Georgia Department of Public Health:
Strike & Support Team Office Hours Kick-Off for Skilled Nursing Care Centers, Hospice, ICF’s, and Medical Directors
July 15, 2022
Meet the Team

Presenters:
Swati Gaur, MD, MBA, CMD, AGSF
Medical Director, Alliant Health Solutions

Raybun Spelts, PharmD, MPH, BCIDP
Pharmacist, Department of Public Health

Regina Howard, BSN, RN, CIC
Infection Preventionist, Department of Public Health

Panelists:
Melody Brown, MSM
Patient Safety Manager, Alliant Health Solutions

Teresa Fox, M.Ed., CIC
Infection Preventionist, Department of Public Health

Renee Miller
Infection Preventionist, Department of Public Health
Thank You to Our Partners

- Georgia Department of Public Health
- University of Georgia
Purpose

• These sessions consist of a regularly scheduled monthly webinar for skilled nursing facilities (SNFs) and SNF medical directors. Office hours are your opportunity to come and learn, share, vent and more!

• Each month, we will provide updates on infection prevention, clinical protocols and ideas for new tools and resources. This is your chance to access subject matter experts on infection control and clinical practice in long-term care.

• Come prepared to ask questions to subject matter experts and learn from your peers about their best practices and barriers.
Trainings

There will be two training sessions per year focused on relevant infection prevention topics, updates and best practices shared.

- August Office Hours: Cleaning and Disinfection of Shared Medical Equipment
- Training 2: October/Dates TBD
Your Opinion Matters

• Share in CHAT what is keeping you up at night related to infection prevention.

• We want to provide you with information relevant to what you are doing every day.
Hot off the Press

• COVID cases—where are we now?
Current State: COVID-19

The blue bars show daily cases. The red line is the 7-day moving average of cases. The orange line represents the percentage of Emergency Department (ED) visits with diagnosed COVID-19.

Daily Trends in Number of Cases and Percentage of ED visits with Diagnosed COVID-19 in The United States Reported to CDC

United States
New Cases: 14,389
7-Day Moving Avg Cases: 14,806
7-Day Avg % of ED Visits: 0.0%
Date: June 8, 2021
Current State: COVID-19

Daily Trends in Number of Cases and 7-day Average of New Patients Admitted to Hospital with Confirmed COVID-19 in The United States Reported to CDC

- **United States**
  - New Cases: 152,294
  - 7-day Moving Avg Cases: 124,514
  - New COVID-19 Hospital Admissions: 10,619
  - Date: August 12, 2021
Resident Cases of COVID-19

Confirmed COVID-19 Cases among Residents and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week—United States

* Data are likely accruing, all data can be modified from week-to-week by facilities
For the purpose of creating this time-series graph, data that fail certain quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns for data-entry or excluded from analysis
Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network
For more information: [https://www.cdc.gov/nhsn/ltc/covid19/index.html](https://www.cdc.gov/nhsn/ltc/covid19/index.html)
Accessibility: [Right click on the graph area to show as table]
Staff Cases of COVID-19

Confirmed COVID-19 Cases among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week—United States

* Data are likely accruing, all data can be modified from week-to-week by facilities
For the purpose of creating this time-series graph, data that fail certain quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns for data-entry or excluded from analysis
Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network
For more information: https://www.cdc.gov/nhsn/ltcreporting/ltcreporting.html
Accessibility: [Right click on the graph area to show as table]
Wastewater Surveillance

Select legend categories to filter points on the map.

- 100%
- 99% to - 10%
- 9% to 0%
- 1% to 9%
- 10% to 99%
- 100% to 999%
- 1000% or more
- No recent data
### Wastewater Surveillance 15-Day Change

#### Percent change of SARS-CoV-2 in the last 15 days by site, United States

<table>
<thead>
<tr>
<th>15-day % change category</th>
<th>Num. sites</th>
<th>% sites</th>
<th>Category change in last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 100%</td>
<td>36</td>
<td>6</td>
<td>177%</td>
</tr>
<tr>
<td>- 99% to -10%</td>
<td>206</td>
<td>35</td>
<td>-24%</td>
</tr>
<tr>
<td>- 9% to 0%</td>
<td>30</td>
<td>5</td>
<td>-36%</td>
</tr>
<tr>
<td>1% to 9%</td>
<td>19</td>
<td>3</td>
<td>-47%</td>
</tr>
<tr>
<td>10% to 99%</td>
<td>99</td>
<td>17</td>
<td>-42%</td>
</tr>
<tr>
<td>100% to 999%</td>
<td>106</td>
<td>18</td>
<td>-41%</td>
</tr>
<tr>
<td>1000% or more</td>
<td>91</td>
<td>16</td>
<td>42%</td>
</tr>
</tbody>
</table>

*Note: The table shows the number of sites (Num. sites) and the percentage of sites (% sites) that experienced specific changes in the 15-day period.*
Current COVID-19 Variant

HHS Region
USA

Week Ending
7/2/2022

United States: 3/27/2022 – 7/2/2022

United States: 6/26/2022 – 7/2/2022 NOWCAST

HHS Region
USA

Week Ending
7/2/2022

United States: 3/27/2022 – 7/2/2022

United States: 6/26/2022 – 7/2/2022 NOWCAST

WHO label Lineage # US Class %Total 95%PI

Omicron BA.5 VOC 53.6% 49.5-57.6%
BA.2.12.1 VOC 27.2% 24.2-30.3%
BA.4 VOC 16.5% 13.9-19.4%
BA.2 VOC 2.8% 2.4-3.3%
B.1.1.529 VOC 0.0% 0.0-0.0%
BA.1.1 VOC 0.0% 0.0-0.0%

Delta B.1.617.2 VBM 0.0% 0.0-0.0%

Other Other* 0.0% 0.0-0.0%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates.
† AY.1-AY.133 and their sublineages are aggregated with B.1.617.2, BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. For regional data, BA.1.1 and its sublineages are also aggregated with B.1.1.529, as they currently cannot be reliably called in each region. Except BA.2.12.1, BA.2 sublineages are aggregated with BA.2. BA.5.1 is aggregated with BA.5.
The Three Pillars

1. Up-to-date vaccinate (booster for all eligible)
2. PPE and Infection Control
3. Testing
# Vaccine Effectiveness

<table>
<thead>
<tr>
<th>Event</th>
<th>Dose Type</th>
<th>Effectiveness</th>
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<tbody>
<tr>
<td>SARS-CoV-2 infection</td>
<td>3 doses mRNA</td>
<td>69%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>3 doses mRNA</td>
<td>90%(\rightarrow) 84% for Omicron</td>
</tr>
<tr>
<td>ED visits</td>
<td>3 doses mRNA</td>
<td>83%</td>
</tr>
<tr>
<td>Mechanical ventilation or death</td>
<td>3 doses mRNA</td>
<td>94%</td>
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</table>
Vaccine Effectiveness in LTC
Effect of 3rd vs 4th Dose Against Omicron (6.23)

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2793699
Checklist

• Up-to-date vaccine
  – Residents
  – Staff

• PPE and infection control
  – Staff
  – Residents
  – Visitors

• Test early
  – Cohort
Preventing Spread

- Healthier staff
- ↓ Risk of giving to resident

- ↓ Risk of giving to resident

- → Risk of getting COVID
- → Risk of giving to resident

- → Risk of giving to resident
- → Risk of giving to resident

- ↓ Risk of giving to resident
Therapeutic Considerations

<table>
<thead>
<tr>
<th>PATIENT DISPOSITION</th>
<th>PANEL’S RECOMMENDATIONS</th>
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</thead>
<tbody>
<tr>
<td>Does Not Require Hospitalization or Supplemental Oxygen</td>
<td>All patients should be offered symptomatic management (AIII). For patients who are at high risk of progressing to severe COVID-19, use 1 of the following treatment options:</td>
</tr>
</tbody>
</table>

**Preferred Therapies**
*Listed in order of preference:*
- Ritonavir-boosted nirmatrelvir (Paxlovid)*b,c* (AIIa)
- Remdesivir*c,d* (BIIa)

**Alternative Therapies**
*For use ONLY when neither of the preferred therapies are available, feasible to use, or clinically appropriate. Listed in alphabetical order:*
- Bebtelovimab*e* (CIII)
- Molnupiravir*c,f* (CIIa)

The Panel **recommends against** the use of dexamethasone*g* or other **systemic corticosteroids** in the absence of another indication (AII).
Clostridium/Clostridioides difficile Infection (CDI)

Raybun Spelts, PharmD, MPH, BCIDP
Regina Howard, BSN, RN, CIC
Objectives

• Identify initial emergence of Clostridium difficile
• Discuss management of residents with CDI
• Identify proper specimens for CD testing
• Discuss environmental cleaning and disinfection of CD rooms
• Update C. diff treatment protocols
• Discuss C. diff prevention and control basic practices
• Discuss “Core Elements of Antibiotic Stewardship”
Abbreviations and Definitions

CDI = *Clostridium/ Clostridioides difficile* infection

CD = *Clostridium/Clostridioides difficile*

PCR = polymerase chain reaction identifies DNA or RNA of a pathogen in a specimen or abnormal cells in a sample.

Antigen - any substance capable of producing an immune response.

Toxin - a chemical substance that damages an organism

*C. diff* produces two exotoxins: toxin A and toxin B
Epidemiology

- Causes almost a half-million infections in the United States per year
- More than 80% of *C. diff* deaths occur in people ages 65 and older.
- Risk factors for infection:
  - Recent antibiotic use
  - Age
  - Recent hospitalization or nursing home stay
  - Weakened immune system
  - Previous infection

https://www.cdc.gov/cdiff/what-is.html
Residents at High Risk of Colonization

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Other Factors With Increased Risk of Colonization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotic use in the previous 3 mo</td>
<td>Multiple antibiotic use</td>
</tr>
<tr>
<td>History of previous <em>Clostridium difficile</em> infection</td>
<td>Duration of antibiotic therapy</td>
</tr>
<tr>
<td>Fecal incontinence</td>
<td>Renal insufficiency</td>
</tr>
<tr>
<td></td>
<td>Patients receiving chemotherapy</td>
</tr>
<tr>
<td></td>
<td>Recent hospitalization</td>
</tr>
<tr>
<td></td>
<td>H2 blocker use</td>
</tr>
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</table>

Chopra, T., & Goldstein, E. J. (2015). Clostridium difficile infection in long-term care facilities: a call to action for antimicrobial stewardship. *Clinical Infectious Diseases, 60*(suppl_2), S72-S76.
UP TO 70% OF NURSING HOME RESIDENTS RECEIVED one or more COURSES OF SYSTEMIC ANTIBIOTICS IN A YEAR

Increases in Antibiotic Use During COVID Pandemic

https://emergency.cdc.gov/coca/calls/2021/callinfo_111821.asp
Diagnosis
Who Should Be Tested?

- Resident with at least three unformed stools in 24 hours
- Is the resident on laxatives?
- Could any antibiotics be discontinued?
- Are there other possible causes of diarrhea?
- If the test is negative, do not re-test within seven days.
- Consider nursing standing order for testing.

https://www.cdc.gov/hai/prevent/tap/cdiff.htm

https://upload.wikimedia.org/wikipedia/commons/9/9e/BristolStoolChart.png
# Stool Toxin Test With Multi-Step Algorithm

<table>
<thead>
<tr>
<th>Results</th>
<th>Implication</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antigen –, Toxin –</td>
<td>C. diff ruled out</td>
<td>Treatment &amp; isolation precautions NOT necessary</td>
</tr>
<tr>
<td>Antigen +, Toxin +</td>
<td>C. diff infection</td>
<td>Treatment &amp; isolation precautions</td>
</tr>
<tr>
<td>Antigen –, Toxin +</td>
<td>Discrepant result</td>
<td>Perform reflex PCR</td>
</tr>
<tr>
<td>Antigen +, Toxin –</td>
<td>Discordant result</td>
<td>Perform reflex PCR</td>
</tr>
<tr>
<td>PCR –</td>
<td>Non-toxigenic C. diff that does not cause colitis</td>
<td>Treatment &amp; isolation precautions NOT necessary</td>
</tr>
<tr>
<td>PCR +</td>
<td>May be asymptomatic C. diff colonization or active C. diff</td>
<td>Isolation advised; treatment on clinical judgment</td>
</tr>
</tbody>
</table>

Antigen=Glutamate Dehydrogenase

McDonald, et al. *Clinical Infectious Diseases*, Volume 66, Issue 7, 1 April 2018, Pages e1–e48, [https://doi.org/10.1093/cid/cix1085](https://doi.org/10.1093/cid/cix1085)
CDC C. diff Algorithm
Treatment
Basics

- Do not use anti-diarrheal medications.
- Do not perform the test of cure.
- Is this the first episode or has the resident had CDI before?
- If previously infected, what treatment did the resident receive then?
- IDSA/SHEA 2017: oral metronidazole no longer recommended
- IDSA/SHEA 2021: Fidaxomicin, if available, recommended over vancomycin

DOI: 10.1093/cid/cix1085
DOI: 10.1093/cid/ciab549
Initial Episode

- Preferred: Fidaxomicin 200 mg po BID x 10 days
- Alternative: Vancomycin 125 mg po QID x 10 days
- Alternative (for non-severe only if other agents unavailable): Metronidazole 500 mg po TID x 10-14 days
Recurrent C. *diff* Infections

About 1 IN 6 patients who get C. *diff* infection will get it again in the subsequent 2–8 weeks.
First Recurrence

- **Preferred:** Fidaxomicin 200 mg po BID x 10 days OR Fidaxomicin 200 mg po BID x 5 days, followed by once every other day x 20 days
- **Alternative:** Vancomycin tapered/pulse regimen
  - 125 mg QID x 10-14 days
  - 125 mg BID x 7 days
  - 125 mg daily x 7 days
  - 125 mg every 2-3 days x 2-8 weeks
- **Alternative:** Vancomycin 125 mg po QID x 10 days
- **Adjunctive:** Bezlotoxumab 10 mg/kg IV once over 1 hour

DOI: 10.1093/cid/ciab54
Second or Subsequent Recurrence

• Several options:
  • Fidaxomixin 200 mg po BID x 10 days
  • Fidaxomixin 200 mg po BID x 5 days, followed by once every other day x 20 days
  • Vancomycin taper/pulse
  • Vancomycin 125 mg po QID x 10 days, followed by rifaximin 400 mg po TID x 20 days
  • Fecal microbiota transplant
• Adjunctive: Bezlotoxumab 10 mg/kg IV once

DOI: 10.1093/cid/ciab54
Role of Bezlotoxumab

• Monoclonal antibody targeting toxin B
• Lasts about three months
• Recommended for residents with recurrence within the last six months
• Could also use in primary CDI in residents at high risk of recurrence
  • Age>65 plus at least one of the following: healthcare-associated CDI, hospitalization in the last three months, concomitant antibiotics, PPIs (and prior CDI)
• Use in combination with standard treatment
• Data is limited when bezlotoxumab is combined with fidaxomicin
• Warning: CHF

DOI: 10.1093/cid/ciab54
Fulminant CDI

- Hypotension or shock, ileus, megacolon
- Vancomycin 500 mg po QID PLUS metronidazole IV 500 mg q8 hours
- If ileus, use rectal vancomycin enema.

DOI: 10.1093/cid/ciab54
Vancomycin

- Commercially available dosage forms: capsule, oral solution
- Compounding recipe for solution in Lexicomp
- Administration: oral or rectal (off-label as retention enema)
- Side effects:
  - Signs of low potassium, such as muscle pain or weakness, cramps or irregular heartbeat
  - Gas, abdominal pain, nausea, diarrhea
  - Headache

Fidaxomixin

- Dosage form: tablet and oral suspension
- Side effects: N/V/D, constipation, abdominal pain
- Precaution: macrolide allergy

Infection Prevention and Control

Regina Howard
Colonization and Infection

What are the differences between colonization and infection?

• Colonization with *C. diff* is more common than infection
  • Colonized residents do not have a disease caused by *C. diff* and often exhibit NO clinical symptoms (asymptomatic) of infection (e.g., diarrhea)
  • Colonized residents may test positive for the *C. diff* organism or its toxin

• Residents with infection exhibit clinical symptoms and test positive for the *C. diff* organism and its toxin

https://www.bing.com/search?q=image+of+C.+diff&src=IE-SearchBox&FORM=IESR4A
C. *diff* Prevention Efforts

Efforts include:

- Vulnerability of resident population to *C. diff* infection
  - Conduct surveillance, including calculation of facility-wide *C. diff* rates
  - Tracking *C. diff* available through LTCF NHSN Module
- Reduce possible exposure
  - Infection prevention and control practices
    - Residents are a major source of transmission
    - Focus on reducing the risk of transmission from symptomatic residents using infection prevention basic measures
- Environmental cleaning and
Pillars of *C. diff* Prevention and Control

- **Hand Hygiene**
- **Contact Enteric Precautions**
- **Environmental Cleaning and Disinfection**
- **Antimicrobial Stewardship**
Hand Hygiene

- Perform hand hygiene
  - before contact with the resident
  - after removing gloves
  - after contact with the environment

- For enhanced measures, do not use alcohol hand rubs with the CDI resident – use soap and water
  - Washing away the spores may be the optimal way to perform hand hygiene when transmission of C. difficile is occurring

- Audit adherence to hand hygiene
Standard and Enteric Contact Precautions

- Create nurse-driven protocols to facilitate rapid identification and isolation of residents with suspected or confirmed CDI
- Place symptomatic residents on enteric contact precautions and limit the transport of resident
- Place resident in a single-resident room with a dedicated toilet. If single-resident rooms are not available, room residents with confirmed CDI together
- Isolate and initiate Enteric Contact Precautions for suspected or confirmed CDI
  - Perform hand hygiene using soap and water when leaving the room
  - Maintain adequate supplies outside the room, gowns, gloves and cleaning wipes
  - Keep cubicle curtain drawn to limit movement between cubicles and as a reminder of precautions if not in a private room
  - Preferentially use dedicated or disposable equipment, if not used, shared equipment must be thoroughly cleaned before leaving the resident’s room
- May discontinue precautions when diarrhea ceases (may consider 48 hours without a loose stool)
- **DO NOT** test “for cure” once diarrhea has stopped (Lab should not accept stool for toxin if the stool is formed)
- Should not use rectal thermometers—have been associated with transmission of enteric pathogens

Isolation Precautions Signage: Contact Enteric (e.g., Clostridioides difficile)
Environmental Cleaning and Disinfection

- Create policies and procedures to ensure a systematic approach
- Increase the frequency of cleaning and disinfecting, particularly for high-touch surfaces (e.g., bed rails, over-bed tables)
- Audit adherence of cleaning and disinfecting to the facility’s environmental cleaning/disinfection policies
- Use single-use disposable noncritical equipment or dedicate equipment to one resident.
- Use List K: EPA’s Registered Antimicrobial Products Effective against *Clostridium difficile* Spores

  [https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium](https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium)

  - Quaternary cleaners and daily disinfectants are not effective against *C. diff.*
  - During outbreaks, consider the use of a sporicidal agent for all routine disinfection
- Follow manufacturer instructions for use
- Re-educate housekeeping staff on cleaning and disinfecting specific for *C. diff.*
  - Consider designating specific housekeeping staff to the affected resident care unit
Before cleaning, perform hand hygiene and don gloves. Change gloves throughout the task and perform hand hygiene in-between. EVS staff should don additional PPE based on patient/resident isolation status.

The cleaning should start from one point in the room and move in a clockwise or counter-clockwise motion to ensure no items in the rooms are missed.

Clean from the least soiled to most soiled and from physically high to physically low areas. End around the patient/resident bed.

Use an Environmental Protection Agency (EPA) registered disinfectant to clean floors in critical areas such as isolation rooms.

Adhere to the contact time of each disinfectant to ensure the product is given enough time to kill bacteria.

Change privacy curtains routinely, if they become soiled, and after the patient/resident is discharged, transferred, or taken off precautions.

Florida Department of Public Health
Inter-Facility Infection Control Transfer Form

• When transferring residents, notify receiving wards or facilities about the resident’s CDI status so precautions are maintained at the resident’s new location

https://www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf
Antibiotic Stewardship

Raybun Spelts
Antibiotic Stewardship

- Avoid high-risk antibiotics.
  - Fluoroquinolones
  - Carbapenems
    - 3rd and 4th generation cephalosporins
- Use the shortest duration of therapy.
- Always document indication.
- Develop facility-specific empiric antibiotic guidelines.
- Develop facility antibiogram.

https://www.cdc.gov/cdiff/clinicians/cdi-prevention-strategies.html#engage
Use Antibiotics Wisely

Core Elements of Antibiotic Stewardship

1. Leadership commitment
2. Accountability
3. Drug expertise
4. Action
5. Tracking
6. Reporting
7. Education

Core Elements: Leadership Commitment

• Facility written statements of support
• Antibiotic stewardship duties in job descriptions
• Stewardship policies
Core Elements: Accountability

• Best practices are expected by leadership.
• Involves:
  • Medical director
  • Director of nursing
  • Consultant pharmacist
  • Infection preventionist
  • Laboratory
  • State and local health departments
Core Elements: Drug Expertise

- Consult experts in antibiotic stewardship
  - Consultant pharmacist
  - Local hospitals
  - Infectious disease providers
Core Elements: Action

• Develop and promote policies
• Target interventions
  • Antibiotic time outs
  • Appropriate indication
  • Review cultures
Core Elements: Tracking

- Track interventions
- Measure antibiotic use in DOT or antibiotic starts
- Tract adverse outcomes
  - CDI
  - Antibiotic resistant bacteria
- NHSN [https://www.cdc.gov/nhsn/ltc/index.html](https://www.cdc.gov/nhsn/ltc/index.html)
Core Elements: Reporting

- Discuss findings in antibiotic stewardship meetings
- Present reports at medical staff meetings
Core Elements: Education

• All employees
• Residents and families
Continuing Education

https://www.cdc.gov/antibiotic-use/training/continuing-education.html
Resident and Family Education

The Four Moments of Antibiotic Decision Making Posters | Agency for Healthcare Research and Quality (ahrq.gov)

Four Questions To Ask Your Doctor or Nurse About Antibiotics

**Question 1**
Do I need an antibiotic?
Before starting an antibiotic, your provider should consider these alternatives:
- Increase fluids
- Encourage rest
- Treat pain
- Review other medications

**Question 2**
Is this the right antibiotic?
Cultures and other laboratory tests help your doctor and nurse know if an antibiotic will work. These should be collected before starting an antibiotic. It may take several days to get results.

**Question 3**
How long do I need to be on antibiotics?
Most bacterial infections can be treated with 5 to 7 days of antibiotics:
- Urinary tract infection
- Pneumonia
- Cellulitis
- Some bloodstream infections

**Question 4**
Do I still need to take antibiotics?
Your doctor or nurse should check back with you in a few days to see if you are feeling better and share test results. If it turns out you did not have a bacterial infection, the antibiotics should be stopped.
Probiotics?

IDSA/SHEA 2017
• Insufficient evidence to recommend

AGA
• Prevention of CDI while taking antibiotics
• Treatment of pouchitis

DOI: 10.1093/cid/cix1085
doi: 10.1053/j.gastro.2020.05.059
PPIs?

• Discontinue PPIs (proton-pump inhibitors) with no indication.

# Georgia Department of Public Health HAI Team Contacts

<table>
<thead>
<tr>
<th>State Region/Districts</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (Rome, Dalton, Gainesville, Athens)</td>
<td><a href="mailto:Sue.bunnell@dph.ga.gov">Sue.bunnell@dph.ga.gov</a> (404-967-0582)</td>
</tr>
<tr>
<td>Districts 1-1, 1-2, 2, 10</td>
<td><a href="mailto:Mary.Whitaker@dph.ga.gov">Mary.Whitaker@dph.ga.gov</a> (404-967-0578)</td>
</tr>
<tr>
<td>Atlanta Metro (Cobb-Douglas, Fulton, Clayton, Lawrenceville, DeKalb, LaGrange)</td>
<td><a href="mailto:Teresa.Fox@dph.ga.gov">Teresa.Fox@dph.ga.gov</a> (404-596-1910)</td>
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<tr>
<td>Districts 3-1, 3-2, 3-3, 3-4, 3-5, 4</td>
<td><a href="mailto:Renee.Miller@dph.ga.gov">Renee.Miller@dph.ga.gov</a> (678-357-4797)</td>
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<td>Central (Dublin, Macon, Augusta)</td>
<td><a href="mailto:Theresa.Metro-Lewis@dph.ga.gov">Theresa.Metro-Lewis@dph.ga.gov</a> (404-967-0589)</td>
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<td>Districts 5-1, 5-2, 6, 7</td>
<td><a href="mailto:Karen.Williams13@dph.ga.gov">Karen.Williams13@dph.ga.gov</a> (404-596-1732)</td>
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<tr>
<td>Southeast (Columbia, Albany)</td>
<td><a href="mailto:Connie.Stanfill1@dph.ga.gov">Connie.Stanfill1@dph.ga.gov</a> (404-596-1940)</td>
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<tr>
<td>Southwest (Valdosta, Savannah, Waycross)</td>
<td><a href="mailto:Regina.Howard@dph.ga.gov">Regina.Howard@dph.ga.gov</a> (404 967-0574)</td>
</tr>
<tr>
<td>Districts 9-1, 9-2</td>
<td></td>
</tr>
<tr>
<td>Backup/Nights/Weekends</td>
<td><a href="mailto:Jeanne.Negley@dph.ga.gov">Jeanne.Negley@dph.ga.gov</a> (404-657-2593)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Joanna.Wagner@dph.ga.gov">Joanna.Wagner@dph.ga.gov</a> (404-430-6316)</td>
</tr>
</tbody>
</table>
Questions?
Save the Date

Next Office Hours:
August 19, 2022
11 a.m.
Thanks Again…

- Georgia Department of Public Health
- University of Georgia
Making Health Care Better

This material was prepared by Alliant Health Solutions, under contract with the Georgia Department of Public Health as made possible through the American Rescue Plan Act of 2021.

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