Utah Department of Health & Human Services

Meeting Minutes

Multidrug-resistant organisms (MDRO) Utah Healthcare Infection Prevention Governance Committee

Date: 07/06/2023

Attendees:
Amy Glidden, Angela Weil, April Clements, Ashley Miller, Bea Jensen, Charisse Schenk, Elena Snelten, Giulia De Vettori, Jeanmarie Mayer, Jeff Rogers, Linda Rider, Marci Thrall, Sarah Rigby, Stephanie Williams, Trina Keane
Agenda Topics:
Introductions 1:00–1:05 Introductions Action Steps/Plan 1:05–1:40 Review action plan & outcomes, Action plan updates, Disseminate information, Project Firstline resources, IPC resource list Situational Awareness 1:40–1:50 Current state of MDROs Additional Questions/Discussion topics 1:50–2:00 Convene
Discussion:
Introductions - Giulia De Vettori ● Chair: Elena Snelten, Lead IP at the VA, CIC ○ Attendees introduced themselves in the chat **Action Steps/Plan - Elena Snelten** ● Review action plan and outcomes ○ Elena explained the purpose of the subcommittee ■ To support the main UHIP committee as a whole. This subcommittee focuses on the MDRO education aspect in order to provide additional support to all healthcare settings in Utah, but mainly focus on those that have a deficiency in IPC knowledge ○ Refer to the agenda that was sent out on 07/06/2023 for the subcommittee's mission, vision, goals, and action plan ● Action plan updates ○ Interfacility transfer form - many do not know that there is an interfacility transfer form. The current transfer form was designed after the CDC's recommendations. The

intent of that form was to help identify patients going from facility A transferring to facility B and identify any organism that they might have. The current form was 2 pages and the subcommittee felt it would be best to consolidate it down to 1 page, in a simplified format to be more user friendly across the board for everyone. The form was presented at the Healthcare facility call where feedback was given from Dr. Mayer, Dascomb, and Pavia.

- Giulia showed what the previous transfer looked like
  - The form previously had arrows, a PPE section, and the precaution section did not mention Enhanced barrier precautions
- Updates to the new transfer form
  - Form is down to 1 page
  - More user friendly (removed the arrows)
  - Added Enhanced barrier precautions as an option under Isolation Precautions
  - Added Enterobacterales bacteria resistant to ESBL
  - Removed the PPE and Immunization section
- A few members just left the healthcare call where suggestions were given
  - Giulia took notes on the suggestions in order to incorporate them into the new transfer form
  - Suggestions included:
    - Restructure the listings of the organisms and put them in the hierarchy of level of concern
      - Anything that is carbapenamse-producing organism, C. auris, CREs
    - Make it a red, yellow, and green light system
      - Elena has a concern with the color light system because it may be confusing because if they see green they may think that isolation is not required
      - There are other facilities in the system that use a color coated system so it may not be a good idea to incorporate this into a statewide form
    - Elena asked Dr. Mayer if she had an idea on the kind of verbiage should be included:
      - Dr. Mayer mentioned that since there is a big list of organisms that is so broad, do we even isolate for some of those at acute care facilities? If they do not isolate at acute care facilities, maybe they shouldn't be posted on the form? Or if the definitions are different. Dr. Mayer also mentioned concerning CRPA, an idea from Dr. Pavia, that it can be labeled as "difficult to treat". That may be more clinically applicable.

        - Elena suggested listing the more difficult organisms as they are, but some of the less concerning organisms under “Other” and write “Identify what organism is being isolated”. That way the nurse or social worker would need to indicate that. The facility is still being notified what the organism is and the facility can place the needed isolation practices as needed.
        - Dr. Mayer also mentioned that on the previous call, we can have this form and people can use it, do people actually see it, use it, and implement it within the facility?
        - Elena said that that is one of the other goals of this subcommittee, that if we are going to go to all the work to create this form, the point of this group to help disseminate this information out
        - Dr. Mayer mentioned that even if it is not always implemented, this could be a tool for staff to notice which organisms to pay attention to
    - The interfacility form will be attached to form the minutes for attendees to review and provide suggestions

- Which routes/pathways to take to disseminate information within this subcommittee
    - The way that this subcommittee will be fruitful is through this mult-disciplinary collaboration through different providers, nurses, managers, administrators throughout the healthcare systems in Utah - getting more participants from these aspects, that would be helpful
    - Let's use our networking skills to help increase our participation for this meeting

- Project Firstline Resources - Sarah Rigby
    - Project Firstline is a CDC initiative to bring infection prevention training to frontline staff
    - Sarah gave updates on what the Project Firstline team at DHHS has been working on:
        - **MDRO Guide**: Finalized the creation of the MDRO binder/guide. The MDRO guide has recently been printed so it is available for distribution
            - https://epi.health.utah.gov/wp-content/uploads/Utah-healthcare-associated-infections-guide_MDRO.pdf
        - **Flashcard deck**: Based off the information from the MDRO guide, leaders can use the flashcards to help train staff on-the-go
        - **Module creation**: New modules that are currently being created include a Building Concerns Series, which highlights building management concerns that relate to IPC

- Elena mentioned that she likes that the materials have been created looks similar to the CDC threats materials that the CDC has created, but this is much more tangible and user friendly
- Basic infection prevention self-paced modules: https://utah.publichealthcloud.com/www/lms2/training-library.aspx?trainingLibraryID=3
- Candida auris modules: https://utah.publichealthcloud.com/www/lms2/training-library.aspx?trainingLibraryID=4
- MDRO guide: https://epi.health.utah.gov/wp-content/uploads/Utah-healthcare-associated-infections-guide_MDRO.pdf on DHHS MDRO website: https://epi.health.utah.gov/mdro/
- How can PFL help your IPC education? Fill out the content request survey if you have ideas or would like to discuss more: https://redcap.link/pflcontent

Situational awareness - Jeff Rodgers/Giulia De Vettori

Current State of MDROs

- C. auris - Have not identified anymore in state transmission. The most recent case that we do have came from NV. We are trying to track down the path of the patient when the patient arrived at UT. More to come.
- CRAB - We have seen increasing numbers and encourage to perform admission screenings, especially in vent/trach units
  - CRAB is notorious for being an environmental reservoir it can be on skin, a wound, on equipment, and in the environment
  - If you have someone coming from a facility with a known CRAB, have that documented and communicated to the receiving facility
- VIM CRPA - We have seen increasing numbers - several are linked to the contaminated artificial tears. We recommend making sure that recalled items have been discarded
  - Initially it was only a single facility that the cases were isolated to
  - Nationwide outbreak of pseudomonas aeruginosa attributed to contaminated artificial tears products
  - Initially it was thought that there weren't any epidemiological links between the patients. They were looking at international tourism, but no links were identified. Started to see other hits once the CDC was involved in WGS. Results started coming into the CDC and a pattern was discovered. Finalized that it was not epi-linked, but due to a contaminated product
  - Currently the HAI/AR team has identified another facility in Utah that has 2 additional cases. It appears that one case is directly linked to the artificial tears contamination and the other we anticipate it will be connected as well. HAI/AR team recommends making sure all of these recalled items have been discarded from facilities

- The good news is that the VIM CRPA does not seem to be connected to IPC practices, but related to contaminated products
- Dr. Mayer: So you said that there are two facilities, does that mean these are new cases that have been identified that have cropped up?
- Jeff: At the initial facility, we have identified 6 patients. Most of those were clinical infections. One came from a screening we did at a facility. These two new cases were identified as clinical infections. We are working with the LHD and facility to schedule a screening to see if there are any others that have been exposed or used this contaminated product
- Dr Mayer: So it sounds like there have been 8 patients that have been identified in the state, 6 at one facility, 2 at another facility. The one with 6 patients, all were exposed through the contaminated product and you haven't identified any other than that.
- Jeff: Correct
- Elena asked concerning the CRA, in terms of locality of the infections, are they wounds? Are they trach patients? Where are these infections occurring?
- Giulia mentioned that the HAI/AR team has been testing for sputum, skin, and wound. Now as we are looking at screening, the team is looking more at sputum and skin and focusing on vent/trach patients.
- Dr. Mayer: How widespread is the screening? Is it something that the state helps the facility if they notice cases or are there a number of facilities that just do active screening as part of their routine?
- Angela: There is no widespread screening effort specifically for this in particular. I think that likely some of the reason that many of the cases have been identified in vent/trach patients is because of the fact that it's the eye drops. It is often identified in the sputum as a part of the asymptomatic admission screening to other facilities. We possibly look back at the facility of origin. It makes sense with the artificial tears in the direct pathways into the sputum, that is where we happen to see a lot of cases. There is no widespread screening of every patient without any case to screen specifically for this. Just admission screenings for facilities that do them.
- Dr. Mayer mentioned that she thought that in the past, at least one LTACH did universal screening on every patient that got admitted. She asked if there are a few centers that do it
- Angela mentioned that yes, there are a few centers that do that. It is more broad, sending a culture rather than looking for this specifically. It is more looking at a high-risk population for anything that may come up and sometimes this is identified in that process
- Elena asked if there were any IPs from an LTACH on this call that can speak to their screening practices on their admission screenings
- Elena mentioned that back when she worked at an LTACH three years ago, they screened for everything

Additional Questions/Discussion Topics

- Dr. Mayer: Tariq was talking about the ECHO webinar series, is there anything within this group that could be used as an ECHO call for LTCF about these organisms?
    - Elena mentioned that she would love to be able to identify some sort of training communication like that. Elena would love any input or guidance or direction.
    - Dr. Mayer asked if that is something the HAI/AR team can work with Tariq to have one dedicated to awareness about MDROs?
    - Angela mentioned that previously we had a HAI ECHO series for the LTCF and it is something that we would consider doing again. There was difficulty getting engagement from the target population, which is always one of the biggest challenges. We are hoping that with the current ECHO series that Tariq has set up, we are hoping to recruit more physician and nursing staff than what was present in the past because it is going to be clinically focused. If we are able to get those people to participate, we would like to try and see if we can leverage those calls to see if there would be interest in expanding that to some IPC topics.
    - Dr. Mayer suggested that there is tension between AS group and the infection prevention group because if we screen and identify organisms, that may prompt people to think they need to treat or eradicate, so working together to get that message out
    - Angela mentioned that oftentimes in LTC, they aren't separate groups because it typically would be their director and DON, so there is an advantage that there isn't a push and pull, but the disadvantage that there is only a very small piece of what they are focused on when trying to comprehensively take care of their residents
    - Elena mentioned that there is an advantage at LTC that usually it is the same providers because they do not rotate. There is always the same NP and administrators that you see everyday
- Elena asked everyone to review the documents that Giulia sends out, feel free to email Giulia or Elena
- Dr. Mayer: Jeff had mentioned that the 6 patients all had been linked to the contaminated products. Was there any who weren't linked and haven't investigated the other facility where there was the two patients? Dr. Mayer is surprised that the contaminated products are still out there
    - Jeff mentioned that he doesn't think that with the other facility that they have been able to look at the coordination has been done to send in the product. They do appear, and at least one confirmed, is related to the others, it fits the profile for the case definition that CDC outlined. We are finalizing the results on the second one
- Dr. Mayer asked how many out-of-state patients/residents that have been from other states that have come in with C. auris? Has there been 3 that have been identified?
    - Angela mentioned that it is still the four mostly in the Southern Utah area. Currently none of them are still in any Utah healthcare facility.
    - Dr. Mayer asked that since the U had one out-of-state individual that was cared for at the U, then would that individual be counted in those four if they are not a Utah resident?
        - Angela mentioned that in regards to how the CDC counts numbers, we would still see Utah as zero because they do not attribute the cases to us, unless

transmission occurred in Utah. Those are the investigations that we have done, but we do not attribute any of those to Utah

- Dr. Mayer asked about CP-CREs, has that been an issue as well?
  - Angela mentioned that it is something that is always on our radar. A lot of the large volume cases that we've seen recently have been more of the VIM CRPA and the CRAB cases, but we do always see a baseline number of the CP-CRE as well
  - Dr. Mayer mentioned that they see very few, so if there was an issue in a facility or other parts of the state, that would be helpful to know
  - Angela mentioned that most of the cases that we've seen have been more one-off cases where its been identified here and there

Convene - Giulia De Vetorri

Every eight weeks

- 08/24/2023

Minutes will be posted to the HAI website on Monday

- https://epi.health.utah.gov/uhip-governance-minutes/