Screening Decision Tree for Local Health Departments (LHDs) Conducting Phase 2 Responses[1]

New Tier 2 pathogen[2] case identified

Transmission suspected or ongoing in the healthcare facility, regardless of facility type
OR
Patient or resident admitted to long-term acute care hospital (LTACH) or ventilator unit in skilled nursing facility (vSNF)

NO
(No transmission suspected, and patient or resident admitted to an acute care hospital (ACH) or skilled nursing facility (SNF))[3]

For all ACH units and SNFs,[3] screen high-risk contacts.[4]

If **high-risk contacts were discharged to another healthcare facility,** screen there.

- Consider notifying the patient or resident, and flagging their chart for screening and empiric Contact Precautions or Enhanced Standard Precautions (ESP) if SNF upon readmission within 6 months.

In **ACH units with increased risk of transmission** (e.g., ICU, burn, oncology), consider broader screening such as point prevalence survey (PPS).[5]

YES

Conduct or continue PPS in the affected unit(s)

- If LTACH, conduct PPS facility-wide; if vSNF, PPS in vent unit; if ACH or SNF, PPS in the affected unit(s).
- Continue PPS every 2 weeks until 2 consecutive rounds are negative and no new clinical cases. After this:
  - For ACH and SNF, discontinue biweekly PPS.
  - For LTACH and vSNF, reduce PPS frequency to monthly for 3 months; if negative, move to quarterly PPS if LTACH, and biannual if vSNF.

For patients or residents discharged prior to PPS:

- For ***all*** **patients in LTACH and residents on affected vSNF unit/other geographic location**, and ***only*** **high-risk contacts in ACH and SNF**, if discharged before PPS, flag the chart for screening and empiric Contact Precautions or ESP if SNF/vSNF upon readmission within 6 months. If discharged to another healthcare facility, screen there.

Notes

- **High-risk contact** is defined as a roommate (including patients in the same open bay unit); patient/resident who shared a bathroom with the index patient/resident; or patient/resident occupying the same bed space immediately following the index patient/resident.[6]
- LHD can **consider screening additional contacts who do not meet high-risk criteria**. Prioritize contacts discharged to higher acuity settings (e.g., LTACH, vSNF vent unit, ACH).[7]
- If a contact (high-risk or otherwise) is **discharged home**, screening at home is not recommended.
- In some situations, broader screening may not be indicated.[8]

Screening Decision Tree Definitions and Considerations

[1] Please see CDPH Prevention and Response Strategy document (PDF) to identify your LHD's phase for relevant Tier 2 antimicrobial-resistant (AR) pathogen prevention and response activities. (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Cauris_Phases.pdf)

[2] Tier 2 AR pathogens are those not commonly detected in California (although epidemiology can vary by region within California), for example: *Candida auris,* non-KPC-producing Enterobacterales, carbapenemase-producing *Pseudomonas* species (spp.) and *Acinetobacter* spp. (excluding OXA-23-, OXA-24/40-, and OXA-58-like carbapenemases).

[3] In addition to ACHs and SNFs, this could apply to other congregate care settings including but not limited to assisted living facilities, group homes, and board & care facilities, prioritizing residents with risk factors for AR pathogen acquisition or transmission (e.g., presence of indwelling device or unhealed wound, total dependence on others for assistance with activities of daily living, or frequent healthcare exposure).

[4] High-risk contacts should be screened regardless of whether the index patient or resident was being managed with Contact Precautions or Enhanced Standard Precautions and regardless of the amount of time they overlapped with the index patient or resident.

[5] LHD can consider PPS in ACH units with increased risk of transmission in situations including, but not limited to, healthcare settings with high-acuity patients with longer lengths of stay (e.g., 1 week); or if it will take time to identify high-risk contacts or if most high-risk contacts have been discharged from a unit/healthcare facility. This generally excludes the emergency department.

[6] The highest yield is likely to be the patient exposed to Tier 2 pathogen contamination following a single terminal cleaning. Subsequent patients occupying the same bed space, including current occupant(s) may be considered for screening if feasible.

[7] Considerations for pursuing screening of additional contacts who do not meet high-risk criteria can include, but are not limited to, contacts who shared a common primary or consultative service, healthcare personnel, procedure, or device; or contacts who have risk factors for AR pathogen acquisition (e.g., presence of indwelling device or unhealed wound, total dependence on others for assistance with activities of daily living receive high-level care).

[8] In some situations, broader screening may not be recommended by public health. For example, if the index patient's length of stay was very short (e.g., <24 hours), screening may not be indicated. During a response to a single case in an ACH unit with a short average length of stay where patients are ambulatory and not mechanically ventilated, broader screening could be limited to situations where the index patient is currently admitted or recently discharged (<7 days prior). See CDC Containment Strategy (www.cdc.gov/hai/mdro-guides/containment-strategy.html).