Scott Walker
Governor

Kitty Rhoades
Secretary

**DIVISION OF PUBLIC HEALTH**

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**State of Wisconsin**
Department of Health Services

May 3, 2016

The Honorable Representative Peter Barca
Assembly Minority Leader
201 West, State Capitol
Madison, WI 53708

The Honorable Representative Katrina Shankland
Assistant Assembly Minority Leader
119 North, State Capitol
Madison, WI 53708

The Honorable Representative JoCasta Zamarripa
Democratic Caucus Vice-Chair
112 North, State Capitol
Madison, WI 53708

Dear Representatives Barca, Shankland, and Zamarripa:

Thank you for your letter to Governor Scott Walker regarding concerns over the *Elizabethkingia anophelis* investigation. The Division of Public Health (DPH) in the Department of Health Services (DHS) is the lead agency on the *Elizabethkingia anophelis* investigation, and we appreciate the opportunity to offer a response and clarification. In addition, should you have any concerns relating to public health investigations, or our collaboration with the Centers for Disease Control and Prevention (CDC), we would be happy to meet with you in person to discuss those issues.

We appreciate your interest in this important situation and want to assure you that DPH, in coordination with the CDC, local health departments, clinical providers, and the Wisconsin State Laboratory of Hygiene, has worked swiftly and diligently to investigate and respond to this unique outbreak.

The *Elizabethkingia anophelis* outbreak is primarily affecting patients who are over age 65, and all patients have a history of at least one underlying serious illness. To date, despite some news reports to the contrary, **there have been no confirmed cases of this outbreak strain among infants or children,** as you state in your letter. We have worked diligently and carefully since the onset of the outbreak to offer timely, accurate information. Sometimes, especially during unusual outbreaks, we must combat the dissemination of sensational claims and misinformation.

Our civil service employees (who include nationally recognized scientists) within DPH are committed to protecting the health and wellness of all Wisconsinites, and this is reflected in the

work they have done investigating the *Elizabethkingia anophelis* outbreak. Our staff received initial reports of infected patients between December 29, 2015, and January 4, 2016. We reached out to CDC for guidance on January 5, 2016, as this appeared to be an outbreak with a unique organism.

We immediately launched the investigation with CDC's guidance and assistance, and reached out to health care partners to request and share information. On January 6, 2016, we issued a memo to Wisconsin infection preventionists and clinical microbiology laboratories notifying them of this situation and requesting that clinical microbiology labs look back as far as January 1, 2014, for any positive blood cultures for *Elizabethkingia*, *Flavobacterium*, or *Chryseobacterium* (names formerly used for this bacterium). We were searching for additional cases that might be associated with the first six that had been reported to us. As a result of this request, we learned that there were patients possibly infected with the organism going back to November 2015.

Because this is an organism that had so rarely caused infection in humans, there was no known treatment regimen. Our team immediately went to work to identify the most effective treatment, as this information was critical in life-saving efforts. We notified Wisconsin infection preventionists and clinical microlaboratories of initial treatment guidance on January 15, 2016. This was important as *Elizabethkingia anophelis* is naturally resistant to some antibiotics. Early identification and communication of appropriate treatment is critical in improving patient outcomes. The memo we sent out on February 24, 2016, provided *additional* guidance to health care providers as we learned more about this bacterium and how to treat it, but this was not the first time we shared treatment guidance, and certainly was not the first time we alerted health care providers and facilities of the potential presence of the bacteria.

Our focus throughout this period was providing accurate information rapidly to the providers who would play a role in the identification and treatment of patients infected with *Elizabethkingia anophelis*. On March 18, 2016, we sent out a message announcing we had created a new listserv that allowed any interested healthcare party to sign up for weekly routine updates from DHS, whether or not they would have a role in treating patients with *Elizabethkingia anophelis*. This messaging approach would serve as an *additional* avenue for sharing information: any breaks in the investigation or updated protocols related to treatment would be shared immediately with health care providers through our usual alerting systems as well. Again, this was another tool used in our outreach, and was *not* our initial communication with the larger health care community, which includes hospitals, facilities, and local health departments.

From the very beginning of the investigation we had frequent, daily contact with the CDC, which is based in Atlanta; and in early February, we requested that CDC send an Epi-aid, or on-the-ground disease detectives, to Wisconsin. Significant time is required to conduct the investigation of each case, and as the number of cases increased we needed to augment our Wisconsin team. CDC staff arrived in Wisconsin the week of February 15, 2016, providing us with short-term epidemiological capacity. They assisted our team with interviews, environmental sampling, and

data analysis. Throughout the investigation there have been no delays or lapses in our communication and collaboration with CDC.

This is the largest known outbreak of *Elizabethkingia anophelis* ever recorded, and as we work through this investigation, we are learning more about the bacterium and how it behaves. We conduct disease investigations every day, and most often, the facts of the case (all patients attended the same potluck dinner, or swam at the same beach, or used the same product, or were treated at the same facility, etc.) allow investigators to determine a cause quite quickly, and we are able to inform and educate people about what they can do to protect themselves and their families.

Because we have not yet identified a source in this outbreak, we have not been able to provide guidance on how people can protect themselves. In the early stages of this investigation, we very carefully considered the impact of sharing what limited information we had. To be clear, there was nothing we could share that would help people avoid the *Elizabethkingia anophelis* bacteria. As the number of cases grew, we gained a general understanding of who was most likely to be affected by this outbreak, the region where the outbreak is located, and how it can be successfully treated. We issued our press release on March 2, 2016, because we felt, at that time, we had enough information to inform the public of what we knew about the outbreak, while limiting the risk of unwarranted, widespread fears.

I am confident that we have provided timely, accurate updates related to the outbreak. In order to keep the public informed, we have also created a website that includes the most recent numbers of confirmed and possible cases, and cases under investigation. Our information sharing also paved the way for both Michigan and Illinois to share information quickly when they identified cases linked to the outbreak in Wisconsin.

At this time, the source of these infections is still unknown, and we are working diligently on this outbreak. We continue to conduct a comprehensive investigation, which includes:

- Interviewing patients with *Elizabethkingia anophelis* infection and/or their families to gather information about activities and exposures related to health care products, food, water, restaurants, and other community settings.
- Obtaining environmental and product samples from facilities that have treated patients with *Elizabethkingia anophelis* infections. To date, these samples have tested negative and there is no indication the bacteria were spread by a single health care facility.
- Conducting a review of medical records.
- Obtaining nose and throat swabs from individuals receiving care on the same units in health care facilities as a patient with a confirmed *Elizabethkingia anophelis* to determine if they are carrying the bacteria. To date, all of these specimens tested negative, which suggests the bacteria are not spreading from person to person in health care settings.
- Obtaining nose and throat swabs from household contacts of patients with confirmed cases to identify if there may have been exposure in their household environment.
- Performing a “social network” analysis to examine any commonalities shared between patients including health care facilities or shared locations or activities in the community.

We continue to work with the CDC on a daily basis. We provide weekly email updates with outbreak information to interested members of the health care community, including local health departments, clinicians, and facilities. We provide daily updates to Governor Walker, and after meeting with staff directly involved in the investigation, he approved nine project positions to ensure we are able to continue the work we do on the many issues and outbreaks related to public health.

Again, thank you for your letter. I appreciate the opportunity to provide an up-to-date, accurate timeline of our activities and response to the *Elizabethkingia anophelis* outbreak.

Sincerely,

Karen McKeown
State Health Officer and Administrator