MDHHS Liaison Report

BUREAU OF EPIDEMIOLOGY AND POPULATION HEALTH

Communicable Disease Division

Viral Hepatitis, HAI, and TB section

Surveillance for Healthcare-Associated and Resistant Pathogens (SHARP) Unit

Staffing Changes in the SHARP Unit

The SHARP Unit would like to welcome Chardé Fisher as our new Health Educator. Chardé comes to us from the Viral Hepatitis Unit where she served as the VH Prevention Coordinator. Chardé will be helping the SHARP Unit with everything from trainings, brochure development, factsheets, posters, website content, curriculum development, conference planning, social media and more! Though she will be sitting in the SHARP Unit, Chardé will also be helping the VH/HAI/TB and BA Section and CD Division.

Allie Murad will be departing the SHARP Unit. Allie accepted the position as the BRFSS Coordinator with Lifecourse Epi and Genomics Division. Allie has been in the SHARP Unit over 6 years and has been affectionately… and nationally known as a NHSN Super User. Allie has contributed a lot of great work, time, data, reports, ideas, and fun to our unit and Division. She will be missed, but we wish her well! Allie's last day with SHARP will be 11/3.

Michigan SHARP HAI Surveillance Initiative

To date, the SHARP Unit has recruited 106 hospitals that have agreed to share their NHSN data with us. 105 of the 106 participating hospitals have given us permission to share select NHSN data with the Michigan Health & Hospital Association (MHA), and 14 hospitals have given us permission to share NICU data with the Vermont Oxford Network (VON).

Additional hospitals are welcome to join this surveillance initiative. The SHARP Unit is particularly interested in enrolling more Long-Term Acute Care (LTAC) facilities. We are also encouraging skilled nursing facilities to use NHSN and to share their HAI data with us by using the Long-Term Care Component within NHSN. Questions from hospitals or skilled nursing facilities about joining this HAI surveillance initiative can be sent to Sara McNamara at mcnamaras5@michigan.gov.

Bi-Monthly Michigan NHSN User Calls

On the 4th Wednesday every other month at 10:00 a.m., the SHARP Unit holds a one-hour conference call to provide updates on NHSN, review problem areas using NHSN, and/or provide brief training on NHSN definitions, modules, or case studies. Anyone using NHSN may participate in these calls. You do not need to identify yourself or your facility on the call. The next call is scheduled for Wednesday, October 25th. Call-in information, an agenda, and meeting minutes from previous calls can be found on the MDHHS SHARP HAI website approximately one week in advance at www.michigan.gov/hai.

MDHHS SHARP NHSN Reports

The 2015 Statewide and 2016 Q1 thru 2017 Q1 Regional TAP Reports are being updated, and will be posted soon to the www.michigan.gov/hai website. Participating hospitals will receive corresponding individual TAP reports via password-protected email.

Communicable Disease Surveillance and Reporting Changes Coming January 2018

Disease/Condition	Required to be Reported	New Condition in MDSS	New Standardized Case Definition	New form in MDSS
Carbapenemase-Producing Carbapenem-Resistant Enterobacteriaceae (CP-CRE)	**Y**	**Y**	**Y**	**Y**
Perinatal Hepatitis C	**Y - no changes to current reporting requirements**	**Y**	**Y**	**Y**
Perinatal Hepatitis B	**Y - no changes to current reporting requirements**	**N**	**N**	**N**
Candida auris	**Y – Unusual Occurrence**	**N**	**Y**	**N**
Extrapulmonary Non-Tuberculous Mycobacterium (NTM)	**N - Optional**	**N**	**Y**	**Y**
Latent Tuberculosis Infection (LTBI)	**N - Optional**	**Y**	**Y**	**Y**

CP-CRE Becoming Reportable January 2018

Council for State and Territorial Epidemiologists (CSTE) Position Statement 17-ID-04 was passed in June 2017 making CP-CRE nationally notifiable, meaning that reports of cases should be reported by states to the CDC. In Michigan, this reporting is facilitated by the Michigan Disease Surveillance System (MDSS). The position statement also lays out standards for reporting and classification of CP-CRE. Laboratories will soon be able to electronically report CP-CRE results to our surveillance system via HL7 v2.5.1 messages. These HL7 messages can be more complex for CP-CRE than some of the other reportable conditions and we're developing guidance on how to properly format them. If a laboratory cannot report CP-CRE to MDSS via HL7 message by January 2018, facilities should develop processes to manually report these cases into the MDSS. More specific information on ELR construction will be provided soon.

CRE Surveillance and Prevention Initiative

Though CP-CRE is becoming reportable in January, there is still prevention work to be done! The CRE Surveillance and Prevention Initiative enrolled 22 new facilities and is now up to 63 facilities. All facilities are joining the same cohort in September 2017 – no more phases! Changes to the surveillance algorithm include: expanding to *Klebsiella* spp., adding *Enterobacter* spp., re-baselining September 2017-February 2018, and new/re-engergized prevention plan(s) will be implemented March 2018.

Novel Resistance activity

Since 2014, Michigan has detected 12 NDM-1, 4 VIM, 9 OXA-48, 3 MCR-1, and 3 IMP. As we get more progressive in our testing and the BOL increases its testing capabilities, more and more of these novel carbapenemase and resistance mechanisms will be detected. Extensive investigations and sample collection often follow notification of these events.

CP-CRE Surveys for Laboratory Detection Practices and Infection Prevention

Carbapenemase-producing carbapenemase-resistant Enterobacteriaceae (CP-CRE) will become reportable in Michigan starting in January 2018. The Michigan Department of Health and Human Services (MDHHS) would like to request your assistance in determining current laboratory practices for CP-CRE used across the state. Your input will help guide our reporting, surveillance and prevention efforts. Please use the links below to complete a short survey (about 15 minutes) that will help us capture this crucial information! We would like to collect at least 1 lab survey response per laboratory, and 1 IP response per healthcare facility. For the laboratory survey, please have the product information on your gram negative susceptibility testing panels or cards, and information on CRE isolates identified in 2016 available before beginning the survey.

If you have any questions or issues related to the survey please contact Brenda Brennan, CRE Prevention Coordinator at (517) 284-4945 or BrennanB@michigan.gov, or Sara McNamara, Antimicrobial Resistance Epidemiologist at (517) 284-4953 or McNamaraS5@michigan.gov.

Link for Laboratories:

https://www.surveymonkey.com/r/MiCRELab

Link for Infection Prevention:

https://www.surveymonkey.com/r/MiCREIP

Special Pathogens Response Network

The Michigan Special Pathogen Response Network (SPRN) continues work to strengthen Michigan's response to new or emerging public health threats through the development of robust infection prevention and control programs at facilities across the spectrum of care and throughout the state.

The SPRN team has conducted over 130 on site visits to hospitals in MI. During these non-regulatory visits, the team has shared best practices learned from other site visits, and information gathered from NETEC (the National Ebola Training and Education Center) and HID (Highly Infectious Disease) training in Anniston, Alabama.

If you have any questions or would like to schedule technical assistance at your facility please contact the SPRN team (DEPR Contact Information: Onyek@michigan.gov, or www.michigan.gov/BETP, SHARP Unit Contact Information: MollonN@michigan.gov or www.michigan.gov/hai).

Infection Control Assessments

The SHARP Unit is currently seeking acute care hospitals, long-term acute care hospitals, outpatient clinics and long term care facilities interested in having an evaluation of their infection prevention and control program performed. Assessments are conducted using tools provided by CDC. All facility types are encouraged to have on-site review of their Infection Control (IC) programs, but the in-person visit is considered optional for LTC and acute care. These evaluations are **not regulatory** in nature, merely consultative. We will provide a summary report to each facility at the end of each visit highlighting strengths and areas for opportunity. Facility identity and findings of the evaluation will not be shared with CDC nor other outside parties. Aggregate findings will be compiled statewide and nationally to direct training efforts.

Participation in these IC evaluations is completely voluntary. In coming years as we conduct additional evaluations, we may target specific facilities in areas with high rates of healthcare-associated infections (HAIs) in the community or at neighboring acute care facilities, or facilities with histories of outbreaks. To date we have conducted over 30 evaluations. They have been well received. Please contact Noreen Mollon (mollonn@michigan.gov) if your facility would like an IC evaluation/needs assessment.

Surveillance and Infectious Disease Epidemiology Section

Enterics and Respiratory Illness Epidemiology (ERIE) Unit

Hepatitis A in SE Michigan – MDHHS held a statewide call with all local health departments on Oct 11, 2017 to advise them of the hepatitis A outbreak investigation underway in SE Michigan and the possibility of further spread. As of October 5, a total of 376 cases of hepatitis A were reported in the City of Detroit and Counties of Macomb, Oakland, St Clair, and Wayne since August 2016. [Hepatitis A is a vaccine-preventable disease. One dose of the hepatitis A vaccine provides 90% protection.] Males comprise 63% of the cases and 86% of cases have been hospitalized. Fourteen deaths have occurred among cases (COD under investigation). Almost half of the cases (48%) reported substance abuse, 12.5% are homeless or transient, and 6% were incarcerated. We are working with the Bureau of Laboratories to bring the NAT (nucleic acid amplification) testing in house to allow for more timely results, which can inform public health action in real time.

Every case of hepatitis A in a food worker or a healthcare worker requires a rapid and robust public health response to identify all close contacts and co-workers to provide post-exposure prophylaxis (vaccine or immune globulin) within a 14-day window from last exposure with the ill person. In Isabella County recently, a food worker at a local Meijer developed a hepatitis A infection; as a result, Meijer and the Central Michigan District Health Department delivered over 500 doses of hepatitis A vaccine in three days. We have partnered with MDARD to develop hepatitis A guidance for food workers and food managers and operators to recognize symptoms; this guidance will be widely distributed across the state to MDARD-regulated food establishments. The guidance recommends that all food workers in SE Michigan receive the hepatitis A vaccine.

MDHHS and local public health have been reaching out to homeless shelters, drug rehab centers, needle exchange programs, rescue missions, Detroit Street Medicine, county jails, hospitals, and the Michigan Department of Corrections, etc., to set up vaccine clinics to target the high risk groups that have been identified. We have a contract with the Visiting Nurse Association to provide trained nurses to assist local health departments with vaccine clinics. The Michigan Volunteer Registry has also been tapped to help.

Over 8000 brochures and 200 posters (available in English and Spanish) have been distributed by the Divisions of Communicable Disease and Immunization to LHDs, medical clinics, mental health services, homeless shelters, family planning programs, jails, the Department of Corrections, rehab centers, drug treatment centers, needle exchange programs, STD clinics, rescue missions, veterans affairs, recovery centers, county sheriffs and law enforcement, and more. We now have a hepatitis A outbreak website that we are updating weekly: www.Michigan.gov/hepatitisaoutbreak, to which we can direct the media and the public.

We are in talks with the CDC to best target vaccine distribution within our State, given the concern about potential shortages owing to the substantial increase in demand for hepatitis A vaccine nationally.

Regional Epidemiology Unit

The MDHHS Regional Epidemiology Unit welcomed Meghan Weinberg, PhD, MPH as the Region 1 Epidemiologist on August 28, 2017. Meghan previously served as an Epidemic Intelligence Service Officer, assigned to MDHHS (2014-2016) and completed a CSTE Health Systems Integration Program fellowship. Meghan is a well-trained epidemiologist, as shown through her education and experience, and throughout her career she has made great working relationships with federal, state, and local partners. Meghan has a MPH and a Microbiology PhD from Northwestern University, but will always be a Wolverine at heart from her undergrad days at the University of Michigan.

Viral Gastroenteritis Outbreaks

The Michigan Public Act 368 of 1978 (333.5111) requires unusual occurrences, outbreaks, or epidemics (including healthcare-associated infections) of any disease or condition to be reported to your health jurisdiction. As of January 1, 2017 to October 16,, 2017; 118 viral gastrointestinal outbreaks have been reported. Fifty percent (50%) of outbreaks have been reported in healthcare facilities. Only 14% have been laboratory confirmed. Please remember that the MDHHS Bureau of Laboratories provides free testing for outbreak situations. Contact your local health jurisdiction or MDHHS at 517-335-8165 to arrange for outbreak testing and reporting. Visit the MDHHS webpage, www.michigan.gov/cdinfo, for guidance documents on environmental cleaning and disinfection, as well as, reporting forms.

HIV & STD Section

Molecular HIV Surveillance (MHS):

In Michigan, and across the US, HIV genotypes run by care providers are required by law to be reported to MDHHS by all private and commercial laboratories. HIV genotypes are used by MDHHS in a number of ways:

- as evidence of a care visit to complete our HIV care continuums
- to monitor rates of drug resistance and identify rare or variant strains
- to identify growing clusters of public health importance

Michigan leads the country in MHS completeness of genotype reporting with over 70% of all PLWH in our jurisdiction having at least one reported sequence. We need your help to maintain this funding-mandated benchmark. **We urge providers to follow national and international clinical guidelines and run a baseline genotype on all individuals newly diagnosed with HIV.** The U.S. Department of Health and Human Services AIDS Info site states, "HIV drug-resistance testing is recommended for persons with HIV infection at entry into care to guide selection of the initial antiretroviral therapy (ART) regimen." More information can be found here: https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/6/drug-resistance-testing

Annual HIV Overviews and Surveillance Reports:

The 2016 Michigan, Detroit Metro Area (DMA), and Detroit Overviews and Surveillance Reports are now available on our website:

http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_46000_46003-35962--,00.html#current

The Overviews present the most relevant surveillance data using graphical, user-friendly displays. The HIV Surveillance Reports contain the surveillance data most commonly requested by agencies and individuals for grants or other data requests.

Of special note: The community viral suppression rate in Michigan for PLWH is quickly approaching the "care ceiling". As an individual cannot be virally suppressed without first entering care, the proportion in care acts as a ceiling for the proportion virally suppressed (aka community viral suppression). In Michigan that ceiling is currently 81%, in the DMA it's 80%, and in Detroit it's 79%. In order to continue improving community viral suppression and, in turn, reducing transmission, the proportion of PLWH in care needs to increase (see page 4 of the Overviews). Across the state, teens, persons who inject drugs, Hispanics/Latino(a)s, and foreign born persons consistently receive care less often than other PLWH.

HIV Diagnostic Testing Review:

In recent years there has been significant changes to the HIV diagnostic testing algorithm. MDHHS continues to receive a significant number of incomplete and incorrectly ordered algorithms that result in delays and in diagnosis and individuals with an unresolved status. Please see the below the CDC HIV testing algorithm, showing that:

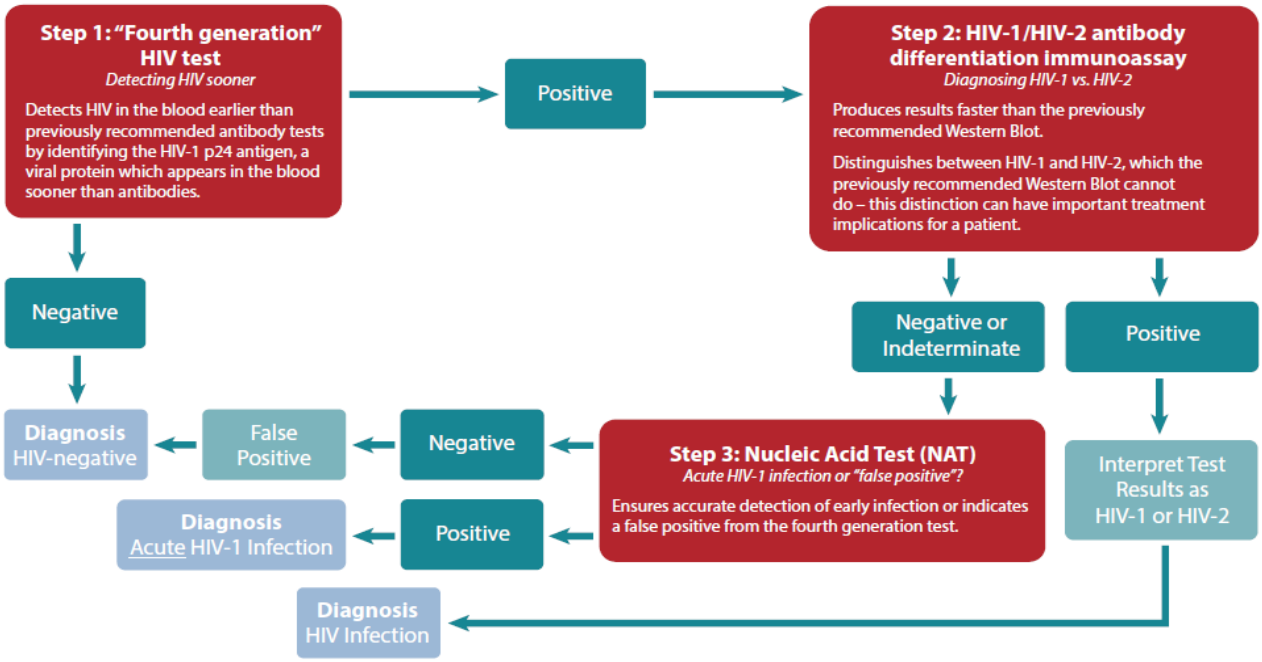
1. First HIV test should be an antigen/antibody lab-based screen (even if patient has had a rapid reactive result)
2. Second test is HIV-1,2 Differentiation test: should only be run after a reactive lab-based antigen/antibody screen
3. Third test, nucleic acid test (NAT) may be needed if first two tests don't agree (reactive screen and negative or indeterminate differentiation)

New CDC Recommendations for HIV Testing in Laboratories

A step-by-step account of the approach

CDC's new recommendations for HIV testing in laboratories capitalize on the latest available technologies to help diagnose HIV infections earlier – as much as 3-4 weeks sooner than the previous testing approach. Early diagnosis is critical since many new infections are transmitted by people in the earliest ("acute") stage of infection.

By putting the latest testing technology to work in laboratories across the United States, we can help address a critical gap in the nation's HIV prevention efforts.



Emerging and Zoonotic Infectious Diseases Section