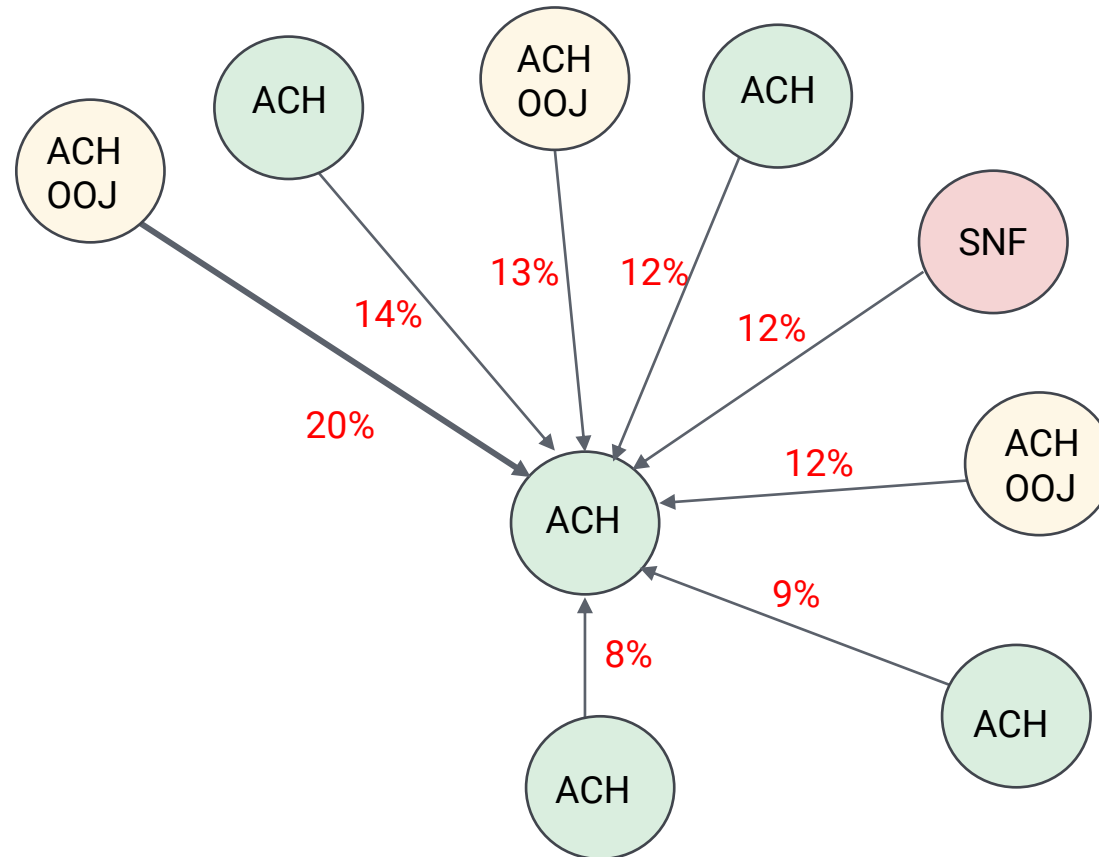
**Out of jurisdiction (i.e., Chicago)*





Patients are transferred between setting types across the continuum of care

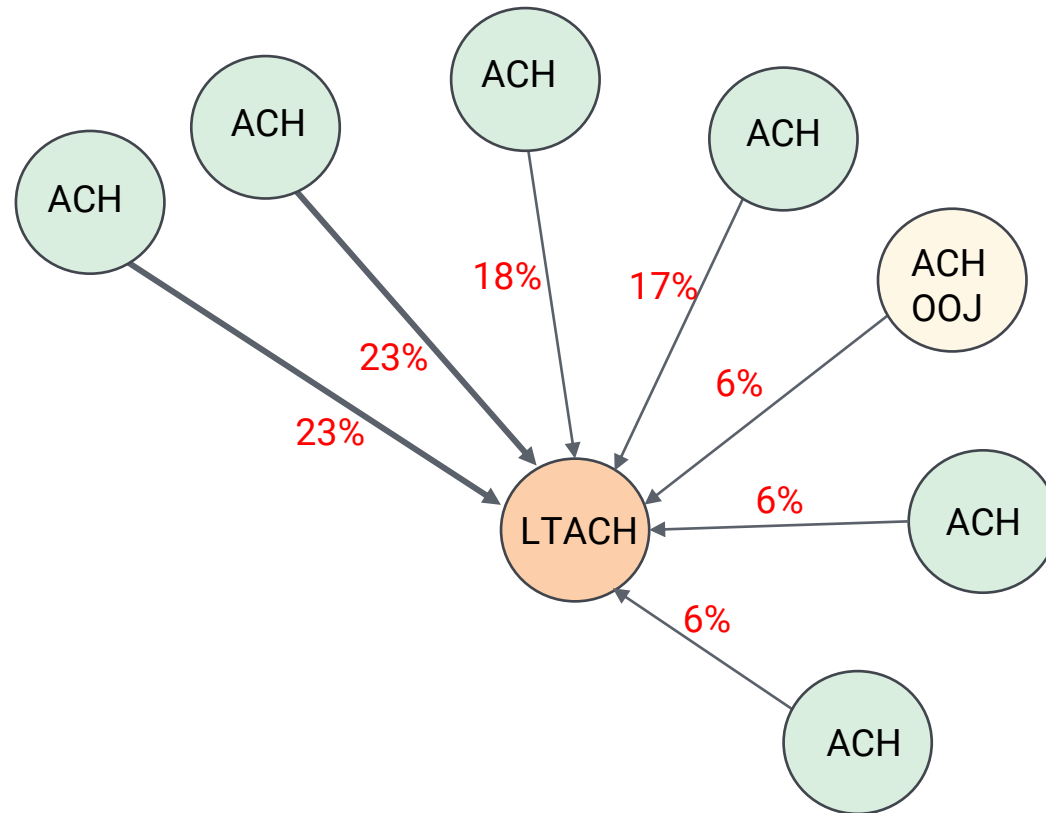
- Example 2 of ACH patient transfer network – community hospital





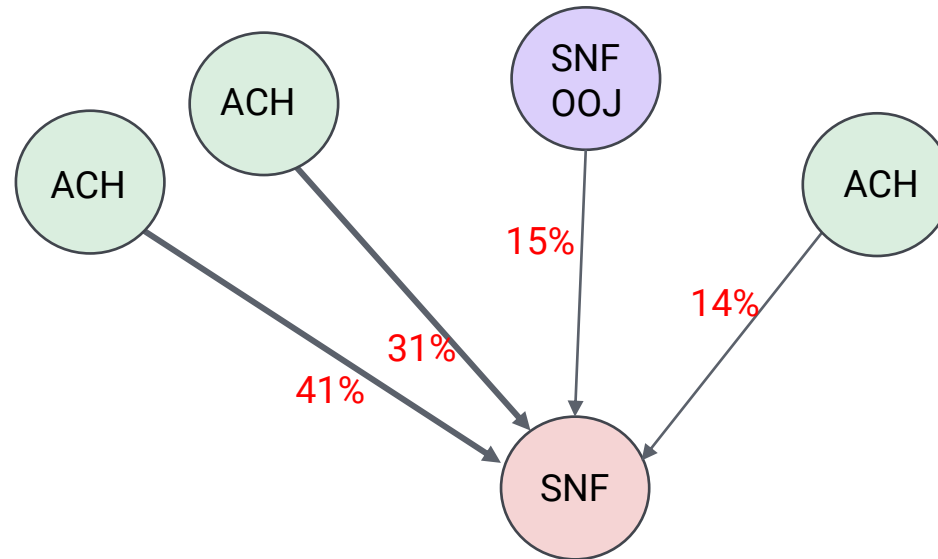
Patients are transferred between setting types across the continuum of care

- Example of LTACH network



★ Patients are transferred between setting types across the continuum of care

- Example of SNF patient transfer network



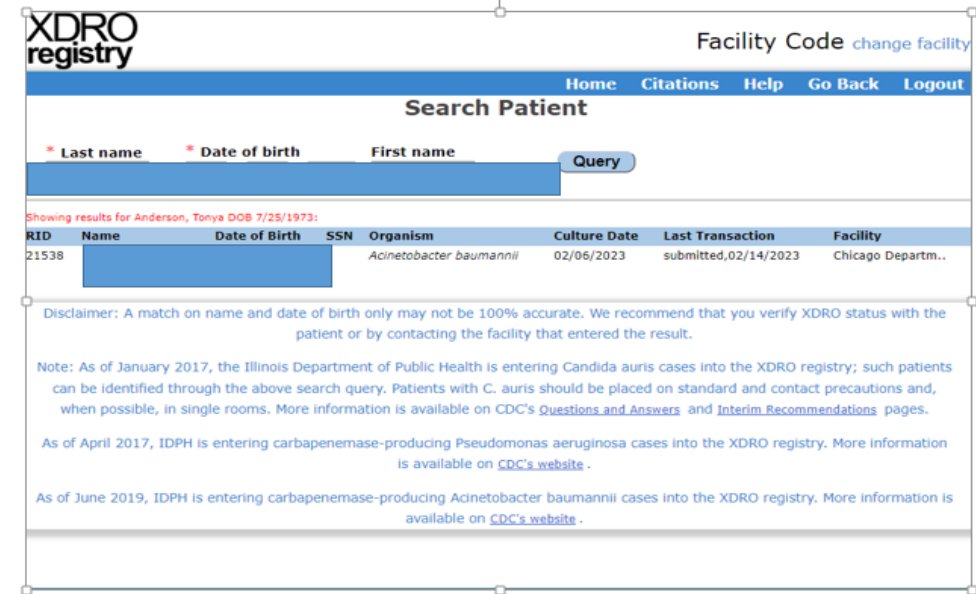


Patient transfer networks are complicated and allow for the spread of MDROs across different settings and jurisdictions



Guidance for facilities

- Query XDR0 Registry on all new admissions
- If patient is found in XDR0 registry, initiate **enhanced barrier** precautions and be sure to use appropriate cleaners/disinfectants
- If a patient has a positive culture for MDRO, it is important to add them to the XDR0 registry
 - Doing so ensures that patient can easily be identified as having previous colonization and expedites placing them on contact precautions and reduces chance of transmission
- When transferring a patient colonized with a MDRO please notify the receiving facility



The screenshot shows the XDR0 registry search interface. At the top left is the 'XDR0 registry' logo. At the top right is the 'Facility Code' field with a 'change facility' link. Below this is a navigation bar with links for 'Home', 'Citations', 'Help', 'Go Back', and 'Logout'. The main heading is 'Search Patient'. Below the heading are search fields for '* Last name', '* Date of birth', 'First name', and a 'Query' button. A search result is displayed for 'Anderson, Tonya' with a date of birth of 7/25/1973. Below the search fields is a table with the following data:

RID	Name	Date of Birth	SSN	Organism	Culture Date	Last Transaction	Facility
21538	[Redacted]	[Redacted]	[Redacted]	Acinetobacter baumannii	02/06/2023	submitted,02/14/2023	Chicago Departm..

Below the table is a disclaimer: 'Disclaimer: A match on name and date of birth only may not be 100% accurate. We recommend that you verify XDR0 status with the patient or by contacting the facility that entered the result.' There are also three notes providing updates on the registry's inclusion of Candida auris, Pseudomonas aeruginosa, and Acinetobacter baumannii cases.



Ongoing outbreak of significance

- Extensively Drug-resistant *Pseudomonas aeruginosa* Associated with Artificial Tears
 - VIM-GES-carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)
 - EzriCare or Delsam Pharma's Artificial Tears
- As of February 21, 2023, 58 patients in 13 states (1 in IL) have been identified
 - Thirty-five patients were linked to 4 healthcare facility clusters
 - One person has died and there have been 5 reports of vision loss
- To report suspected case(s) in Chicago residents (e.g., ocular infection due to CRPA with specimen collection dates since May 1, 2022), please call 312-744-1100. For questions, please email doyoung.kim@cityofchicago.org
- Ask your clinical laboratories to save these isolates for further characterization at public health laboratories
- Outbreak information: [CDC](#) and [Chicago HAN](#)



What do I do if I have a cluster at my facility?

- Cluster definitions vary by pathogen. When in doubt call us!
- CDPH may be able to support a Point Prevalence Survey at your facility.
- For any cluster reporting or guidance please contact a member of the SNF team:
 - Elizabeth.Shane@cityofchicago.org
 - Winter.Viverette@cityofchicago.org
 - Stephanie.Villarreal@cityofchicago.org
 - Nisreen.Droubi@cityofchicago.org





Point Prevalence Survey (PPS)

- **WHAT is a PPS?**

A PPS is a data collection tool used to identify the number of people with a disease or condition at a specific point in time.



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PPSs are an important tool used in disease control and surveillance, especially for infections with asymptomatic spread, like COVID-19 and certain Healthcare Associated Infections. It is crucial to identify these infections so infection prevention and control (IPC) measures can be done to mitigate spread among residents in congregate living spaces.



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- **WHO supports the PPS?**

PPSs are commonly suggested or required by Public Health Agencies of the above settings when there is epidemiological evidence or risk of disease spread. For novel diseases such as *Candida auris*, and certain multidrug resistant organisms, Public Health will likely support these efforts



CDPH Supported Point Prevalence Survey

CDPH monitors prevalence of MDROs in long-term care facilities

Infection Control Champions in Chicago

- 3 Long-Term Acute Care Hospitals
- 4 Ventilator Capable-SNFs
- Bi-annual PPSs are conducted at each facility looking for *C.auris*, CRE, CP-CRPA and CP-CRAB
 - An axilla/groin specimen and a rectal specimen are collected from each resident
 - Facilities can choose to use their own staff for specimen collection or request clinical assistance from CDPH
 - Logistics and data management is supported by CDPH staff on-site
 - Post-PPS a detailed results report and ICP guidance is provided





CDPH Supported Point Prevalence Survey

CDPH conducts PPSs or screenings during an outbreak response or when a MDRO is found in a new setting

For example:

- If *C. auris* is found in a SNF, roommate screening and floor/whole-house PPS may be scheduled to assess transmission





CDPH Supported Point Prevalence Survey

CDPH also conducts periodic prevention PPSs at SNFs based on the Patient Transfer Network analysis

If your facility is selected:

- CDPH PPS Lead will reach out and walk you through the process
- All levels of support will be provided by CDPH, including expenses
- What CDPH needs from you:
 - A current list of all residents with demographics, room/bed, indwelling devices, CP status.
 - Rolling carts
 - Some staff support on the floor to help identify and locate residents





Transmission-Based Precautions Scenarios

Scenario 1

- A resident from your 2nd floor complains of body aches and fever for two days. Her PCR COVID test is pending but her rapid test is positive.



TBP Poll Question 1

What PPE is required for the transmission-based precautions in scenario 1?

- a) Gloves only
- b) Gloves and Gown
- c) N95 Mask
- d) Gloves , Gown, N95 and Eye protection

★ Answer

D) Gloves , Gown, N95 and Eye protection

DROPLET/CONTACT PLUS* PRECAUTIONS



VISITORS: Please report to nursing staff before entering



Everyone MUST clean their hands before entering and when leaving room

Staff wear:

- **N95 respirator**
- Eye protection (face shield or goggles)
- Gown and Gloves
- Single room recommended

For Aerosol Generating Medical Procedures (AGMPs)

- N95 respirator required during AGMP and until settle time is achieved
- Eye protection
- Gown and gloves
- Place patient in a room with hard walls and door; ensure the door is closed
- If available, place patient in negative pressure room or Airborne Infection Isolation Room (AIIR)



Scenario 2

- You are a nurse working on the 3rd floor and a resident reports of cough with blood-streaked sputum for almost two months with night sweats and an unintended 20-lb weight loss. You suspect tuberculosis (TB).



TBP Poll Question 2

What type of precautions would be appropriate for Scenario 2?

- a) Contact
- b) Droplet
- c) Airborne
- d) Contact & Droplet
- e) Enhanced Barrier Precautions

Answer

C) Airborne

Residents with suspected or confirmed tuberculosis should be placed in airborne precautions, ideally in an airborne infection isolation room (AIIR)

TBP Poll Question 3

What PPE is required for airborne isolation?

- a) Gloves only
- b) Gloves and Gown
- c) N95 Mask
- d) Gloves , Gown, N95 and Eye protection

★ Answer

c) N95 mask

- Airborne isolation requires the use of a fit-tested N95 or higher-level respirator



STOP AIRBORNE PRECAUTIONS **STOP**

EVERYONE MUST:

-  Clean their hands, including before entering and when leaving the room.
-  Put on a fit-tested N-95 or higher level respirator before room entry.
-  Remove respirator after exiting the room and closing the door.
-  Door to room must remain closed.

 U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



Scenario 3:

- A 75 year-old male resident with trach and vent on one of your floors has a large draining wound on his hip that's difficult to keep covered and draining onto his linens.



TBP Poll Question 4

What type of transmission-based precautions should this resident be placed into?

- a) Contact
- b) Droplet
- c) Airborne
- d) Contact & Droplet
- e) Enhanced Barrier Precautions



Answer

- A) Contact Precautions
- Residents should be placed on contact precautions in any of the following situations:
 - Presence of acute diarrhea
 - Draining wounds or other sites of secretions or excretions that are unable to be covered or contained

TBP Poll Question 5

What PPE is required for contact precautions?

- a) Gloves only
- b) Gloves and Gown
- c) N95 Mask
- d) N95 Mask with eye protection
- e) Surgical Mask with eye protection

★ Answer

- Gloves and a gown are required for contact precautions.
 - Note that gowns and gloves should be donned and doffed for each individual entry into the patient's room and should never be used for multiple residents or reused.





Scenario 4:

- A resident has an indwelling urinary catheter. The resident does not have any wounds, diarrhea, or other site secretions or excretions that are unable to be covered or contained.

TBP Poll Question 6

What type of transmission-based precautions should be used for this resident?

- a) Contact
- b) Droplet
- c) Airborne
- d) Contact & Droplet
- e) Enhanced Barrier Precautions



Answer

e) Enhanced Barrier Precautions

Enhanced Barrier Precautions should be used during high-contact resident care activities for residents known to be colonized or infected with an MDRO OR those at an increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).

TBP Poll Question 7

What PPE is required when bathing the resident in scenario 4?

- a) Gloves only
- b) Gloves and Gown
- c) N95 Mask
- d) N95 Mask with eye protection
- e) Surgical Mask with eye protection

★ Answer

- b) Gloves and Gown
- Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities.



STOP **ENHANCED BARRIER PRECAUTIONS** **STOP**
EVERYONE MUST:

 Clean their hands, including before entering and when leaving the room.

PROVIDERS AND STAFF MUST ALSO:

 **Wear gloves and a gown for the following High-Contact Resident Care Activities.**

- Dressing
- Bathing/Showering
- Transferring
- Changing Linens
- Providing Hygiene
- Changing briefs or assisting with toileting

Device care or use:
central line, urinary catheter, feeding tube, tracheostomy

Wound Care: any skin opening requiring a dressing

 Do not wear the same gown and gloves for the care of more than one person.

 U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



Questions & Answers

For additional resources and upcoming events,
please visit the CDPH LTCF HAN page at:
<https://www.chicagohan.org/covid-19/LTCF>