MANAGEMENT OF INFECTIOUS DISEASES AND INFECTION PREVENTION AND CONTROL PROGRAMS

1. SUMMARY OF MAJOR CHANGES: This Veterans Health Administration (VHA) directive:

a. Revised the infectious diseases reporting appendix to consolidate requirements for both internal and external reporting.

b. Removed and relocated the following content to the National Infectious Diseases Service website located at https://vaww.va.gov/INFECTIOUSDISEASES/index.asp. ***NOTE:*** *This is an internal Department of Veterans Affairs (VA) website that is not available to the public.*

(1) Background of the National Infectious Diseases Service.

(2) Guidance on Infection Prevention and Control Surveillance, Framework for Outbreak Responses, and Formulation of Rates for Infection Prevention and Control Surveillance.

(3) Information on the Multi-drug Resistant Organism (MDRO) Prevention Initiative (PI) Task Force and processes for MDRO PI development and approval.

(4) Details on specific MDRO PIs.

2. RELATED ISSUES: VHA Directive 1031, Antimicrobial Stewardship Programs, dated September 22, 2023; VHA Directive 1300.01, National Viral Hepatitis Program, dated May 23, 2018; VHA Directive 1304, National Human Immunodeficiency Virus Program, dated August 15, 2019; and VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

3. POLICY OWNER: The National Infectious Diseases Service (11SPEC13), within Specialty Care Program Office (11SPEC), Office of the Assistant Under Secretary for Health for Clinical Services (11) is responsible for the contents of this directive. Questions may be referred to the National Program Executive Director, National Infectious Diseases Service at (513) 246-0270 or through the Specialty Care Program Office at VHA11SPECActions@va.gov.

4. RESCISSIONS: VHA Directive 1131(5), Management of Infectious Diseases and Infection Prevention and Control Programs, dated November 7, 2017, is rescinded.

5. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of November 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on November 30, 2023.

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MANAGEMENT OF INFECTIOUS DISEASES AND INFECTION PREVENTION AND CONTROL PROGRAMS

MANAGEMENT OF INFECTIOUS DISEASES AND INFECTION PREVENTION AND CONTROL PROGRAMS

1. POLICY

It is Veterans Health Administration (VHA) policy that each Department of Veterans Affairs (VA) medical facility establishes and maintains an Infectious Diseases Program and an Infection Prevention and Control Program to foster evidence-based practices in order to optimize patient care, promote safety of patients, residents, employees, and visitors, and meet accreditation requirements. ***NOTE:*** *Based on program alignment in VHA, requirements regarding Human Immunodeficiency Virus (HIV) and viral hepatitis are beyond the scope of this directive and the purview of the National Infectious Diseases Service (NIDS) and are under the National HIV Program and the National Viral Hepatitis Program in the HIV, Hepatitis, and Related Conditions Program within the Specialty Care Program Office.* **AUTHORITY:** 38 U.S.C. § 7301(b).

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer.** The Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer is responsible for providing national administrative and clinical oversight for infectious diseases and infection prevention and control programs, and collaborating with the Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer to support implementation of this directive.

c. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Service/Chief Nursing Officer is responsible for supporting the program offices within Patient Care Services and collaborating with the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer to support implementation of this directive.

d. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

e. **Chief Officer, Specialty Care Program Office.** The Chief Officer, Specialty Care Program Office (SCPO) is responsible for providing guidance to the National Infectious Diseases Service.

f. **National Program Executive Director, National Infectious Diseases Service.** The National Program Executive Director, National Infectious Diseases Service (NIDS) is responsible for:

(1) **Program Management.**

(a) Managing the National Infectious Diseases Service Divisions of Infectious Diseases, Infection Prevention and Control, and Multi-Drug Resistant Organism (MDRO) Prevention.

(b) Collaboratively managing other National Programs with other National Program Offices as appropriate (e.g., Antimicrobial Stewardship, *Legionella* prevention, biosurveillance).

(2) **Consultation and Technical Assistance.**

(a) Providing consultation on clinical care for infectious diseases and strategies that support reducing health care-associated infections (HAIs), as appropriate.

(b) Providing consultation on emerging infectious diseases issues and high consequence infections to VA, VHA Central Office, VHA program offices, VISNs and VA medical facilities.

(3) **Educational Activities.**

(a) Providing educational activities including but not limited to national and regional education meetings, national conference calls, national training programs, webinars and website resources, as appropriate.

(b) Maintaining, evaluating, and updating the NIDS website, http://vaww.va.gov/INFECTIOUSDISEASES/, with current information. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) **Development of Policy and Guidance.** Authoring, documenting, and coordinating the development and updating of policy and guidance that support the Infectious Diseases Program and an Infection Prevention and Control Program, Antimicrobial Stewardship, MDRO Prevention Initiatives, and other emerging infectious diseases issues nationwide. Guidance documents can be found at the NIDS website http://vaww.va.gov/INFECTIOUSDISEASES/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(5) **Oversight.** Overseeing implementation of this directive at all VISNs and VA medical facilities by conducting reviews on an annual basis (e.g., by requesting

certification of implementation from the VISN Directors or by VA medical facility surveys).

(6) **Development of National Surveillance Criteria.** Establishing national surveillance criteria for specified infectious diseases and infection prevention and control program issues and working collaboratively on national biosurveillance issues by coordinating with other internal and external entities.

(7) **Coordination.** Collecting annually a list of all VISN Infectious Diseases Leads and VISN Infection Prevention and Control Leads for coordination with VISNs.

g. **Chairs, Field Advisory Boards and Task Forces.**

(1) Field Advisory Board (FAB) Chairs for Infectious Diseases and Infection Prevention and Control are responsible for advising the National Program Executive Director, NIDS on pertinent issues. Some of the areas in which the FABs might make recommendations include, but are not limited to, work force, policies, and recommendations on educational needs.

(2) Task Force Chairs with Infectious Diseases or Infection Prevention and Control charges from VA and VHA Central Office leadership (e.g., National MDRO PI Task Force, National Antimicrobial Stewardship Task Force) are responsible for implementing the specific missions and functions assigned as part of that charge. A task force may be time limited in nature or long-standing. The initial responsibilities of each task force are determined at the time of establishment of the charge.

h. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that a comprehensive, evidence-based Infectious Diseases Program and a comprehensive, evidence-based Infection Prevention and Control Program is available at VA medical facilities' settings, including but not limited to acute care, long-term care/rehabilitation, ambulatory care, outpatient surgery, VA clinics, and Community-Based Outpatient Clinics(CBOCs), and residential care settings. ***NOTE:*** *See Appendix A for information on the Infectious Diseases Program and the Infection Prevention and Control Program at VA medical facilities.*

(2) Ensuring that all VA medical facilities in the VISN comply with policy developed to support the Infectious Diseases Program and Infection Prevention and Control Program, MDRO PI, ASP and biosurveillance activities. ***NOTE:*** *Policy documents can be found at https://vaww.va.gov/vhapublications/ and documents established by NIDS can be found at http://vaww.va.gov/INFECTIOUSDISEASES/. These are internal VA websites that are not available to the public.*

(3) Facilitating partnerships or consultative arrangements within the VISN or through Clinical Resource Hubs for VA medical facilities that do not have sufficient infectious diseases and infection prevention and control staffing.

(4) Collaborating with the VA medical facility Director to ensure that adequate resources (e.g., personnel, training, space, equipment, supplies, information technology needs, professional development) are provided at all VA medical facilities and are secured in order to meet the requirements set forth in Appendix A, paragraphs 5 and 6.

(5) Collaborating with the VA medical facility Director, VA medical facility Chief of Staff and Associate Director for Patient Care Services to ensure that the VA medical facility has access to clinical care staff with expertise in infectious diseases and infection prevention and control.

(6) Selecting and assigning a VISN Lead for Infectious Diseases and VISN Lead for Infection Prevention and Control for coordination of communication between VHA Central Office (e.g., NIDS) and VISN or VA medical facility staff, and submitting contact information to NIDS. ***NOTE:*** *This includes updating NIDS when a change is made to a selected Lead.*

(7) Providing leadership and support for key issues as identified by VA medical facility level experts in infectious diseases and infection prevention and control.

(8) Ensuring that VA medical facility Directors within their VISN report designated infectious diseases information internally in VHA and externally to local entities legally authorized to receive such reports, according to Infectious Disease Reporting requirements as established in Appendix B.

(9) Collaborating with the VA medical facility Director to establish partnerships or consultative arrangements to have access to an Infectious Diseases physician in another VA medical facility (e.g., within the VISN or with telehealth or with Clinical Resource Hubs) or have an arrangement with a community Infectious Diseases physician to provide these services, if the VA medical facility does not have sufficient infectious diseases staffing.

i. **Veterans Integrated Service Network Lead for Infectious Diseases.** The VISN Lead for Infectious Diseases is responsible for coordinating communication related to infectious diseases between VHA Central Office (e.g., NIDS) and VISN or VA medical facility staff.

j. **Veterans Integrated Service Network Lead for Infection Prevention and Control.** The VISN Lead for Infection Prevention and Control is responsible for coordinating communication related to infection prevention and control between VHA Central Office (e.g., NIDS) and VISN or VA medical facility staff.

k. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive and that appropriate corrective action is taken if non-compliance is identified. ***NOTE:*** *See Appendix A for information on the Infectious Diseases Program and the Infection Prevention and Control Program at VA medical facilities, Appendix B for infectious disease reporting, Appendix C for standard terms for special and transmission-based*

precaution categories, and Appendix D for information on MDRO PI procedural guidance.

(2) Establishing an effective Infectious Diseases Program, as defined in Appendix A, paragraph 1, at the VA medical facility.

(3) Establishing an effective Infection Prevention and Control Program at the VA medical facility, as specified in Appendix A, paragraph 2.

(a) Granting authority to the identified individual(s) responsible for the VA medical facility Infection Prevention and Control Program to implement strategies and day-to-day practices for the prevention and control of infectious disease directed towards patients, residents, visitors, employees, and others identified by local needs.

(b) Granting authority to the VA medical facility Infection Preventionists (IPs), MDRO Prevention Coordinators (MPCs) and registered nurses to implement isolation precautions based on mode(s) of transmission. ***NOTE:*** *Local needs and assessments, as determined with input from VA medical facility IPs or MPCs, may require the use of other precaution methods (e.g., enhanced barrier precautions for Methicillin-resistant Staphylococcus aureus (MRSA) in Community Living Centers (CLC)). See Appendix A, paragraph 2.a.(5).*

(c) Granting authority, during an outbreak, hyperendemic, or epidemic situation, to the Chair of the Infection Prevention and Control Committee, generally the Hospital Epidemiologist (or designee), to implement strategies for the prevention and control of infectious diseases for the protection of patients, residents, visitors, employees, and others identified by local needs. *See Appendix A, paragraph 2.a.(6).*

(4) Establishing a VA medical facility Infection Prevention and Control Committee (see Appendix A, paragraph 4).

(5) Collaborating with the VISN Director to ensure adequate staffing and resources, as defined in Appendix A, paragraphs 5 and 6, to implement an effective Infectious Diseases Program and an effective Infection Prevention and Control Program. These activities must be conducted in accordance with requirements, Federal statutory and regulatory requirements, health care accreditation requirements (e.g., The Joint Commission) and other accreditation standards and requirements. ***NOTE:*** *The model defined in Appendix A does not specifically address Infectious Diseases-Patient Aligned Care Team (ID-PACT), HIV, or viral hepatitis staffing needs. These are beyond the scope of this directive and purview of NIDS. Staffing levels for ASPs are detailed in VHA Directive 1031, Antimicrobial Stewardship Programs (ASP), dated September 22, 2023, and are additional to the staffing levels in Appendix A of this directive.*

(6) Collaborating with the VISN Director, VA medical facility Chief of Staff, and Associate Director for Patient Care Services to ensure that the VA medical facility has access to clinical care staff with expertise in infectious diseases and infection prevention and control.

(7) Annually assessing VA medical facility-level staffing for Infectious Diseases Program and Infection Prevention and Control Program as delineated in Appendix A, paragraphs 5 and 6, and reporting the staffing level to the VISN Director (see paragraph 2.h.(4)).

(8) Ensuring that VA medical facility Service leadership reinforces implementation of and compliance with infection prevention and control requirements. This includes ensuring that IPs are represented on Service-level activities, policies and procedures that have infection prevention and control implications.

(9) Collaborating with the VISN Director to establish partnerships or consultative arrangements to have access to an Infectious Diseases physician in another VA medical facility (e.g., within the VISN or with telehealth or with Clinical Resource Hubs) or have an arrangement with a community Infectious Diseases physician to provide these services, if the VA medical facility does not have sufficient infectious diseases staffing.

(10) Ensuring that the VA medical facility's organizational structure includes the Infectious Diseases Program, the Infection Prevention and Control Program (to include MDRO prevention), and the ASP as partners in the delivery of care. ***NOTE:*** *The exact organizational structure is determined locally.*

(11) Reporting designated infectious diseases information internally in VHA and externally to local entities legally authorized to receive such reports, according to Infectious Disease Reporting requirements as established in Appendix B.

(12) Defining the personnel reporting structure within the VA medical facility that reflects staffing, patient and resident care needs, and considerations for integrated care models. ***NOTE:*** *This must be determined at the facility level. It is recommended that the personnel in Infection Prevention and Control fall under the Infectious Diseases Section that reports to the Chief of Medicine. However, this may be assigned differently based on local needs and considerations.*

(13) Ensuring that educational resources related to infectious diseases, infection prevention and control, antimicrobial stewardship and biosurveillance are available for patients, residents, visitors, employees, and others identified by local need.

l. **VA Medical Facility Chief of Staff and Associate Director for Patient Care Services.** The VA medical facility Chief of Staff and the Associate Director for Patient Care Services are responsible for:

(1) Ensuring implementation of an Infectious Diseases Program and an Infection Prevention and Control Program at the VA medical facility as described in this directive. See Appendix A for additional details.

(2) Collaborating with the VA medical facility Director and VISN Director to ensure that the VA medical facility has access to clinical care staff with expertise in infectious diseases and infection prevention and control.

m. **VA Medical Facility Chief, Infectious Diseases Section.** The VA medical facility Chief, Infectious Diseases Section is responsible for advocating for the Infectious Diseases Program and the Infection Prevention and Control Program within the VA medical facility structure. See Appendix A for further details.

n. **VA Medical Facility Chief, Pathology and Laboratory Medicine Service.** The VA medical facility Chief, Pathology and Laboratory Medicine Service (P&LMS) is responsible for liaising with the VA medical facility Chief, Infectious Diseases Section or designee and infection prevention and control on the development and implementation of programs and procedures in the Microbiology Section, P&LMS. See Appendix A, paragraphs 1.c. and 7.c. for further details.

o. **VA Medical Facility Infection Prevention and Control Committee.** The VA medical facility Infection Prevention and Control Committee is responsible for providing consultative input, policy support, program oversight and subject matter expertise to the Infection Prevention and Control Program, as well as to VA medical facility leadership. See Appendix A, paragraph 4 and Appendix C, paragraph 4 for additional details.

p. **VA Medical Facility Infection Preventionist.** The VA medical facility IP is responsible for conducting actions in support of the Infection Prevention and Control Program as described in Appendix A, paragraphs 2 and 8; and Appendix C, paragraph 5.

q. **VA Medical Facility Multi-Drug Resistant Organism Prevention Coordinator.** The VA medical facility MPC is responsible for managing the local aspects of the MDRO Prevention Initiative (PI) as described in Appendix A, paragraphs 2.l. and 8; Appendix C; and Appendix D.

3. TRAINING

There are no formal training requirements associated with this directive.

4. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

5. BACKGROUND

a. In 1990, the National Infection Prevention and Control Program was organizationally aligned to NIDS from the Office of Nursing Service. This was a result of a Government Accountability Office (GAO) report (HRD-90-27 Infection Control: VA Programs are Comparable to Nonfederal Programs but Can Be Enhanced) which recommended that a single unit in VA's Central Office oversee its infection prevention and control programs. VHA's Infection Prevention and Control Program is a program at

each VA medical facility which supports efforts to prevent and reduce the transmission of infectious diseases, as well as control further transmission once acquired. It is designed to support the health of all Veterans, employees, and visitors within the local VA medical facility.

b. VHA's Infectious Diseases Program is the global effort at each VA medical facility to assist health care providers in the diagnosis and treatment of infectious diseases pathology. This differs from the Infection Prevention and Control Program which has a different focus; however, these two typically work in concert.

c. Management of infections and control and prevention of infectious diseases in VHA follow evidence-based practices across VA medical facilities. While some basic national guidance and framework is provided, many aspects of the Infectious Diseases Program and the Infection Prevention and Control Program are locally administered and applied, based on local context, needs, and assessments of risk. This VHA directive provides policy and establishes requirements for the management of the Infectious Diseases Program and the Infection Prevention and Control Program within VA. This directive also defines the minimum Infectious Diseases Program and the Infection Prevention and Control Program and services that must be made available at all VA medical facilities.

d. NIDS is comprised of several different programs (Clinical Management Services, Infection Prevention and Control Program, and Infectious Diseases Biosurveillance) and provides primary subject matter expertise in VA and VHA for infectious diseases, antimicrobial stewardship, infection prevention and control, emerging pathogens, high consequence infections, and infectious diseases biosurveillance activities. NIDS is a consultant and subject matter expert to VA and VHA Central Office, VISNs, and VA medical facilities, and provides current and evidence-based guidance related to infectious diseases and infection prevention and control in order to provide the highest quality of care to Veterans. Information about NIDS policy and guidance can be found at the NIDS website, http://vaww.va.gov/INFECTIOUSDISEASES/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

e. The provision of infectious diseases clinical services and infection prevention and control within VHA follows, at a minimum, the core guidance and recommendations developed by NIDS. ***NOTE*****:** *Based on Program alignment in VHA, requirements regarding HIV and viral hepatitis are beyond the scope of this directive and the purview of NIDS. See VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014, for additional policy related to infectious diseases PACT*. Recognizing that each VA medical facility is unique with local programs that may vary from other facilities, as part of a national system, each VA medical facility must provide consistent high-quality care. In VHA, Infectious Diseases physicians, IPs, MPCs, Primary Care Providers, Antimicrobial Stewardship "Champions", Occupational Health Providers, Facility Managers, front-line clinical personnel and others work as partners in prevention and management of infections toward the health and well-being of the Veteran and health care personnel.

6. DEFINITIONS

a. **Antimicrobial Stewardship.** Antimicrobial stewardship is an activity that promotes the appropriate selection of antimicrobials, dosing of antimicrobials, and route and duration of antimicrobial therapy. It is an integral component of an effective infectious diseases program with accreditation requirements. See VHA Directive 1031 for additional details.

b. **Biosurveillance.** Biosurveillance is the process of gathering, analyzing, and interpreting information and data to achieve early detection and situational awareness of biological events, including but not limited to emerging infectious diseases.

c. **Cohorting.** The placement and care of individuals who are infected or colonized with the same microorganism in the same room.

d. **Epidemiology.** Epidemiology is the study of the distribution and determinates of health conditions or events in specific populations and the application of this study to the control of health problems.

e. **Health Care-Associated Infection.** Health care-associated infection (HAI) is an infection acquired during the course of receiving medical care, formerly called nosocomial infection.

f. **Hyperendemic.** Hyperendemic is used to refer to a disease which is persistently present in a population at a high rate of incidence or prevalence.

g. **VA Medical Facility Infection Prevention and Control Committee.** The VA medical facility Infection Prevention and Control Committee is a multidisciplinary membership committee within the health care facility that supports the VA medical facility's infection prevention and control program to minimize HAI risk.

h. **Infectious Disease.** An infectious disease is a disease caused by a pathogenic microorganism (e.g., bacteria, fungi, virus, unicellular or multicellular parasite) or agent (e.g., prion).

i. **Multi-Drug Resistant Organism.** MDROs are microbes able to withstand the killing or inhibitory effect of several different antimicrobial agents. The exact number and types of antimicrobial classes to which a microorganism is resistant varies depending on the pathogen.

j. **Multi-Drug Resistant Organism Prevention Initiative.** The MDRO PI is a VA standardized program to reduce HAIs caused by multi-drug resistant and related organisms (e.g., MRSA, *Clostridioides difficile*, Carbapenem-resistant Enterobacterales (CRE)).

k. **MDRO Prevention Initiative Task Force.** The MDRO Prevention Initiative Task Force is an advisory group composed of representatives of NIDS, facility-based clinicians who are MDRO subject matter experts, and representatives from VHA offices

with a focus in reducing health care-associated transmission of, and infection by, MDROs.

l. **Outbreak.** An outbreak is an increase in the incidence of a disease, complication, or event above the background rate.

m. **Surveillance.** Surveillance is the ongoing, systematic collection, recording, analysis, interpretation, and dissemination of data. When applied to disease, it may be defined as the continuing scrutiny of those aspects of the occurrence and spread of disease that are pertinent to effective control.

7. REFERENCES

a. 38 U.S.C. § 7301(b).

b. VHA Directive 1031, Antimicrobial Stewardship Programs, dated September 22, 2023.

c. VHA Directive 1304, National Human Immunodeficiency Virus Program, dated August 15, 2015.

d. VHA Directive 1605.01, Privacy and Release of Information, dated July 24, 2023.

e. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

f. NIDS website: http://vaww.va.gov/INFECTIOUSDISEASES/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

g. NIDS MDRO PI website: http://vaww.mrsa.va.gov/index.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

INFECTIOUS DISEASES PROGRAMS AND INFECTION PREVENTION AND CONTROL PROGRAMS AT DEPARTMENT OF VETERANS AFFAIRS (VA) MEDICAL FACILITIES

This Appendix defines the minimum Infectious Diseases Program and Infection Prevention and Control Program services that must be made available at all VA medical facilities. The goal is to provide effective, evidence-based services at all VA medical facilities, based on local needs, assessments, and considerations. ***NOTE:*** *Based on Program alignment in VHA, requirements regarding HIV and viral hepatitis are under the National HIV Program and the National Viral Hepatitis Program in the HIV, Hepatitis, and Related Conditions Programs within the Specialty Care Program Office (SCPO).*

1. INFECTIOUS DISEASES PROGRAM

a. An Infectious Diseases (ID) Section should be a subspecialty under Medical Service, or equivalent, at VA medical facilities where it is feasible for an ID Section to carry out the activities and responsibilities of the ID Program. If an ID Section is not feasible, then the ID Program responsibilities must be assigned by the VA medical facility Chief of Staff to an appropriate designee at the VA medical facility (see paragraph 2.l.).

b. The functions of the ID Program are the following:

(1) Provide optimal patient/resident care related to infectious diseases by consultation/referral throughout the VA medical facility. This would include the consideration of inpatient and outpatient concerns. Telehealth, E-consultation, or both Telehealth and E-consultation should be available, when appropriate, for patients not requiring examination or direct interview.

(2) Provide input to the VA medical facility Infection Prevention and Control Committee, including but not limited to:

(a) Procedures for precautions towards the prevention of infections.

(b) Environmental sanitation and disinfection.

(c) Infection surveillance.

(d) Epidemiologic reviews.

(e) Consultation on surveillance, prevention and epidemiological follow up, when appropriate, on communicable diseases or infections affecting VA staff in cooperation with Employee Occupational Health.

(3) Advise and participate in appropriate local VA medical facility committees (e.g., Pharmacy and Therapeutics, Research, Water Safety).

(4) Provide guidance for activities in the Infection Prevention and Control Program (see paragraph 2 in this Appendix).

(5) Participate in the VA medical facility Antimicrobial Stewardship Program in collaboration with Pharmacy. ***NOTE:*** *See VHA Directive 1031, Antimicrobial Stewardship Programs, dated September 22, 2023.*

c. The role of the VA medical facility Chief, Infectious Diseases Section (or designee) should include the following:

(1) Have a close liaison with Pathology and Laboratory Medicine Service (P&LMS), if feasible, and work actively with the Chief, P&LMS, on the development and implementation of programs and procedures in the Microbiology Section, P&LMS, particularly with regards to staffing, space and equipment. The Chief, Infectious Diseases Section (or designee) should collaborate with appropriate members of P&LMS regarding:

(a) The collection of specimens and the establishment of priorities for collections of specimens.

(b) The establishment of priorities for cultures, susceptibility tests and new diagnostic procedures.

(c) Prompt turnaround time and rapid diagnostic testing.

(d) The compilation of laboratory data for epidemiologic evaluation.

(e) Determination of any specific internal reporting requirements for infectious diseases and infection prevention and control entities.

(f) Development and uses of antibiograms. ***NOTE:*** *If the microbiology laboratory is located at another site, liaison with that site is to be established for these purposes.*

(g) Packaging and shipping of infectious substances.

(2) Have substantive collaborative input with the following individuals:

(a) Associate Chief of Staff for Education or equivalent. Maintain a program of in-service education to provide improved knowledge of infectious diseases and infection prevention and control to appropriate VA medical facility personnel.

(b) Chief of Pharmacy. Issues pertaining to antimicrobials and vaccines and to establish an effective Antimicrobial Stewardship Program.

(c) Employee Occupational Health Function. Employee-specific infection prevention, control, and treatment issues.

(d) Health Promotion and Disease Prevention Program Managers. Health promotion and disease prevention initiatives that relate to infection prevention and control, including immunization outreach efforts.

(3) Verify the time allocation (labor mapping) of personnel in the Infectious Diseases Section in proportion to the time spent on the following activities in the VHA National Labor Mapping Tool, https://mcareports.va.gov/vhanlmt.aspx, formerly the Decision Support System (DSS), or equivalent. ***NOTE:*** *The Chief, Infectious Diseases Section (or designee) and the VA medical facility Managerial Cost Accounting (MCA) Coordinator (or designee) are responsible for reviewing the mapping of personnel with activities.*

(a) Clinical duties, which must be documented in the most current workload capture system including, but not limited to, Patient Care Encounters (PCE). Clinical duties can include providing outpatient specialty care to a panel of patients, inpatient hospital care, electronic consultation and telehealth services.

(b) Research activities includes time spent working on research that is approved by the local VA medical facility Research and Development Committee and does not produce clinical workload is research support time.

(c) Education activities is time spent in didactic education including time spent preparing and delivering classroom training, formal presentations or lectures, as well as time spent managing a resident, fellow, or other type of student teaching program and does not include clinical supervision where clinical workload is produced.

(d) Administrative activities, including but not limited to time serving as the Chair or member of the Infection Prevention and Control Committee, preparing reports and participating in day-to-day Antimicrobial Stewardship and Hospital Epidemiology activities.

2. INFECTION PREVENTION AND CONTROL PROGRAM

a. Each VA medical facility is required to have an Infection Prevention and Control Program. Ideally the Infection Prevention and Control Program is under the Infectious Diseases Section of Medical Service, or medical equivalent. ***NOTE:*** *This must be determined at the facility level. It is recommended that the personnel in Infection Prevention and Control fall under the Infectious Diseases Section that reports to the Chief of Medicine. However, this may be assigned differently based on local needs and considerations.* The Infectious Diseases Section has collateral intellectual leadership of the Infection Prevention and Control Program. There should be support and collaboration provided by a multidisciplinary VA medical facility Infection Prevention and Control Committee. Evidence-based prevention and control activities directed toward health care-associated infections (HAIs) and other infectious conditions are integral components of the Infection Prevention and Control Program. The Infection Prevention and Control staff, as well as other VA medical facility personnel, work cooperatively to prevent and control infections in the health care environment. Using, at a minimum,

guidance established by VHA Central Office and other applicable regulatory/accreditation agencies, the VA medical facility Director must implement and support an effective Infection Prevention and Control Program, which includes, but is not limited to, written protocols, procedures or other authoritative documents for the following activities (see paragraph 2.k.(3) in the directive):

NOTE: *While the following different activities are noted to be part of the overall Infection Prevention and Control Program, the local program does not necessarily need to generate or have responsibility for these activities. Rather the Infection Prevention and Control Program should work in a collaborative effort with those services/sections which already have responsibility for these activities.*

(1) Supporting compliance with regulations and accreditation requirements related to infection prevention and control (e.g., The Joint Commission, Ascellon).

(2) Establishing the Infection Prevention and Control Committee, its activities, and its reporting structure within the institutional hierarchy (see paragraph 4 of this Appendix).

(3) Establishing HAI surveillance including:

(a) Having an HAI monitoring system that includes following VHA Inpatient Evaluation Center (IPEC) and the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) definitions.

(b) Ensuring that HAI surveillance reporting to VHA IPEC (see Appendix B for additional information).

(c) Analyzing and disseminating data and information to appropriate stakeholders as it relates to surveillance of HAIs.

(4) Defining indications for specific transmission-based precautions to prevent transmission of infection.

(5) Ensuring that authority is given to VA medical facility Infection Preventionists (IPs), MDRO Prevention Coordinators (MPCs) and registered nurses to implement isolation precautions based on mode(s) of transmission (see paragraph 2.k.(3)(b) in the directive). ***NOTE:*** *Situations may occur, based on local needs and assessments, which require the use of other precaution methods (e.g., Enhanced Barrier Precautions for Methicillin-resistant Staphylococcus aureus (MRSA) in the Community Living Center (CLC)).*

(6) Ensuring that, during an outbreak or epidemic situation, authority is given to the Chairperson of the Infection Prevention and Control Committee, generally the Hospital Epidemiologist (or designee), to implement strategies for the prevention and control of disease directed towards patients, residents, visitors, employees, and others identified by local needs (see paragraph 2.k.(3)(b) in the directive).

(7) Assuring provision of infection prevention and control guidance on the handling and disposal of refuse considered by regulations, laws, or statutes to be regulated medical waste and/or infectious waste.

(8) Collaborating with the VA medical facility Employee Occupational Health Program Managers for reporting infections, evaluation and intervention as appropriate for exposure of employees to a potentially communicable agent as well as prevention efforts.

(9) Ensuring the provision of infection prevention and control guidance on cleaning, disinfection, decontamination, and sterilization of medical equipment and devices as appropriate. ***NOTE:*** *The local Infection Prevention and Control Program does not generate or have responsibility for these activities. Rather the Infection Prevention and Control Program works in a consultative role with other services or sections.*

(10) Ensuring the provision of infection prevention and control guidance on separation of soiled and contaminated versus clean or sterile (e.g., medical supplies, patient procedures, equipment storage).

(11) Overseeing the monitoring of VA medical facility staff compliance with specific patient care practices and activities as they relate to infection prevention and control issues.

(12) Developing mechanisms for VA medical facility staff to obtain consultation from persons in infection prevention and control regarding appropriate supplies and equipment related to environment of care cleaning and disinfection in the facility.

(13) Developing mechanisms for VA medical facility staff to obtain consultation from persons in infection prevention and control regarding renovation and construction, water safety, and other maintenance activities that may disrupt the environment of care and pose an infection prevention and control concern.

(14) Developing educational efforts directed toward infection prevention and control topics for orientation classes for new employees and in-service and annual periodic/ongoing training/re-training for relevant employees.

(15) Guiding interventions to prevent the transmission of infectious diseases using:

(a) Routine control measures. Prevention and control measures for HAIs or adverse infectious events that occur at the usual incidence during a specified time period. They are also called endemic control measures.

(b) Outbreak control measures. Prevention and control measures for HAIs or adverse infectious events that occur above the expected rate or when an unusual microorganism or adverse event is recognized. They are also called epidemic or pandemic control measures. (For additional information on developing a framework for outbreak response, see NIDS Infection Prevention and Control Framework for Surveillance Activities and Outbreak Response:

https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/InfectionPreventionandControlSurveillanceandOutbreakResponseGuidanceDocument.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public*).

b. Each VA medical facility's Infection Prevention and Control Program must include a periodic systematic review process (e.g., Risk Assessment, subsequent development of a Plan, and follow-up Evaluation), in alignment with accreditation requirements. Strategies for this Risk Assessment rely upon surveillance findings and circumstances within individual VA medical facilities and in the surrounding community. The Infection Prevention and Control Program should work with their local accreditation program to ensure a continuous state of preparedness, meeting current requirements from external oversight regulatory bodies and comply with written VA requirements (see paragraph 2.k.(5) in the directive).

c. Each VA medical facility's Infection Prevention and Control Program must establish a hand hygiene program and comply with the current health care organization accreditation standards (see paragraph 2.k.(5) in the directive). Hand hygiene is a process to clean hands and reduce the number of microorganisms on the hands. Hand hygiene is considered a primary measure in preventing health care-associated infections by reducing the risk of transmitting microorganisms. The following components of a hand hygiene program are required:

(1) Implementing, at a minimum, categories IA, IB and IC of the most current CDC hand hygiene guidelines: in addition, consider current recommendations from the World Health Organization (WHO). Some VA medical facilities, based on the local risk assessment, may also choose to implement some CDC category II Recommendations (e.g., if moving from a contaminated body site to another body site during care of the same patient). ***NOTE:*** *The CDC Guideline for Hand Hygiene in Health-Care Settings Part II Recommendations states "This guideline and its recommendations are not intended for use in food processing or food-service establishments and are not meant to replace guidance provided by FDA's Model Food Code." Refer to CDC Guideline for Hand Hygiene in Health-Care Settings: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.*

(2) Periodically monitoring and recording adherence as the number of hand hygiene episodes performed by personnel relative to the number of hand hygiene opportunities, by ward or unit, and providing feedback to personnel regarding their performance.

(3) Establishing goals for improving adherence with hand hygiene guidelines.

(4) Assuring that hand hygiene products selected by the VA medical facility have been evaluated by the Infection Prevention and Control Program and approved by the Infection Prevention and Control Committee.

d. Written infection prevention and control documents must be reviewed periodically and updated by the Infection Prevention and Control Program at the VA medical facility

level when clinically indicated or based on the most current written rules and regulations generated by the VA and/or valid oversight regulatory bodies.

e. Each VA medical facility's Infection Prevention and Control Program participates in VA/VHA required activities of infection prevention and control (e.g., IPEC modules, NIDS point prevalence surveys, and other activities defined by NIDS).

f. Each VA medical facility's Infection Prevention and Control Program collaborates with each VA medical setting (e.g., Acute Care, Primary Care, Behavioral Health, CLC, Rehabilitation Unit, Specialty Care) to support infection prevention and control practices are in place and to ensure that they are consistent with VA authoritative documents and guidelines recommended by accrediting agencies.

g. Each VA medical facility's Infection Prevention and Control Program collaborates with each VA medical setting (e.g., Acute Care, Primary Care, Behavioral Health, CLC, Rehabilitation Unit, Specialty Care) to support compliance with VA authoritative documents and regulations related to animals in the health care setting.

h. Each VA medical facility's Infection Prevention and Control Program consults and participates with other committees at the VA medical facility on matters relevant to infection prevention and control.

i. Each VA medical facility's Infection Prevention and Control Program collaborates with other VA medical facilities and community care facilities and public health authorities in the community regarding infectious diseases.

j. The role of the VA medical facility Infection Preventionist (IP) is integral to the success of the Infection Prevention and Control Program. An IP should understand concepts of behavioral change, the principles of epidemiology, the ability to collect and analyze data, basic knowledge of microbiology, basic elements of patient care practice. The IP should have the ability to provide or facilitate education about infection prevention and control to a variety of audiences. Advanced training or certification in infection prevention and control is preferred. The IP should receive ongoing training in infection surveillance, infection prevention and control, and epidemiology. The IP serves as a subject matter expert, consultant, and collaborator for areas related to infection prevention in the VA medical facility, facilitating or leading if time permits. Examples include, but are not limited to, prevention of: catheter associated urinary tract infection (CAUTI), central line associated blood stream infection (CLABSI), surgical site infection (SSI), surveillance, and initiatives such as influenza immunizations, personal protective equipment donning/doffing education, etc. In addition, the IP is a member of key committees within the VA medical facility related to infection prevention and control, such as quality, construction/renovation, safety, water management, environmental rounds, etc. IPs work collegially with others in the VA medical facility Infection Prevention and Control Program, seeking advice and providing support if needed. The IP roles should include, at a minimum, the following (see paragraph 2.p. in the directive):

(1) General problem identification.

(2) Data collection and analysis for infections.

(3) Development of policies and procedures for infection prevention and control.

(4) Equipment and product evaluation.

(5) Review of facility's plan for major/minor construction and renovation projects.

(6) Collaboration with, among others, the medical facility's Dental Service, Employee Occupational Health, Facilities Management/Environmental Management Services, Nursing, Pathology & Laboratory Medicine Service, Surgery Service (including VA Surgical Quality Improvement Program [VASQIP]), Process/Quality Improvement, Sterile Processing Service, Safety Departments and Environment of Care processes, Nutrition and Food Services, Accident and Sharps Review Board, Clinical Informatics, along with CLC leadership and other clinical care programs.

(7) Consultation/facilitation in an outbreak or pandemic response.

(8) Input into the educational needs for staff (including trainees and volunteers), patients/residents, and visitors.

k. The role of the VA medical facility Hospital Epidemiologist, or equivalent, is also important to the Infection Prevention and Control Program. This person will collaborate with the infection prevention and control program using principles of epidemiology and data analysis. The Hospital Epidemiologist will generally be the Chair of the Infection Prevention and Control Committee.

l. The role of the VA medical facility MPC is to manage local aspects of the national MDRO Prevention Initiatives (PIs) and is to be an important contributor to the VA medical facility Infection Prevention and Control Program. The MPC serves as the focal point and liaison for day-to-day operations, as well as for the collection and reporting of MDRO data for national MDRO PIs (e.g., methicillin-resistant *Staphylococcus aureus* [MRSA], *Clostridioides difficile* [*C. difficile*], carbapenemase-producing carbapenem-resistant Enterobacterales [CP-CRE]). While the activities of this individual are distinct from those of the IP, the MPC works collegially with IPs and others in the facility Infection Prevention and Control Program seeking advice and providing support as needed. MPC responsibilities include (see paragraph 2.q. in the directive):

(1) Serving as a liaison for communicating with the VHA NIDS MDRO Prevention Division on subjects related to MDRO prevention issues.

(2) Identifying individuals infected or colonized with MDROs through active or passive surveillance as appropriate for the organism. This may involve working with VA medical facility nursing, clinician, and laboratory personnel to ensure proper diagnostic stewardship (e.g., for *C. difficile*).

(3) Ensuring individuals infected or colonized with MDROs are known to other healthcare workers and providing information and education to these colleagues about MDROs.

(4) Routinely making rounds in the medical facility to be sure patients/residents with MDROs are appropriately placed in the proper transmission-based precautions and that these are discontinued when appropriate, monitoring infection prevention and control practices, and answering questions.

(5) Providing education on hand hygiene and proper use of gowns and gloves.

(6) Providing education and feedback to facility healthcare workers (including leadership) on local and national rates and trends in MDRO HAIs to obtain a cultural transformation where infection prevention and control becomes everyone's business.

(7) Monitoring all facility MDRO surveillance and MDRO HAI data (including MRSA surgical site infections) and reporting these through IPEC (see Appendix B), or through other mechanisms (e.g., operational queries) when requested.

(8) Working with other services in the VA medical facility (e.g., Environmental Management Service, Nutrition & Food Service, Chaplain Service) to ensure policies for the prevention of MDRO HAIs are understood and followed. Additionally, working collegially with these other services to develop service specific MDRO policies and guidance as needed.

(9) Collecting and reporting data and developing and evaluating local VA medical facility procedures related to the national MDRO PIs as well as local MDRO initiatives.

3. INFECTION PREVENTION AND CONTROL SURVEILLANCE

A major goal of an Infection Prevention and Control Program is to lower the risk of HAIs. Surveillance activities have a significant influence on the infection prevention and control activities employed to achieve the goal of a lower risk for an HAI. In addition to participating in the VA/VHA required surveillance activities noted in paragraph 2.a.(3) of this Appendix and the reporting activities in Appendix B, the VA medical facility must determine local surveillance priorities as well.

4. VA MEDICAL FACILITY INFECTION PREVENTION AND CONTROL COMMITTEE

a. Each VA medical facility Director must establish an Infection Prevention and Control Committee through local channels for authority. The Infection Prevention and Control Committee will serve as a multidisciplinary body of the medical facility to provide consultative input, policy support, and subject matter expertise to the Infection Prevention and Control Program, as well as to VA medical facility leadership, with the goal of providing an optimally safe environment for patients, residents, staff and visitors.

b. The Infection Prevention and Control Committee should report to the VA medical facility Medical Staff Clinical Executive Board, or equivalent, from where the Infection Prevention and Control Committee should derive its authority.

c. The Infection Prevention and Control Committee functions as the central decision-making and policy-making body for infection prevention and control issues and often refines and ratifies the ideas of the Infection Prevention and Control Program:

(1) Playing a significant role in representing their discipline and disseminating the information discussed in the meeting.

(2) Serving as a mechanism to obtain multidisciplinary support and collaboration for changes, interventions and actions.

(3) Assisting with the development and review of Service-specific protocols or procedures, and approving VA medical facility or service-specific protocols, procedures or other authoritative documents related to infection prevention and control issues.

(4) Approving the monitoring and surveillance activities, including surveillance of health care-associated infections (HAIs), to meet the goal of prevention and control of infections.

(5) Identifying risks for acquiring and transmitting infections by conducting a risk assessment that is done at least annually and recording findings in the minutes of the VA medical facility Infection Prevention and Control Committee.

(6) Developing an annual prioritized infection prevention and control plan based on a risk assessment and results of the effectiveness of previous year's plan that is recorded in the committee minutes.

(7) Implementing the VA medical facility infection prevention and control plan using evidence-based strategies to reduce or prevent infections.

(8) Evaluating the effectiveness of the VA medical facility infection prevention and control plan annually and evaluating, surveillance reports and significant laboratory reports; recommending actions to prevent or contain infections or infection potential in patients, personnel, and visitors. The conclusions, recommendations/actions, and follow-ups must be documented in the minutes of the VA medical facility Infection Prevention and Control Committee.

d. The Infection Prevention and Control Committee must be chaired by a physician, generally the Hospital Epidemiologist, preferably trained in Infectious Diseases or Infection Prevention and Control. ***NOTE:*** *If the VA medical facility does not have a physician trained in Infectious Diseases, then the chairperson should at least be a physician with an interest in Infectious Diseases or Infection Prevention and Control. The VA medical facility could also develop a partnership or consultative arrangement with another facility within the Veterans Integrated Service Network (VISN) or have a*

contractual agreement with a local Infectious Diseases physician to provide these services.

e. Membership should represent the various disciplines and needs of the VA medical facility, as appropriate. Committee representation typically includes members of administration and clinical and ancillary staff because infection prevention and control issues and measures often cross departmental lines. Specifically:

(1) The Infection Prevention and Control Committee must include, at a minimum, representation from the following areas:

(a) Infectious Diseases (if available)

(b) Infection Prevention and Control,

(c) Multidrug Resistant Organism Prevention Coordinator (MPC),

(d) Pharmacy Service,

(e) Environmental Management Services,

(f) Engineering/Facilities Management,

(g) Surgery,

(h) Sterile Processing Service,

(i) Pathology and Laboratory Medicine Services (in particular Microbiology),

(j) Employee Occupational Health,

(k) Safety/Industrial Hygiene,

(l) CLC (if the VA medical facility has a CLC),

(m) Nursing (Associate Chief, or equivalent),

(n) Health care provider representation (both leadership and front-line) and

(o) VA medical facility leadership or designee.

(2) Other stakeholders in infection prevention and control may be included on the Infection Prevention and Control Committee, as appropriate. Some areas for consideration include, but are not limited to:

(a) Dental,

(b) Emergency Department,

(c) Nutrition and Food Service,

(d) Hemodialysis,

(e) Home-Based Primary Care,

(f) Respiratory Therapy,

(g) Logistics,

(h) Health Promotion and Disease Prevention Program Manager,

(i) Clinical and Nursing Unit Managers,

(j) Quality Improvement,

(k) front-line nursing staff, and

(l) labor partners.

f. At a minimum, routine Infection Prevention and Control Committee meetings must be held at least quarterly. The Committee may choose to meet more frequently based on local needs, considerations, and activities at the VA medical facility and/or at the discretion of the Chairperson.

g. Routine Committee meeting topics, discussions and recommendations are disseminated to appropriate stakeholders within the VA medical facility.

5. MINIMUM RECOMMENDED STAFFING GUIDELINES FOR INFECTIOUS DISEASES AND INFECTION PREVENTION AND CONTROL FUNCTIONS

a. To have an effective Infectious Diseases Program and an effective Infection Prevention and Control Program, adequate resources, including personnel, are required at VA medical facilities. Table 1 in this Appendix (below) provides a listing of some essential individuals for these programs. Minimum recommended staffing guidelines for the listed clinical and administrative functions are presented for VA medical facilities, with consensus from the Infectious Diseases Field Advisory Board and the Infection Prevention and Control Field Advisory Board. The minimum recommended staffing level for each function is based on VA medical facility complexity ratings and acute care bed sizes, with additional staffing for extended stay beds, including the CLC and other programs, to obtain a total recommended minimum full-time equivalent (FTE) for the VA medical facility, per the table. If funded research is being conducted by any of the personnel involved in Infectious Diseases or Infection Prevention and Control, the portion of FTE compensated by research should be designated separately and in addition to the staffing matrix below (it should not be counted toward the staffing matrix below which only accounts for clinical and administrative functions).

b. Staffing levels for antimicrobial stewardship are detailed in VHA Directive 1031, Antimicrobial Stewardship Programs, dated September 22, 2023, and are in addition to the staffing levels listed in Table 1.

c. Comprehensive staffing guidelines regarding provision of care to HIV and viral hepatitis patients are beyond the scope of this document and the purview of NIDS. Any staffing support of HIV and viral hepatitis programs should be in addition to the staffing levels listed in Table 1 below. See VHA Directive 1304, National Human Immunodeficiency Virus Program, dated August 15, 2019, for further information.

d. See VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014, for further information on Infectious Diseases PACT (ID-PACT) requirements for integrated care; these requirements are also beyond the scope of this directive and the purview of NIDS and should also be in addition to the staffing levels listed in Table 1.

e. Table 1 (below) provides minimum recommended staffing guidelines. Specific positions may be under multiple service lines (e.g., medical services, nursing, quality management) as determined by the VA medical facility. However, all positions are required to support the mission of robust, effective Infectious Diseases and Infection Prevention and Control Programs. Each row is considered separate and distinct from the others. The FTE recommended is dependent upon multiple factors, such as the complexity of the VA medical facility and services offered (e.g., VHA-designated Transplant Centers, polytrauma services), patient population, research commitments, and collateral duties. ***NOTE:*** *Additional information regarding each row in the table is provided in paragraphs 5.f.(1) - (7) below.*

Table 1: Recommended Minimum FTE* for VA Medical Facility Infectious Diseases and Infection Prevention and Control Functions.

The minimum recommended FTE is based on VA medical facility complexity level with additional FTE based on number of acute care beds and presence of extended stay beds (e.g., Community Living Center (CLC), and other programs**).

Position Title	FTE Based on Facility Complexity Level							Additional FTE Based on Extended Stay Beds (CLC and Other Programs**)
	Complexity Levels 1a and 1b		Complexity Levels 1c and 2		Complexity Level 3			
	Baseline FTE (includes up to 100 acute care beds)	+ FTE per each additional 100 acute care beds	Baseline FTE (includes up to 100 acute care beds)	+ FTE per each additional 100 acute care beds	Baseline FTE (includes up to 100 acute care beds)	+ FTE per each additional 100 acute care beds		
Chief, Infectious Diseases Section*** (Administrative FTE)	0.25-0.375	N/A	0.25	N/A	0.125	N/A	+	N/A
Infectious Diseases Physician*** (Clinical FTE)	2	0.75	1.5	0.5	0.5	0.5	+	N/A
Nurse Practitioner or Physician Assistant *** (Clinical FTE)	1-2	See Note 1	1	See Note 1	0.50-1	See Note 1	+	N/A
Hospital Epidemiologist/ Medical Director Infection Prevention and Control (Administrative FTE)	0.75	N/A	0.5	N/A	0.25	N/A	+	0.25
Infection Preventionist	3 (See Note 2)	1	2	0.5	1	0.5	+	1 FTE/100 beds
MDRO Prevention Coordinator	1-2	0.5	1	0.5	1	0.5	+	0.5 FTE/100 beds
Program Support Assistant	1-2	N/A	0.5-1	N/A	0.25-0.375	N/A	+	N/A

** FTE is a staffing parameter equal to the amount of time assigned to one full-time employee. It may be composed of several part-time employees whose total time*

commitment equals that of a full-time employee. One FTE is equal to 40 hours of work per week. See paragraph 5.f. below for additional information about each Position Title.

**Other programs with extended stay beds include, but are not limited to, spinal cord injury, polytrauma, residential inpatient psychiatry, domiciliary, and blind rehabilitation.

*** For VA medical facilities where there is a staffed infectious diseases section.

NOTE 1: *For this case, no specific recommendations were made by the Infectious Diseases Field Advisory Board and the FTE for the positions is left to the discretion of the VA medical facility to meet access, productivity, and programmatic needs.*

NOTE 2: *The Infection Prevention and Control Field Advisory Board recommends that VA medical facilities that have four or more personnel in their Infection Prevention and Control Program determine if an Infection Prevention and Control (IPC) Manager (Supervisor, Leader) with IPC background would provide increased program stability and continuity.*

NOTE 3: *Staffing guidelines regarding antimicrobial stewardship are detailed in VHA Directive 1031.*

NOTE 4: *Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.*

NOTE 5: *For additional guidance related to staffing for Infectious Diseases Programs and Infection Prevention and Control Programs, see the supplementary document, "Guidance on Staffing for Infectious Diseases Programs and Infection Prevention and Control Programs at VA Medical Facilities", available at this link: https://vaww.va.gov/infectiousdiseases/docs/ipc/directive_1131/staffingidandipcprograms.pdf. This is an internal VA website that is not available to the public.*

f. The following explanatory information is to be considered for each position listed in Table 1 above at the VA medical facility:

(1) **Chief, Infectious Diseases Section.** If no Infectious Diseases Section exists in the VA medical facility, then availability should be provided for a physician specifically trained in infectious diseases, who has taken at the minimum, one training course in hospital infection prevention and control. The responsibilities of the Chief, Infectious Diseases Section are independent of clinical workload. Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.

(2) **Infectious Diseases Physician.** The recommended FTE for this position strictly pertains to conducting infectious diseases consults or other clinical duties that are independent of the duties of the Chief, Infectious Diseases Section, Hospital Epidemiologist, or Infectious Diseases Physician - Antimicrobial Stewardship. The number of FTE is to be based on the size, complexity and the number of Infectious Diseases outpatient clinics offered by the VA medical facility. If it is not feasible to have this position available on-site, then the VA medical facility Director in collaboration with

the VISN Director must establish a defined partnership or consultative arrangement to have access to an Infectious Diseases physician with another VA medical facility within the VISN or with a community partner. Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.

(3) **Nurse Practitioner (NP) or Physician Assistant (PA).** The specific duties for a Nurse Practitioner or Physician Assistant may vary since prescriptive authorities of the positions may differ. The FTE for these positions is dependent upon the involvement the individual is to have with patients with complex or chronic diseases. NPs/PAs may be assigned duties in infectious diseases with practice scope and reporting requirements defined by the VA medical facility. Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.

(4) **Hospital Epidemiologist/Medical Director Infection Prevention and Control.** It is recommended that this position be an infectious diseases trained physician with additional training and interest in infection prevention and control. If it is not feasible to have this position available on-site, then the VA medical facility Director in collaboration with the VISN Director must establish a defined partnership or consultative arrangement to have access to a Hospital Epidemiologist with another VA medical facility within the VISN. The responsibilities for hospital epidemiology are independent of clinical workload. Funded research is encouraged but is in addition to FTE defined by clinical need in the Table 1.

(5) **Infection Preventionist (IP).** The specific duties for the recommended FTE include routine day-to-day infection prevention and control roles and responsibilities (see Appendix A paragraph 2.j. for details). Specialized training is encouraged. Duties do not include ancillary tasks (e.g., utilization review, employee occupational health, quality management); if included, additional FTE should be added. The number of FTE will be dependent on the complexity of health care services provided at the VA medical facility, as well as the patient/resident population (e.g., transplant program), not just population numbers alone. The highest number of FTE would be needed by large VA medical facilities or those with multiple complex sites. Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.

(6) **MDRO Prevention Coordinator (MPC).** The FTE recommended for this position includes all MDRO PI activities (see Appendix A paragraph 2.l. for details). The FTE recommended for this position should not support collateral roles and responsibilities for the VA medical facility. Duties do not include ancillary tasks (e.g., utilization review, employee occupational health, quality management); if these duties are included, additional FTE should be added. Funded research is encouraged but is in addition to FTE defined by clinical need in Table 1.

(7) **Program Support Assistant.** The FTE recommended for this position is to support the Infectious Diseases Program, Infection Prevention and Control Program, MDRO Program and Antimicrobial Stewardship.

6. RESOURCE REQUIREMENTS FOR THE INFECTIOUS DISEASES PROGRAM AND THE INFECTION PREVENTION AND CONTROL PROGRAM

The VA medical facility Director must furnish the required space, equipment, office supplies and other administrative services necessary for the effective operation of the Infectious Diseases Program, Infection Prevention and Control Program, and the Infection Prevention and Control Committee. This includes:

a. **Space.** Sufficient clinical space must be available to ensure adequate access for patient care needs. The Infectious Diseases Section and the Infection Prevention and Control Program should be granted adequate office space for personnel, office equipment, storage and supplies. ***NOTE:*** *It is recommended for Infectious Diseases and Infection Prevention and Control personnel to be physically located in close proximity wherever feasible.* The VA medical facility Director must consider the needs for surveillance documentation and privacy concerns when determining storage space. The space provided should have the capacity to secure documents in accordance with relevant VA privacy and confidentiality statutes.

b. **Information Technology.** Quality health care depends on the ability of VA medical professionals to collect and access the protected health information of VHA patients in a timely manner, while safeguarding the integrity and confidentiality of that information. To achieve this goal, information technology (IT) that is necessary for patient care, education, research, and administrative activities, needs to be available and must comply with VA IT requirements, regulations and policies. Examples of appropriate IT include, but are not limited to, Veterans Health Information Systems and Technology Architecture (VistA) and Computerized Patient Record System (CPRS) applications, Electronic Health Record Modernization applications and solutions (e.g., ORACLE-Health/Millennium), computer systems, mobile devices, and equipment to scan, send and copy pertinent medical information. This also includes access to and availability of personnel who can access basic systems within VA (e.g., run Fileman routines, access MCA) to support infectious diseases and infection prevention and control activities. Additionally, there should be support of graphical, statistical, and epidemiological software applications to perform infection prevention and control surveillance and epidemiology activities to support local, regional, and national data needs, and to support access to local, regional, and national data warehouse resources as apropos their programs. Adequate equipment and software must be available for teleconferencing and telemedicine.

c. **Equipment & Supplies.** Adequate equipment and supplies must be available to fulfill the mission of the Infectious Diseases Section and the Infection Prevention and Control Program. The equipment and supplies should be near where personnel from infectious disease and infection prevention and control perform their activities.

d. **Professional Development.**

(1) **Clinical Skills and Scholarly Pursuits.** To realize the patient care, research, and educational benefits of having a professionally active infectious diseases and

infection prevention and control staff, individuals are encouraged to participate in clinical skills enhancement activities and scholarly pursuits. Each VA medical facility Director must facilitate and accommodate the temporal and general resource needs required of active infectious diseases and infection prevention and control staff to advance professionally. Appropriate activities may include: attendance and completion of educational training courses and programs in clinical areas; attendance at key national conferences of professional organizations; academic pursuits leading to faculty appointments; professional organization involvement with officer or committee responsibilities; pursuit of special meritorious recognition from recognized professional organizations; research and publication endeavors; training program development or responsibilities; and participation in *ad hoc* national Infectious Diseases and Infection Prevention and Control Programs responsibilities.

(2) **Continuing Education.** To keep staff current on infectious diseases knowledge and techniques and infection prevention and control procedures, the VA medical facility Associate Chief of Staff for Education should typically provide support of continuing medical education (CME) and continuing education units (CEUs) for its infectious diseases and infection prevention and control staff.

(a) Funding consisting of tuition, travel, and per diem expense support must be provided as local resources permit.

(b) Time may be granted in accordance with the most current VHA time and attendance policies, to attend CME/CEU meetings. In general, continuing education should be granted at a minimum of once a year, and could be more, depending on the needs of the Service.

(3) **Administration.**

(a) To promote development of future administrative leaders, VA medical facilities are encouraged to include active infectious diseases and infection prevention and control staff in administrative activities at the local facility or higher level.

(b) The Infectious Diseases Program and Infection Prevention and Control Program staff participate in the development of and adherence to VA medical facility processes and procedures with infectious diseases or infection prevention and control components that are authored by other Services or Programs at the VA medical facility.

7. PATHOLOGY AND LABORATORY MEDICINE SERVICE

a. The laboratory should have sufficient resources (e.g., staff, reagents, supplies, equipment), based on the VA medical facility size and complexity, to provide pertinent information in support of the Infection Prevention and Control Program of the VA medical facility and the clinical mission of the Infectious Diseases Program. ***NOTE:*** *For complex VA medical facilities, it is strongly recommended that the Microbiology Laboratory be led by a doctoral-level trained microbiologist. A board certified clinical pathologist combined with a master's level-trained microbiologist technology supervisor could also be acceptable. It is recommended that at least one doctoral level trained*

microbiologist be available in each VISN to assist VISN leadership and other VISN facilities that lack such expertise.

b. Specialized immunology and microbiology testing (e.g., for determination of exposure to infectious agents and molecular typing of pathogens) should be available either at the VA medical facility, a facility within the VISN, or a contract laboratory, in support of outbreak investigations. Timely testing is essential for the identification of microorganisms for surveillance and outbreak investigations.

c. The Chief, P&LMS or designee should liaise with Chief, Infectious Diseases Section or designee and infection prevention and control regarding (see paragraph 2.n. in the directive and paragraph 1.c. in this Appendix):

(1) The collection of specimens and the establishment of priorities for collection of specimens.

(2) The establishment of priorities for cultures, susceptibility tests, new diagnostic tests.

(3) Prompt turnaround time and rapid diagnostic testing.

(4) The compilation of laboratory data for epidemiologic evaluation.

(5) Determination of any specific internal and external reporting requirements for infectious diseases (e.g., requirements for reporting infectious diseases to local public health in accordance with Appendix B).

(6) Other laboratory resources in support of the clinical mission of the infectious diseases section and infection prevention and control at the VA medical facility, including introduction of any new, evidence-based technologies pertinent to infectious diseases and infection prevention and control.

(7) Microbiology and other laboratory reports that are pertinent to infectious diseases care and infection prevention and control at the VA medical facility.

(8) Provision of a VA medical facility (or unit specific) antibiogram on a periodic basis (e.g., annually).

(9) Representation of the Microbiology Laboratory on the Infection Prevention and Control Committee structure (see paragraph 4 of this Appendix).

8. QUALITY IMPROVEMENT

The evaluation and improvement of infectious diseases and infection prevention and control services enhances the VA medical facility's overall Quality Improvement (QI) program. This includes both service specific as well as interdisciplinary monitoring of quality indicators. The Infectious Diseases health care providers, IPs, and MPCs are

responsible for assisting the effective implementation of the QI plan as it pertains to infectious diseases and infection prevention and control.

9. SAFETY

Infectious Diseases and Infection Prevention and Control play integral roles in the overall safety program at the VA medical facility, working collaboratively with patient safety, employee occupational health, and occupational health and safety.

10. RESEARCH AND DEVELOPMENT

a. Research and development are integral parts of the VHA Infectious Diseases and Infection Prevention and Control programs and should be encouraged and promoted by leadership within each VISN. Staff infectious diseases health care providers, residents, fellows and students along with nursing staff, pharmacy staff and others, as appropriate, are encouraged to develop research skills and participate in research studies. Protected time for research should be provided in accordance with any relevant VA/VHA policy and is in addition to the FTE outlined in Table 1 of this Appendix for clinical and administrative duties. All research activities must be in compliance with VHA policies and other applicable Federal regulations, including being approved by all applicable VA research review committees.

b. VHA has a robust Research and Development program. Specific information regarding policies and procedures can be found in the 1200 series of VHA Directives. Information on the Research and Development Program can be found at the public VHA Office of Research and Development website: https://www.research.va.gov/default.cfm or at the VA Intranet website: http://vaww.research.va.gov/. ***NOTE:*** *The second link is an internal VA website that is not available to the public*. Specific inquiries regarding programs and eligibility should be directed to the VHA Office of Research and Development.

11. FRAMEWORK FOR OUTBREAK RESPONSE

An outbreak is defined as an increase in cases of disease in time or place that is greater than expected. If a condition is rare (e.g., measles) or has serious public health implications (e.g., bioterrorism agent), an outbreak may involve only one case. The urgency of case investigations depends on the seriousness of the disease as well as the timeframe within which control measures must be implemented. This, in turn, is dependent on the incubation period of the disease, the mode(s) of transmission (e.g., respiratory, fecal-oral, foodborne), the mortality rate, potential for complications, and the patient/resident population affected (e.g., inpatient versus outpatient). An effective surveillance program can assist in the timely identification of an outbreak, along with astute clinical observation. For additional information on developing a framework for outbreak responses, see NIDS Infection Prevention and Control Framework for Surveillance Activities and Outbreak Response: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/InfectionPrevent

ionandControlSurveillanceandOutbreakResponseGuidanceDocument.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

INFECTIOUS DISEASE REPORTING BY DEPARTMENT OF VETERANS AFFAIRS (VA) MEDICAL FACILITIES

1. PURPOSE

This Appendix describes Veterans Health Administration (VHA) policy requirements for the mandatory reporting of infectious diseases internally in VHA and externally to local public health authorities and territorial entities legally authorized to receive such reports.

2. REPORTING INFECTIOUS DISEASES IN VHA

a. VHA has had a longstanding commitment to practices aimed at reducing health care-associated infections (HAIs), including internal reporting of certain infections by VA medical facilities to the Inpatient Evaluation Center (IPEC), or most current reporting system, to facilitate surveillance. Many of the infectious diseases modules in the IPEC system are used for internal quality reports or assist VA with meeting legislative mandates such as the MISSION Act and Veterans Access, Choice and Accountability (VACA) Act.

b. A listing of required and optional NIDS-endorsed IPEC modules for infection reporting can be found at Inpatient Evaluation Center (IPEC) Reporting Modules for Infectious Diseases: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/AppendixBIPECmodules.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.* Reporting is to follow the instructions for each IPEC module in their respective user manuals and any additional guidance from IPEC or the responsible program office.

3. REPORTING INFECTIOUS DISEASES TO LOCAL PUBLIC HEALTH AUTHORITIES

a. VHA recognizes the importance of public health and prevention. In that regard, it is important that policy and programs emphasize improving and protecting the health of Veterans and VHA employees through the reporting of infectious diseases designated as reportable to public health authorities and territorial entities legally authorized to receive such reports.

b. Each State or territorial legislature establishes a list of diseases designated as reportable to the local, district, State, or territorial entities legally authorized to receive such reports. The Centers for Disease Control and Prevention (CDC) maintains a list of nationally notifiable diseases and requests that States report voluntarily. Local health care facilities or local health departments typically do not report disease occurrences directly to CDC. While the reportable disease laws of States or territories do not apply to Federal entities, including VHA, VHA has voluntarily chosen to report reportable infectious diseases when legally permitted as a measure of sound public health practice.

c. VA medical facility Directors must report on the designated reportable diseases according to the laws, regulations, and policies of States and territories and to follow VHA Directive 1605.01, Privacy and Release of Information, dated July 24, 2023, and other applicable policies and laws on release of information. VA medical facilities may disclose protected health information for the public health or safety pursuant to a standing request as outlined in VHA Directive 1605.01. The VA medical facility Director must account for any disclosures made at the local level to public health authorities for infectious disease reporting.

STANDARD TERMS FOR SPECIAL AND TRANSMISSION-BASED PRECAUTIONS CATEGORIES

1. PURPOSE

This Appendix establishes required standard terms for patients and residents who are in special and transmission-based precautions to prevent transmission of a communicable infectious disease or condition, or to prevent harm to the patient, for recording in the electronic health record (EHR) in all VA medical facilities (across the enterprise).

2. BACKGROUND

The use of standard terms for transmission-based and other special precautions provides consistent documentation in EHR in support of Electronic Health Record Modernization (EHRM) efforts. ***NOTE:*** *EHR is the digital collection of patient health information resulting from clinical patient care, medical testing, and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Oracle Cerner-Millennium platforms.* Documentation templates in the EHR have been developed for use in all VA medical facilities which reflect these terms. VHA and Defense Health Agency (DHA) of the Department of Defense use standardized terms for special and transmission-based precautions categories that are consistent with the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions in most circumstances with some adaptations. ***NOTE:*** *Refer to the CDC Guideline for Isolation Precautions for a complete list of infectious agents and recommended precautions, at https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf.*

3. ISOLATION PRECAUTIONS CATEGORIES

Each of the precaution categories intended to be used for documentation of transmission-based precautions or special precautions in the EHR are defined below. Sample indications for each type of precaution and recommended prevention measures and personal protective equipment (PPE) are included in the definitions. Each of these precaution categories for transmission-based precautions or special precautions are used as indicated based on the infectious disease/condition in addition to Standard precautions. Standard precautions are used for all patient care. They are based on a risk assessment and make use of common-sense practices and PPE use that protect health care providers from infection and prevent the spread of infection from patient to patient. ***NOTE:*** *Refer to the CDC website for information on Standard Precautions for All Patient Care at: https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html.* At times, the use of a combination of transmission-based precautions

for a patient may be appropriate depending on the infectious diseases or conditions present.

a. **Airborne Precautions.** Airborne precautions are used for diseases transmitted by very small respiratory droplet nuclei (<5 µm in size) that can remain suspended in air and travel great distances and do not require direct face-to-face contact (e.g., pulmonary tuberculosis, chickenpox, measles, disseminated herpes zoster). Patient placement requires an airborne infection isolation room – AIIR, as per CDC recommendations (single-patient room, negative air pressure with stipulated room air changes per hour). Generally, a fit-tested NIOSH-approved N95 or higher- level respirator is required upon room entry. Cohorting is generally not permitted.

b. **Contact Precautions.** Contact precautions are used for infectious diseases or conditions transmitted by direct or indirect contact with patient or patient's environment (e.g., methicillin-resistant Staphylococcus aureus (MRSA), vancomycin- resistant *Enterococcus* (VRE), other specified multi-drug resistant organisms (MDROs) [e.g., Carbapenemase-Producing Carbapenem-resistant Enterobacterales (CP-CRE)], lice, scabies, and some of the respiratory viruses). Use of gloves and gowns is required upon room entry and a single room per patient is recommended; however, cohorting of patients is permitted.

c. **Contact Plus Precautions.** Contact Plus precautions are typically used for enteric diseases transmitted by contact with a patient or a patient's environment and are difficult to eradicate with routine environmental disinfection products (e.g., *Clostridioides difficile* and norovirus). Appropriate disinfectants with activity against the respective infectious agent are used for environmental cleaning and disinfection. Other prevention measures include mechanical hand hygiene with an antimicrobial or non-antimicrobial soap and water after removing gloves. Other forms of hand hygiene such as alcohol-based hand sanitizers/rubs may be appropriate in the absence of an outbreak or hyperendemic situation. Use of gloves and gowns is required upon room entry and a single room per patient is recommended; however, cohorting of patients is permitted. ***NOTE:*** *Contact Plus Precautions may be known by different designations at local sites (e.g., Contact Bleach, Enteric, Enhanced Contact, High Five Alert, Special Contact). These designations have the same intent but in order to standardize documentation of isolation precautions in the EHR, Contact Plus Precautions must be used for documentation of these precautions. All other local VA medical facility terms are to be retired from the EHR.*

d. **Droplet Precautions.** Droplet precautions are used for diseases transmitted by face-to-face contact via large respiratory droplets (>5 µm in size) [e.g., influenza, pertussis and bacterial meningitis (*Neisseria meningitidis*)]. A face mask is required upon room entry and a single room per patient is recommended; however, cohorting of patients is permitted.

e. **Enhanced Barrier Precautions.** Enhanced Barrier precautions (EBP) are used only in the long-term care setting, such as the VA Community Living Centers (CLC), for residents infected or colonized with MDROs (e.g., MRSA, CP-CRE, or other MDROs

determined nationally or locally) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) when Contact Precautions do not otherwise apply and when transmission of MDROs can occur by direct or indirect contact with a resident or resident's environment. Measures for implementing EBP in VHA CLCs are detailed in NIDS Standard - Enhanced Barrier Precautions: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/StandardEnhancedBarrierPrecautions.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public. EBPs do not apply to* Clostridioides difficile*. Refer to the CDC website for information on EBPs at: https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.*

f. **Protective Environment Precautions.** Protective precautions or Protective Environment precautions is recommended for hematopoietic stem cell transplant (HSCT) recipients to reduce the risk of invasive environmental fungal infections and other opportunistic pathogens. Hand hygiene is required upon room entry. Patient placement in a single room with special ventilation (positive pressure and HEPA filtration) is required.

g. **Other.** This category is for any type of exceptional special precautions not already covered by the previous terms. For example, there may be a need for special precautions which require additional PPE beyond Transmission Based Precautions. This category provides some flexibility in the event an unusual pathogen or situation arises which requires precautions not already listed and before a national solution agreed to by VHA and DHA can be developed.

4. ISOLATION PRECAUTIONS SIGNS FOR PATIENT ROOMS

The first six precaution category titles outlined in paragraph 3 of this Appendix (3.a.-3.f.) are required to be present on the signs used to post and communicate special or transmission-based precautions outside the patient's room, so the sign title aligns with the standard terms used in the EHR. For the exceptional circumstance when signage is needed for the seventh category, 'Other' (3.g.), the VA medical facility Infection Prevention and Control Committee must choose a title which reflects the transmission-based needs for the unusual pathogen or circumstance (typically pathogen-specific names are not used). Each VA medical facility can determine the formatting, design, size, color, and instructions for the signs at their VA medical facility.

5. DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS AND SPECIAL PRECAUTIONS

a. Transmission-based precautions or special precautions remain in effect for limited periods of time (i.e., while the risk for transmission of the infectious agent persists or for the duration of the illness). For most infectious diseases, this duration reflects known patterns of persistence and shedding of infectious agents associated with the natural history of the infectious process and its treatment.

b. Discontinuation of transmission-based precautions or special precautions should be done by or in consultation with the VA medical facility Infection Preventionist, MDRO Prevention Coordinator (MPC), or Infectious Diseases physician/Hospital Epidemiologist.

c. Recommendations on discontinuation of transmission-based precautions or special precautions for specific MDROs are available in the standards in Appendix D. For MDROs not covered in Appendix D, it is recommended to use CDC guidance unless future guidance is published by the MDRO Prevention Division of the National Infectious Diseases Service. ***NOTE:*** *Refer to the CDC website for information on the Type and Duration of Precautions Recommended for Selected Infections and Conditions at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html.*

d. Enhanced Barrier precautions are intended to be used for the duration of a residents stay in a VA medical facility. A transition back to Standard precautions, alone, may be appropriate for residents placed on Enhanced Barrier precautions solely because of the presence of a wound or indwelling medical device when the wound heals, or the device is removed.

PREVENTION OF MULTI-DRUG RESISTANT ORGANISMS (MDROs)

1. BACKGROUND

a. The National Infectious Diseases Service (NIDS), Specialty Care Program Office (SCPO) is the Veterans Health Administration (VHA) office responsible for Multi-Drug Resistant Organism (MDRO) Prevention policy and guidance within VHA designed to reduce MDRO transmission and infection in populations served by VHA. In 2007, VHA implemented the Methicillin-resistant *Staphylococcus aureus* (MRSA) Prevention Initiative and established policy to implement a nationwide program to decrease health care-associated MRSA infections in acute care facilities. In 2011, the MRSA Prevention Initiative was renamed the Multi-Drug Resistant Organism Prevention Initiative (MDRO PI) to include other pathogens. Additional information about the MDRO Prevention Initiative can be found at the MDRO PI website (http://vaww.mrsa.va.gov/index.asp). ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. MDROs are microbes that cause serious infections that are difficult to treat because the organisms are not susceptible to many of the agents used for therapy. Examples of MDROs include methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant enterococci (VRE), Carbapenemase-Producing Carbapenem-resistant *Enterobacterales* (CRE), *Candida auris*, and other multi-drug resistant gram-negative bacteria. *Clostridioides difficile* infection (CDI), although not considered multidrug-resistant, is often included with MDROs.

c. MDROs can cause infections in the ambulatory, acute, and long-term care settings, and are associated with increased lengths of stay, morbidity, mortality, and costs.

d. In health care settings, MDROs may be transmitted from patient to patient by health care workers or patients, or by contact with contaminated inanimate objects and environmental surfaces. Such transmission amplifies the number of patients who become colonized and are then at risk for clinical infection.

e. An organized approach to the identification and isolation of patients carrying an MDRO, along with an emphasis on good hand hygiene and a cultural transformation where infection control becomes everyone’s responsibility, was associated with a significant drop in MRSA health care-associated infections (HAIs) in VA acute care, spinal cord injury, and long-term care settings. Similar organized approaches, including an emphasis on adherence to standardized cleaning and disinfection processes, may be beneficial for controlling HAIs due to other MDROs and *Clostridioides difficile*, the most common cause of antibiotic-associated colitis.

2. MDRO POLICY DEVELOPMENT

The goal of MDRO policies is to establish MDRO PIs for the implementation of practices to reduce MDRO transmissions and infections in populations served by VHA.

Mechanisms that must be followed by NIDS to develop, approve, or update MDRO PIs, and disseminate related Standards, can be found at MDRO Task Force Charter: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/MDROTaskForceCharter.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

3. MDRO PREVENTION INITIATIVE TASK FORCE

The MDRO PI Task Force serves as an advisory group to senior leadership in VHA. The MDRO PI Task Force is an approving body for the selection of MDRO PIs and new and revised MDRO Standards. The MDRO PI Task Force advises the National Program Executive Director, NIDS, and VHA leadership on health issues affecting the development, deployment, and expansion of the MDRO PI. See the following link for more information on the structure and objectives of the MDRO PI Task Force: MDRO Task Force Charter: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/MDROTaskForceCharter.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

4. STANDARDS FOR SPECIFIC MDRO PREVENTION INITIATIVES

a. **Methicillin-Resistant *Staphylococcus Aureus* (MRSA).** The following implementation standards specify required and optional processes for the prevention of MRSA infections in VHA health care settings.

(1) Prevention of MRSA infections in VHA acute care facilities. See NIDS Standard – Prevention of MRSA in Acute Care: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/StandardMRSAandAcuteCare.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) Prevention of MRSA infections in VHA Community Living Centers. See NIDS Standard - Prevention of MRSA Infections in VHA CLCs: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/StandardMRSAandCLC.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. ***Clostridioides Difficile*.** The following implementation standard specifies required and optional processes for the prevention of *Clostridioides difficile* infections in VHA health care settings. See NIDS Standard – Prevention of CDI: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/StandardCDI.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

c. **Carbapenemase-Producing Carbapenem-resistant *Enterobacterales* (CP-CRE).** The following implementation standard specifies required and optional processes for the prevention of CP-CRE infections in VHA health care settings. See NIDS Standard – Carbapenemase-Producing Gram-negative Organisms: https://vaww.va.gov/INFECTIOUSDISEASES/docs/IPC/Directive_1131/StandardCarbapenemaseProducingOrganisms.pdf. ***NOTE:*** *This is an internal VA website that is not available to the public.*

d. **Other MDROs.** New multidrug-resistant organisms can emerge quickly and information on such organisms can be found on the MDRO Prevention Initiative website at https://vaww.mrsa.va.gov/. ***NOTE:*** *This is an internal VA website that is not available to the public.* As new VHA standards are developed for emerging MDROs through the formal development and approval process outlined in the VHA MDRO National Task Force Charter (see paragraph 3 above), they will be added to this paragraph of the Appendix.