

# State of Florida *Candida auris* Action Plan 2023-2025

June 28, 2024



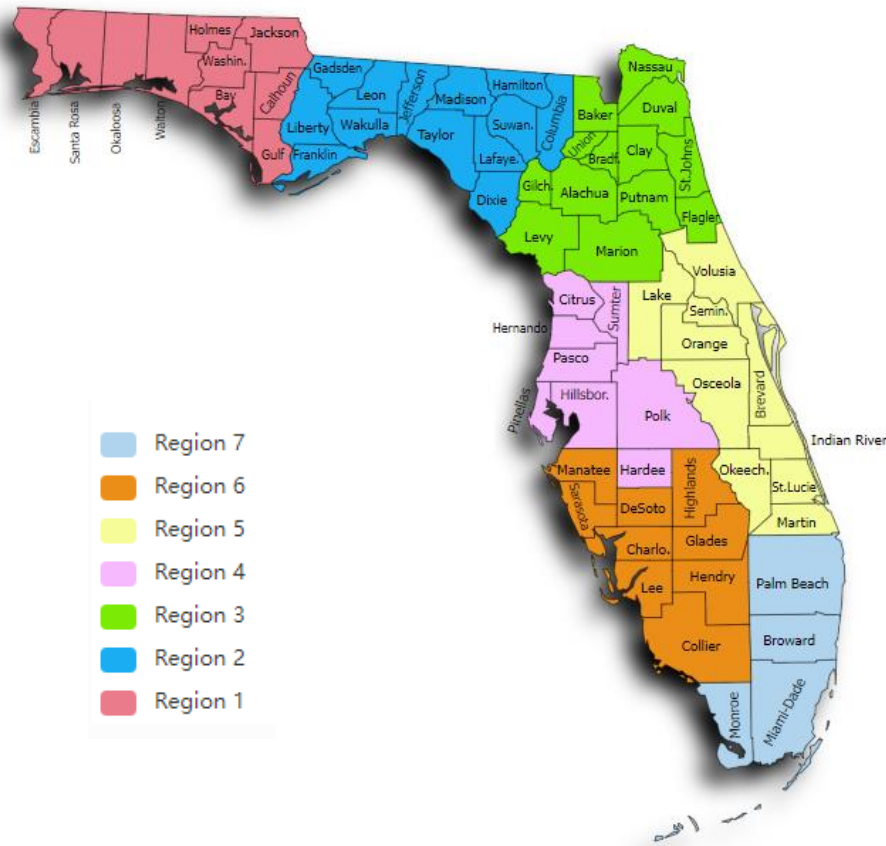
# Table of Contents

Executive Summary .....	3
<i>Candida auris</i> Action Plan Timeline.....	3
Background.....	5
Florida Data.....	5
Infection and Colonization .....	7
Transmission.....	7
Regulations .....	8
Learning Needs Assessment (LNA) .....	9
LNA Results Summary .....	9
First Workgroup Meeting.....	11
Weaknesses and Threats.....	11
Strengths and Opportunities .....	12
Second Workgroup Meeting.....	13
Co-Lead Information.....	13
Action Plan Goals and Objectives .....	14
Goal 1.....	14
Goal 2.....	15
Goal 3.....	16
Goal 4.....	17
Goal 5.....	18
Measuring and Reporting Progress.....	19
Goal and Objective Tracker .....	19
Appendix.....	22
Definitions .....	22
Acronyms .....	23

# Executive Summary

The *Candida auris* (*C. auris*) Statewide Action Plan (2023–2025) presents strategic actions the Florida Department of Health (DOH) and the Agency for Health Care Administration (AHCA), in partnership with stakeholders across the state, will take to improve interfacility communication, data transparency, educational resources, and continuity of care for all Floridians affected by *C. auris*. DOH and AHCA will report annually on progress toward the objectives in this plan.

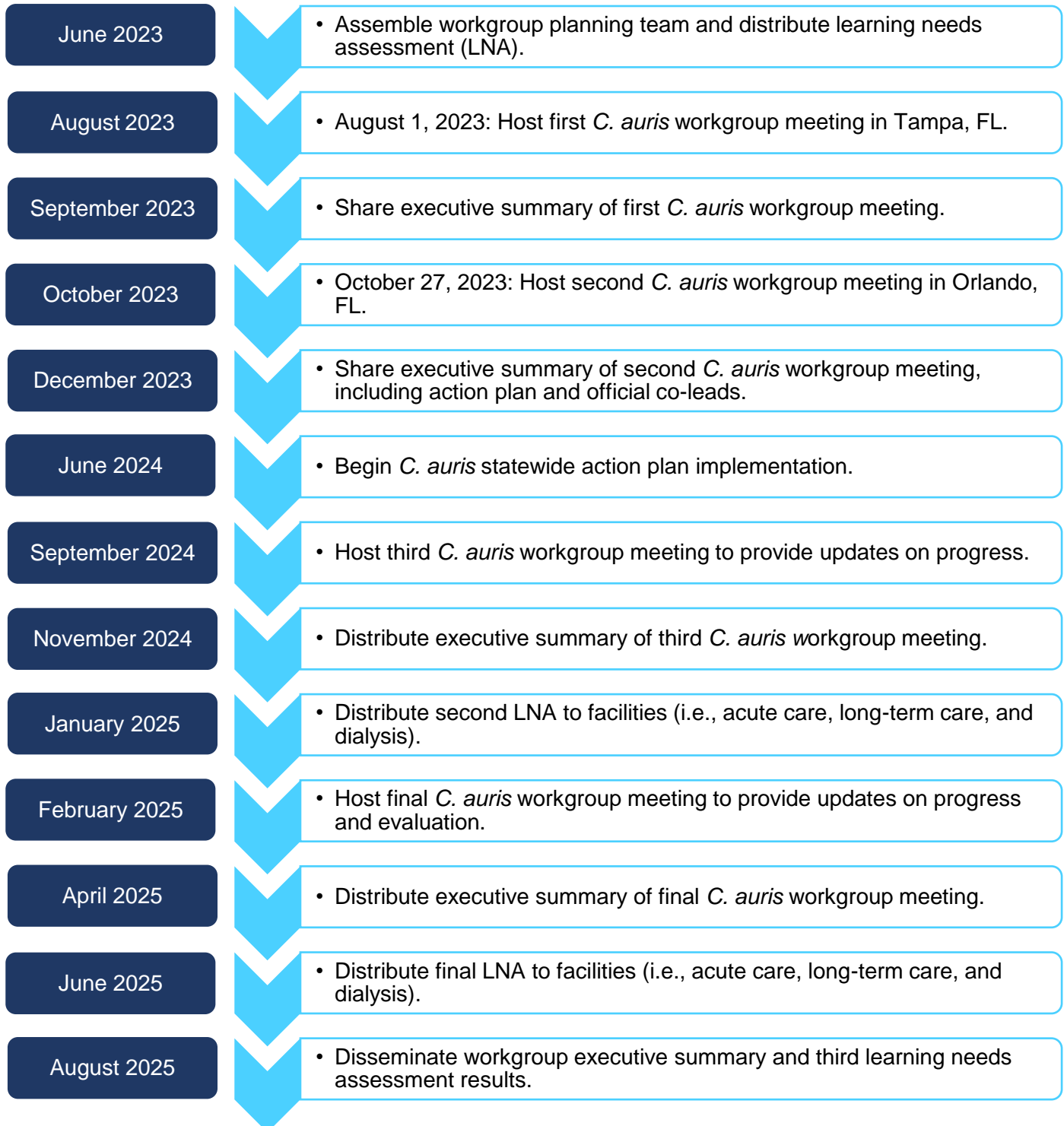
This plan was created in collaboration with key stakeholders and professional organizations throughout the state. *C. auris*-related challenges were identified through in-person workgroup meetings that occurred on August 1 and October 27, 2023. The first meeting discussed participants' experience with *C. auris*, incorporating feedback from long-term care, acute care, and end-stage renal disease facilities using a Strengths, Weaknesses, Opportunities, and Threats (SWOT) framework. The second workgroup meeting used information from the SWOT framework to develop actionable Specific, Measurable, Achievable, Realistic, Time-Bound (SMART) objectives. Five objectives were identified regarding communication, education, testing, resources, and policy. Then, workgroup representatives nominated five co-leads to serve as liaisons for all health care facility types and facilitate collaboration to complete designated action items.



Florida comprises 67 counties divided into seven regions to support regional and county response related to health care-associated infections.

## Candida auris Action Plan Timeline

DOH and AHCA are undertaking the following preliminary actions from 2023 to 2024 to support public health efforts that reduce *C. auris* transmission across the state. 2025 activities will primarily involve measurement and evaluation, which are detailed in later pages.



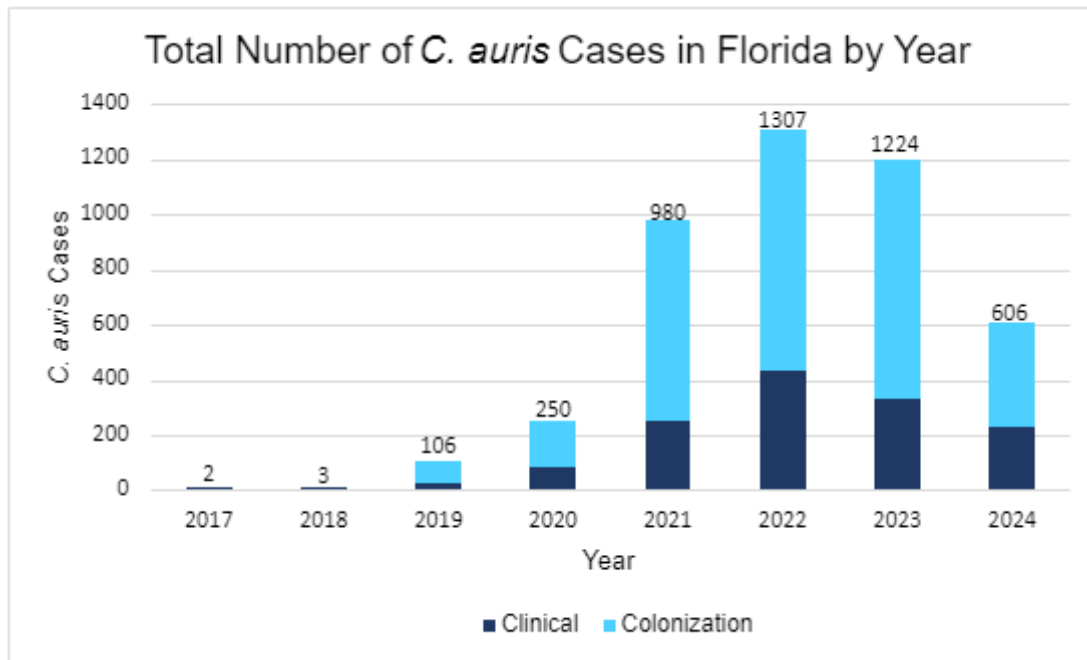
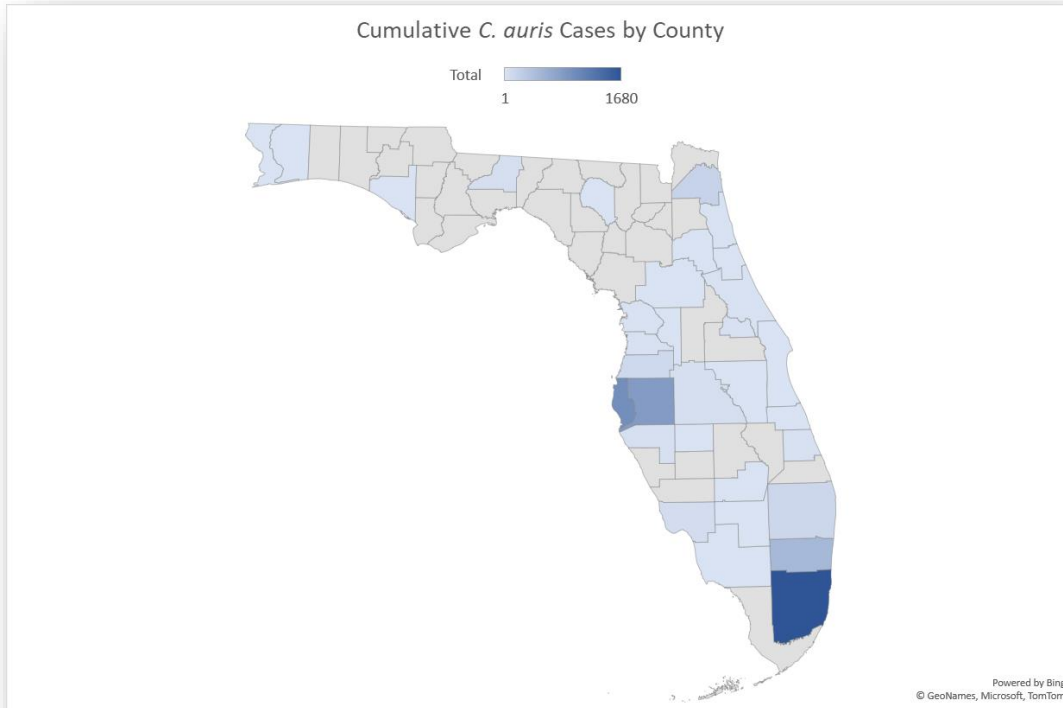
## Background

*C. auris* is an emerging fungus classified as a multidrug-resistant organism (MDRO) of public health concern. The earliest known case of *C. auris* in the United States was in 2013 in New York. As of December 2022, there have been more than 5,654 clinical cases and 13,163 colonized cases identified across the nation. Florida, along with California, New York, and Illinois have the highest prevalence of *C. auris* cases. As of March 15, 2024, there have been a total of 4,478 *C. auris* cases in 40 counties within Florida, including 3,120 colonized cases and 1,358 clinical cases. Of those identified cases, there was a higher prevalence in Miami-Dade, Broward, Clay, Duval, Pinellas, and Hillsborough counties. Approximately 60% of cases are identified in patients who are 65 years of age and older.

The rise of cases in Florida is a public health concern for several reasons. *C. auris* can cause serious infections, is often resistant to antifungal medications, and can be difficult to identify. Additionally, it can spread easily in hospitals and nursing homes. *C. auris* also adds strain to health care systems and health insurance, especially in cost. For instance, between November 2021 and March 2022, one Florida hospital system estimated that the total cost of excess hospital stays for 31 *C. auris*-identified patients was \$121,367, with an average cost of \$3,915 per patient. In the facility's analysis, *C. auris* was found to be responsible for 303.4 excess patient days for 31 patients, which averaged to 9.8 excess days per patient. Due to barriers in discharge coordination from acute care hospitals to lower levels of care, patients face an increased length of stay within acute care settings, contributing to an increased risk of acquiring additional infections. Addressing *C. auris*-related challenges with a unified and multidisciplinary approach can help reduce costs for health care systems and the state.

## Florida Data

As of March 15, 2024, there have been a total of 4,478 *C. auris* cases in 40 counties within Florida, including 3,120 colonized cases and 1,358 clinical cases with a mean patient age of 67. Cases have been documented within acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and outpatient facilities.



## **Infection and Colonization**

Infection indicates the organism has entered a patient's body causing signs and symptoms in any body site, including wounds, ears, and the bloodstream. Most *C. auris* infections may be treated with three main classes of antifungal medications: azoles, echinocandins, and polyenes. However, some *C. auris* infections are resistant to all three classes, making them more difficult to treat.

Colonization means the organism lives on the skin, usually in the axilla or groin, without causing illness. There are currently no decolonization methods available, so colonization status is indicated as indefinite. It is important to note that patients may be infected or colonized with *C. auris* without detection, partly because of patient comorbidities and the similarity of symptoms to other fungal infections.

## **Transmission**

*C. auris* spreads through contact with contaminated environmental surfaces or equipment. It can also spread through physical contact with a person who is infected or colonized. Health care workers' hands serve as a vehicle for transmission, but there is no notable evidence or research to support that health care workers are at high-risk for colonization or infection with *C. auris*. Within acute care hospitals and long-term acute care hospitals, contact precautions should be used to manage patients with *C. auris*. Within nursing homes, including skilled nursing facilities, residents with *C. auris* can be managed using either contact precautions or enhanced barrier precautions depending on the situation. *C. auris* can survive on surfaces for weeks. Use of an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant that is effective against *C. auris* is recommended. Effective disinfectants can be found on EPA List P; if listed products from EPA List P are not available, EPA List K can be used following the manufacturer's directions and contact time. It is important to note that dedicating units and staff to care for patients colonized or infected with *C. auris* is not required.

The primary infection control measures recommended for prevention of *C. auris* transmission in health care settings are:

- Adherence to proper hand hygiene.
- Appropriate use of transmission-based precautions based on the setting.
  - For skilled nursing facilities, use of enhanced barrier precautions can be implemented if criteria are met. Please refer to the appendix for outlined enhanced barrier precautions criteria.
  - For all other facility types, contact precautions are the recommended practice.
- Proper cleaning and disinfection of the patient care environment (e.g., daily and terminal cleaning) and reusable equipment with recommended products, including focus on shared mobile equipment (e.g., glucometers and blood pressure cuffs).
- Communication about patient *C. auris* status when patient is discharged or transferred.
- Screening contacts of newly identified case patients to identify *C. auris* colonization.

## Regulations

AHCA provides regulatory oversight for over 300 acute care settings, 700 skilled nursing facilities, 500 end-stage renal disease facilities, and approximately 3,000 assisted living facilities. Each facility subtype has specific regulations that they must adhere to concerning infection control for multidrug-resistant organisms (MDROs), including *C. auris*.

The acute care setting regulations include:

- Active hospital-wide programs for the surveillance, prevention, and control of health care-associated infections (HAIs) and other infectious diseases.
- Optimization of antibiotic use through stewardship.
- Demonstration of adherence to nationally recognized infection prevention and control guidelines, including improving antibiotic use where applicable and reducing the development and transmission of HAIs and antibiotic-resistant organisms.
- Infection prevention and control problems as well as antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement program.

The long-term care facility regulations include:

- Establishment and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
- A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.
- Written standards, policies, and procedures for the program.

The end-stage renal disease facility regulations include:

- Recommendations for preventing transmission of infections among chronic hemodialysis patients.

The assisted living facility regulations include:

- Providing services in a manner that reduces the risk of transmission of infectious diseases.
- Implementing policies for infection control and staff training.



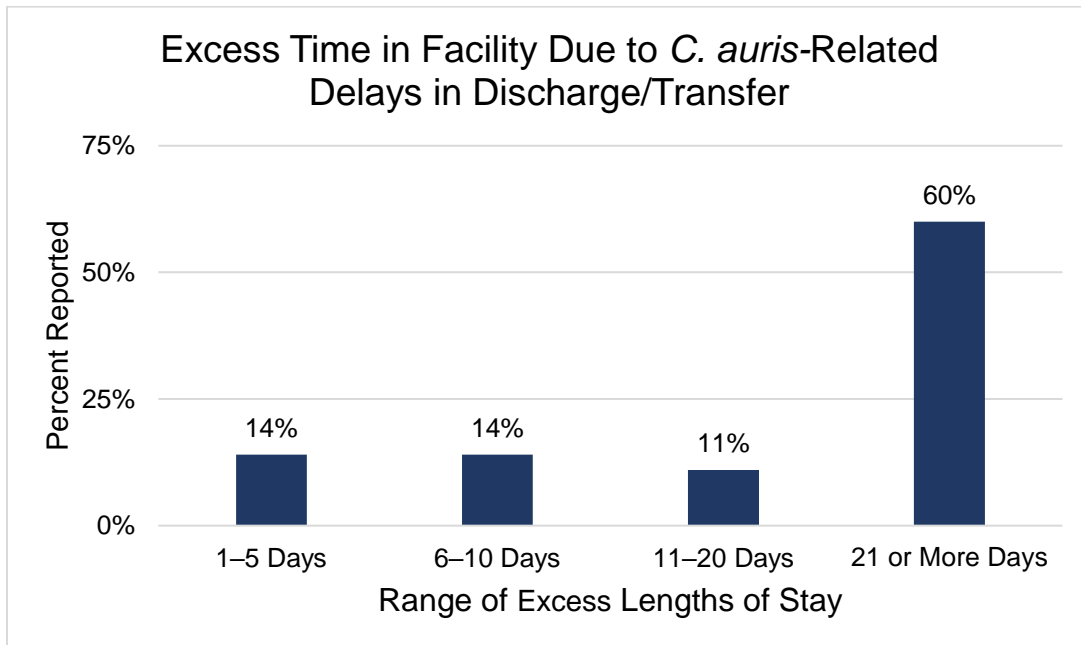
## Learning Needs Assessment

A non-regulatory, voluntary, and anonymous Learning Needs Assessment (LNA) was developed by DOH's HAI Prevention Program and AHCA to increase knowledge and understanding of challenges and barriers related to *C. auris* infection control management and discharge within an array of health care facilities.

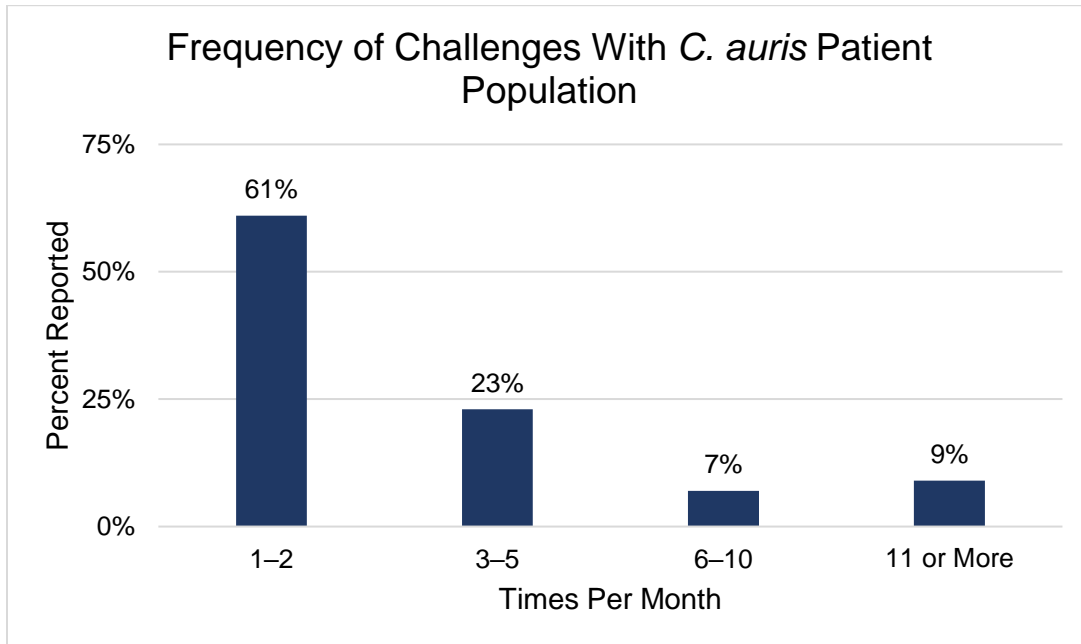
On June 6, 2023, the LNA was distributed to 7,500 National Healthcare Safety Network users in Florida with a closing date of June 20, 2023. Responses were recorded from 781 individuals in health care settings, including acute care hospitals, long-term acute care hospitals, outpatient dialysis facilities, and skilled nursing facilities.

### LNA Results Summary

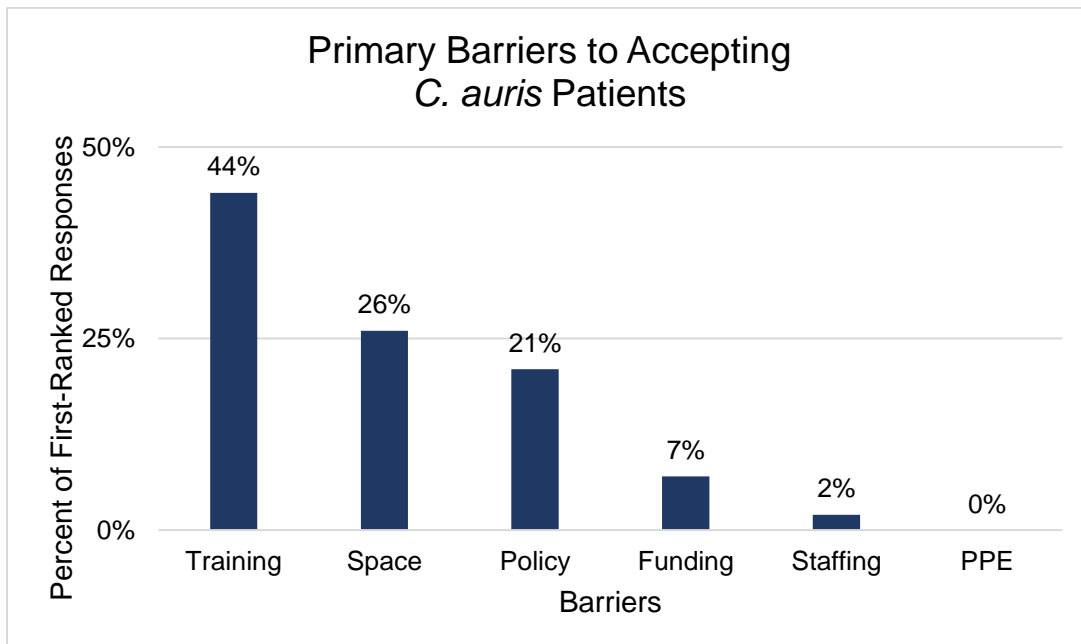
*In the past 12 months, approximately how many days of excess time in your facility would you estimate that C. auris patients stayed due to C. auris-related delayed discharge/transfers?*



In the past 12 months, on average, how many times would you estimate that these challenges occurred with unique patients?



Please rank the major barriers to accepting infected and/or colonized *C. auris* patients from 1 to 6 (1 being the most influential and 6 being the least influential).



Note: PPE refers to personal protective equipment.

## First Workgroup Meeting

The purpose of the first *C. auris* workgroup meeting was to increase collaboration on *C. auris*-related efforts with key health care stakeholders by discussing *C. auris*-related challenges and their root causes, identifying potential solutions that can be incorporated into an action plan, and agreeing to an ongoing commitment to enhance the care and safety of Floridians.

Meeting attendees represented acute care hospitals, long-term care and nursing facilities, renal care, and other professional organizations. The facilitated discussions used a modified SWOT framework as seen below.

### Weaknesses and Threats

Discussion prompts:

- What areas of improvement would you like to address within your organization?
- What kinds of risk is your organization currently facing?
- What additional barriers exist beyond your control?
- Are there any significant changes in affected patient characteristics/demographics?

Summation of five key challenges addressed:

1. **Communication:** Facilitate community partnerships and collaboration between health care facilities to improve communication flow, patient transfers, and address barriers to case management.
  - Attendees mentioned issues related to inter- and intra-facility communication when patients with *C. auris* transitioned to different levels of care. Communication issues include failing to report a patient's *C. auris* status to the accepting facility, failing to follow up regarding pending *C. auris* laboratory results, and failing to effectively communicate a patient's *C. auris* status to other departments within a facility.
2. **Education:** Improve knowledge and training in appropriate infection control practices for management of *C. auris* across the continuum of care to include health care staff, providers, patients, and families.
  - Attendees mentioned perception and knowledge deficits that continue to foster fear and misunderstanding among health care staff, patients, and their families related to *C. auris*. Education deficits mentioned included lack of appropriate training tailored to all levels of staff (e.g., education level, language barriers), lack of education for patients and their families after diagnosis, and lack of engagement in education for physicians and health care providers.
3. **Testing:** Address laboratory and facility capacity for *C. auris* testing, provide recommendations for screening and early identification of cases, and support data transparency for improved surveillance across the local, regional, and state levels.
  - Attendees mentioned testing and surveillance issues related to lengthy colonization testing turnaround time, increased cost of supplies and equipment required for accurate and timely *C. auris* identification, and the need for increased surveillance within all levels of care. The need for increased data transparency across local, regional, and state levels was mentioned multiple times, emphasizing the limited information known about the impact of *C. auris* regarding unnecessary extended lengths of stay and financial impact of the related discharge and transfer issues.

4. **Resources:** Identify needs and barriers to implementing *C. auris* case management across health care settings and provide networking and informational resources among public health partners.
  - Attendees mentioned the following as large factors in continued management of *C. auris* patients: workforce shortages, costly broad-spectrum disinfectants, and the inability to accept additional patients (due to limited staff and the desire to dedicate staff to care for *C. auris* patients).
5. **Policy:** Collaborate with regulatory agencies and other partners in Florida to improve *C. auris* reporting, develop standardized policies across the continuum of care, and support organizational best practices.
  - Attendees mentioned lack of consistent policies related to reporting, treatment, and facility management of *C. auris* patients. Admission and discharge planning challenges were a common theme. Attendees mentioned to be sure to include home health, hospice, and emergency medical services providers in planning discussions.

### **Strengths and Opportunities**

Discussion prompts:

- What do you or your organization do well in identification and treatment?
- What are additional strengths of your organization regarding leadership and/or changes in policy?
- Which resources and assets must your community or organization have to support your management of patients?
- What resources or policies are you aware of but have not been able to implement?

Strengths and opportunities were identified within acute care, long-term care, and end-stage renal disease health care facilities:

- Acute care representatives expressed the importance of utilizing professional organizations to provide education to providers by leaning into specialists within the field, to share data, and to provide PCR screening within the acute care setting. Representatives also highlighted the value of opportunities to share information and network via tabletop discussions, roundtables, and collaborative discussions to share data at least quarterly in a statewide forum. The importance of research and publishing findings was also expressed.
- Long-term care representatives described outreach to community partners, professional organizations, and medical associations to ensure proper infection prevention measures are being used when appropriate. The use of dedicated units for the care of patients colonized or infected with *C. auris* was also discussed.
- End-stage renal representatives provided some successful tools and best practices, which included developing a health care float pool to increase staffing, dedicated shifts for the care of *C. auris* patients, a corporate patient MDRO dashboard, and standardized corporate policies for patient care.

## Second Workgroup Meeting

The purpose of the second *C. auris* workgroup meeting was to establish objectives and action items to address the *C. auris*-related challenges identified in the first workgroup meeting, to increase coordination with key health care partners, and finalize a statewide *C. auris* action plan that addresses patient discharge, infection prevention and control, and other *C. auris*-related concerns.

Meeting objectives included:

- Present regional *C. auris* data to state partners.
- Provide an opportunity for state partners to present internal *C. auris* plans and policies.
- Develop *C. auris*-related SMART objectives and activities for the development of the statewide *C. auris* action plan.

During this meeting regional *C. auris* data was presented to stakeholders and stakeholders were able to present internal *C. auris* plans and policies. Additionally, the SWOT framework was developed into five goals for the statewide *C. auris* action plan. Participants created SMART objectives and action steps to achieve these objectives and goals are delineated in the following pages.

### Co-Lead Information

To ensure the action plan's objectives meet the needs and expectations of all health care organizations, individuals outside DOH/AHCA were nominated as co-leads from acute care, end-stage renal, assisted living facilities, and long-term care.

Primary responsibilities include compiling, analyzing, and presenting regional *C. auris* data with partners; facilitating conversation with statewide health care authorities about their internal *C. auris* action plans, challenges, and policies; and working with fellow co-leads during workgroup meetings and serve as liaisons.

<b>Goal 1: Communication</b>
<b>Co-Lead:</b> Kristen Munsell, RN
<b>Organization:</b> Innovative Renal Care
<b>Goal 2: Training</b>
<b>Co-Lead:</b> Laura Velasco, BSN, RN, CIC
<b>Organization:</b> Kindred/Scion Health
<b>Goal 3: Laboratory Capacity</b>
<b>Co-Lead:</b> Gemma Rosello, MPH, CIC
<b>Organization:</b> Jackson Health System
<b>Goal 4: Case Management</b>
<b>Co-Lead:</b> Adriana Jimenez, PhD, MPH, CIC
<b>Organization:</b> University of Miami Health System
<b>Goal 5: Regulation and Policy</b>
<b>Co-Lead:</b> Rachel Guran, MPH, BSN, RN, CIC, FAPIC Jennifer McConnell RN, CDP; Bonnie Williamson CHC
<b>Organization:</b> Memorial Health System Sen Care Management

## Action Plan Goals and Objectives



### Goal 1

*Improve communication and collaboration within health care facilities and between health care facilities and other health care providers.*

Goal 1 will facilitate community partnerships and collaboration between health care facilities to improve communication flow, patient transfers, and address barriers to case management. This goal will address issues related to inter- and intra-facility communication when patients with *C. auris* are transitioned to different levels of care. Communication issues include failing to report a patient's *C. auris* status to the accepting facility, failing to follow up regarding pending *C. auris* laboratory results, and failing to effectively communicate a patient's *C. auris* status to other departments within a facility.

#### Objective 1.1

By December 2024, disseminate and analyze a voluntary LNA for health care staff in at least 80% of health care settings within Florida including acute care hospitals, long-term care facilities, and dialysis facilities. The LNA results will be shared with stakeholders to address communication needs and barriers and improve current communication tools.

#### Objective 1.2

By March 2025, develop and implement a standardized communication tool to improve intra-facility communication based on facility survey results.



## Goal 2

*Improve knowledge and training in appropriate infection control practices for C. auris.*

Goal 2 will improve knowledge and training for management of *C. auris* across the continuum of care to include health care staff, providers, patients, and families. This goal will address misperception and knowledge deficits that may foster fear and misunderstanding among health care staff, patients, and their families. Education deficits include lack of appropriate training tailored to all levels of staff (e.g., based on education level and language barriers), lack of education for patients and their families after diagnosis, and lack of engagement in education for physicians and health care providers.

### Objective 2.1

By June 2024, develop a *C. auris* training and education toolkit to distribute to facilities based on care setting type. The toolkit will include educational tools (e.g., one-pagers, quick references), infection prevention recommendations tailored to specific setting types, and regional data trends of novel and targeted multidrug-resistant organisms.

### Objective 2.2

By March 2025, develop and disseminate infection prevention and control training resources for facility employees to be integrated into existing orientation for completion within three months of hire and annually thereafter.



## Goal 3

*Expand laboratory and facility capacity for C. auris testing.*

Goal 3 will expand laboratory and facility capacity for *C. auris* testing. This goal will address laboratory and facility capacity for *C. auris* testing, provide recommendations for screening and early identification of cases, and support data transparency for improved surveillance across the local, regional, and state levels. Testing and surveillance challenges are related to lengthy colonization testing turnaround times, increased cost of supplies and equipment required for accurate and timely *C. auris* identification, and the need for increased surveillance within all levels of care. The need for increased data transparency across the local, regional, and state levels was mentioned multiple times during the workgroup meetings, emphasizing the limited information about the impact of *C. auris* on unnecessarily extended lengths of stay and the financial impact of discharge and transfer delays.



### Objective 3.1

By January 2025, disseminate a LNA to assess available capacity for screening and follow-up testing offered by the DOH Bureau of Public Health Laboratories (BPHL) and facility laboratories in Florida (e.g., commercial laboratories, hospital on-site laboratories). Utilize LNA results to develop and distribute an inventory of laboratories that perform *C. auris* testing including estimated turnaround time.



### Objective 3.2

By March 2025, analyze the *C. auris* case report form using Florida's surveillance system to identify risk factors and create recommendations regarding screening protocols per health care setting type (e.g., acute care hospitals, long-term acute care hospitals, rehabilitation facilities, skilled nursing facilities, dialysis clinics).





## Goal 4

*Reduce barriers to C. auris case management across health care settings.*

Goal 4 will identify needs and barriers to implementing *C. auris* case management across health care settings and provide networking and informational resources among public health partners. This goal will address finding solutions to limited *C. auris* resources, including workforce shortages and costly broad-spectrum disinfectants which are large barriers in the continued management of *C. auris* patients. Some facilities are unable to accept additional patients due to limited staff and the desire to dedicate staff to *C. auris* patients.

### Objective 4.1

By October 2024, the *C. auris* workgroup co-leads will facilitate the development of local networks for roundtable discussions to identify barriers and resources across the continuum of care. DOH and AHCA will meet with co-leads on a biannual basis to integrate best practices from these discussions into training and educational materials.

### Objective 4.2

By February 2025, identify Florida facilities that routinely accept and manage *C. auris* patients to develop a regional-specific collaborative network aimed to assist facilities in strategizing solutions to implement within their infection control programs. Establish or maintain partnerships with national service providers for these settings as appropriate.



## Goal 5

*Standardize policies in collaboration with regulatory agencies and partners to support best practices.*

Goal 5 will develop standardized policies across the continuum of care, and support organizational best practices. This goal will address the lack of collaboration and consistent policies between regulatory agencies and other partners in Florida related to reporting, treatment, and facility management of *C. auris* patients. Admission and discharge planning challenges are also common. It is necessary to include home health, hospice, and emergency medical services providers in planning discussions.



### Objective 5.1

By August 2024, facilitate the implementation of the *C. auris* action plan.



### Objective 5.2

By July 2025, establish standardized guidance and recommendations for best infection control practices in each setting type, aligned with established national guidelines.

## Measuring and Reporting Progress

Workgroup members identified initial barriers to *C. auris* case management through a voluntary LNA administered in June 2023. During the first workgroup meeting, participants also enumerated challenges using a framework to identify organizational strengths, weaknesses, opportunities, and threats. Certain challenges apply to all five goals of the action plan, including interfacility communication, allocation of resources, dissemination of training resources, availability of staff, and capacity.

The *C. auris* action plan sets objectives and actionable steps for the next two years. Each co-lead will report on progress toward these objectives within the relevant timeline. Follow-up LNAs will be distributed at 18-month (January 2025) and 24-month (June 2025) intervals to evaluate progress and ongoing barriers. In future reports, the workgroup will discuss ongoing challenges and any new challenges encountered during the implementation of the action plan.

### Goal and Objective Tracker

Goal 1: Improve communication and collaboration within health care facilities and between health care facilities and other health care providers.				
Objectives	Progress February-August 2024	Progress September 2024- January 2025	Progress February-August 2025	Completed (Y/N)
<p><b>Objective 1.1:</b> By December 2024, disseminate and analyze a voluntary LNA for health care staff in at least 80% of health care settings within Florida including acute care hospitals, long-term care facilities, and dialysis facilities. The LNA results will be shared with stakeholders to address communication needs and barriers and improve current communication tools.</p>				
<p><b>Objective 1.2:</b> By March 2025, develop and implement a standardized communication tool to improve intra-facility communication, based on facility survey results.</p>				

Goal 2: Improve knowledge and training in appropriate infection control practices for <i>C. auris</i> .				
Objectives	Progress February-August 2024	Progress September 2024-January 2025	Progress February-August 2025	Completed (Y/N)
<b>Objective 2.1:</b> By June 2024, build a <i>C. auris</i> training and education toolkit to distribute to facilities, based on care setting type.				
<b>Objective 2.2:</b> By March 2025, develop and disseminate infection prevention and control training resources for facility employees to be integrated into existing orientation for completion within three months of hire and annually thereafter.				
Goal 3: Expand laboratory and facility capacity for <i>C. auris</i> testing.				
Objectives	Progress February-August 2024	Progress September 2024-January 2025	Progress February-August 2025	Completed (Y/N)
<b>Objective 3.1:</b> By January 2025, disseminate a LNA to assess available capacity for screening and follow-up testing offered by the DOH BPHL and facility laboratories in Florida. Utilize LNA results to develop and distribute an inventory of laboratories that perform <i>C. auris</i> testing including estimated turnaround time.				
<b>Objective 3.2:</b> By March 2025, analyze the <i>C. auris</i> case report form using Florida's surveillance system to identify risk factors and create recommendations regarding screening protocols per health care setting type.				

**Goal 4: Reduce barriers to *C. auris* case management across health care settings.**

Objectives	Progress February-August 2024	Progress September 2024-January 2025	Progress February-August 2025	Completed (Y/N)
<b>Objective 4.1:</b> By October 2024, the <i>C. auris</i> workgroup co-leads will facilitate the development of local networks for roundtable discussions to identify barriers and resources across the continuum of care. DOH and AHCA will meet with co-leads on a biannual basis to integrate best practices from these discussions into training and educational materials.				
<b>Objective 4.2:</b> By February 2025, identify Florida facilities that routinely accept and manage <i>C. auris</i> patients to develop a collaborative network aimed to assist facilities in strategizing solutions to implement within their infection control programs. Establish or maintain partnerships with national service providers for these settings as appropriate.				

**Goal 5: Standardize policies in collaboration with regulatory agencies and partners to support best practices.**

Objectives	Progress February-August 2024	Progress September 2024-January 2025	Progress February-August 2025	Completed (Y/N)
<b>Objective 5.1:</b> By August 2024, facilitate the implementation of the <i>C. auris</i> action plan.				
<b>Objective 5.2:</b> By July 2025, establish standardized guidance and recommendations for best infection control practices in each setting type, aligned with established national guidelines.				

# Appendix

## Definitions:

- **Candidemia:** *Candida* bloodstream infection; may result from *C. auris* and other *Candida* species, such as *C. albicans* and *C. tropicalis*. Candidemia can cause life-threatening illness and spread infection to other parts of the body, like the eyes, kidneys, liver, and brain.
- **Colonization:** Colonization, or being colonized with *C. auris*, indicates that a patient has the organism living somewhere on their body but does not have any signs or symptoms of infection.
- **Clinical infection:** Clinical infection of *C. auris* indicates the organism has entered a patient's body causing signs and symptoms. Infections can occur in any body site including wounds, ears, and the bloodstream.
- **Counties by Region:**
  - **Region 1:** Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington.
  - **Region 2:** Columbia, Dixie, Franklin, Gadsden, Hamilton, Jefferson, Lafayette, Leon, Liberty, Madison, Suwannee, Taylor, and Wakulla.
  - **Region 3:** Alachua, Baker, Bradford, Clay, Duval, Flagler, Gilchrist, Levy, Marion, Nassau, Putnam, St. Johns, and Union.
  - **Region 4:** Citrus, Hardee, Hernando, Hillsborough, Pasco, Pinellas, Polk, and Sumter.
  - **Region 5:** Brevard, Indian River, Lake, Martin, Orange, Osceola, Seminole, St. Lucie, and Volusia.
  - **Region 6:** Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, Lee, Manatee, Okeechobee, and Sarasota.
  - **Region 7:** Broward, Miami-Dade, Monroe, and Palm Beach.
- **SMART Objectives:**
  - **Specific:** Concrete, detailed, and well-defined; helps guide where to go next and what to expect.
  - **Measurable:** Numbers and quantities; provide means of measurement and comparison.
  - **Achievable:** Feasible and easy to put into action.
  - **Realistic:** Considers constraints related to resources, personnel, cost, time frame, etc.
  - **Time-Bound:** Sets deadlines for the objective.
- **SWOT Analysis:**
  - **Strengths:** Internal advantages and capabilities that contribute to success.
  - **Weaknesses:** Internal challenges and areas for improvement.
  - **Opportunities:** External factors or trends that could be beneficial to the plan's execution.
  - **Threats:** External challenges and potential conflicts that lie beyond the organization's control.

**Contact Precautions:**

Implement when the following criteria are met:

- Patients have secretions or excretions that cannot be covered or contained (e.g., draining wounds), **or** there is an investigation of a suspected or confirmed MDRO outbreak.
- Implement these precautions with a plan for discontinuation or de-escalation.
- Cohort patients by pathogen if private rooms are unavailable.
- Require use of gown and gloves every time a person enters a patient's room.
- Require designating dedicated equipment to the patient.
- Require patients to remain in their rooms, except for medically necessary care.

**Enhanced Barrier Precautions:**

- Implement for residents in a nursing home when the following criteria are met:
  - Infection and/or colonization of an MDRO without draining or uncontained secretions/excretions; have indwelling medical devices (e.g., central lines and foley catheters).
  - Implement for the duration of the resident's stay or until the discontinuation of the indwelling medical device.
  - Require the use of gowns and gloves by staff for high-contact resident care activities only (e.g., dressing, toileting, bathing/showering, changing linens, and device care).
  - Does not require resident to be placed in a private room and allows for resident to participate in group activities.
  - Does not require dedicated equipment or staff for resident.

**Acronyms:**

- **AHCA:** Agency for Health Care Administration
- **BPHL:** Bureau of Public Health Laboratories
- **DOH:** Department of Health
- **LNA:** Learning Needs Assessment
- **MDRO:** Multidrug-resistant organism
- **PPE:** Personal Protective Equipment