

UHIP Governance Committee Meeting ~ March 15, 2016

Attendees: Heidi Carter, Pam Clark, Judy Daly, Linda Egbert, Randon Gruninger, Rhonda Hensley, Dr. Jeanmarie Mayer, Kevin McCulley, Susan Mottice, Dr. Allyn Nakashima, Lisa Pearson, Carolyn Reese, Karen Singson, Sherry Varley, Patti Watkins

Excused: Terry Clemmer, Kelly Criddle, Arlen Jarrett, Wayne Kinsey, Doug Smith, Emily Sydonr-Spivak

Action Items Highlighted in Yellow

Agenda Item	Resp. Person	Discussion
Welcome and Introductions	Dr. Mayer	Meeting commenced at 3:00 pm. Dr. Mayer welcomed all attendees present and those calling on the phone. Mr. McCulley asked regarding participation on the committee by a representative from the Local Health Officers Association. Currently, Mr. Mickelson represents local health departments on the committee.
Minutes Reviewed	Dr. Mayer	Dr. Mayer asked for changes or acceptance of the minutes from the December 15, 2015 meeting. Ms. Daly motioned that the minutes be accepted as stands and Ms. Egbert seconded the motion. The minutes were approved unanimously.
HAI Prevention Efforts & Training 2016 NHSN HAI Data Validation Activities 2016 Spring Trainings	Ms. Singson	<p>Ms. Singson proposed an external audit from the UDOH HAI Program of ten facilities who reported postop surgical site infections following colon surgical procedures (COLO SSI), May 16 through June 30, 2016. Facility selection will be based upon facilities' submitted data in the National Healthcare Safety Network (NHSN) and will target: 1) facilities reporting higher rates of COLO SSI than NHSN COLO SSI benchmark data, 2) facilities reporting lower rates of COLO SSI than NHSN COLO SSI benchmark data, and 3) facilities with significant difference between the number of actual COLO SSI reported to NHSN during 2015 as compared the expected number of COLO SSI calculated by NHSN based upon the facility's COLO procedure volumes and case severity. Notification letters will be sent to selected facilities by the end of March.</p> <p>The following trainings will be provided by the UDOH HAI Program:</p> <ul style="list-style-type: none"> ○ Statewide Dialysis Infection Training Sessions, May 4 in SLC, May 16 in St. George ○ Utah School Nurse Association Spring Conference, May 6 ○ Utah Association for Home Care Annual Conference, May 10 ○ Association for Utah Community Health Spring Conference, May 12

UHIP Governance Committee Meeting ~ March 15, 2016

<p>Utah Hepatitis C Investigation</p>	<p>Dr. Nakashima</p>	<p>Dr. Nakashima reviewed findings from the current UDOH Hepatitis C Virus (HCV) Investigation. Cases of healthcare associated HCV have increased due to increased medication security and healthcare medication diversion activities. The CDC asked the UDOH to evaluate a person recently identified with newly acquired CHV infection for a healthcare associated exposure. Upon further evaluation, this person's HCV infection was linked to a healthcare worker who had been identified as diverting drugs in two facilities. These facilities identified several thousand potential exposures. Both hospitals were very cooperative and sent letters to individuals offering free testing. A press conference with UDOH and both facilities is scheduled in April.</p>
<p>Zika Virus Update</p>	<p>Dr. Nakashima</p>	<p>Several practitioners in Utah have requested Zika virus testing in light of the current outbreak in affected countries and associated travel of their patients. Most requests are for pregnant women who have been to affected countries or husbands of pregnant women who have been to these countries. Of those tested, only 19 results have come in. Of the 19 tested, only one was positive and that was from a child who traveled to Tonga with his family. To date, 74 Zika Virus tests have been requested and 64 tests have been sent to the CDC for confirmatory testing. Current result turn-around time is averaging about 4 weeks due to the large volumes currently experienced by the CDC. Initial tests come through the Utah State Public Health Laboratories (UPHL) and then sent to CDC. Physicians can work with local health departments to get correct forms and instructions on how to handle samples. The UPHL will have confirmatory Zika virus testing capability in the next few months.</p> <p>The Utah Department of Health and the CDC have information on their websites. UDOH is testing any pregnant women who feel they have a concern. Men who may feel they have been exposed should abstain from sexual contact with a pregnant woman because there are too many unknowns in this area. Women thinking of becoming pregnant should wait three to four months longer after returning from infected countries for safety concerns. Mosquitoes capable of transmitting Zika virus have not currently been identified in Utah.</p> <p>UDOH and CDC are asking clinicians are asking to follow the suspect patients during the entire pregnancy of those who are tested in order to get a baseline of symptoms, etc. so we can have a better idea of what we can do to help improve our knowledge of Zika virus and associated pregnancy outcomes.</p>

UHIP Governance Committee Meeting ~ March 15, 2016

<p>Ebola Grant Efforts Hospital Ebola Assessments Update</p>	<p>Mr. McCulley</p>	<p>UDOH Public Health Preparedness is currently working on two Ebola grants. One is the Health Care Preparedness Program which focuses on medical facilities, hospitals, regional coalition's facilities and EMS. This grant goes until 2020. The second grant that is being worked on is the CDC Public Health Emergency Ebola Supplemental which was scheduled to go until 2016, but has been extended to July 2017 to give sub grantees an opportunity to adopt their existing Ebola work to include other specific pathogens and to address Zika.</p> <p>A three-part functional Ebola Exercise is scheduled for April 28, 2016. In Phase I, each local health department will identify two healthcare entry points within their jurisdiction and evaluate the facility's capability to appropriately initiate infection prevention measures, identify a suspect Ebola patient, implement isolation precautions, and inform other partners, such as the local health department. In Phase II, local health departments will be notified of a person of concern and then contact Dr. Allyn Nakashima to determine jointly, if this person should be assessed in an Ebola Assessment Hospital. This scenario will include how waste is handled and who else this person has been in contact with, including animals. There will not be any real transport of patients during this exercise. Phase III will allow Utah's three Ebola Assessment Hospitals to test their processes when a suspect Ebola patient enters their facility.</p> <p>Practical protocols are being developed and the functional exercise will help evaluate how difficult these processes are to follow. The EMS portion still has numerous questions. They have a difficult time with how to handle this because their protocol right now is for all EMS personnel to go into the house. It may be time to ask the travel questions when EMS are asked to go into a home. With what has been learned over the past two years, changes need to be made to get information of what and where the patient has been for the last 21 days. Travel questions need to cover inside of the United States as well as travel to other countries. A recommendation would be that even when these problems are not in the news, we keep them in the forefront of our minds and questioning process of patients. Future functional exercises will test movement capabilities of suspect Ebola patients to Ebola Assessment Hospitals and air transport to our designated Ebola Treatment Facility in Denver, Colorado.</p> <p>Dr. Nakashima encouraged attendance at future One Health conferences as much of 70% emerging infectious diseases are zoonotic, such as Ebola.</p>
<p>Frontline Facility Assessments</p>	<p>Ms. Varley</p>	<p>In response to the possibility that healthcare facilities might treat persons with Ebola or other highly infectious diseases, the CDC has required public health departments to assist and assess facilities' capacities to control and prevent transmission of infections. These assessments will enable the CDC to be better positioned to provide technical assistance to states and facilities, and provide status updates of healthcare facilities' infection prevention capacities to the Department of Health and Human Services and other partners. The UDOH HAI Program has collaborated with local health departments to complete these facility assessments. The UDOH HAI Program committed to CDC to complete at least 20 assessments by March 31, 2016; twenty-eight assessments will be completed by the end of March. The UDOH HAI Program will complete assessments of all of Utah's hospitals, long-term care facilities and dialysis centers by the end of the Ebola Supplement Grant cycle, March 31, 2018.</p>
<p>Statewide Outbreak Trainings</p>	<p>Ms. Singson</p>	<p>From mid-January to the end of February, the UDOH HAI Program partnered with local health departments and Emergency Response Coalitions to provide eight statewide outbreak trainings. Persons from healthcare facilities with accountability for Infection Prevention or Emergency Management were invited to learn and network with representatives from their local health departments and preparedness coalitions. Trainings were very well received.</p>
<p>CIC Training Course</p>	<p>Ms. Egbert</p>	<p>The first of two CIC training courses begins tomorrow. Two national presenters, Kate Gass from Barnes Jewish Healthcare System (Kansas) and Carol Vance from St. Elizabeth's Hospital (Illinois) will teach the Spring 2016 course. Thirty-four persons have registered. Participants will be accommodated travel and lodging needs for persons living further than 50 miles from the Crystal Inn in Murray, where the course is being held. The course is not cost and the APIC CIC Study Guide, as well as other course materials, are being</p>

UHIP Governance Committee Meeting ~ March 15, 2016

		<p>provided to participants at no cost. Exam cost reimbursement will be provided to the first 20 participants who successfully pass their initial CIC exam. Fewer participants from outlying areas are coming, so the next course in September 2017 will focus on these facilities. Participants must meet eligibility criteria to take the initial certification exam as set forth by the Certification Board of Infection Control (CBIC) and must practice within Utah.</p>
<p>HAI Module in Epi Trax</p>	<p>Ms. Mottice</p>	<p>Ms. Mottice has joined the UDOH HAI Program and will assist data management needs. Mr. Gruninger will assist the program with data analysis needs. Funding from the Ebola Grant will allow development of a data management infrastructure for the UDOH HAI Program to meet their data needs, as well as develop an electronic surveillance system using lab data submitted from facilities to better detect infection prevention related outbreaks in a more timely manner. Currently, the state electronic surveillance database is modeled after decades-old paper disease surveillance. It is undergoing revision to better collect and utilize electronic data. The HAI team currently doesn't currently use much of the existing state surveillance system (known as TriSano or UT-NEDSS), but part of the Ebola funding will pay to create an HAI-specific module inside of the surveillance system. The Communicable Disease Reporting Rule now includes laboratory identified <i>Clostridium difficile</i>. <i>C. difficile</i> data will be used to build the surveillance system with the desire to expand to other options such as MRSA bloodstream infections and other multidrug resistant organism surveillance.</p>
<p>Current Clostridium difficile NSHN data</p>	<p>Ms. Mottice</p>	<p>Ms. Mottice reviewed NHSN hospital onset <i>C. difficile</i> infection standard infection ratios for the past 8 quarters upon request to evaluate seasonability of <i>C. difficile</i> infections. Upon evaluation, seasonability was not demonstrated. Members of the committee voiced concerns regarding infection preventionists' understanding of testing type in the NHSN CDI module. Linda Egbert will send an email to all IP's with the definitions and terminology explained.</p>
<p>CDC-HAI Prevention Epicenter Program Proposal</p>	<p>Dr. Mayer</p>	<p>Regional outbreak of CRAB in 2010 highlighted need for collaboration. CDC funded health department grant that led to the foundation of a regional collaborative to control MDRO/CRE (2012-2013). This foundation provided:</p> <ul style="list-style-type: none"> ○ Grass roots push to mandate CRAB/CRE reporting ○ UDOH data resource to support outbreak investigation and provide feedback to facilities ○ Connections with stakeholders at varied organizations ○ Surveyed lab resources across Utah ○ Developed transfer form to communicate infection status ○ Involved EMS in communication of MDROs at transfers ○ Trainings in MDRO control for staff in critical access, rural, and LTCFs <p>Future MDRO collaborative projects should include CRE to help recommend surveillance strategies, discuss visualization for regional situational awareness, and consider use of mathematical models to guide interventions. Inclusion of <i>C. difficile</i> will help with antibiotic stewardship needs and further surveillance strategies, as previously discussed by Ms. Mottice.</p> <p>The University of Utah's Epicenter Project to Enable Effective Collaboration has two main aims. Aim 1 will focus on overcoming barriers to regional collaboration by encouraging broader Infection Preventionist participation via individual facilities and APIC, strengthen ties to health department through trainings and work groups, and recruit and encourage participation from LTCFs. Aim 2 will focus on implementation and evaluation of regional system processes to share information. The Joint Commission's "tracer" approach will be used to evaluate current communication between "sender" to "receiver" of patient's infectious status. Aim 2 will also evaluate needs to develop and allow access to a statewide MDRO registry. The tracer evaluation methodology to evaluate inter-facility communication by recruiting pairs of Acute Care Facility: LTACH/SNF sharing patients. This method will require ability to pull/share line list of transfers with the health department. The UDOH MDRO collaborative epidemiologist would be asked to assist the project by reviewing charts to identify who met infectious status criteria, determine if sender completed infection control transfer forms and how, identify if there is</p>

UHIP Governance Committee Meeting ~ March 15, 2016

		<p>documentation of infectious status in transfer materials, and contact front line staff caring for MDRO patients on receiving end, as well as inquire if they aware of / what was their response to MDRO status. This information will be used to identify gaps in communication</p> <p>The project proposes that UDOH be the trusted broker for a statewide MDRO registry. Currently, UDOH Informatics is working on acquiring accurate and comprehensive microbiology data. EpiTrax would be used as the IT platform for the MDRO registry. A MDRO registry would need to address legal, privacy, and security concerns. To do this, an MDRO registry technical advisory team will need to confer with legal experts and administrators from public health and healthcare systems and learn from others, e.g. the Illinois experience. The MDRO registry technical advisory team will also need to develop inter-institutional agreements of data access for providers with "need to know," and conduct a needs assessment of potential future users.</p> <p>To accomplish these outcomes, current CRE reporting needs improvement. Although reporting is mandatory, there are gaps. Facilities may be unaware of reporting criteria. Do sites know about recent rule changes? Variation exists in facilities' MIC breakpoints. Optimally, sites would use <u>current</u> CLSI breakpoints even if interpreted as "S" or "I." Other issues might be that facility personnel may not receive alerts and some labs may not be submitting to the health department. UDOH plans to widely communicate criteria to all reporters (e.g.; via APIC, lab contacts), encourage ELR and provide MICs, apply same breakpoint criteria regardless of interpretation and re-evaluate LHD case report form.</p> <p>The EpiCenter project proposes that CRE surveillance testing recommendations. These recommendations include testing of all select high risk patients, e.g. Johns Hopkins screens all inpts hospitalized outside US over prior 6 months. Testing would be billable to the patient. Other high risk patients would be roommates or other patients in same care location w/shared healthcare personnel. Testing should also attempt to sample discharged patients. To help accomplish testing in smaller facilities, we should consider all healthcare systems contribute to a "rainy day fund." A regional point prevalence survey should also be conducted where all patients in Med/Surg ICU and LTACH high observation beds are tested for CRE using CHROMagar cultures, so the prevalence survey would be relatively inexpensive. Prevalence survey collection would be over a short time and each acute care facility would be asked to cover their own testing costs. The project funds would cover sampling costs from LTACHs and the Veterans Administration Hospital (estimate ~\$200/10 pts depending on # that require additional work up).</p>
		Meeting dismissed at 5:05 p.m.