

Updates from HAI/AR Program

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HAI/AR Surveillance: CRE, PDRO, *C. auris*

Why are we concerned?

- **CRE:** *Enterobacteriaceae* that are resistant to carbapenems, which are often considered antibiotics of last resort
- **PDRO:** Organisms that are resistant to all antimicrobials they are tested against
- *Candida auris*: Difficult to treat, identify, and control in the environment

HAI/AR Reportable Conditions

- Made reportable April 2018:
 - Carbapenem-Resistant *Enterobacteriaceae* (CRE)
 - Pandrug-resistant organisms (PDROs)
 - *Candida auris*

Carbapenem-Resistant <i>Enterobacteriaceae</i> (CRE) Report Form		Philadelphia Department of Public Health Division of Disease Control 1101 Market St., 12th Floor Philadelphia, PA 19107 Telephone: (215) 685-6748 Fax: (215) 238-6947 Form available at hip.phila.gov	
PATIENT DEMOGRAPHIC INFORMATION			
PATIENT'S NAME (LAST, FIRST)		D.O.B.	AGE (years)
			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
RACE <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native-American <input type="checkbox"/> Unknown <input type="checkbox"/> Other		HISPANIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK	
CURRENT ADDRESS <input type="checkbox"/> Private Residence <input type="checkbox"/> Healthcare/Assisted Living Facility		ZIP CODE	PATIENT TELEPHONE <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home
FACILITY NAME, if residing in a healthcare/assisted living facility		WAS FACILITY NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PART OF OUTBREAK/CLUSTER <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
CLINICAL DATA			
HOSPITALIZED <input type="checkbox"/> Yes <input type="checkbox"/> No	HOSPITAL NAME	ADMIT DATE	DISCHARGE DATE
			Admitted to Intensive Care Unit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK
REASON FOR TESTING <input type="checkbox"/> Screening/Surveillance <input type="checkbox"/> Signs/Symptoms of Infection		SIGNS/SYMPTOMS ONSET DATE, if infection	HISTORY OF CRE <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK
			DATE OF FIRST POSITIVE: / /
INFECTION(S) ASSOCIATED WITH CULTURE(S) (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Blood <input type="checkbox"/> Respiratory Tract Infection			
<input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Organ Space/Abscess <input type="checkbox"/> Skin/Soft Tissue Infection or Wound <input type="checkbox"/> Other: _____			
UNDERLYING MEDICAL CONDITIONS (Check all that apply or attach problems list or pertinent sections of medical records)			
<input type="checkbox"/> Chronic Heart/Cardiovascular Disease		<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Neurological, specify: _____	<input type="checkbox"/> Wounds, specify: _____
<input type="checkbox"/> COPD		<input type="checkbox"/> Immunosuppression, specify: _____	<input type="checkbox"/> Other, specify: _____
		<input type="checkbox"/> None	<input type="checkbox"/> Unknown
RISK FACTORS			
IF AVAILABLE, HISTORY OF HEALTHCARE STAYS IN THE UNITED STATES IN THE PREVIOUS YEAR (List where the patient was transferred from first)			
Facility: _____		Admission/Discharge Dates: / / - / /	
Facility: _____		Admission/Discharge Dates: / / - / /	
Facility: _____		Admission/Discharge Dates: / / - / /	
HISTORY OF INTERNATIONAL TRAVEL AND/OR MEDICAL CARE ABROAD IN PREVIOUS YEAR (Check all that apply)			
<input type="checkbox"/> International Travel <input type="checkbox"/> Medical Care Abroad <input type="checkbox"/> No <input type="checkbox"/> Unknown			
		Dates of travel: / / - / /	
if yes, location(s): _____			
SURGERY/PROCEDURE INVOLVING A SCOPING DEVICE IN THE PAST YEAR? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
if yes, date: / / - / /			
CURRENT INDWELLING / INVASIVE DEVICE(S)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
if yes, specify: _____			
LABORATORY (Please attach culture and sensitivity results and any other applicable test results available)			
SPECIMEN COLLECTION DATE: / /		RESULT DATE: / /	
		GENUS and SPECIES: _____	
SPECIMEN TYPE (Check all that apply)			
<input type="checkbox"/> Blood <input type="checkbox"/> Urine			
<input type="checkbox"/> Rectal <input type="checkbox"/> Wound			
<input type="checkbox"/> CSF <input type="checkbox"/> Sputum			
<input type="checkbox"/> Abscess			
Other, specify: _____			
RESISTANT/INTERMEDIATE TO: (Check all that apply)			
<input type="checkbox"/> Daptomycin			
<input type="checkbox"/> Ertapenem			
<input type="checkbox"/> Imipenem			
<input type="checkbox"/> Meropenem			
<input type="checkbox"/> Pandrug-Resistant (PDR)			
<input type="checkbox"/> Other: _____			
CARBAPENEMASE PRODUCTION (Check all that apply)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Test Performed:			
<input type="checkbox"/> Modified Hodge Test			
<input type="checkbox"/> Metallo- β -lactamase Test			
<input type="checkbox"/> CIM <input type="checkbox"/> mCIM			
<input type="checkbox"/> Carba-NP			
CARBAPENEMASE MECHANISMS			
<input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP			
<input type="checkbox"/> OXA-48 <input type="checkbox"/> Other: _____			
Test Performed:			
<input type="checkbox"/> PCR <input type="checkbox"/> Xpert Carba-R			
<input type="checkbox"/> Other: _____			
REPORTER INFORMATION			
REPORT DATE	REPORTER NAME	FACILITY NAME	REPORTER PHONE # & EMAIL
/ /	Role: <input type="checkbox"/> DO/MD <input type="checkbox"/> CP <input type="checkbox"/> PA/NP <input type="checkbox"/> RN <input type="checkbox"/> Other: _____		
PLEASE FAX REPORT TO (215) 238-8647 UPON COMPLETION. RETAIN CRE ISOLATE FOR ONE MONTH			

Form Update #: 05/03/2018

HAI/AR Reportable Conditions

Please fax report to
215-238-6947 upon
completion

Retain CRE isolate for one
month

Carbapenem-Resistant *Enterobacteriaceae* (CRE) Report Form

Philadelphia Department of Public Health
Division of Disease Control
1101 Market St., 12th Floor
Philadelphia, PA 19107
Telephone: (215) 685-6748
Fax: (215) 238-6947
Form available at hip.phila.gov

PATIENT DEMOGRAPHIC INFORMATION

PATIENT'S NAME (LAST, FIRST) _____ D.O.B. _____ AGE (years) _____ SEX Male Female Other _____

RACE African-American White Asian Pacific Islander Native-American Unknown Other _____ HISPANIC Yes No UNK _____

CURRENT ADDRESS Private Residence Healthcare/Assisted Living Facility _____ ZIP CODE _____ PATIENT TELEPHONE Work Cell Home _____

FACILITY NAME, if residing in a healthcare/assisted living facility _____ WAS FACILITY NOTIFIED Yes No Unknown _____ PART OF OUTBREAK/CLUSTER Yes No Unknown _____

CLINICAL DATA

HOSPITALIZED Yes No _____ HOSPITAL NAME _____ ADMIT DATE _____ DISCHARGE DATE _____ Admitted to Intensive Care Unit Yes No UNK _____
Date of Admission _____ Date of Discharge _____

REASON FOR TESTING: Screening/Surveillance Signs/Symptoms of infection _____ SIGNS/SYMPTOMS ONSET DATE, if infection _____ HISTORY OF CRE Yes No UNK _____
Date of Onset _____ Date of First Positive _____

INFECTION(S) ASSOCIATED WITH CULTURE(S) (check all that apply) None Blood Respiratory Tract Infection
 Urinary Tract Infection (UTI) Intra-abdominal Infection Soft Tissue Infection of Wound _____

UNDERLYING MEDICAL CONDITIONS (check all that apply or attach problems list of pertinent sections of medical records)
 Chronic Heart/Cardiovascular Disease Kidney Disease Dialysis in Past Year _____
 Diabetes Neurological, specify _____
 COPD Immunosuppression, specify _____

RISK FACTORS

IF AVAILABLE, HISTORY OF HEALTHCARE STAYS IN THE UNITED STATES IN THE PREVIOUS YEAR (list where the patient was transferred from first)
Facility: _____ Admission/Discharge Dates: _____
Facility: _____ Admission/Discharge Dates: _____

HISTORY OF INTERNATIONAL TRAVEL AND/OR MEDICAL CARE ABROAD IN PREVIOUS YEAR (check all that apply)
 International Travel Medical Care Abroad No Unknown _____ Dates of travel: _____
If yes, location(s): _____

SURGERY/PROCEDURE INVOLVING A SCOPING DEVICE IN THE PAST YEAR? Yes No Unknown _____ If yes, date: _____

CURRENT INWELLING / INVASIVE DEVICE(S)? Yes No Unknown _____ If yes, specify: _____

LABORATORY (Please attach culture and sensitivity results and any other applicable test results available)

SPECIMEN COLLECTION DATE _____ RESULT DATE _____ GENUS AND SPECIES _____

SPECIMEN TYPE (check all that apply) Blood Urine Sputum Abscess Other, specify: _____

RESISTANT INTERMEDIATE TO: (check all that apply) None Cloxacillin Ertapenem Meropenem Pivampicillin (PDR) _____

ONSET/RESUME PRODUCTION Yes No Unknown _____
Test: Escherichia _____
 Modified Hodge Test Ox-AC Other _____

Meropenem- β -lactamase Test PCR Xpert CRE-R _____
 CIM Xpert CRE-R Other _____
 Carbapenem-Resistant (PCR) Carbapenem-Resistant (CRP) Other _____

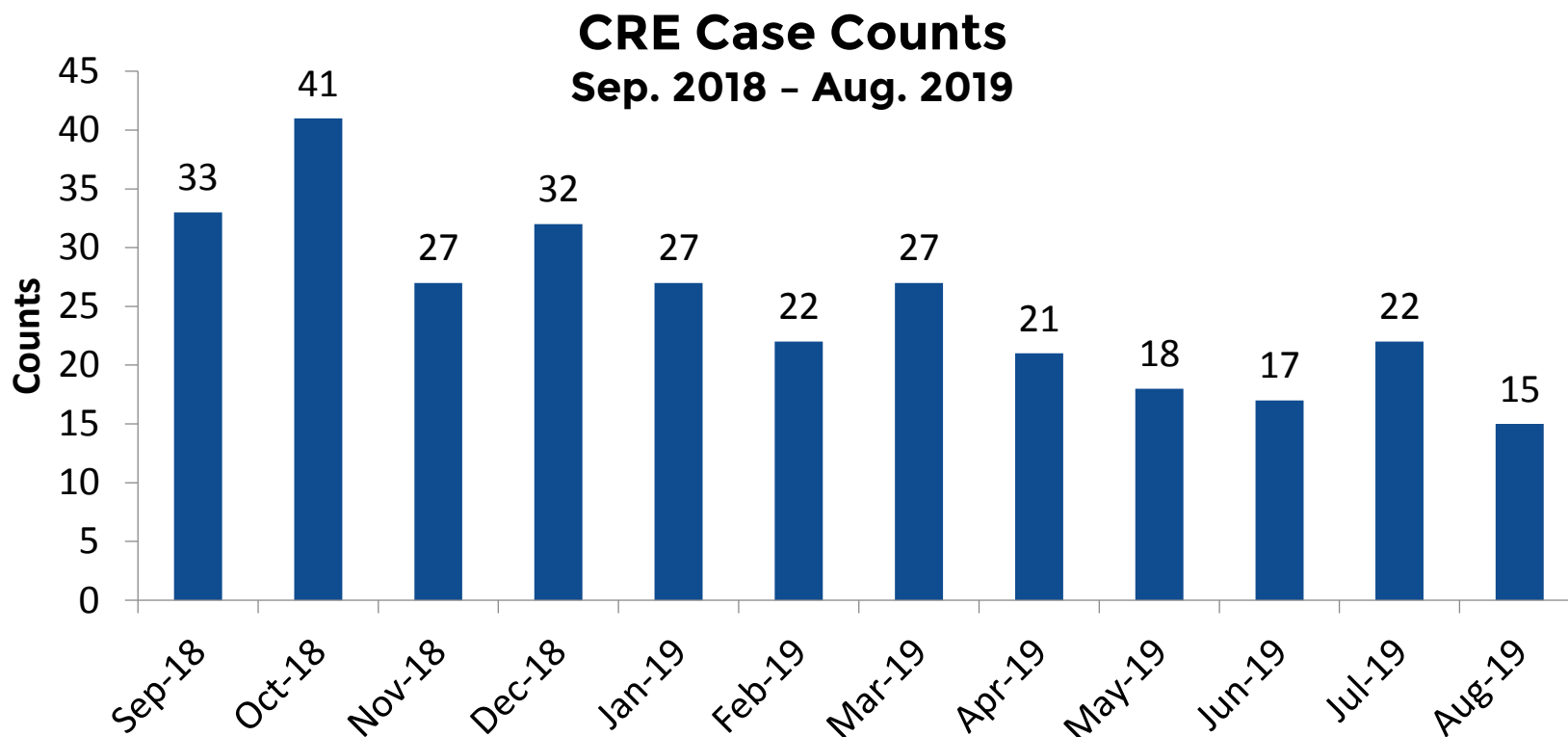
REPORTER INFORMATION

REPORT DATE: _____ REPORTER NAME: _____ FACILITY: _____ REPORTER PHONE & EMAIL: _____

PLEASE FAX REPORT TO (215) 238-6947 UPON COMPLETION. RETAIN ONE ISOLATE FOR ONE MONTH.

Form Update: 03/2018

What have we seen so far?



**Total Number of CRE Cases
from Sep. 2018- Aug. 2019**

=300



Upcoming Activities

Long-term Care Infection Prevention Workgroup

- Do you want to improve your facility's infection prevention program, but you don't know where or how to start?

Long-term Care Infection Prevention Workgroup

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- **Do you want to be able to show the impact of your work?**

Long-term Care Infection Prevention Workgroup

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- Do you want to be able to show the impact of your work?
- **Would you like feedback on a specific infection control issue?**

Long-term Care Infection Prevention Workgroup

- Do you want to improve your facility's infection prevention program, but you don't know where or how to start?
- Do you want to be able to show the impact of your work?
- Would you like feedback on a specific infection control issue?
- **Are you the only person responsible for infection prevention in your LTCF?**
- **Do you wish you were more connected to your peers locally?**

Long-term Care Infection Prevention Workgroup

If you answered “yes” to any of the questions,
PLEASE SIGN UP!

- Bimonthly - quarterly
- Webinar-based and moderated
- Topics that are of interest to you
- Time for discussion
- Opportunities for peer sharing

Long-term Care Infection Prevention Workgroup

Next Events:

- **Using Surveillance Tools to Detect and Manage an Outbreak**
 - **November/December 2019**
- **Enhanced Barrier Precautions**
 - **Early 2020**

Antibiotic Stewardship

Antibiotic Stewardship Commitment Posters

Antibiotics

- Only fight infections caused by bacteria
- Will NOT help you feel better if you have a viral infection such as:
 - A cold or runny nose
 - Bronchitis or a chest cold
 - Flu
- Can cause more harm than good, if you take them when you don't really need them:
 - You can get diarrhea, rashes or yeast infections
 - You might get an infection later that is harder to treat because it is resistant to antibiotics



As your health care provider, I am dedicated to prescribing antibiotics...



Susan E. Coffin
Susan E. Coffin, MD, MPH
HAI/AR Program Medical Director
Philadelphia Department of Public Health

...only when you need them






[Your Facility Logo Here]

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As your health care providers, we are dedicated to prescribing antibiotics...



Steven Alles, MD, MS Susan Coffin, MD, MPH Jane Gould, MD

Steven Alles *Susan Coffin* *Jane Gould*

...only when you need them



[Your Facility Logo Here]

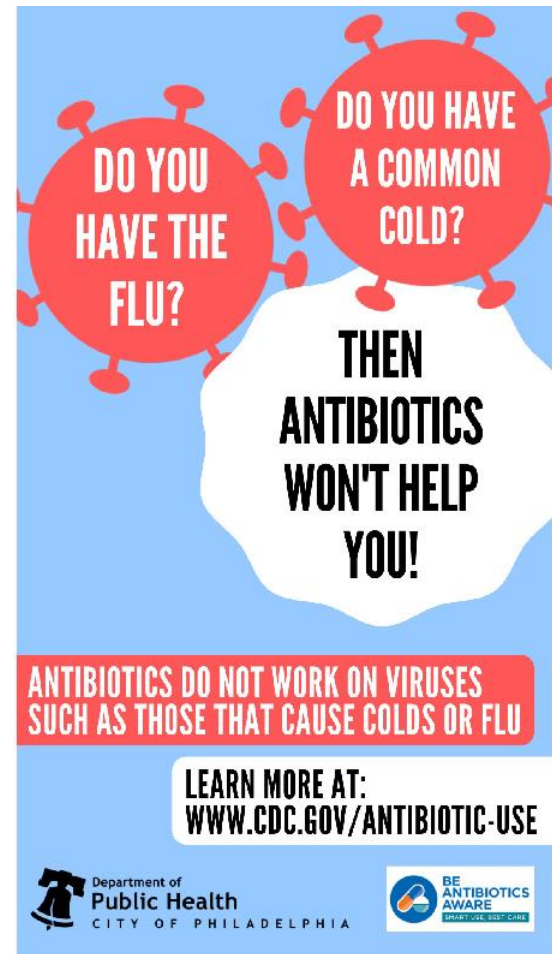
Antibiotic Stewardship

Antibiotic Awareness Week,
November 18-24

- Digital or printed posters
- Contact us at:

HAI.PDPH@phila.gov

(215) 685-4501



THANK YOU!



PDPH HAI/AR Program

HAI.PDPH@phila.gov

(215) 685-4501