



Public Health
Communicable Disease Section

HAIP Collaborative Meeting

April 8, 2025

Presenters:

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Healthcare-Associated
Infections and Infection Prevention
(HAIP) Program



Reporting and Outbreaks



Multidrug-Resistant Organisms
and Point Prevalence Surveys



Enhanced Barrier Precautions
Pop Quiz



Establishing an Effective
Infection Prevention (IP)
Program



Legionnaires' Disease
and Water Management
Plans



Announcements

CORE OBJECTIVES:

- **Prevention:** Implementing evidence-based strategies.
- **Training:** Infection control practices, use of personal protective equipment (PPE), Train-the-Trainer, and current guidelines on managing HAIs.
- **Surveillance:** Identify and report HAIs.
- **Mitigation:** Rapid response and support for facilities experiencing an outbreak.
- **Ongoing Support:** Provide technical assistance and direct support with healthcare facilities.



Reporting and Outbreaks

Jessica Lu, MPH
Public Health Epidemiologist



What and How to Report?

- [Title 17, California Code of Regulations \(CCR\) §2500, §2593, §2641.5- 2643.20, and §2800-2812 Reportable Diseases and Conditions](#)



- Reporting to the Local Health Authority.
- Urgency Reporting Requirements.



- Electronically submit Confidential Morbidity Reports (CMRs) to the [CalREDIE Provider Portal](#) (PP).
- AFL 23-08: Requirements for Reporting Outbreaks and Unusual Infectious Disease Occurrences.

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions *

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS (17 CCR §2500(h)(i))

- ☎ = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ♦ in regulations).
☎ = Report by telephone within one working day of identification (designated by a + in regulations).
FAX ☎ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
WEEK = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(i)

Disease Name	Urgency	Disease Name	Urgency
Anaplasmosis	WEEK	Listeriosis	FAX ☎
Anthrax, human or animal	☎	Lyme Disease	WEEK
Babesiosis	FAX ☎	Malaria	FAX ☎
Botulism (Infant, Foodborne, Wound, Other)	☎	Measles (Rubeola)	☎
Brucellosis, animal (except infections due to <i>Brucella canis</i>)	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ☎
Brucellosis, human	☎	Meningococcal Infections	☎
Campylobacteriosis	FAX ☎	Middle East Respiratory Syndrome (MERS)	☎
<i>Candida auris</i> , colonization or infection	☎	Monkeypox or orthopox virus infection	☎
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella)(Outbreaks, hospitalizations and deaths)	FAX ☎	Novel Coronavirus Infection	☎

What Can You Expect After Reporting?

San Bernardino County Department of Public Health (SBC DPH) HAIIP Program will contact you to:

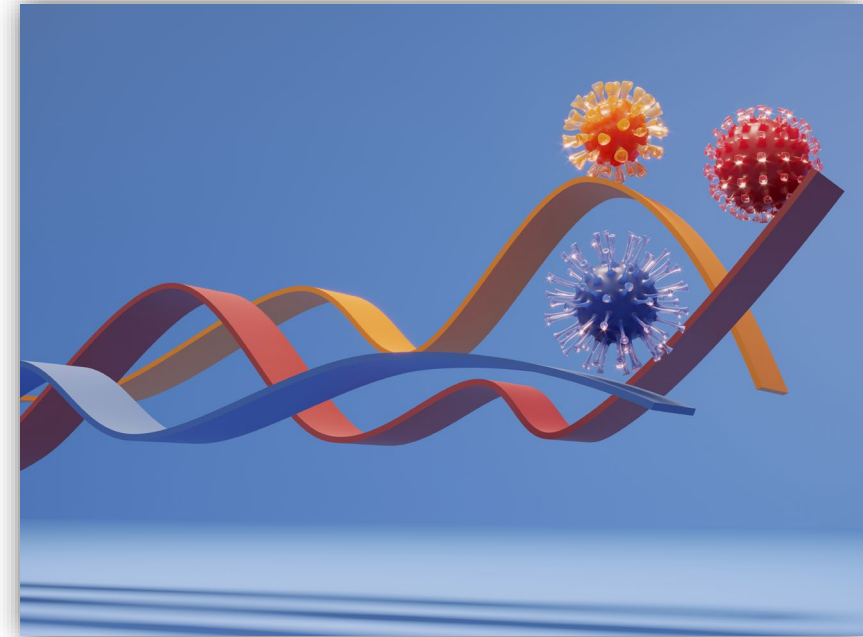
- Request a line list of patient information and epidemiological data.
- Provide recommendations on roommate/contact testing:
 - Contact precautions or Enhanced Barrier Precautions (EBP).
 - Infection prevention and control:
 - Room placement and cohorting
 - Hand hygiene
 - Environmental cleaning and disinfection
 - Training and education



Why Are We Requesting This Information?

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- **For public health's intervention, by:**
 - Obtaining accurate and timely information for effective surveillance.
 - Evaluating risks of transmission and preventing the spread.
- **To provide guidance on:**
 - Responding to an outbreak.
 - Decreasing the spread of disease.
 - Implementing infection prevention and control measures.
- **To share sources of recommendations from:**
 - California Department of Public Health (CDPH) [Quicksheets](#), guidance documents, and adherence monitoring tools.



Centers for Disease Control and Prevention (CDC).

Public Health
Communicable Disease Section

dph.sbcounty.gov

Questions



Multidrug-resistant Organisms (MDROs) and Point Prevalence Surveys (PPS)

Tanya Martinez
Communicable Disease Investigator



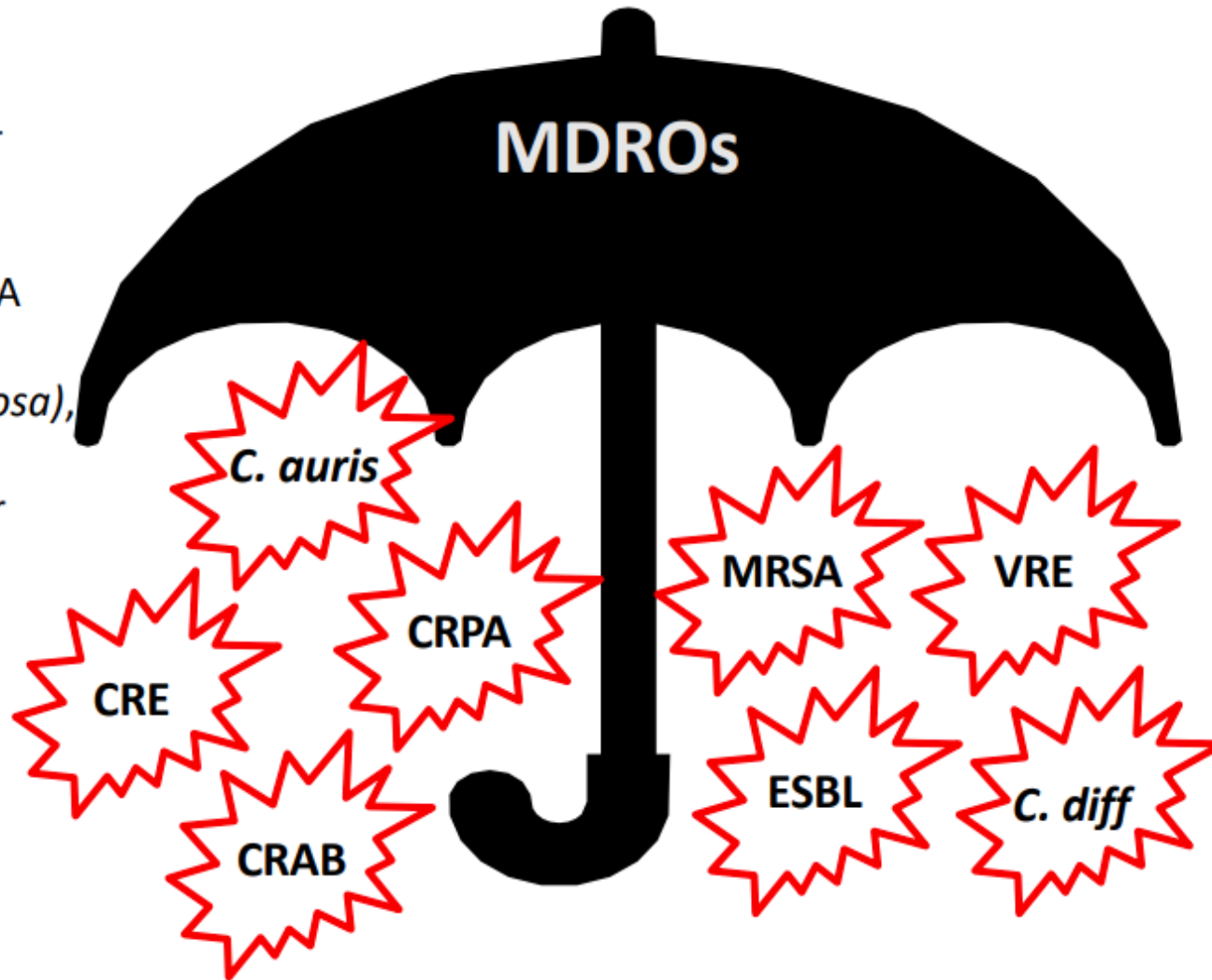
What Are MDROs & How Do They Commonly Spread in SNFs/LTACHs

- Multidrug-resistant organisms (MDROs) are bacteria or fungi that are resistant to multiple classes of antimicrobials.
- How they are commonly spread:
 - Through contaminated surfaces
 - Contaminated equipment
 - Indirect person-to-person contact via the hands or clothing of healthcare personnel



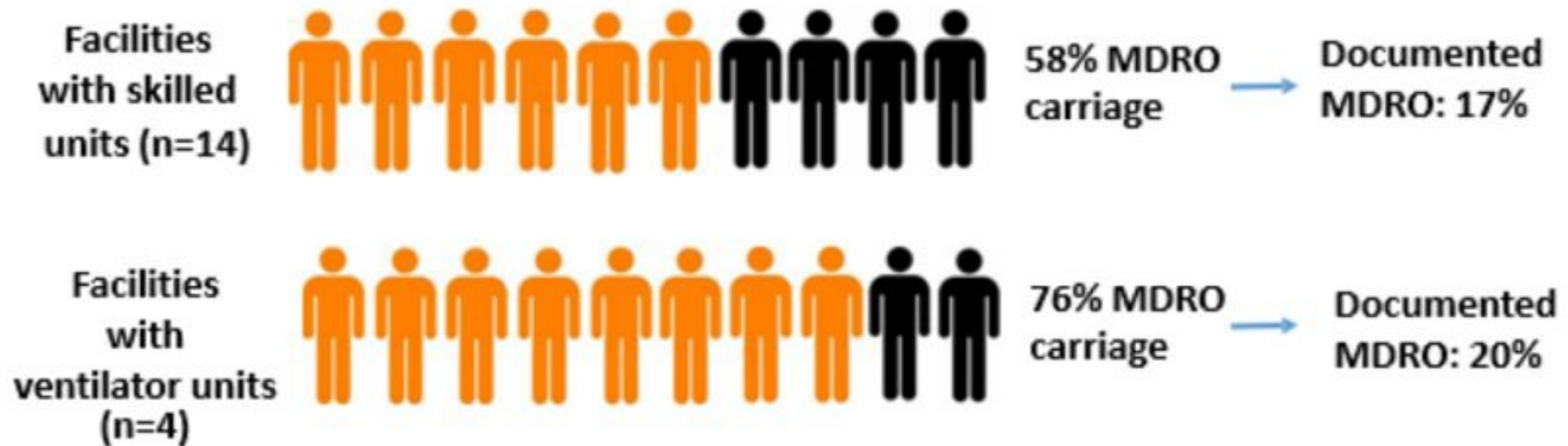
Multidrug-resistant Organisms

- *Candida auris*
- CPO – Carbapenemase-producing CRE (carbapenem-resistant Enterobacterales), CRPA (carbapenem-resistant *Pseudomonas aeruginosa*), CRAB (carbapenem-resistant *Acinetobacter baumannii*)



- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Vancomycin-resistant Enterococci (VRE)
- Extended-spectrum β -lactamase-producing organisms (ESBL)
- *Clostridioides difficile* (*C. diff*)

Most SNF residents are colonized with MDROs



Even when roommates are negative, other residents in facility may be positive

McKinnell JA et al. Clin Infect Dis. 2019; 69(9):1566-1573

Gussin G et al. Open Forum Infect Dis 2023; 27;10(Suppl 2):ofad500.145



- **In Long-Term Acute Care Hospitals (LTACH) and Ventilator-equipped Skilled**

- Nursing Facilities (vSNF) carry out proactive:**

- Baseline and follow-up Point Prevalence Surveys (PPS) and admission screening.
 - Onsite infection prevention and control assessments.
 - Species identification of all *Candida* isolates.
 - Use of EPA List P or List K agents for daily and terminal cleaning and disinfection.

- **In all facilities:**

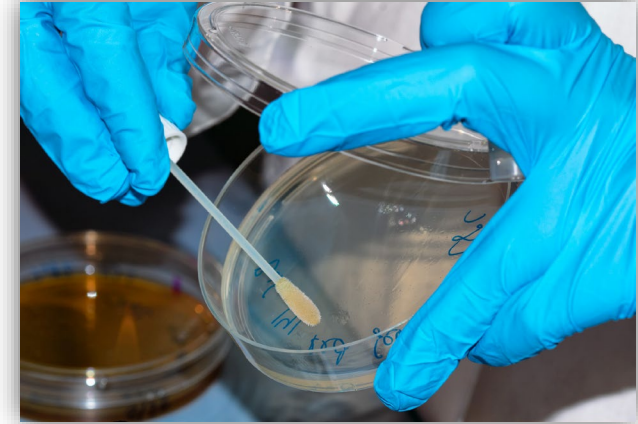
- Prioritize *Candida* species identification for patients with risk factors.
 - Promote antimicrobial stewardship.
 - In SNFs, implement Enhanced Barrier Precautions (EBPs).
 - Ensure [interfacility transfer](#) communication.



Screening Recommendations for *C. auris* in Healthcare Facilities

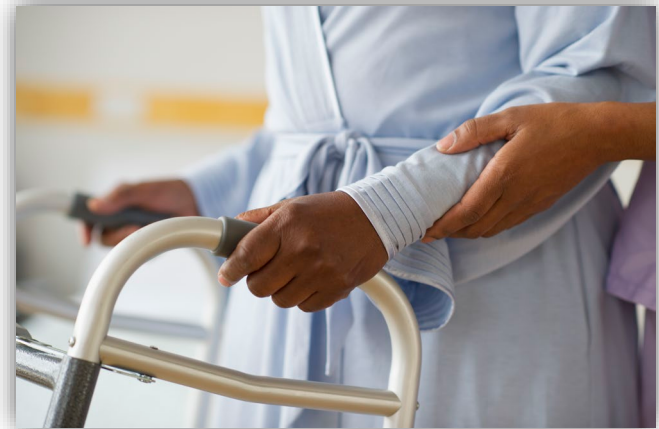
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- Patients in healthcare facilities can be asymptotically colonized with *C. auris* and can spread it to other patients.
- Screening helps identify patients who are colonized with *C. auris* by testing swabs of the skin.
- Screening results should inform infection and control measures for the patient and the facility.
- Facilities determine screening strategies based on local epidemiology, patient risk factors, facility characteristics, and the intended purpose of screening.



Consider screening patients who are at high risk for *C. auris* colonization, such as:

- Those with an epidemiologic link to a patient or resident infected or colonized with *C. auris*.
 - Sharing the same room, unit, or other care areas as a patient or resident with *C. auris*, even if that person has been discharged.
 - Receiving care from the same healthcare personnel during the same time as a person with *C. auris*.
 - Being exposed to common mobile medical equipment previously used by a patient or resident with *C. auris*.



- Patients with risk factors for acquiring *C. auris*, including:
 - Mechanical ventilation.
 - Indwelling medical devices, including central lines, feeding tubes, urinary catheters, and other similar devices.
 - Receipt of complex or high acuity medical care.
 - Frequent or long healthcare stays, especially at high-risk facilities.
 - Colonization or infection with other multidrug-resistant organisms.



- Screening can be conducted using a broad approach by performing a PPS (Point Prevalence Survey).
- **Follow-up screening:** Expanded screening or follow-up response screening after a PPS is often recommended if there is evidence or suspicion of ongoing transmission.
- **Reassessment of colonization:** [CDC](#) does **not** recommend *re-screening* patients known to be infected or colonized with *C. auris*.





- Prevention-based approach.
- Response-based approach.
- Admission screening.
- At discharge or transfer to another facility.
- Public health recommends that ventilator/subacute units (vSNFs) conduct admission screening and regular PPS due to their high-risk population.
- All SNFs should make sure that their lab tests for carbapenem-resistant organisms (CRO).

- HAIP staff will schedule PPS with IP or designated facility staff.
- HAIP staff will deliver specimen kits to the facility.
- IP will provide a line list via email of patients who are being screened to HAIP staff and PH Lab.
- IP or designated facility staff will test (swab) the patients.
- HAIP staff will pick up specimens from the facility and deliver them to PH Lab.
- PH Lab will provide results to facility contact(s).
- HAIP staff will reach out to IP with the next steps, recommendations, and other details.



Goals of Surveillance, Reporting, and Isolate Submission

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- Enable early detection of *C. auris* in a region or facility.
- Facilitate timely investigation and response.
- Publish annual summary data and report to CDC.
- Monitor antifungal resistance trends and the emergence of new strains.
- Support coordination between healthcare facilities, clinical laboratories, and public health departments to **prevent** and **reduce** the spread of MDROs.



PHL is a good resource for conducting PPSs and admission screenings:

- San Bernardino County Public Health [Laboratory Test Fees](#).
 - August 1, 2024, to June 30, 2025.



Public Health Laboratory

PUBLIC HEALTH LABORATORY TEST FEES
August 1, 2024 to June 30, 2025

LABORATORY SERVICES	Test Fees	CPT Code
<u>Bacteriology</u>		
Salmonella/Shigella Culture	\$ 45.00	87045
STEC Culture	\$ 47.00	87046
Miscellaneous Bacterial Culture	\$ 31.00	87070
MALDI-Bacteria	\$ 50.00	87077
CPO PCR	\$ 68.00	87798
<u>Mycology/Fungus</u>		
Fungal Culture	\$ 30.00	87102
Yeast ID/Yeast MALDI	\$ 50.00	87106
Mold ID	\$ 50.00	87107
KOH Prep	\$ 15.00	87220
Candida auris PCR	\$ 68.00	87798
<u>Mycobacteriology/TB</u>		
Acid-Fast Stain	\$ 20.00	87206
AFB Specimen Concentration	\$ 24.00	87015
Acid-Fast Culture - Mycobacteria Screening (Negative)	\$ 50.00	87116
M. tuberculosis-NAAT	\$ 100.00	87556
AFB MALDI ID	\$ 75.00	87143
M. tuberculosis Susceptibility- MGIT method (per drug)	\$ 25.00	87188
Quantiferon	\$ 65.00	86480

Questions



Break
10 minutes



Enhanced Barrier Precautions (EBP) Pop Quiz

**Brittany Avila, BS
Evangelina Patelia, MPH
Communicable Disease Investigators**



1. Staff are required to gown and glove up every time they enter a room of a resident who is on EBP.

False

2. A patient with no indwelling devices, no open wounds, and a known MDRO status should be placed on EBP.

False

3. It is unknown how long a person can be colonized with an MDRO; therefore, BP should be used for the duration of the patient's stay.

True

4. An ostomy or a pacemaker is not considered an indwelling device by the CDC and is not an indication of EBP.

True

5. When preparing a resident who is on EBP to leave their room, it's okay to take them without doing anything.

False

A patient has a trach but can ambulate (walk around). He has an oozing wound on his arm that can't be contained and needs multiple dressing changes a day.

- Should he be on EBP since he is capable of going to common areas independently?
- Why or why not?

Answer:

He should not be on EBP, but contact precautions, since he has an oozing wound. Once his wound drainage can be contained, he can be transitioned to EBP and allowed to access common areas.



A new patient is admitted to ABC SNF. He is ADL (Activities of daily living)-dependent but has no indwelling devices, e.g., G (gastric)-tube, trach, or catheter. His MDRO status is unknown.

- Should he be placed on EBP or contact precautions?
- Why or why not?

Answer:

Since he is ADL-dependent and would require close contact with staff, he should be placed on EBP. EBP is indicated for those who are ADL-dependent, even if they do not have any indwelling devices or MDROs.

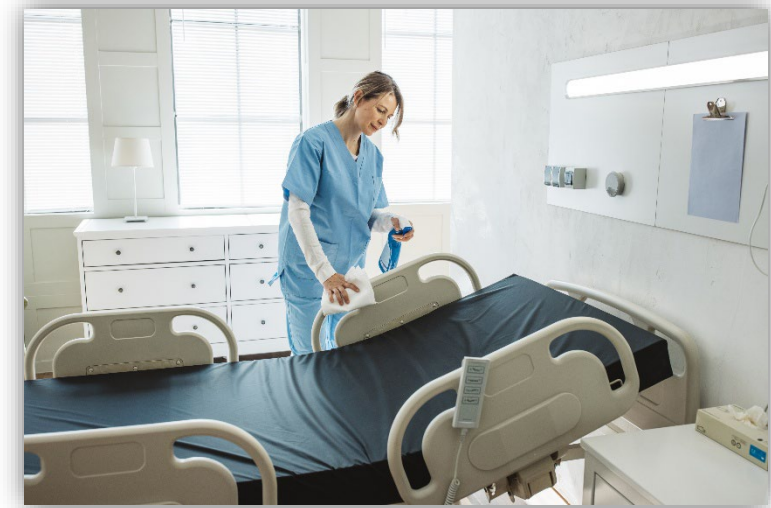


Housekeeping staff enter the room of a resident who is on EBP. Staff will only perform routine cleaning tasks (mopping the floor and emptying the trash).

- Should she be donning PPE?

Answer:

For routine cleaning where there will not be prolonged contact with a resident's personal space, PPE is not required. If the staff were going in to change the soiled linens and wipe down bed handrails, PPE is required.



An IP (infection preventionist) at XYZ SNF just admitted a new patient who is trach and G-tube dependent. Paperwork states the patient had CRPA (Carbapenem-Resistant *Pseudomonas Aeruginosa*) in the urine but was treated with antibiotics in the hospital. She tells you that she is not going to put the resident on any precautions because he has no active infections.

- Are her actions justified?
- Why or why not?

Answer:

No, her actions are not justified. Even if there are no active infections, the patient may still be colonized with the CRPA and can still transmit it. And the fact that he has indwelling devices is an indication of EBP.



The patient is sent to SNF after a knee replacement surgery for PT.

She has a surgical wound.

- Should she be on EBP?
- Why or why not?

Answer:

No, because a surgical wound is not considered a chronic non-healing wound.



Questions



Establishing an Effective Infection Prevention (IP) and Control Program

Karen Arriaga, MPH
Health Education Specialist



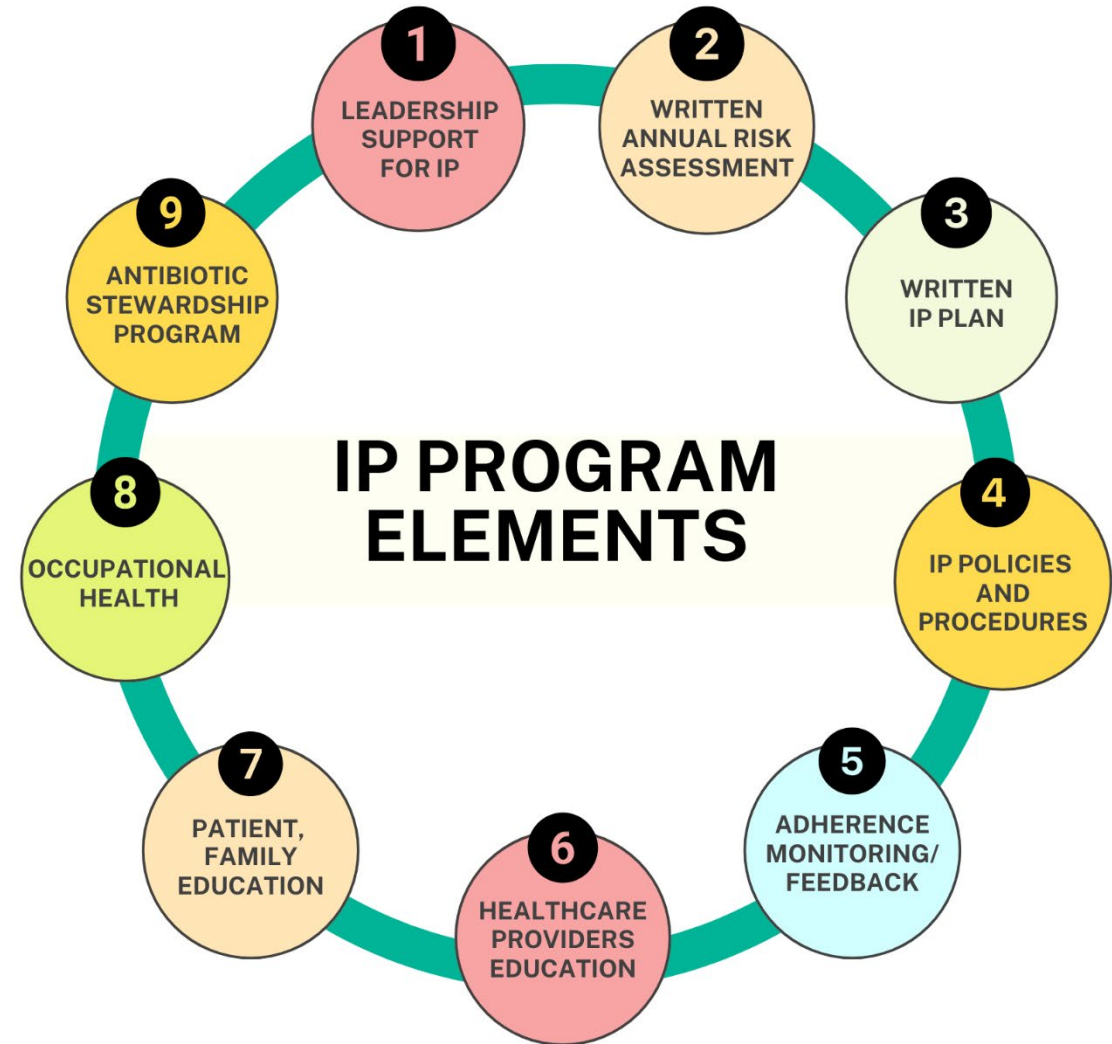
What Makes an Effective SNF Infection Prevention (IP) Program?

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- An effective [IP program](#) must be managed by a trained infection preventionist who ensures that written infection prevention policies and procedures are consistently adhered to by healthcare personnel (HCP).
- Active administrative support and an engaged staff are crucial to an effective IP program.



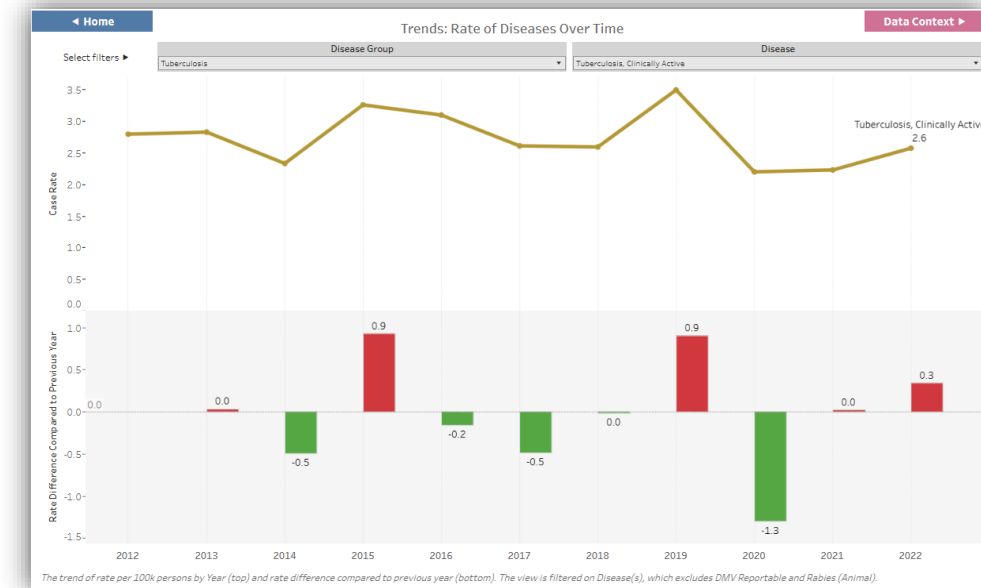
What Elements Should be Included in an IP Program?



- Leaders are accountable for the success of infection prevention activities.
- Sufficient resources are allocated so that adherence to infection prevention practices is feasible.
- An infection preventionist assigned to manage the program is given support and authority.



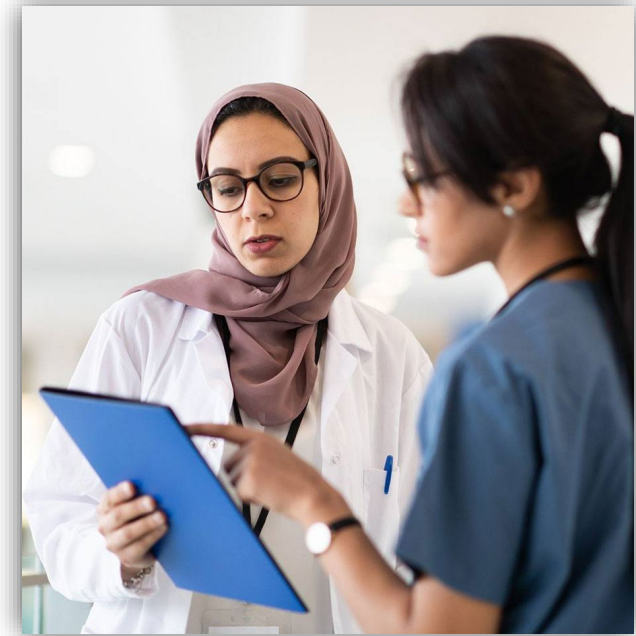
- Number of HAI incidents in the facility over the past year.
- Gaps in infection prevention care practices:
 - Hand hygiene
 - Standard and Transmission-based precautions
 - Environmental cleaning and disinfection
- Community rates of infectious diseases:
 - Tuberculosis (TB) and influenza
- Review DPH sites:
 - [Influenza-Like Illness \(ILI\) Surveillance Dashboard](#)
 - [Communicable Disease Dashboard](#)
- [Sample annual risk assessment](#) (EXCEL)



- The Role of the Infection Preventionist.
- Infection prevention goals for the year.
- HAI surveillance is to be conducted.
- How infections will be recorded and reported.
- Policies and procedures to prevent transmission of infections.
- How and where adherence monitoring will be conducted.
- How feedback will be provided to the healthcare providers (HCP).
- [Sample annual IP program plan](#) (PDF)



- Standard and Transmission-based precautions.
- Respiratory hygiene/cough etiquette.
- Cleaning and disinfection of the environment and resident care equipment.
- Use of Environmental Protection Agency-approved (EPA) cleaning agents according to manufacturer's instructions.
- Implement methods to prevent infections for residents with invasive devices.
- Vaccination for residents and HCP.
- Screening and work restrictions to prevent HCP from working while ill or infected.



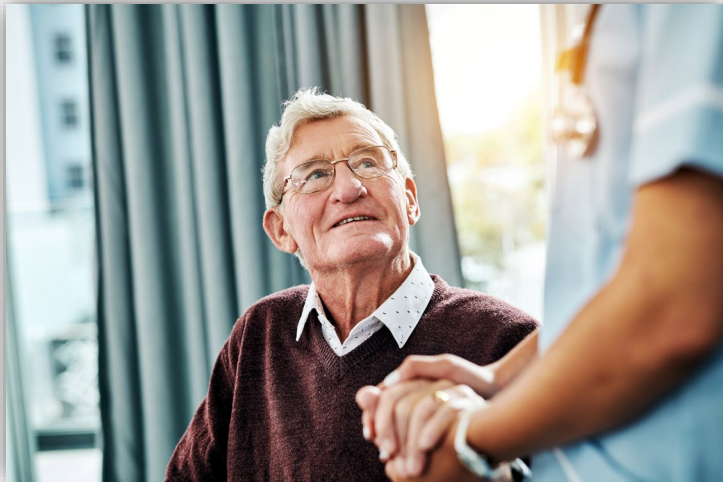
- Standardized tools and definitions to monitor HCP adherence to infection prevention practices.
- Prompt, regular performance feedback to HCP and leadership.
- [Monitoring Adherence to Healthcare Practices that Prevent Infection.](#)



- Job-specific infection prevention training.
- New hire and annual training on:
 - Hand hygiene
 - Standard and Transmission-based precautions
 - Bloodborne pathogen exposure
 - Environmental cleaning
 - Linen handling
 - Hazardous waste disposal
- Additional training when gaps in care practice adherence or increased infection rates are identified.

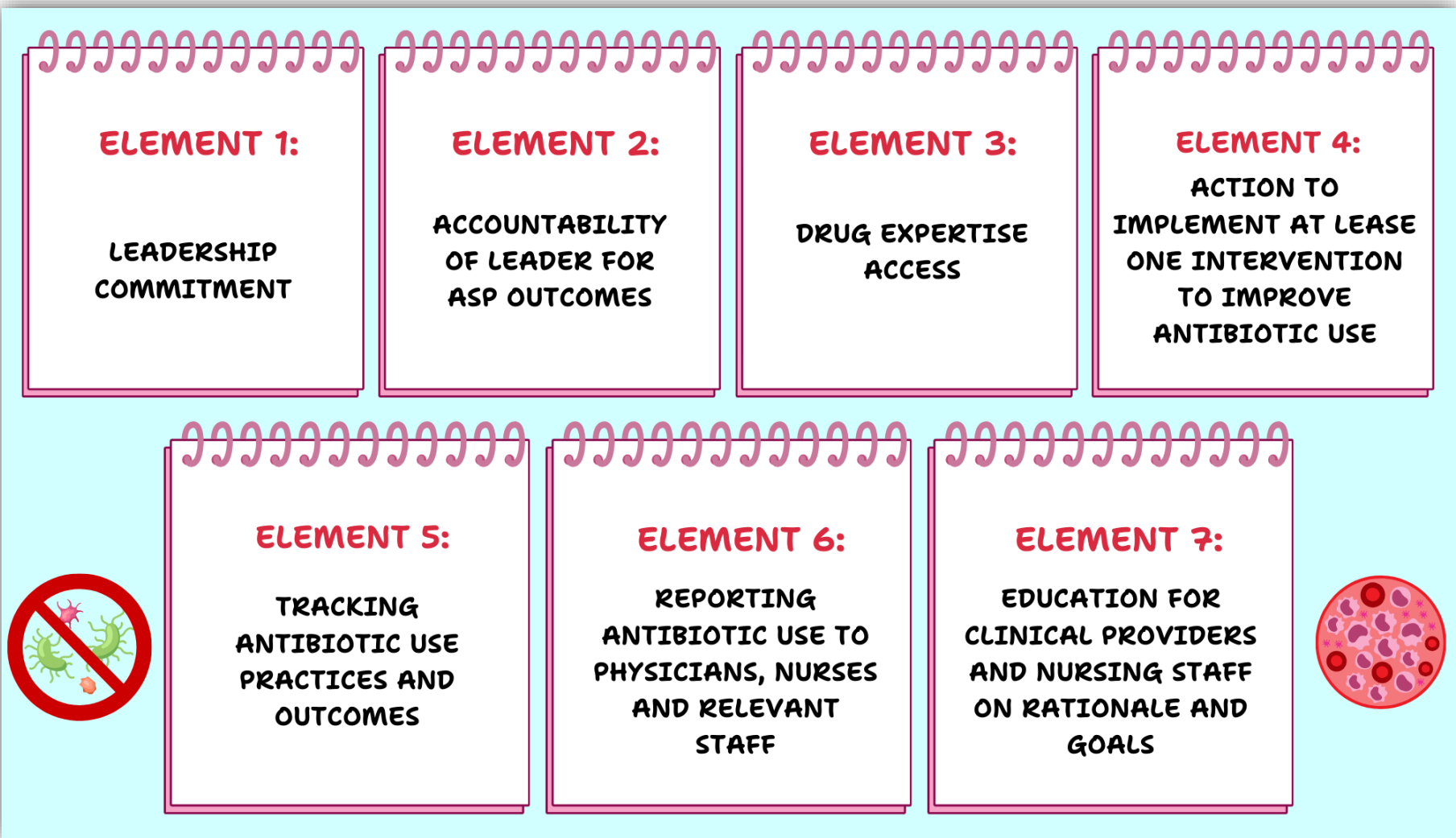


- Provide appropriate infection prevention education to patients, family members, and visitors.
- Include:
 - How infections are spread
 - How they can be prevented
 - What signs and symptoms should prompt evaluation
 - Instructional materials



- Vaccines (Influenza)
- Respirator fit testing
- TB testing
- Infectious disease exposure investigations
- Post-exposure management
- Counseling:
 - Infectious disease exposure risk
 - Work restriction
 - Latex allergies
- Compliance with CA regulation:
 - [Bloodborne Pathogen Standard](#).
 - [Airborne Transmissible Disease Standard](#) (PDF)





[SNF ASP Tool
kit](#)

- The Centers for Medicare and Medicaid Services [CMS §483.95\(e\)](#) mandates that the Infection Preventionist (IP) in SNFs complete infection prevention training. The following courses meet this requirement:
 - [CDPH HAI Program Basics of Infection Prevention 2-day Course](#) (ONLINE)
An introduction to infection prevention and control practices, including a track for skilled nursing facilities. CEU available.
 - [SNF Online Infection Prevention Course](#):
An 18-hour self-paced course available in Spring 2025.
 - [CDC Nursing Home Infection Preventionist Training Course](#):
A 20-hour course offering CEUs.
 - [APIC Infection Prevention in Long-Term Care Certificate Series](#):
Online classes are available.

Questions



Legionnaires' Disease & Water Management Plans

John Holguin, MPH
Public Health Epidemiologist

Joseph Pak
Supervising Communicable Disease Investigator



- *Legionella* was discovered after an outbreak in 1976 among people who went to a Philadelphia convention of the American Legion. Those who were affected suffered from a type of pneumonia that eventually became known as Legionnaires' disease.
- Pontiac Fever was first identified in 1968 in Pontiac, MI, among individuals who worked at or visited the local health department.

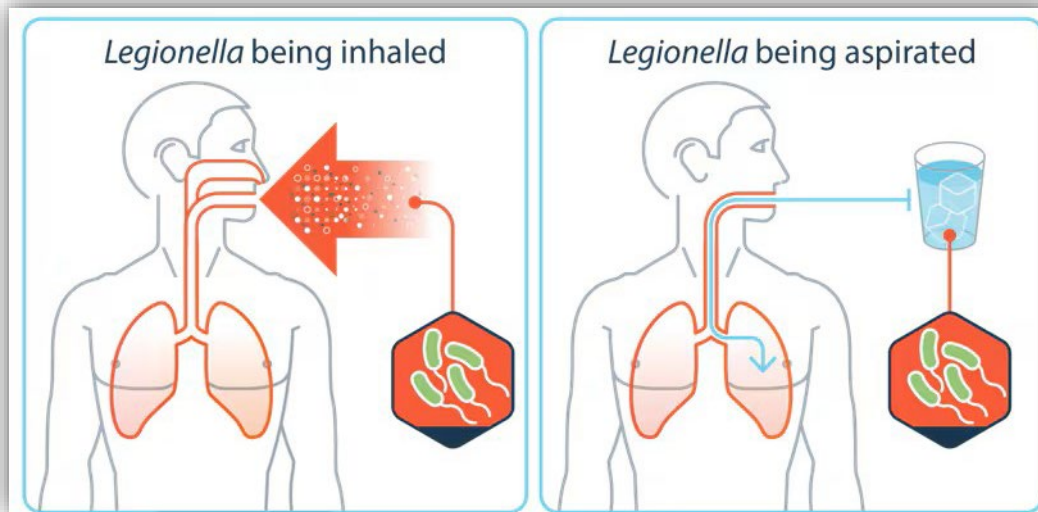


Legionnaires' Disease

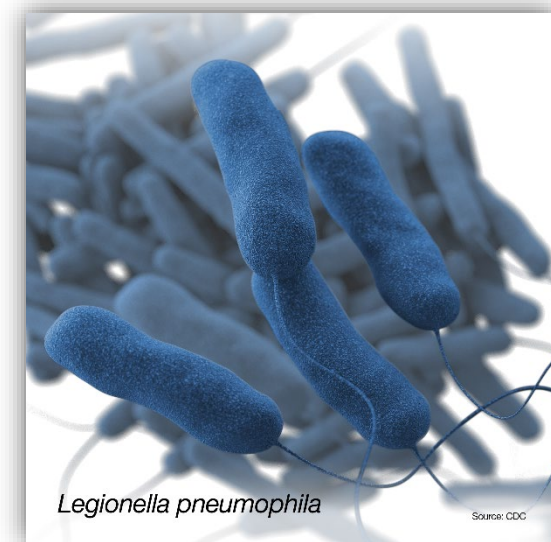
- Severe lung infection, pneumonia.
- Hospitalization.
- Antibiotic treatment.

Pontiac Fever

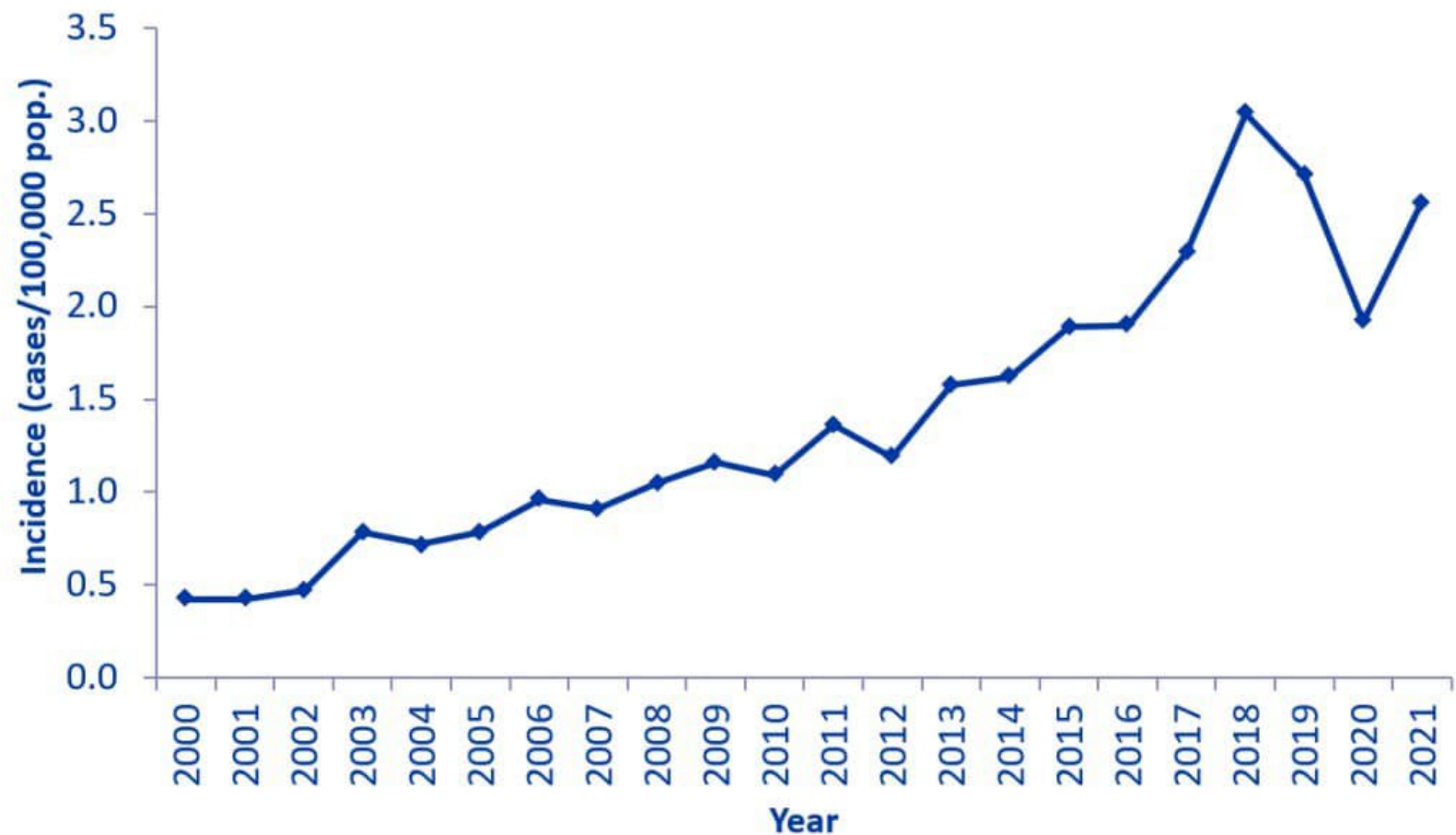
- Mild, self-limiting infection.
- Does not usually require medical care.



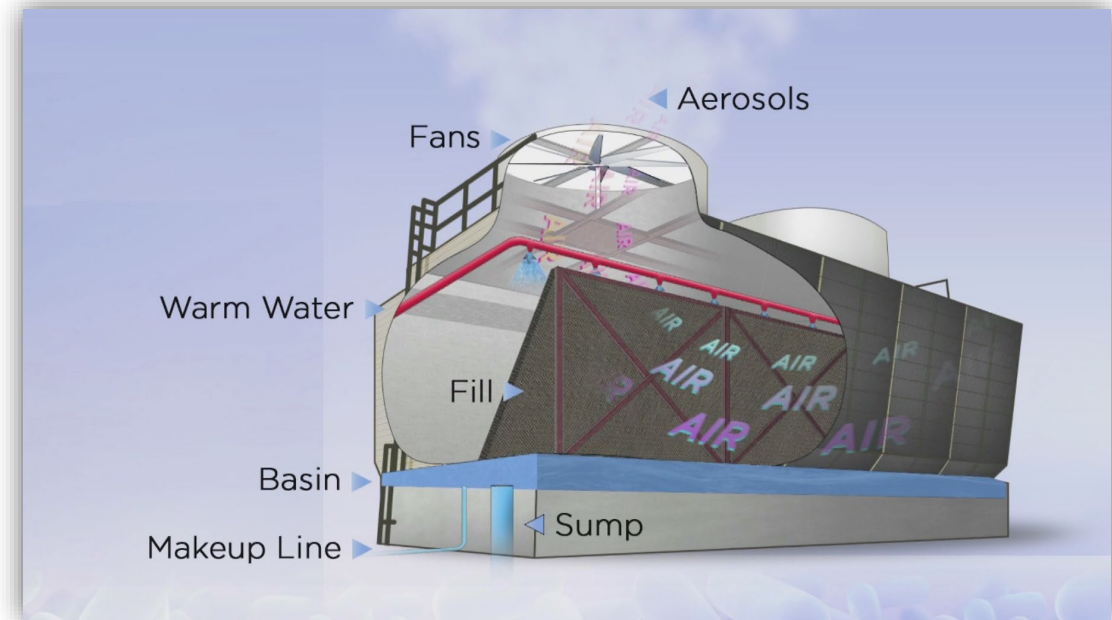
- *Legionella* are bacteria (*L. pneumophila* serogroup 1) that are naturally found in freshwater sources such as lakes and streams.
- Grows and spreads in human-made water systems:
 - Hot tubs
 - Cooling towers (which use water to cool air as part of centralized air conditioning systems for buildings or industrial processes)
 - Hot water tanks
 - Decorative fountains
 - Large buildings with complex water systems
 - Mistifiers



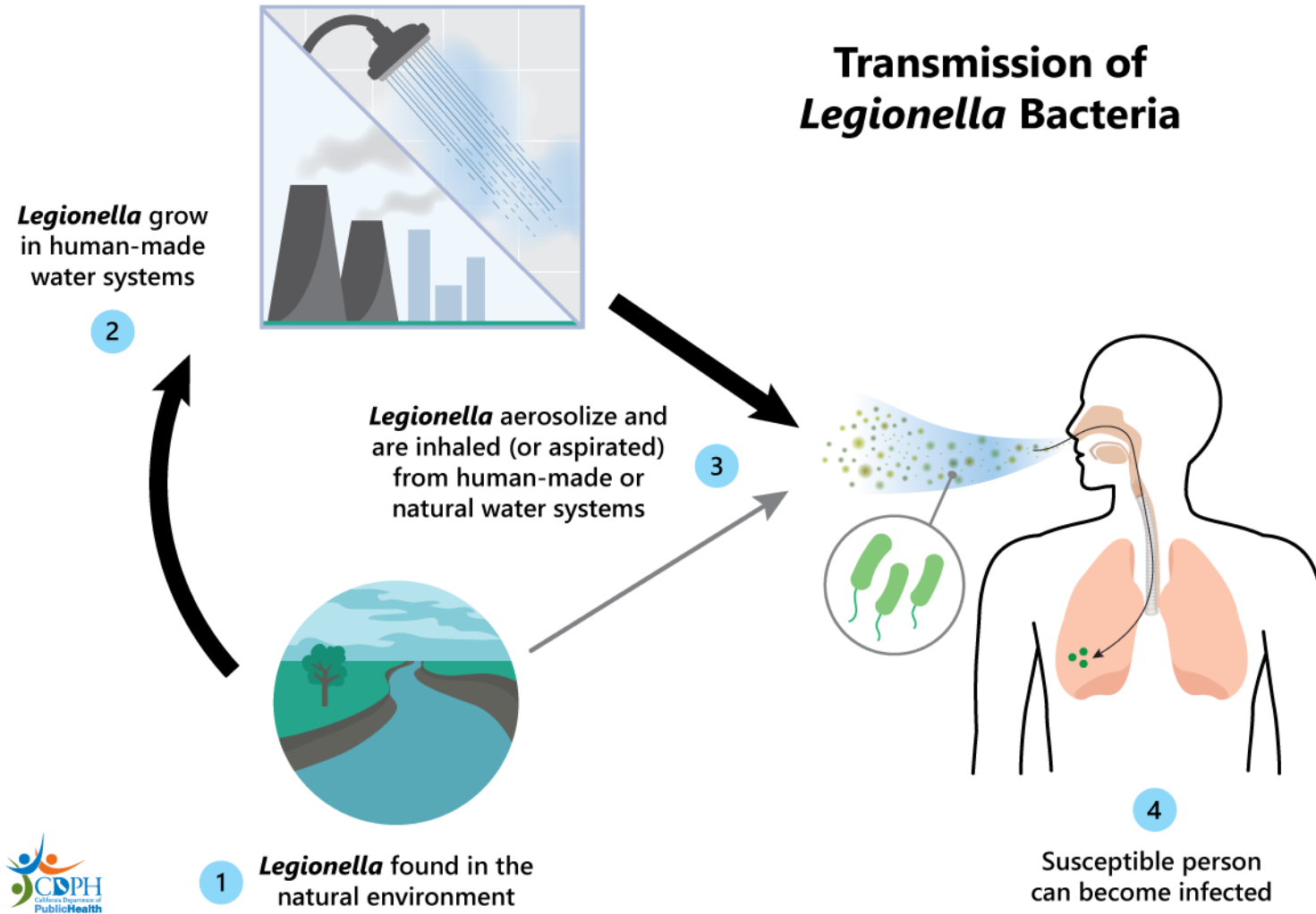
Legionnaires' disease in the United States, 2000-2021



- Approximately 500 laboratory-confirmed cases are reported each year in California.
- Most are sporadic rather than outbreak-related.
- Outbreaks have been associated with:
 - Healthcare settings
 - Congregate living facilities
 - Hotels
 - Hot tubs
 - Cooling Towers



- Incubation period:
 - 2-14 days before the onset of symptoms (PF: 24-72 hours).
- Confirmed:
 - Isolation of any *Legionella* organism from lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site.
 - Detection of any *Legionella* species from lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary sites by a validated nucleic acid amplification test.
 - Detection of *Legionella pneumophila* serogroup one antigen in urine using validated reagents.
 - A fourfold or more significant increase in specific serum antibody titer to *Legionella pneumophila* serogroup 1 using validated reagents.





- Age ≥ 50 years.
- Smoking (current or past).
- Chronic lung disease (emphysema or COPD).
- Immune system disorders resulting from disease or medication.
- Systemic malignancy.
- Underlying illnesses such as diabetes, renal failure, or hepatic failure.
- Recent travel with an overnight stay outside the home.
- Recent care at a healthcare facility.
- Exposure to hot tubs.



Approximately 20% of cases are HA-LD, 5% are considered “presumptive”

Presumptive:

- A case with >10 days of continuous stay at a healthcare facility during the 14 days before onset of symptoms.

Possible:

- A case that spent a portion of the 14 days preceding the date of symptom onset in one or more healthcare facilities but does not meet the criteria for presumptive HA-LD.

- If a healthcare exposure occurred during part or all of the incubation period, collect the facility's name, address, and dates of stay or exposure.
- Obtain medical records if the exposure occurred during an inpatient stay.

HEALTHCARE-ASSOCIATED OUTBREAK

A single case of presumptive HA-LD or multiple cases of possible HA-LD associated with the same facility

Healthcare-Associated

- CDC recommends that public health officials perform a full investigation for the source of *Legionella* in a facility upon identification of:
 - ≥ 1 case of presumptive healthcare-associated Legionnaires' disease at any time.
 - ≥ 2 cases of possible healthcare-associated Legionnaires' disease within 12 months of each other.

Healthcare Facilities by Settings

CLINIC	HOSPITAL	LONG-TERM CARE	OTHER
✓ Ambulatory (same day) surgery center ✓ Dental clinic ✓ Dialysis center ✓ Outpatient clinic: general and specialty ✓ Outpatient rehabilitation clinic	✓ Acute care hospital: general or specialty ✓ Children's hospital ✓ Critical access hospital ✓ Long-term acute care hospital ✓ Psychiatric hospital	✓ Inpatient hospice ✓ Nursing home ✓ Psychiatric residential treatment facility ✓ Rehabilitation hospital ✓ Skilled nursing facility	✓ Outpatient Laboratories ✓ Pharmacies

- The CDC defines community-associated outbreaks as an increase in Legionnaires' disease cases in a specific geographic area.
- If data indicate an increase in Legionnaires' disease in a specific geographic area, consider conducting a comprehensive outbreak investigation.
- The first step in an investigation will be to identify familiar sources of exposure for outbreaks, such as:
 - Cooling towers
 - Decorative fountains
 - Hot tubs
 - Misters



- To help identify sources of exposure, consider conducting Active Case Surveillance, which should be done through both retrospective surveillance and prospective surveillance.
- **Retrospective Case Surveillance** involves collecting information on patients who have been diagnosed with Legionnaires' disease to identify potential sources of exposure to *Legionella* and a timeline of when the exposures might have occurred.
- **Prospective Case Surveillance** involves monitoring patients who show signs of pneumonia or acute respiratory symptoms that may indicate further exposure. Patients presenting with symptoms can be tested for *Legionella* to confirm exposure.
- Information collected in retrospective and prospective case surveillance may involve:
 - Date and time symptoms started.
 - Locations where the patient has been staying.
 - Potential sources of exposure to *Legionella*.

An environmental assessment is a part of an outbreak investigation that determines where conditions could support the growth and spread of Legionella.

Showers



Fountains



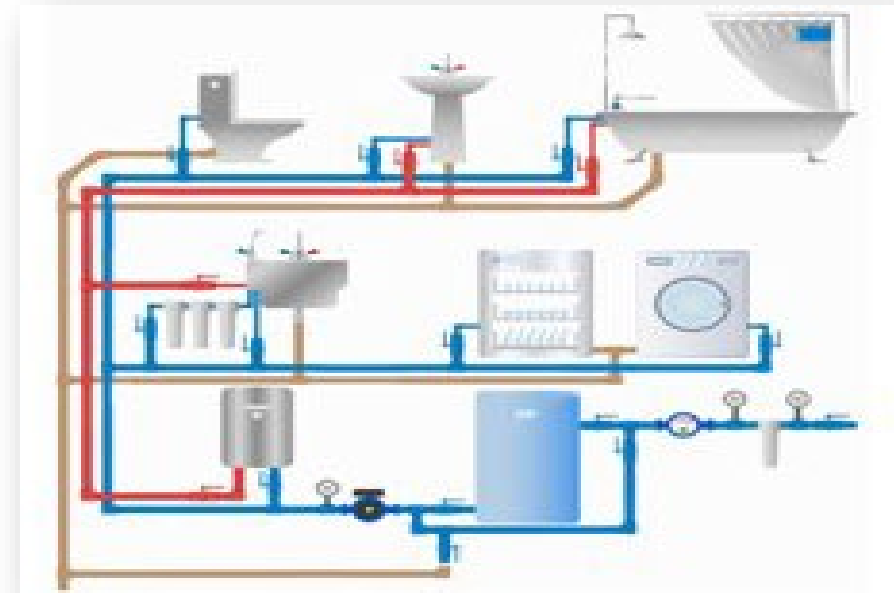
Hot tubs



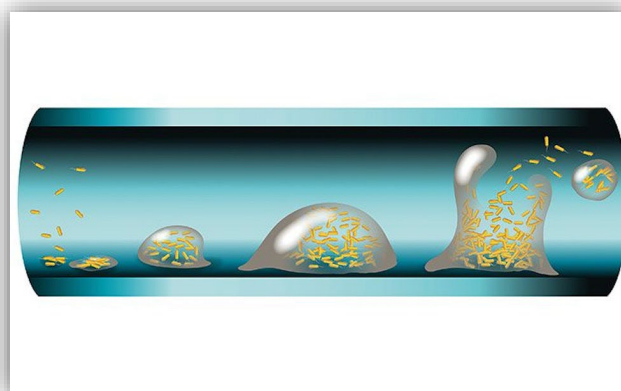
Cooling towers



- **WMP** is a written plan of action and documentation for managing building water.
- **Purpose:** Prevent the spread of pathogens through contaminated water sources within a facility. A WMP is a good practice for identifying vulnerabilities and pointing out any recommended actions needed to prevent waterborne pathogens.
- **Why make a WMP?** A better quality of life, a deeper understanding, and a proactive disease prevention strategy (e.g., waterborne pathogens).



- **Principles of WMP:** Ensure adequate disinfection, regular maintenance to prevent build-ups, optimal water temperatures, and prevent water stagnation.
- **Building Factors to Focus on:** Age, location and surroundings, components of the water system, areas at risk of *Legionella* growth, and who uses the building.
- **WMP may cover whole buildings or specific devices:**
 - Fountains, cooling towers, water storage, ice machines, sinks/faucets, respiratory equipment
 - The idea is anything with constant moisture.



1. Establish WMP Team.
2. Describe the building's water system.
3. Identify areas susceptible to *Legionella* growth/spread.
4. Decide where and how to place control measures.
5. Establish interventions for when control limits are not met.
6. Verify and validate the program is running as designed.
7. Document and communicate all actions.



- Who conducted water testing?
- Did they complete a Legionella Environmental Assessment Form (LEAF)?
- What are the changes to WMP, if any?
- What is the timeline of patient symptoms and their time in the facility?
- Where was the patient, and what are some potential places they could have encountered Legionella in the facility?
- Is surveillance in place for Legionella symptoms? If so, does additional cases indicate a weakness in WMP?



- [Toolkit: Developing a Legionella Water Management Program | Control Legionella | CDC.](#)
- Legionella Environmental Assessment Form (LEAF)
- Legionella Consultants.
- Local DPH Environmental Health Services.
 - SBC EHS: [Contact Us – Environmental Health Services.](#)
- Vendors specializing in water testing services.



Questions



Site Visits and Announcements

Alia Caldwell, MPA



- The HAIP Program offers on-site Infection Prevention and Control (IPC) assessments to help facilities prepare, prevent, and respond to outbreaks.
- Assessments are conducted by HAIP nurses, who identify gaps in IPC practices, potential outbreak causes, and systemic issues that require attention.
- HAIP nurses share their findings and recommendations with the facility Infection Preventionist (IP) and leadership.



The Core Infection Prevention and Control Practices training is for infection preventionists and environmental services (EVS) staff.

Topics: hand hygiene, recommendations for setting up an EVS cart, and best practices for the cleaning and disinfection of patient rooms.

Virtual Trainings (Zoom)

- **English:**
Tuesday, April 29, 2025
1- 3:30 P.M.
- **Spanish:**
Wednesday, April 30, 2025
1- 3:30 P.M.



- The San Bernardino County Healthcare Preparedness Planning Partnership (HP3) Meetings:
 - Bi-monthly coalition meeting
 - Hosted by Inland Counties Emergency Medical Agency (ICEMA)
 - A voluntary, multidisciplinary, multi-agency coalition created to address issues and challenges that affect healthcare delivery in disasters and emergency incidents.
 - Members work to ensure the highest quality of patient care and safety, even in times of crisis.
- For more information, please contact Steven Dougherty at doughertys@armc.sbcounty.gov.

California Health Alert Network (CAHAN) Healthcare-Associated Infections (HAI) / Antimicrobial Resistance (AR) Health Advisories:

- www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CAHAN.aspx

CDPH Healthcare-associated Infections (HAI) Program:

- <https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIQuicksheets.aspx>
- [Title 17, California Code of Regulations](#)
- [MDRO Patient Cohorting](#)
- [CDPH - Personal Protective Equipment FAQ](#)
- [CDPH - Best Practices for Skilled Nursing Facilities \(SNFs\) in Accepting Residents with Multidrug-resistant organisms \(MDROs\)](#)
- [CDPH – HAI Program – Establishing an Effective Infection Prevention and Control Program](#)

Training for IPs & EVS Staff:

- www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ProjectFirstlineEVSToolkit.aspx
- www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/IP_TrainingForSNFs_OnlineCourse.aspx
- www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF_EstablishingIC_Program.aspx (bottom of page)

Health Services Advisory Group (HSAG) HAI Updates:

- [HAI Updates](#)

Legionella:

- www.cdc.gov/legionella/index.html
- [Toolkit: Developing a Legionella Water Management Program | Control Legionella | CDC](#)
- www.cdc.gov/control-legionella/php/toolkit/wmp-toolkit.html
- [Legionella Environmental Assessment Form \(LEAF\)](#)
- [Overview of Water Management Programs | Control Legionella | CDC](#)

American Journal of Respiratory and Critical Care Medicine:

- www.atsjournals.org/doi/full/10.1164/rccm.201908-1581ST

CDPH Legionellosis website:

- [www.cdph.ca.gov/Programs/CID/DCDC/Pages/Legionellosis\(Legionella\).aspx](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Legionellosis(Legionella).aspx)

CDC:

- [CDC - MDRO Prevention Strategies](#)
- [CDC – MDRO Containment Strategy](#)



Contact us!

**HAIP Program
Communicable Disease Section**

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Public Health
Communicable Disease

THANK YOU