<table>
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<th>Agenda Item</th>
<th>Resp. Person</th>
<th>Discussion</th>
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<tr>
<td>Welcome and Introductions</td>
<td>Dr. Mayer</td>
<td>Meeting commenced at 3:00 pm. Dr. Mayer welcomed all attendees present and those calling on the phone. New committee members announced; Steve Mickelson, Utah Co. Health Dept., Michelle Marquez, from Avalon Healthcare representing Long-Term Care, and Lisa Pearson, from Specialty Hospital of Utah representing Long-term Acute Care.</td>
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<td>Minutes Reviewed</td>
<td>Dr. Mayer</td>
<td>Dr. Mayer asked for changes or acceptance of the minutes from the September 22, 2015 meeting. Dr. Doug Smith motioned that the minutes be accepted as stands and Dr. Nakashima seconded the motion. The minutes were approved unanimously.</td>
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<td>Utah Hepatitis C Investigation</td>
<td>Dr. Dunn</td>
<td>An acute Hepatitis C (HCV) case was identified with no apparent risk factors. The individual had a history of HCV negative results from Sept 2014 and a positive test in Nov 2014. There were three healthcare exposures during the window period. Two were ruled out as low risk, (dermatology and dental) with an Emergency Department (ED) visit with high risk. Upon further investigation into the ED visit, it was discovered from the Department of Professional Licensing (DOPL) website that a healthcare worker (HCW) who treated the index case was fired for diversion activities. An expanded investigation was begun with the hospital where the index case and diverting HCW came into contact, and expanded to a second hospital when known diversion had taken place. All at-risk patients who were potentially exposed were identified and testing logistics were developed with the facilities. Currently, 31% of the patients at-risk have been tested. Associated cases have been identified. The Utah Department of Health now has the capability to track negative Hep C cases, which will help with new HCV case identification in the future. With the new monitoring systems that track medication usage used by many healthcare facilities, many health care professionals who divert medications are no longer stealing the medication vials, but may share the medication using the same needle and thus increasing the spread of bloodborne pathogens. The need to identify and help HCWs who are stressed needs to be addressed which hopefully will avoid potential drug diversion in facilities. All HCV cases identified in this investigation are currently receiving care.</td>
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<td>HAI Prevention Efforts &amp; Training</td>
<td>Ms. Egbert</td>
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<td>The CUSP/ CAUTI Collaborative with long-term care facilities is continuing. There has been a struggle to keep facilities engaged. Receiving data from facilities is a challenge. Additional people were added to help with getting data results. An additional quality improvement contract has begun regarding <em>Clostridium difficile</em> prevention in nursing homes. There are also proposed CMS guidelines for nursing homes requiring Infection Prevention Programs to be in place with a dedicated Infection Preventionist.</td>
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<td><strong>Dr. Mayer suggested Dr. Bert Lopansri attend the next UHIP GC meeting to present about his C.diff studies in Utah.</strong></td>
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| Ms. Reese |
|---------------------------------|------------|
| Utah Health Care Fall Conference: There was good turnout at the Fall conference with approximately 600 people attending. Karen Singson did a wonderful job with the infection prevention presentation. Collaboration of where we need to be in infection control is the focus. Membership has increased with 111 facilities across the state and would like to work on collaboration with two conferences this coming year, one in St. George and one at the South Towne Expo Center. **Dr. Mayer suggested that at the South Towne Center in September, we aim to have Acute Care facilities partner with Long Term Care Facilities** regarding antibiotic stewardship needs. |
| Speakers are currently being contacted for the Spring conference in St. George and they are accepting suggestions for the September conference with MDRO, CDI or other suggestions. Education is important and Dr. Mayer suggested Dr. Eddie Stenehjem and others for speakers. Ms. Allie Spangler with the Utah Healthcare Association may be contacted with suggestions and ideas for speakers for the conference. |

| Ms. Singson |
|---------------------------------|------------|
| Ventilator Associated Event Education for LTAC facilities: As of January 1, 2016, Long Term Acute Care Facilities will be required to report ventilator associated events in the National Healthcare Safety Network (NHSN). To support this requirement, the UDOH HAI Program offered training to Utah Long-Term Acute Care (LTAC) Facilities in December 2015. Three of the four state LTAC Facilities attended. Surveillance definitions were discussed and case studies were presented. The education was appreciated. |
| **Dialysis Infection Training at American Nephrology Nurses Association (ANNA) Utah Chapter:** The UDOH HAI Program has contacted the ANNA Utah chapter about potentially presenting infection prevention education at the conference in February 2016. Response from the Utah ANNA Chapter is pending. The UDOH HAI Program will also partner with HealthInsight for future dialysis infection prevention trainings across the state during Spring 2016. |
## 2016 NHSN HAI Data Validation Proposal

| Ms. Singson | As decided in the Sept. 2015 UHIP GC Meeting, the HAI event to be validated in 2016 by the UDOH HAI Program will be Colon (COLO) Surgical Site Infections (SSI). Plans are being made to validate 10-12 acute care facilities statewide. Facilities will be selected based on their NHSN 2015 standardized infection ratios (SIRs) for this event, with several high and low outliers chosen in addition to a random selection of those within the middle bounds. The CDC Validation Toolkit for SSIs will be used for the process. Validations will be conducted between May-July 2016. Facilities selected for validation will be notified during first quarter 2016. |
| Mr. McCulley/ Ms. Brinton | **Ebola Assessment Hospital Evaluations:** Intermountain Medical Center, University of Utah Hospital and Primary Children's Hospital are designated as Utah's Ebola Assessment Hospitals. All three have now been evaluated by the Infection Control Assessment Response (ICAR) Team with representatives from CDC, UDOH, and the Salt Lake Health Department. The ICAR Team Assessments went very well. A verbal summary of strengths and suggestions for improvement took at the end of each on-site visit. These facilities have expended great effort to become prepared for Ebola patient management. Some overall suggested areas for improvement noted within some of the Assessment Hospitals were:  
- Regularly scheduled review and continuation of training on donning and doffing of personal protective equipment (PPE)  
- Adequate numbers of trained nursing staff to give patient care up to 96 hours of hospital stay prior to patient transfer  
- Appropriate plans for storage and disposal of CATEGORY A Waste. Assessment Hospitals without on-site autoclaves could fill up containers quickly and may not have adequate storage space available for the expected volume of waste  
- Adequate security of movement of waste through facilities  
- Adequate and prompt decontamination of areas as waste is moved to storage areas.  
- Concern with the ergonomics of smaller statured nurses pulling large, heavy waste bags without risking contamination There is a need for Public Health to interface and assist communication with waste management partners. Federal partners led by state departments have jets available within 24 hours to transport patients and are readily on call with a full, high level critical care flight team. Currently, the specific choice of airport location has not been finalized, but will most likely be Airport No. 2 or Salt Lake International. Other concerns are the transfer of patients within distant areas (Richfield and further south in the state). The distance would require emergency medical personnel to remain in PPE for an extended duration. Continued trainings will take place on how to prepare for walk-in patients and how to handle these emergencies. |
| Ms. Varley | **Frontline Hospital Assessments Guidance/Visits:** Preparations are in place to assess Utah's Frontline facilities as directed by the CDC. The CDC has prepared comprehensive Infection Prevention and Control Assessment Tools for the Acute Care, Long-Term Care, Dialysis, and Outpatient Facilities settings. The UDOH HAI Program has placed the acute care tool into Survey Monkey in order to have Infection Preventionists complete it prior to on-site visits. Initially, 11 facilities have been sent the Survey for completion. On-site visits to address mitigation of gaps will be scheduled beginning January 2016. |
| Ms. Singson | **Statewide Outbreak Trainings and CIC Training Course:** As part of the Ebola grant, the UDOH HAI Program, in conjunction with local health departments and emergency response coalitions, will be conducting Outbreak Investigation and Response Trainings statewide to healthcare facility Infection Preventionists, along with facility emergency managers. Trainings will be held in January and February 2016. |
HealthInsight was awarded a contract with UDOH to the increase of the number of infection preventionists who are certified in infection prevention and control by facilitating two Certification in Infection Prevention and Control (CIC) Course Trainings. The course faculty is currently being finalized and then HealthInsight will begin to invite and register pre-qualified Infection Preventionists to the trainings. The first course will be held March 2016 and a second course September 2017. This generous grant will cover the expenses for taking the course, the review materials, and for the first 20 who pass the CIC certification exam, the testing fee will be reimbursed. This is not a course to help new IPs learn more; it is designed for IPs who have at least two years of experience in infection prevention and control. When invitations are extended, course candidates will be asked to pre-qualify, similar to what Certification Board of Infection Control and Epidemiology (CBIC) requires for the CIC exam. Each course will be limited to 50 individuals.

Utah has been named as a CDC Epicenter Site. This a unique research program in which CDC’s Division of Healthcare Quality Promotion collaborates with academic investigators to conduct innovative infection control and prevention research. The program initiated in 1997 as a way to work directly with a network of academic centers to address important scientific questions regarding prevention of HAIs, antibiotic resistance, and other healthcare-associated adverse events. The University of Utah was named as one of the five new facility sites, joining with current Epicenters to make a total of 11 across the country. The main focus for the New Epicenters is to identify innovations for preventing transmission of pathogens, including Ebola, in healthcare settings during interactions between healthcare workers, patients, personal protective equipment, and the environment.

There are four major projects which include: 1) measure transmission of pathogens; 2) regional coordinated strategy to prevent transmission; 3) enhance effectiveness of PPE use against transmission; and 4) transmission of pathogens to healthcare personnel (HCP). Utah’s Regional Coordinated Strategy builds on a substantial foundation of the past Utah Regional MDRO Collaborative. Healthcare epidemiology community in Utah has already worked across facilities and partnered with state and local health departments when public reporting of infection started 2008 and emphasized collaboration, consensus, and transparency. A Carbapenem-Resistant Acinetobacter (CRAB) outbreak throughout Utah facilities in 2009-10 highlighted problems in sharing information as patients were transferred between facilities and the need for mandatory reporting of patients with highly resistant GNRs. This grassroots activity among epidemiologists and infection preventionists led to adding CRAB/CRE to the Communicable Disease Reporting Rule in 2013 and the development of a regional approach to MDRO control in 2012 with a multi-disciplinary MDR collaborative with stakeholders from healthcare, public health, emergency medical services and labs.

Utah’s Regional Coordinated Strategy for the future includes:

- Use theory and methods drawn from social psychology and sociotechnical system analysis to improve generalizability and advance implementation science in public health
- Evaluate effectiveness of information flow using a novel tracer methodology
- Work with public health to advance development of an automated MDRO registry
- Develop agent-based models which can guide selection of surveillance strategies to help inform the regional approach to MDRO control
This will enhance the Utah Regional MDRO Collaborative by:

- Expand the membership to include all healthcare systems and involve some skilled nursing facilities
- Create additional work-groups to provide outreach education and a forum to develop recommended practices
- Include advisory teams to plan for informatics innovations and surveillance strategies
- Add an advisory board of recruited national and local leaders in quality initiatives, epidemiology, public health, and organizational psychology to provide vision, strategic direction, and expert advice

There are 2 important aims in being successful with this work. They are:

**Aim 1: Overcome barriers to regional collaboration**

- Relationships among groups in the collaborative
  - If each organization gives up some self-interest and acts collaboratively, then collectively all do better
  - From the cognitive science perspective, the key question is
    - What drives decision-making!
    - Research on social dilemmas suggests mental models of individuals are most influential in shaping the “identification of the situation”
- To understand how to optimize our relationships
  - Focus groups
  - Surveys
  - Plan to
    - Promote social connections
    - Come to consensus regarding how information will be shared
    - Identify incentives for participation

**Aim 2: Implement and evaluate regional system processes to share information**

- Evaluate communication between “senders” to “receivers” to identify potential areas for improvement
- Use an adaptation of the JC tracer methodology
- Trace known MDRO patients as they are transferred across facilities to assess full chain of communication
- Two key steps: the infection control transfer form used by the sending facility, and if so, is it accurate?
- Do bedside nurses demonstrate awareness of a patient’s MDRO status and do they respond appropriately?
- Recruit 2 facility pairs with back/forth movement
- Chart reviews at Sending Facility
- Contact bedside nurse caring for transferred patient at Receiving Facility
- MDRO Collaborative to serve as a forum
- Discuss and decide on methods to generate graphical displays, exposure networks, aberration detection models, and modeling potential surveillance strategies and interventions
- Lay the foundation to develop an automated MDRO registry
- Provide more comprehensive notification of MDRO status at readmission or transfer
- Promote a trusted broker in the form of a regional public health agency
- Need to address legal, privacy, and security concerns
- MDRO registry technical advisory team will learn from the Illinois XDRO registry experience
- Confer with legal experts and administrators from public health and healthcare systems
- Conduct a needs assessment with relevant healthcare stakeholders to determine preferred mode of access
• Develop inter-institutional data access agreements for providers with a “need to know”

Updates from the CRE Surveillance Task Force:
• HAI Administrative Rule
  • CRE definitions not yet updated...
  • Once updated, CRE lab documents on UDOH website will need to mirror
• Current CRE/CRAB surveillance:
  • 2015 preliminary data for CRE:
    • Thru 9/15: CRAB 28; CRE E. coli 3; CRE Klebsiella 14 (8 surveillance); CRE-Enterobacter 4
    • Thru 2009 -11/15: 19 Carbapenemase Producers
      • 15 KPC; 2 NDM; 1 IMP
    • From 2015: 11 KPC, 1 NDM, 1 IMP (9 of the 13 were from surveillance testing)

Proposal for a Targeted CRE Point Prevalence Study
Chicago's REALM project is the model
• CRE surveillance 2 x/year from all adults in ICU and LTACH beds across the city
But no designated funding: need a feasible approach for the Wasatch Front
• Develop cost effective options that will provide value to all healthcare systems
  • Selected ICUs?
  • Selected facilities?
  • Work with labs to identify cost effective approach
    • Screening inexpensive -> submit suspicious isolates to CDC for carbapenemase testing

Next steps:
• Early 1/16: Meet w/ IH Epi Lab and ARUP early Jan 2016
• Late 1/16 -2/16: Meet w/ Epidemiologists/Infection Prevention Manager (or appropriate facility rep) from various healthcare systems/LTACHs
  • Facility representatives to discuss with administration and/or J Mayer to request time at a UHA venue
  • Present proposal at next UHIP-GC
• Develop protocols to test high risk individuals
• Requested from other medical centers
• Recommendations for outbreaks
  • Triggers for when, as well as guidance for where, who and how
• How the Epicenter work on relationships will help us:
  • Confidentiality
  • If all gain from the info, can we address barriers with resources
    • e.g.; all commit to a rainy day fund
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<tr>
<th>Committee Membership and 2016 Meeting Schedule</th>
<th>Dr. Mayer</th>
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<td>UHIP GC meeting schedule for 2016 will be as follows:</td>
<td>Dr. Mayer will work on getting the CRE Task Force and the MDRO Collaborative together again.</td>
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<td>Tuesday, March 15,  3:00 to 5:00 pm</td>
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<tr>
<td>Tuesday, June 21,  3:00 to 5:00 pm</td>
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Meeting adjourned at  4:53 pm

Next meeting will be  March 15, 2016  3:00pm, State Capitol, Olmsted Room