The Australian Commission on Safety and Quality in Health Care sponsored a workshop to assist jurisdictions and the private hospital sector to manage *Clostridium difficile* infection (CDI). Representatives of the state and territory health departments, public and private hospital sectors, laboratories, infection prevention professional associations and members of the Commission’s HAI Advisory Committee were invited to attend (see Attachment 1).

In December 2008 Australian Health Ministers endorsed a recommendation that all hospitals monitor and report CDI through their relevant jurisdiction into a national data collection. This recommendation was given in response to the prevalence of CDI as a healthcare associated infection causing significant patient morbidity and mortality for infected patients in hospitals and long term care facilities. To date there has been an inconsistent approach to the identification and management of CDI in Australia, and local capacity to detect and respond to such an occurrence is limited. The absence of surveillance also means it is difficult to detect trends, such as an upsurge in cases similar to those reported overseas. It has been noted that highly virulent strains of CDI emerging overseas must be detected early in Australia to prevent major harm to Australian patients.

Since endorsement by Australian Health Ministers the Commission has undertaken several initiatives, such as the development of a draft Data Set Specification in 2009 to support the development of local processes and systems for surveillance of CDI. More recently, as part of a two-phased approach beginning with the national workshop, the Commission has commenced work with the Australian Society for Infectious Diseases (ASID) to undertake a one-month snapshot survey of all stool specimens positive for CDI for the hypervirulent strain. This ‘snapshot’ study has been proposed in order to gain a rapid understanding of disease prevalence and molecular epidemiology. With the identification of apparent local transmission of an epidemic strain of *C difficile* in 2010, it has been deemed important that an estimate of the disease burden and relative frequency of epidemic strains be determined in Australia.

The main objective of the national workshop was to provide an understanding of hypervirulent strains of CDI and an overview of the prevalence of CDI, as well as to discuss strategic options to prevent hypervirulent CDI from gaining a foothold in Australia.

Participants were issued with a workshop manual containing pertinent background information (see Attachment 2). The agenda comprised two parts: the morning session provided an overview of the history and pathophysiology of CDI, mechanisms of diagnosis, and strategies for containment; the afternoon session was predominantly devoted to discussion about ways in which the experts could assist the health system to manage CDI (see Attachment 3). Copies of all attached documentation as well as presentations from the workshop and the manual are available for download on the Commission’s website.
1. Infection Control Issues
The management and containment of CDI formed a significant part of the agenda and discussions around management from an infection control perspective were paramount. Key issues highlighted included the impact of CDI in hospitals, the primary role that antimicrobial stewardship plays in prevention of *C. difficile* transmission and disease, and the important roles of hand hygiene, environmental cleaning/disinfection and additional transmission-based precautions. Claire Boardman, President of AICA, provided attendees with an overview of the ASID/AICA Position Statement: Infection Control Guidelines for Patients with *Clostridium difficile* Infection in Healthcare Settings. A copy of this document was included for attendees in the workshop proceedings manual and will also be published shortly in the MJA. Associate Professor Allen Cheng provided attendees with an overview of clinical diagnosis and management around *Clostridium difficile* infection, and further referenced the ASID/AICA Position Statement.

2. Notifiability
Discussion surrounding the appropriate mechanisms for identifying and reporting CDI noted some views both for, and against, notification. It was also noted that outbreaks were currently notifiable under most state policy/legislation. Subsequent discussion ensued around the specifics of notification, and whether all cases should be notified or only cases of an epidemic nature, and whether notification should be active or passive.

3. Implications for aged care and residential care facilities
The relationship of CDI with aged care and residential facilities was highlighted by several participants. The potential for transfer of infection between such facilities and the hospital setting was discussed and noted as a topic of concern. The complexities of policy and governance in the area of aged and residential care facilities, which in most cases are people’s homes, were discussed.

It was agreed that a strategy for managing the risk of infection transfer from aged care and residential care facilities would be an important factor in the minimisation of CDI impact in the hospital setting.

It was noted that an approach towards education of prescribers and other staff (extending to cleaning and food preparation staff) would be important in the management of CDI.

4. Coordination between jurisdictions
It was agreed that a coordinated approach to the management of CDI is of fundamental importance. The jurisdictional representatives agreed that the management of hypervirulent strains of CDI should be undertaken at a state-based level, with national channels of communication and a coordinated media strategy where government funding was used for studies. It was noted that in these cases such an approach was necessary to ensure a standardised response is achieved and the general public are informed appropriately.
5. Definition of hospital CDI
The pertinent topic of national definitions was raised by several attendees and subsequent discussion followed regarding finalisation of the denominators for CDI. It was noted that clarification of nationally agreed denominators is a priority for action, and the Commission’s recently-formed Technical Working Group (chaired by Dr Helen Van Gessel) is suitable to develop associated documentation. It was noted that the Commission’s Technical Working Group has developed implementation guidelines for the management and surveillance of CDI, and the Australasian Society for Infectious Diseases Clostridium difficile working group has developed guidelines for the diagnosis and treatment of CDI. Draft copies of each of these guidelines were included in the workshop proceedings manual.

6. Laboratory testing
A survey of current C. difficile laboratory practice in Australian and New Zealand laboratories was presented. Draft evidence-based recommendations for standard practice were also presented and these will be an important basis for future surveillance programs for CDI, together with a new C. difficile quality assurance program to be conducted by the RCPA.

The jurisdictional representatives and other participants discussed the technicalities of laboratory testing and the need to optimise laboratory diagnostic practice in this area. A significant barrier to testing in private pathology raised by the laboratory experts is the lack of funding from the Medicare Benefits Scheme for laboratory-generated add-on C. difficile testing for inpatients as is currently recommended across the world, and the need for funding and establishment of harmonized routine isolate characterisation testing at jurisdictional level.

7. Australian Clostridium difficile infection Point Prevalence Survey
Representatives from two jurisdictions raised issues with the proposed Australian Clostridium difficile Point Prevalence Survey. These issues were concerned with the way in which patients were to be advised and the approach to more public information and subsequent media response. Concerns were raised in regard to public perception of results reported following the study. It was agreed that a proactive approach should be taken, with a coordinated media response developed across the jurisdictions. It was agreed that if requested by jurisdictions, the Commission would coordinate a suitable media response to address anticipated scenarios with impact analysis, and disseminate among relevant members of the jurisdictions. Issues surrounding governance and ethical considerations were also addressed. The information gathered by the survey will not include any demographic data, and would only include hospital-identified data relating to samples, dates and geographical information. Advice to the Commission is that the survey is considered a bacteria-related data collection only, not requiring Human Research Ethics Committee (HREC) approval.

A key issue raised was that any such national laboratory initiative should follow established PHLN protocols of engaging with and working through, where possible, jurisdictional PHLN labs. This is to ensure jurisdictions and their labs know what is happening to what where and when within their jurisdiction and that following any time-limited initiative opportunities for ongoing local testing are created.
8. Priorities for action
Experts in attendance were asked to note priorities for action for jurisdictions in regards to the management and surveillance of CDI. The following priority areas were agreed upon and ranked by experts in terms of urgency of response.

1. Implementation of antibiotic stewardship programs in all health care facilities
2. Cleaning protocols (policy, education, compliance and auditing thereof)
3. Early risk identification / assessment of patients
4. Investigation of *Clostridium difficile* infections (Root Cause Analysis, sentinel events and feedback to hospitals)
5. Provision of education and information to frontline staff (including cleaners) on the prevention of CDI
6. Consistent national definition of CDI and criteria for classification of severe disease for surveillance purposes

9. Summary
A summary of the key issues, advice received, suggested actions and resources that may assist such actions is included in Attachment 4.
Below is a list of all organisations and individuals invited to the National *Clostridium difficile* Infection Workshop.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation/Network</th>
<th>Attendance Status</th>
</tr>
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<tbody>
<tr>
<td>Professor Jim Bishop AO</td>
<td>Chief Medical Officer, Department of Health and Ageing</td>
<td>Apology</td>
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<tr>
<td>Dr Andrew Singer</td>
<td>Representative, Department of Health and Ageing</td>
<td>Attended</td>
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<tr>
<td>Professor Warwick Anderson</td>
<td>National Health and Medical Research Council</td>
<td>Attended</td>
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<tr>
<td>Mary Murnane</td>
<td>Deputy Secretary, Department of Health and Ageing</td>
<td>Apology</td>
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<tr>
<td>Deanne Behrendorff</td>
<td>Representative, Department of Health and Ageing</td>
<td>Attended</td>
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<tr>
<td>Dr Jeremy McAnulty</td>
<td>Communicable Diseases Network Australia</td>
<td>Apology</td>
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<tr>
<td>Dr Christine Selvey</td>
<td>Representative, Communicable Diseases Network Australia</td>
<td>Attended</td>
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<tr>
<td>John Bates</td>
<td>Public Health Laboratory Network</td>
<td>Apology</td>
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<tr>
<td>Dr Geoff Hogg</td>
<td>Representative, Public Health Laboratory Network</td>
<td>Attended</td>
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<tr>
<td>Christine Gee</td>
<td>Private Sector</td>
<td>Apology</td>
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<tr>
<td>Glenna Parker</td>
<td>Private Sector</td>
<td>Attended</td>
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<tr>
<td>Dr Jenny Robson</td>
<td>Private Laboratories</td>
<td>Attended</td>
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<tr>
<td>Dr Gillian Wood</td>
<td>Private Laboratories</td>
<td>Attended</td>
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<tr>
<td>Dr Lynette Waring</td>
<td>Private Laboratories</td>
<td>Attended</td>
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<tr>
<td>Dr Tom Gottlieb</td>
<td>Australasian Society for Infectious Diseases</td>
<td>Attended</td>
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<tr>
<td>Carmel Scott</td>
<td>Australian Infection Control Association</td>
<td>Attended</td>
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<tr>
<td>Jenny Bradford</td>
<td>Australian Infection Control Association</td>
<td>Attended</td>
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<tr>
<td>Dr Peggy Brown</td>
<td>Chief Executive, ACT Health</td>
<td>Australian Capital Territory</td>
<td>Apology</td>
</tr>
<tr>
<td>Dr Charles Guest</td>
<td>Chief Health Officer, ACT Health</td>
<td>Australian Capital Territory</td>
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</tr>
<tr>
<td>Wendy Beckingham</td>
<td>Representative, ACT Health</td>
<td>Australian Capital Territory</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Sanyaja Senanayake</td>
<td>Representative, ACT Health</td>
<td>Australian Capital Territory</td>
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<tr>
<td>Fiona Kimber</td>
<td>Representative, ACT Health</td>
<td>Australian Capital Territory</td>
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</tr>
<tr>
<td>Professor Debora Picone</td>
<td>Director General, NSW Health</td>
<td>New South Wales</td>
<td>Apology</td>
</tr>
<tr>
<td>Dr Kerry Chant</td>
<td>Chief Health Officer, NSW Health</td>
<td>New South Wales</td>
<td></td>
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<tr>
<td>Dr Annette Pantle</td>
<td>Clinical Excellence Commission</td>
<td>New South Wales</td>
<td>Apology</td>
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<tr>
<td>Robyn Donnellan</td>
<td>Representative, NSW Health</td>
<td>New South Wales</td>
<td>Attended</td>
</tr>
<tr>
<td>Deborah Hyland</td>
<td>Representative, NSW Health</td>
<td>New South Wales</td>
<td>Attended</td>
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<tr>
<td>Wendy Manning</td>
<td>Representative, NSW Health</td>
<td>New South Wales</td>
<td>Apology</td>
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<tr>
<td>Dr Andrew Marich</td>
<td>Representative, NSW Health</td>
<td>New South Wales</td>
<td>Attended</td>
</tr>
<tr>
<td>Jenny Cleary</td>
<td>Director General, NT Department of Health and Families</td>
<td>Northern Territory</td>
<td>Apology</td>
</tr>
<tr>
<td>Dr Barbara Paterson</td>
<td>Chief Health Officer, NT Department of Health and Families</td>
<td>Northern Territory</td>
<td>Apology</td>
</tr>
<tr>
<td>Dr Jeannette Young</td>
<td>Chief Health Officer, Queensland Health</td>
<td>Queensland</td>
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<tr>
<td>Michael Reid</td>
<td>Director General, Queensland Health</td>
<td>Queensland</td>
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</tr>
<tr>
<td>Dr Lisa Hall</td>
<td>Centre for Healthcare Related Infection Surveillance and Prevention</td>
<td>Queensland</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Graeme Nimmo</td>
<td>Queensland Health / Public Health Laboratory Network</td>
<td>Queensland</td>
<td>Attended</td>
</tr>
<tr>
<td>Dr Stephen Christley</td>
<td>Executive Director, SA Health</td>
<td>South Australia</td>
<td>Attended</td>
</tr>
</tbody>
</table>
Dr Tony Sherbon    Chief Executive, SA Health    South Australia    Apology
Ann Koehler    Representative, SA Health / CDNA / AIGC Steering Committee    South Australia    Apology
Dr Celia Cooper    Chair, Antimicrobial Stewardship Advisory Committee, ACSQHC    South Australia    Apology
David Roberts    Director General, Department of Health and Human Services    Tasmania    Apology
Dr Craig White    Chief Health Officer, Department of Health and Human Services    Tasmania    Apology
Brett Mitchell    Representative, Department of Health and Human Services    Tasmania    Attended
Dr John Carnie    Chief Health Officer, Department of Human Services    Victoria    Attended
Fran Thorn    Secretary, Department of Human Services    Victoria    Apology
Alison McMillan    Representative, Department of Health Victoria    Victoria    Attended
Bernadette Kennedy    Representative, Department of Health Victoria    Victoria    Attended
Kim Snowball    Director General, Department of Health    Western Australia    Apology
Dr Tarun Weeramanthri    Chief Health Officer, Department of Health    Western Australia    Apology
Rebecca McCann    Representative, HISWA    Western Australia    Attended
Irene Wilkinson    HAI Advisory Committee, ACSQHC / SA Health    South Australia    Attended
Professor Peter Collignon    HAI Advisory Committee, ACSQHC / ACT Health    Australian Capital Territory    Attended
A/Professor Cathryn Murphy    HAI Advisory Committee, ACSQHC    Queensland    Attended
Dr Alistair McGregor    HAI Advisory Committee, ACSQHC    Tasmania    Attended
Mr Philip Russo    HAI Advisory Committee, ACSQHC    Victoria / National    Attended
Professor Lyn Gilbert    Chair / Institute of Clinical Pathology and Medical Research    New South Wales    Attended
Professor Thomas V Riley    Speaker, University of Western Australia    Western Australia    Attended
Dr Dena Lyras    Speaker, Monash University    Victoria    Attended
Michele Squire    Speaker, University of Western Australia    Western Australia    Attended
A/Professor Michael Richards    HAI Advisory Committee, ACSQHC    Victoria    Attended
Professor David Paterson    HAI Advisory Committee, ACSQHC    Queensland    Attended
A/Professor Allen Cheng    Speaker, Monash University    Victoria    Attended
Dr Tony Korman    Speaker, Monash Medical Centre    Victoria    Attended
Professor John Turnidge    Antimicrobial Stewardship Committee, ACSQHC    South Australia    Attended
Dr John Ferguson    Chair HAI Advisory Committee ACSQHC    New South Wales    Attended
Dr Helen van Gessel    HAI Advisory Committee, ACSQHC    Western Australia    Attended
Claire Boardman    HAI Advisory Committee, ACSQHC    Queensland    Attended
Megan Robertson    Speaker, Private Sector    Attended

Commission staff    Attended
Prof Chris Baggoley    Australian Commission on Safety and Quality in Health Care    Attended
Neville Board    Australian Commission on Safety and Quality in Health Care    Attended
Dr Marilyn Cruickshank    Australian Commission on Safety and Quality in Health Care    Attended
Sue Greig    Australian Commission on Safety and Quality in Health Care    Attended
Elizabeth Hanley    Australian Commission on Safety and Quality in Health Care    Attended
Emily Parker    Australian Commission on Safety and Quality in Health Care    Attended
Tom Sanders    Australian Commission on Safety and Quality in Health Care    Attended

Report on National Clostridium difficile Infection Workshop   - 6 -
Attachment 2  Proceedings Manual for the National CDI Workshop

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Patients with Clostridium difficile Infection in Healthcare Settings ....... page 18 
Australasian Society for Infectious Diseases guidelines for the 
diagnosis and treatment of Clostridium difficile infection ....................... page 29

Appendix

1. Riley TV. Epidemic Clostridium difficile: We need to know if and when this organism arrives in 

2. Bauer MP, Kuijper EJ, van Dissel JT. European Society of Clinical Microbiology and Infectious 
Diseases (ESCMID): Treatment guidance document for Clostridium difficile infection (CDI). 

3. Association for Professionals in Infection Control and Epidemiology. Guide to the Elimination of 

4. Health Protection Agency, Department of Health. Clostridium difficile infection: How to deal with 
the problem. 2008:140.

Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) 
and the Infectious Diseases Society of America (IDSA). Infection Control and Hospital 
Epidemiology 2010;31:25.

in Acute Care Hospitals. Infection Control and Hospital Epidemiology 2008;29:12.

7. Clements ACA, Magalhães RJS, Tatem AJ, Paterson DL, Riley TV. Clostridium difficile PCR 

8. Van Gessel H. Measuring the incidence of Clostridium difficile-associated diarrhoea in a group of 


Further Reading


Attachment 3  National *Clostridium difficile* Infection Workshop Agenda

August 20 2010

**Aim:** to develop a strategy to contain hypervirulent strains of *Clostridium difficile* infection

Workshop Opening  
Lyn Gilbert /  
Chris Baggoley

1. **Situation Analysis:** *Clostridium difficile* infection  
   a. Background Epidemiology and International Perspectives  
      Tom Riley  
   b. Pathogenesis / Genetics  
      Dena Lyras  
   c. Animal Reservoirs  
      Michele Squire  
   d. Local transmission of hypervirulent strain  
      Michael Richards /  
      Megan Robertson

2. **ANZ *Clostridium difficile* Laboratory Survey Results and Recommendations for Testing and Laboratory Practice**  
   John Ferguson

3. **Clinical Management (ASID Position Paper)**  
   Allen Cheng /  
   Tony Korman

4. **Infection Control (AICA/ASID Position Paper)**  
   Claire Boardman

5. **Antibiotic Stewardship**  
   John Turnidge

**Discussion / Questions**

**BREAK**

6. **Current Australian Surveillance**  
   Helen Van Gessel

7. **Point Prevalence Study**  
   David Paterson

8. **Jurisdictional and National Management Options**  
   Chris Baggoley  
   a. What testing should be undertaken to identify CDI?  
   b. Indications for testing for hypervirulent strains of CDI  
   c. How should CDI and hypervirulent strains be reported eg. Should hypervirulent strains be classified as a notifiable disease?  
   d. Reporting and feedback on the national survey for hypervirulent strains  
   e. How can the Commission assist state and territory responses that may be required if hypervirulent strains are detected in the ASID survey?  
   f. What national approach should be undertaken to assist with national coordination strategy?

9. **Future Directions**  
   Lyn Gilbert /  
   Chris Baggoley
### Attachment 4 Summary of the key issues, advice received, suggested actions and resources

<table>
<thead>
<tr>
<th>Issue</th>
<th>Advice from Experts</th>
<th>Resources Available</th>
<th>Gaps / Suggested Action</th>
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</thead>
<tbody>
<tr>
<td>1. How can the health system decrease CDI?</td>
<td></td>
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</tr>
<tr>
<td>i. Implementation of Antimicrobial Stewardship programs in hospitals</td>
<td>Antimicrobial Stewardship publication, <em>Antimicrobial stewardship in Australian hospitals</em>, by the ACSQHC.</td>
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<td></td>
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<tr>
<td>ii. Implementation of Antimicrobial Stewardship programs in aged care and long term residential facilities</td>
<td>Antimicrobial Stewardship publication, <em>Antimicrobial stewardship in Australian hospitals</em>, by the ACSQHC.</td>
<td></td>
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<tr>
<td>iii. Regular audits of ward cleaning and education/training of cleaners</td>
<td>Resources available at state-based level as well as internationally, and the <em>Australian Guidelines for the Prevention and Control of Infection in Healthcare</em>, NHMRC.</td>
<td>Implemented at a state-based level.</td>
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<tr>
<td>iv. Hand hygiene programs</td>
<td>National Hand Hygiene Initiative and relevant State/Territory policies.</td>
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<tr>
<td>vi. Guidance on building design and equipment that can be cleaned easily to minimise infection</td>
<td>The <em>Australian Guidelines for the Prevention and Control of Infection in Healthcare</em>, NHMRC, provide a list of additional resources for facility design. UK “Design the bugs out” program.</td>
<td></td>
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<tr>
<td>vii. Root Cause Analysis undertaken on deaths due to CDI</td>
<td></td>
<td>Implemented at a state-based or at facility level.</td>
<td></td>
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<tr>
<td>viii. Governance of infection control programs</td>
<td><em>Australian Guidelines for the Prevention and Control of Infection in Healthcare</em>, NHMRC, provide guidance on the core components of an infection control program.</td>
<td></td>
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</tr>
<tr>
<td>2. How should CDI be approached in Aged care?</td>
<td>i. Increase awareness to improve detection ii. Increase laboratory testing, and</td>
<td></td>
<td>Implemented at a state-based level.</td>
</tr>
<tr>
<td>Issue</td>
<td>Advice from Experts</td>
<td>Resources Available</td>
<td>Gaps / Suggested Action</td>
</tr>
<tr>
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</tr>
<tr>
<td>Consider laboratory-added testing as indicated</td>
<td>Antimicrobial stewardship in aged care and long term residential facilities.</td>
<td>Guidance from state or facility level.</td>
<td></td>
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<tr>
<td>iii. Laboratory notification of positive <em>C. difficile</em> results to identify reservoirs of infection and clusters</td>
<td></td>
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<tr>
<td>iv. Treatment of UTI infections and separate education programs</td>
<td></td>
<td>Implemented at a state-based or facility level.</td>
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<tr>
<td>v. Education of antimicrobial prescribers</td>
<td></td>
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<tr>
<td>vi. Auditing of Antimicrobial usage with feedback to prescribers</td>
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<tr>
<td>3. How can CDI be established as a notifiable disease</td>
<td>i. Examine whether CDI meets CDNA criteria for notifiability (prevalence, seriousness, potential for action)</td>
<td>Point Prevalence Study conducted nationally from September 2010, to determine rate and severity of risk.</td>
<td>Currently no mandating reporting of such cases.</td>
</tr>
<tr>
<td>iii. CDI not notifiable in conventional sense (i.e. mandatory to report all cases)</td>
<td>Formation of a CDNA working party.</td>
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</tr>
<tr>
<td>Further work</td>
<td>i. Consensus statement on specimen selection, laboratory testing and reporting</td>
<td></td>
<td>Potential for funding of recommended primary detection testing to be recognised on Medicare Benefits Scheme. Promulgation of final recommendations within publication and also via the FRCPA QAP program. Negotiation required with the Health Insurance Commission.</td>
</tr>
<tr>
<td>ii. Funding issue: laboratory determined add-on testing requires medicare recognition, especially in Private Pathology setting.</td>
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<tr>
<td>iii. Surveillance approach</td>
<td>ACSQHC working on agreed national definition for CDI.</td>
<td></td>
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</tr>
<tr>
<td>iv. Most states already using the one case definition</td>
<td>ACSQHC Technical Working Group Implementation Guidelines for CDI.</td>
<td></td>
<td></td>
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<tr>
<td>v. ACSQHC Technical Working Group includes jurisdictional representatives</td>
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</tbody>
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