

# LEGIONELLA PNEUMOPHILA

*What It Is and How To Navigate Through an Outbreak*



# JAMIE MUNDA

- Nalco Water – Water Safety Industry Technical Consultant (2017)
- Dow Chemical – Senior Microbiologist / Industrial Hygiene Auditor (2006)
- University of Illinois – B.S. Molecular Cellular Biology
- Avid Baseball Fan
- Married to Steve
- Mom to 3



# AGENDA

- *Legionella* Review
- Post Implementation of QSO (CMS) 17-30
- I got a “POSITIVE” – Time to Take Action!
- Defining a *Legionella* Outbreak & the Investigation Process
- Short Term/Long Term Control Strategies

# WATER SAFETY – ESSENTIAL TO MANAGE RISK

## PROTECTING WHAT MATTERS MOST



**PATIENT**



**STAFF**



**COMMUNITY**



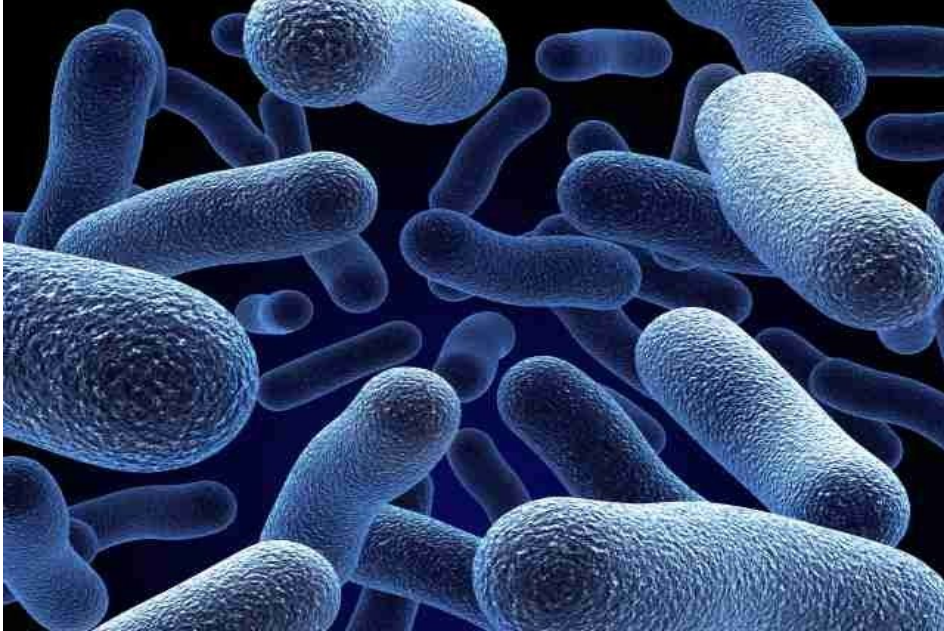
**BRAND**

# 1<sup>ST</sup> LEGIONNAIRES' DISEASE OUTBREAK

- Disease first recognized in 1976
- Infection occurred in attendees at American Legion's state convention in Philadelphia (Bellevue-Stratford)
  - 221 cases, 34 deaths
- After months of research, CDC identified causative agent – a bacteria
  - Bacteria was named *Legionella pneumophila*
- Source unknown initially, *Legionella* eventually found in cooling tower

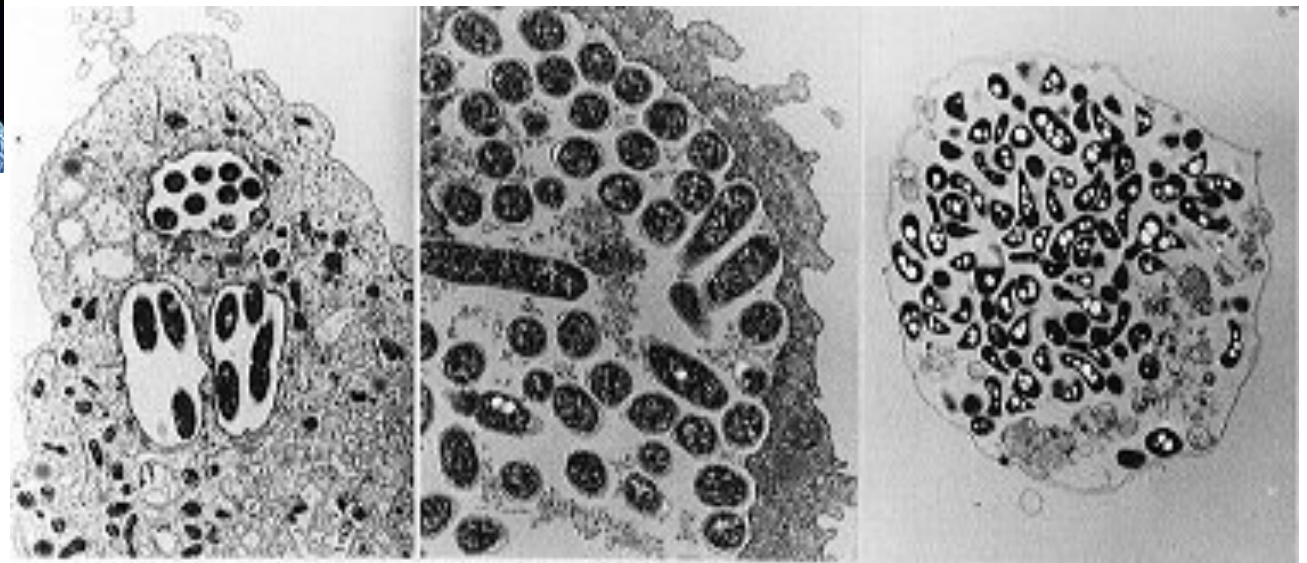


# LEGIONELLA



- Grows inside amoebae which provides protection & nutrients
- Can grow & amplify in human designed water systems

- Gram-negative, rod like bacterium found in fresh water environments
- > 60 species of *Legionella*
- ~90% of LD cases caused by *Legionella pneumophila*



# LEGIONELLOSIS

## ■ Legionnaires' Disease (LD)

- Atypical pneumonia
- Hospitalization common
- Incubation → 2-14 days after exposure
- 6,000 – 18,000 cases/year in USA
- Fatality rate more than 10%

## ■ Pontiac Fever

- Less-severe influenza-like illness
- Hospitalization uncommon
- Incubation → 24-72 hrs after exposure
- # of cases/year unknown
- Not typically fatal



Inhaled as an aerosol or mist



Aspirating water or ice chips has caused disease (rare cases)



Not considered contagious



Drinking contaminated water does NOT cause legionellosis

# WHO IS AT RISK?

- > 50 years of age
- Smokers
- Immunocompromised
- Existing Respiratory Disease





1

## MUNICIPAL WATER SOURCE

*Legionella* bacteria can enter the water as an “escapee” from the water treatment facility



2

## WATER MAIN DAMAGE

Water infrastructure failures can allow bacteria to enter the drinking water system



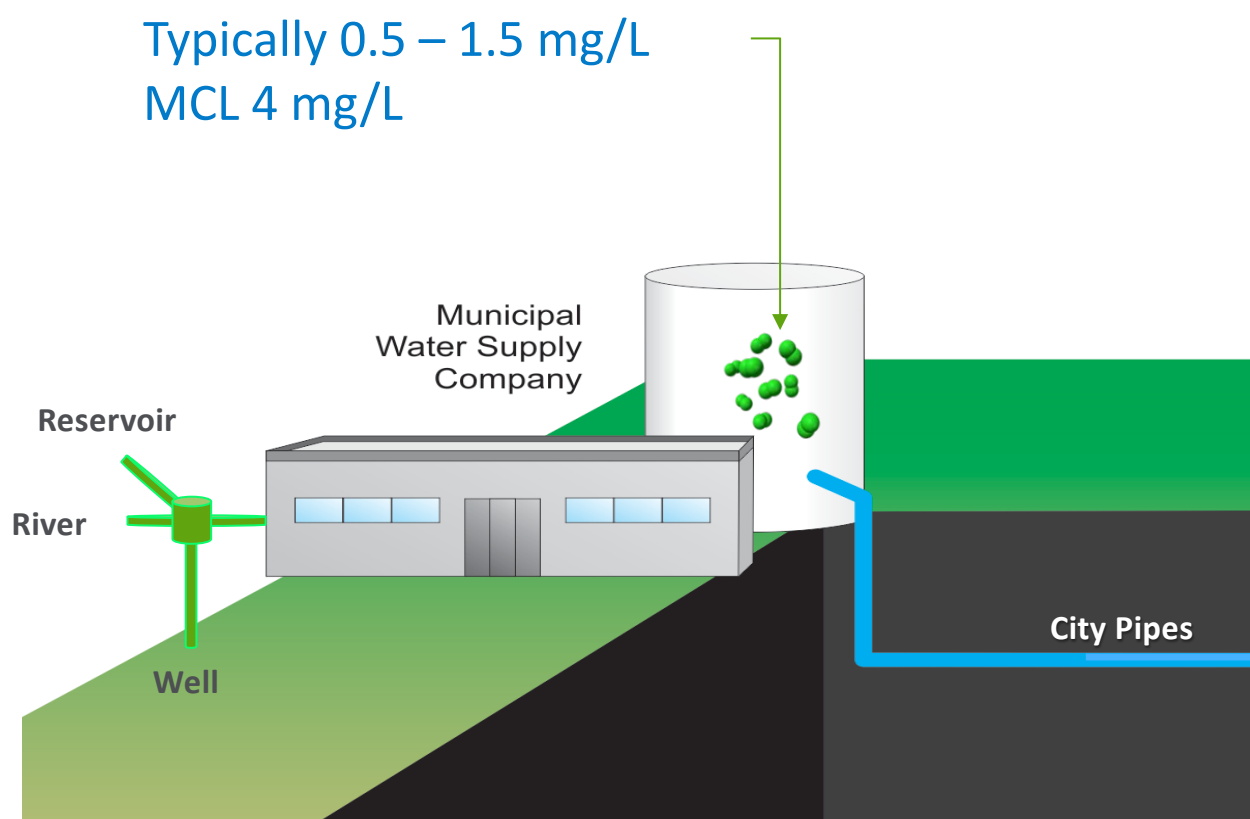
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## CONSTRUCTION

“Stowaway” *Legionella* bacteria can enter a plumbing system during installation or repair

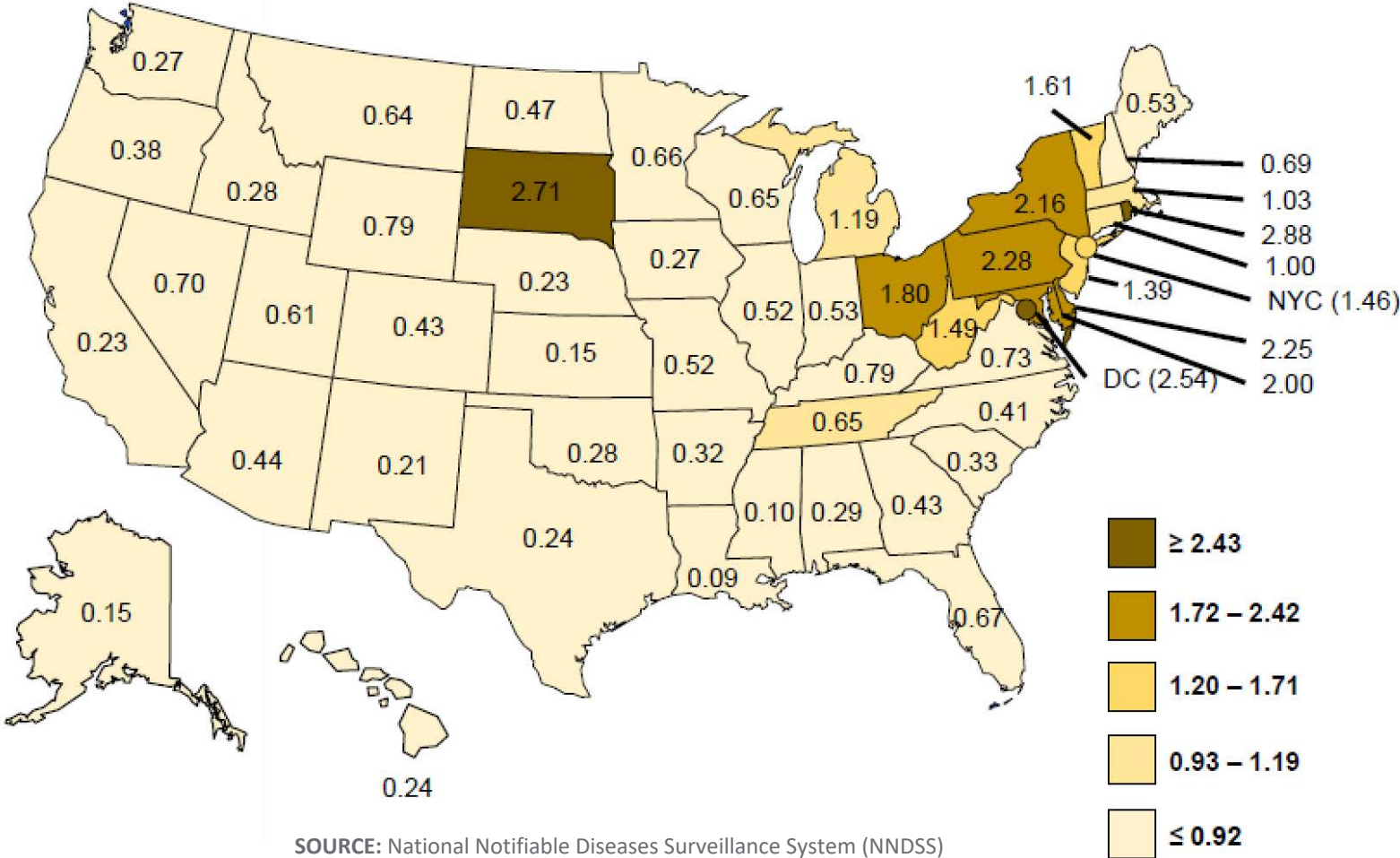
# WATER IS NOT STERILE

Chlorine or Chloramine  
Typically 0.5 – 1.5 mg/L  
MCL 4 mg/L



# 2005 LEGIONELLOSIS CASES

Rates of reported legionellosis cases by state / 100,000 Population

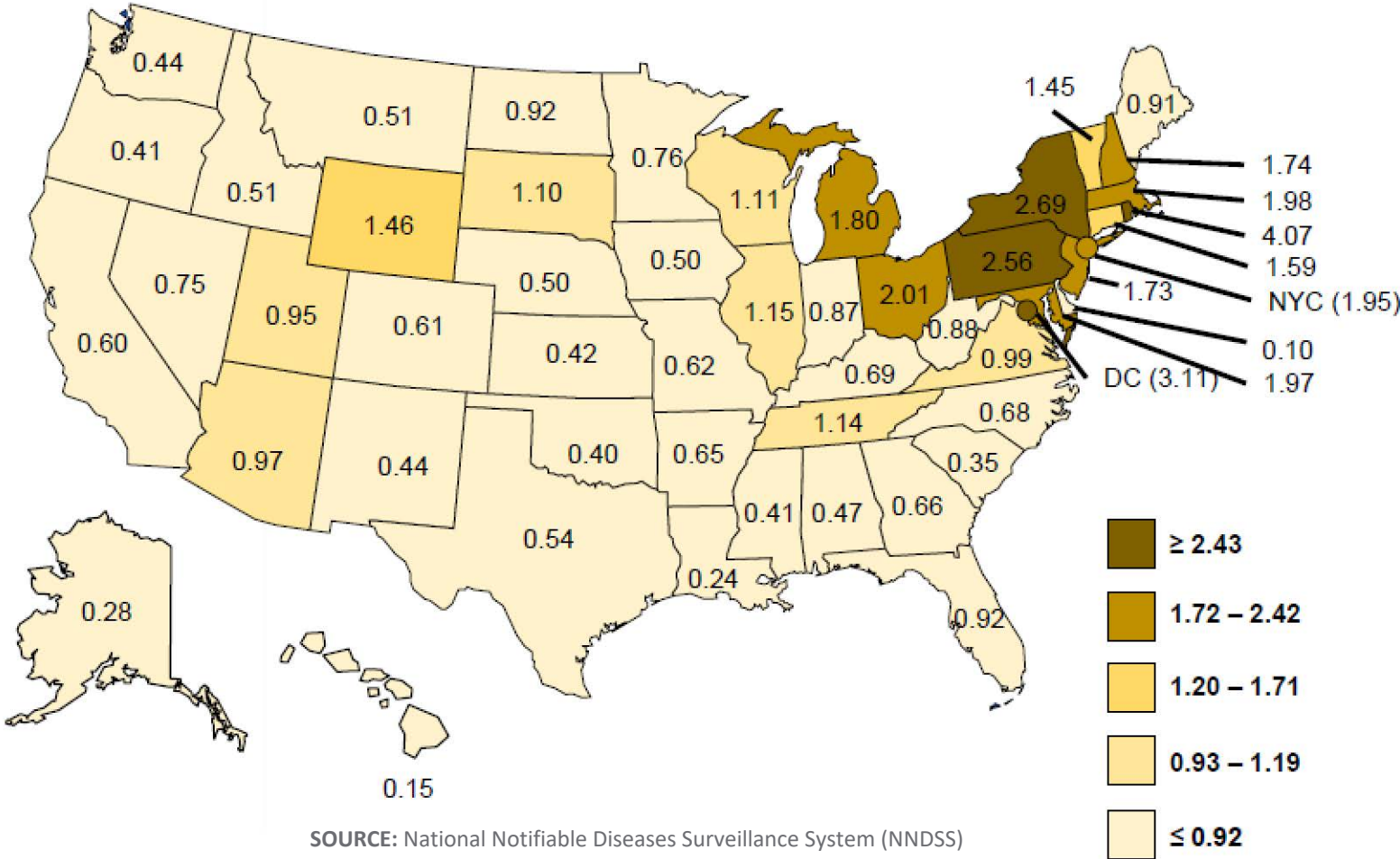


SOURCE: National Notifiable Diseases Surveillance System (NNDSS)



# 2010 CASES - INCREASE APPARENT

Rates of reported legionellosis cases by state / 100,000 population

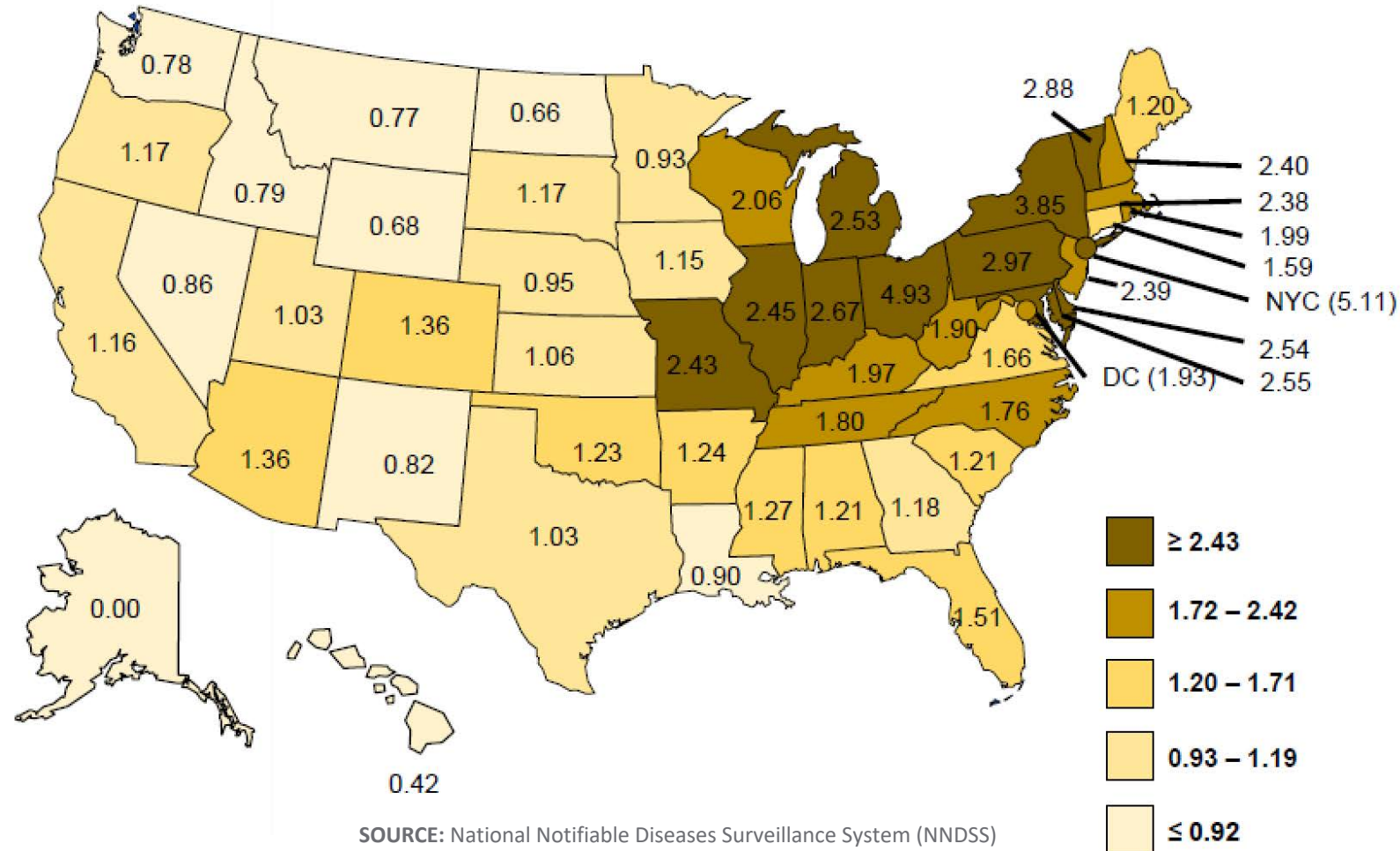


SOURCE: National Notifiable Diseases Surveillance System (NNDSS)



# 2015 CASES - INCREASE CONTINUES

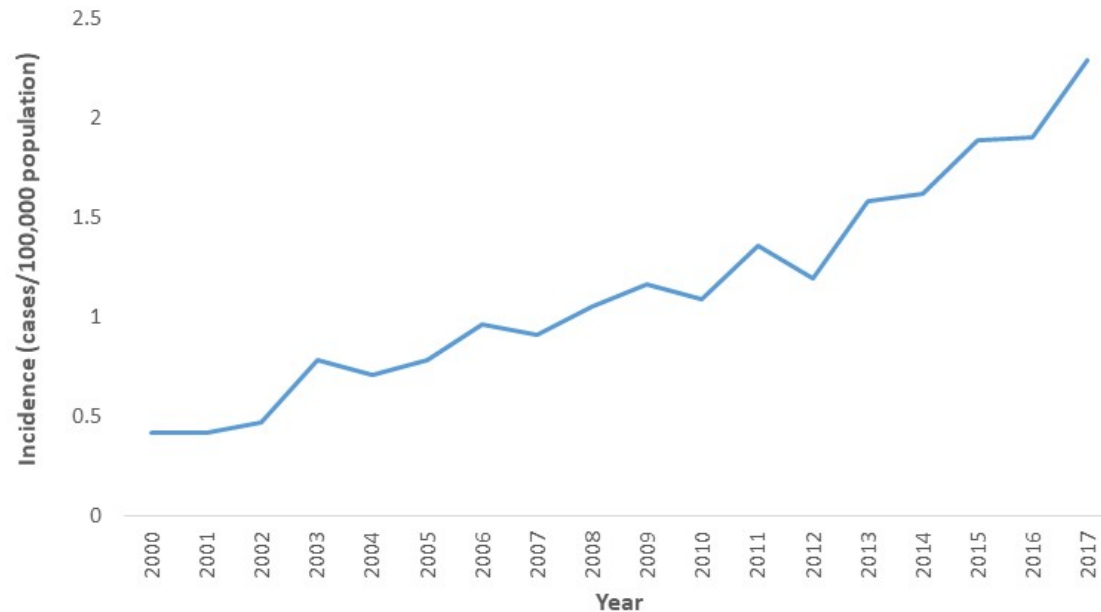
Rates of reported legionellosis cases by state / 100,000 population



SOURCE: National Notifiable Diseases Surveillance System (NNDSS)

# LEGIONNAIRES DISEASE IS ON THE RISE

Legionnaires' disease is on the rise in the United States



Rate of reported cases increased 5.5 times (2000–2017)

Source: National Notifiable Diseases Surveillance System

Centers for Disease Control and Prevention (CDC)

## Possible Reasons

- Urine antigen test
- Increased awareness, more testing
- Aging population, more immunocompromised people
- More engineered water systems
- Aging infrastructure
- Water-saving building modifications

# ASHRAE STANDARD 188 – JUNE 2015

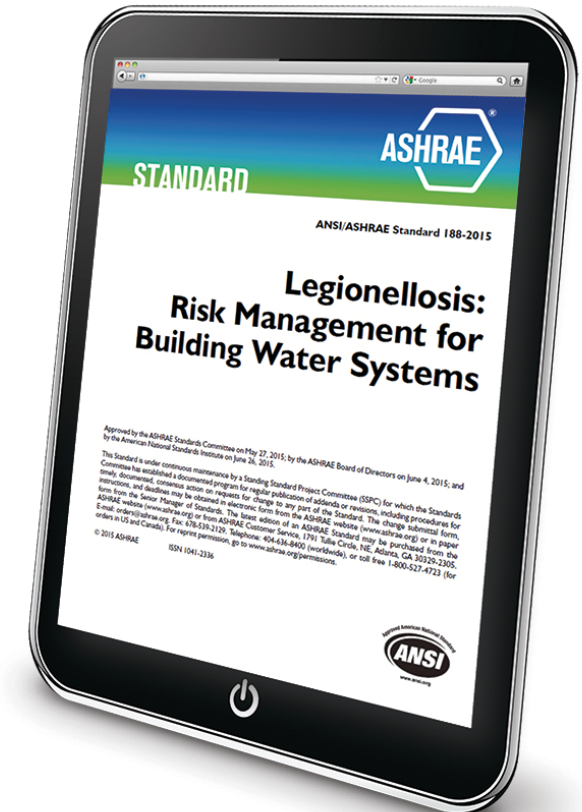
American Society of Heating, Refrigerating and Air-Conditioning Engineers

Mandates building owners and managers to establish a **water management program**

Applies to almost every type of human-occupied building

Intended for use by owners and managers of buildings

Intended for those involved in the construction, commissioning, maintenance, and service of building water systems



**First US Standard** to define the minimum legionellosis risk management requirements for building water systems

# CMS REQUIREMENT S&C 17-30

Centers for Medicare and Medicaid Services (CMS)

- A facility must
  - Conduct a Risk Assessment
  - Implement a Water Management Program per ASHRAE Standard 188 & CDC Toolkit
  - Define and specify testing protocols, control measures/limits & document specific actions
- Developed to prevent illness caused by Legionella and other opportunistic pathogens in water



# THE JOINT COMMISSION

## Relevant Standards to Address Infection Prevention & Control

Standard	Definition
EC.01.01.01	Hospital has written plan for managing utility systems
EC.02.01.01	Organization manages safety & security risks
EC.02.05.01	Organization manages risks associated with utility systems
EC.02.05.05	Organization inspects, tests & maintains utility systems
IC.01.03.01	Organization identifies risks for acquiring & transmitting infections
IC.01.05.01	Organization has an infection prevention (IP) & control plan
IC.02.01.01	Organization implements its IP & control plan
IC.03.01.01	Organization evaluates effectiveness of its IP & control plan

# THE JOINT COMMISSION

Demonstrating Compliance

## FACILITY RISK ASSESSMENT

1

IDENTIFY WHERE  
BACTERIA COULD  
GROW & SPREAD

## WATER MANAGEMENT PROGRAM

2

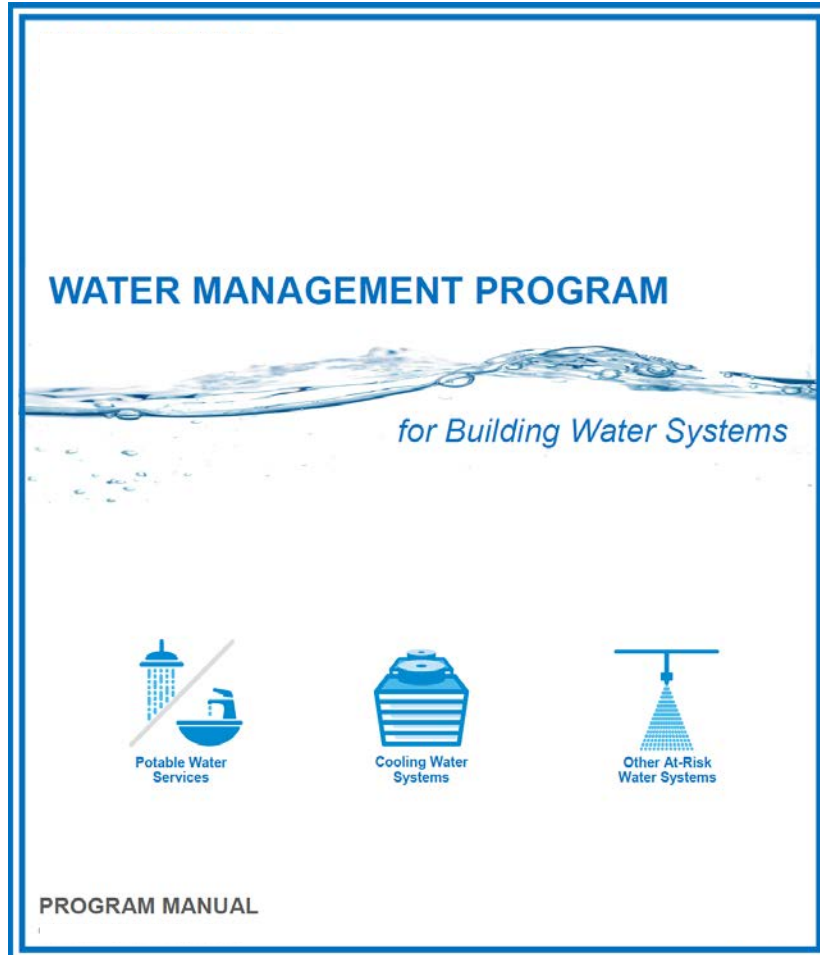
CONSIDER  
ASHRAE ST. 188  
& CDC TOOLKIT

## DEFINED TESTING PROTOCOLS & ACCEPTABLE RANGES

3

RESULTS OF TESTING &  
CORRECTIVE ACTIONS

# WATER MANAGEMENT PROGRAM



Complete guide for the prevention and control of *Legionella* within building water systems.

# EMERGENCY

**I GOT A POSITIVE, TIME TO TAKE ACTION!**

# EMERGENCY – POSITIVE *LEGIONELLA* TEST

My *Legionella* test results came back positive.....now what?



- Test results are validating an issue and telling you about your system
- Results ONLY have to be reported to public health authorities IF there is a suspected or confirmed case of *legionellosis*

Check your Contingency Response Plan in your Water Management Program

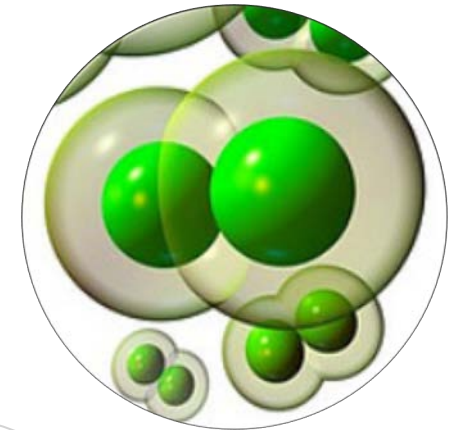
- Procedures for emergency disinfection of potable water systems
- Procedures to be followed if there are known or suspected cases of *legionellosis*



# IMMEDIATE RESPONSES

Common Actions to Address & Reduce the Immediate Risk

- Outlet Flushing
- Outlet Cleaning
- Point-of-Use Filters
- Hyperchlorination
- Thermal Shock Treatment



# TEMPERATURE & OXIDANT PROFILING

How Water Moves Once It Enters Your System

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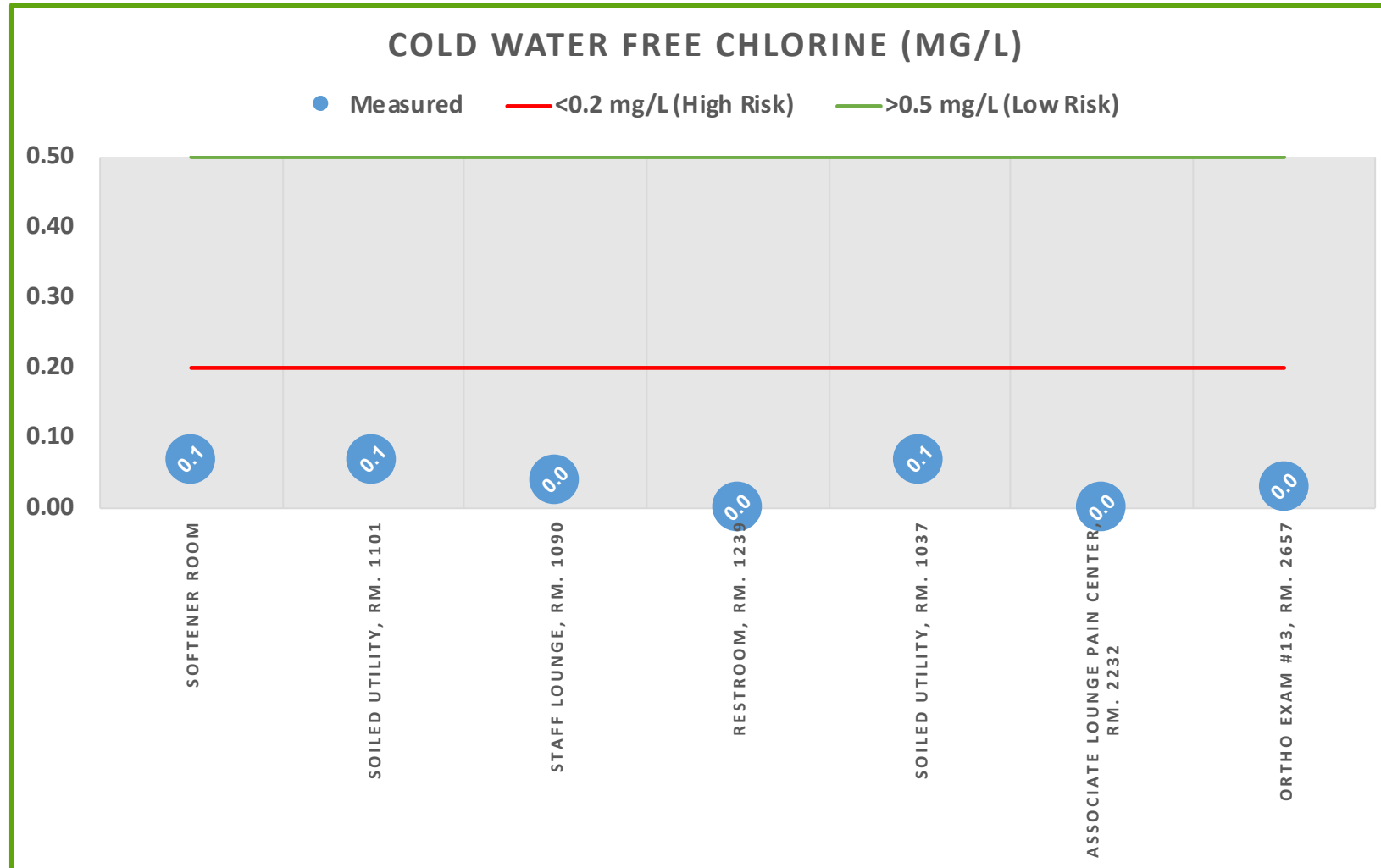
- Highlight areas of stagnation and low-use
- Identify cross connections between hot and cold water systems

## PROCESS:

- Temperature and Chlorine levels are recorded throughout the entire facility
- Results are plotted on a graph
- Compare systems, buildings, floors, risers, loops to find trends and help identify areas that may be of concern

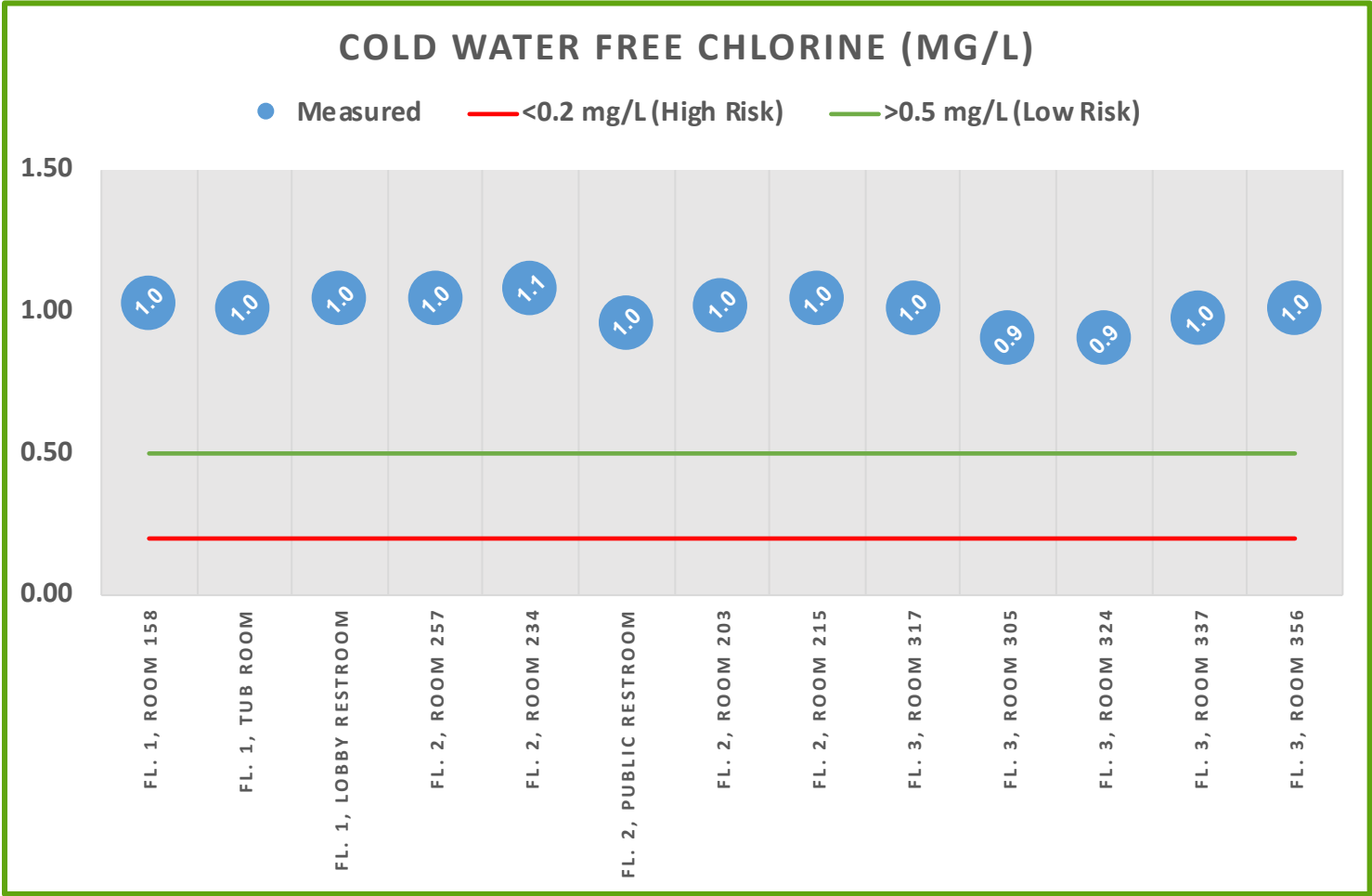
# INVESTIGATING SYSTEM PROFILES

## Real-Life Example



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## Real-Life Example

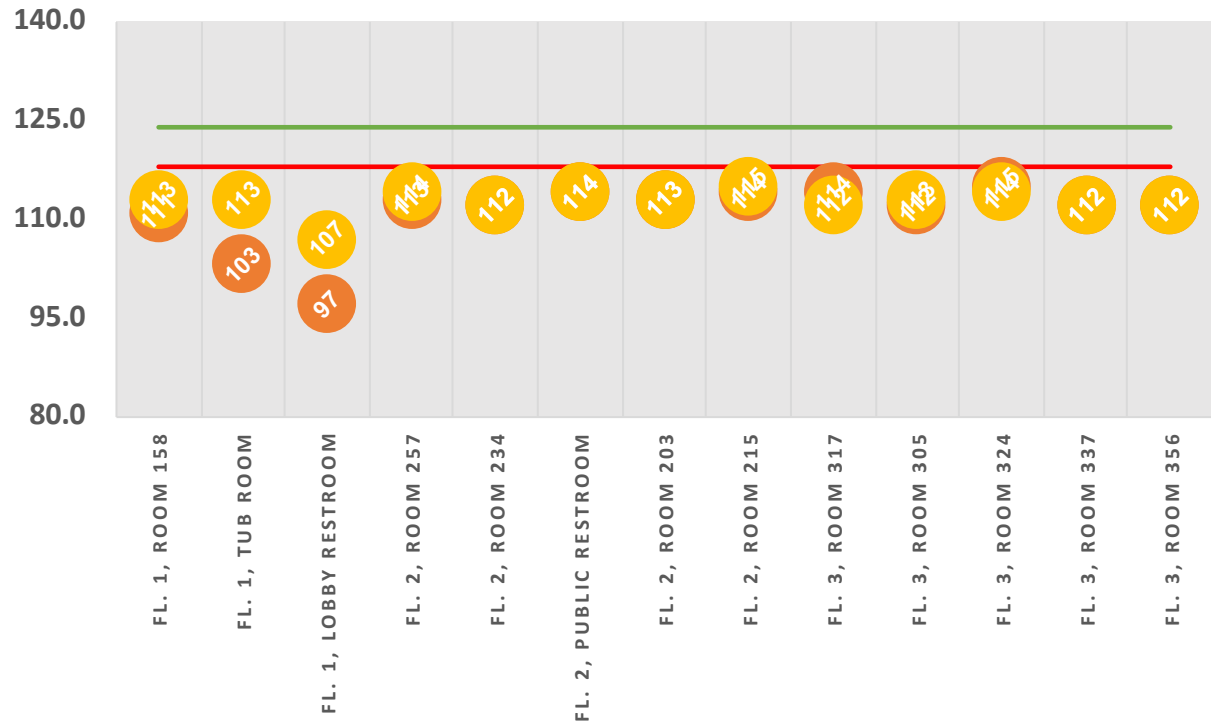


# INVESTIGATING SYSTEM PROFILES

## Real-Life Examples

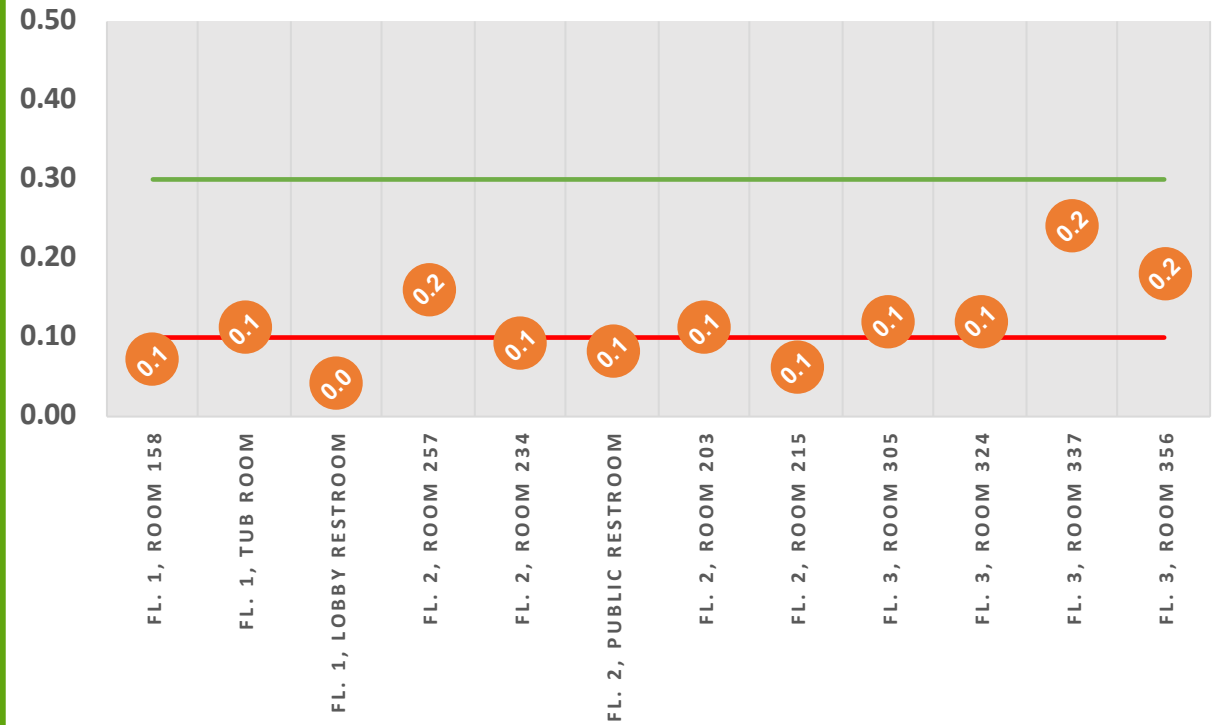
### HOT WATER TEMPERATURE (DEG-F)

● T1 ● T2 — <118°F (High Risk) — ≥124°F (Low Risk)



### HOT WATER FREE CHLORINE (MG/L)

● Measured — <0.1 mg/L (High Risk) — >0.3 mg/L (Low Risk)



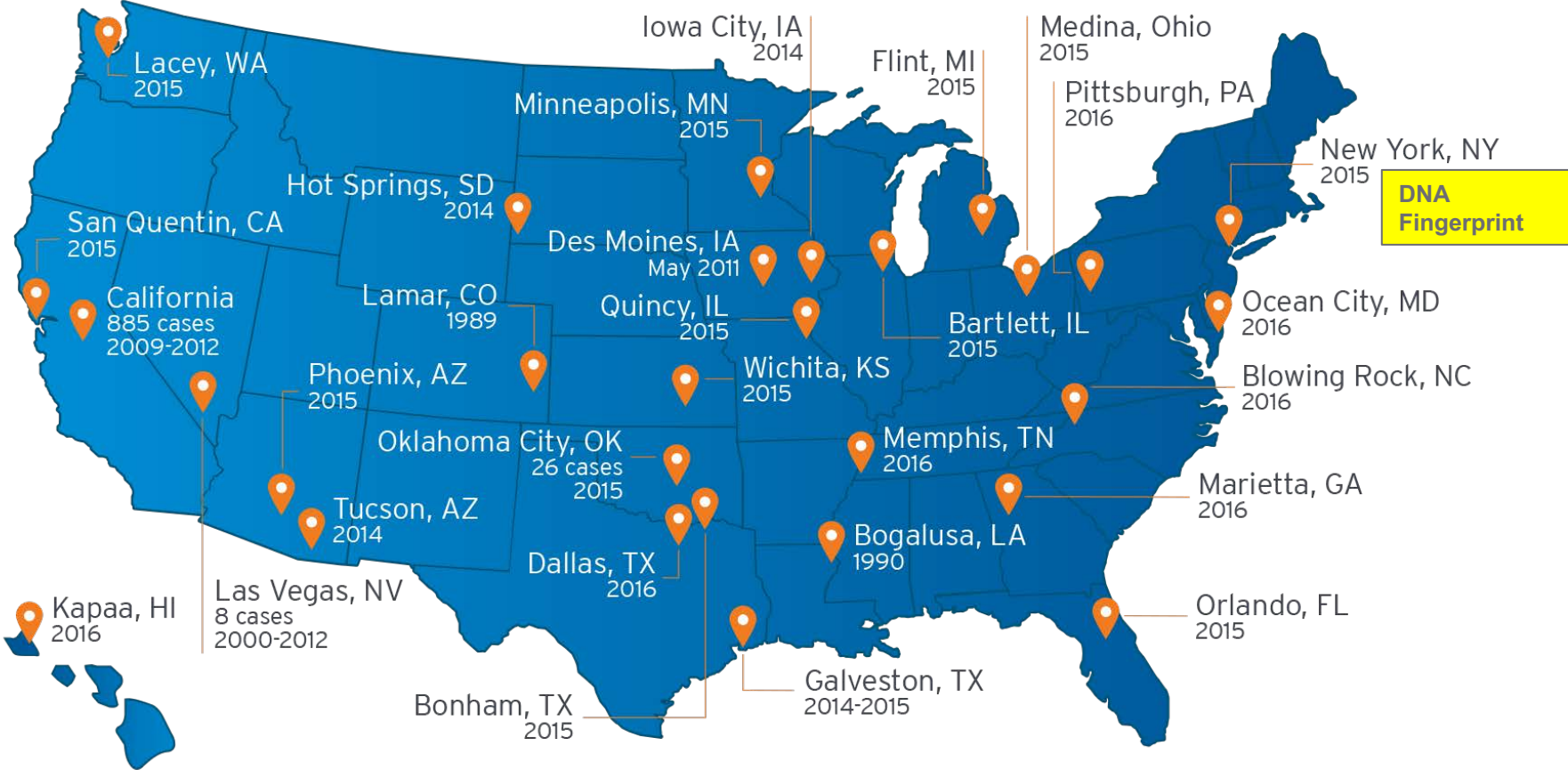
# - EMERGENCY -

A *LEGIONELLA* INCIDENT or OUTBREAK

**THE INVESTIGATIVE PROCESS**

# LEGIONELLA: OUTBREAKS

**ON THE RISE:**  
REPORTING, OUTBREAKS & PUBLIC AWARENESS



# POTENTIAL OUTBREAK CONSEQUENCES

- Outbreak Ensues Chaos
- Investigation & Remediation Costs
- Temporary Shutdown - Production & Revenue Loses
- Litigation, Fines or Civil Lawsuits
- Damage to Brand / Facility Reputation
- Increased Insurance Premium



# OUTBREAK INVESTIGATIONS

## Defining the Outbreak Case Type

### Definite Healthcare-Associated Case

Patient spent entire 10 days before date of symptom onset in a healthcare facility

### Possible Healthcare-Associated Case

Patient spent a portion of the 10 days before date of symptom onset in a healthcare facility

### A Full Investigation is Conducted if...

- $\geq$  1 case of Definite Healthcare-Associated Legionnaires Disease at any time
- $\geq$  2 cases of Possible Healthcare-Associated Legionnaires Disease within 12 months

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# OUTBREAK INVESTIGATION

## Communication Considerations

- Be prepared – consider establishing a communications plan for outbreaks ahead of time
- Develop key messages and coordinate early and often
- Do not speculate – only provide information
- Gauge public concern and address accordingly
- Discuss with staff how to notify employees, visitors & patients
- Encourage anyone who has symptoms to see a healthcare provider



SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>

# OUTBREAK FULL INVESTIGATION

## Part 1 • Retrospective Review of Cases

- Search Health Department surveillance database for other reported cases
- Review of Facility routine surveillance for healthcare-associated pneumonia
- Create line list defining past 12 months pneumonia cases to determine if they were healthcare-associated
- Review of Facility *Legionella* testing protocol and any positive results
- Identify all new and recent patients with healthcare-associated pneumonia and test them for *Legionella*

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# OUTBREAK FULL INVESTIGATION

## Part 2 • Active Clinical Surveillance

- Review protocol for active clinical surveillance with public health official
- Identify all new and recent patients with healthcare-associated pneumonia and test them for *Legionella*
  - Daily review of chest radiographs and CT scans to diagnose pneumonia
  - Daily review of new pneumonia diagnoses in intensive care units
  - Daily review of laboratory testing ordered to diagnose pneumonia
- Obtain post-mortem specimens, when applicable

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# OUTBREAK FULL INVESTIGATION

## Part 3 • Implementation of Immediate Control Measures

### ■ Water Restrictions

- Restricting Showers
- Avoiding exposure to hydrotherapy tubs
- Avoiding use of water from sink/tub faucets
- Using bottled or sterile water
- Avoiding consumption of non-sterile ice
- Halting new admissions or temporarily closing the affected area(s)

**NOTE:** Periodic flushing may be necessary to avoid stagnation in facility systems due to water restrictions.

### ■ Point-of-Use Filters

- At a minimum, 0.2 micron biological filters on any showerheads or sink/tub faucets intended for use
- May need to be removed during remediation procedures



SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>

# OUTBREAK FULL INVESTIGATION

## Part 4 • Perform an Environmental Assessment

- Used to gain thorough understanding of a facility's water systems and identify possible environmental sources of *Legionella*
- Monitoring of Water Quality Parameters
  - Temperature
  - pH
  - Residual Disinfectant
- Determine sampling plan for *Legionella* environmental testing

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# OUTBREAK FULL INVESTIGATION

## Part 5 • Perform Environmental Sampling

- Used to characterize extent of *Legionella* colonization within water system
- Sampling Plans based upon
  - Environmental Assessment
  - Building Characteristics
  - Possible exposure sites
  - Available resources/supplies to support sampling
- Important for verifying remedial actions are working

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# TYPES OF ENVIRONMENTAL SAMPLING



## CULTURE TEST ISO 11731

Industry accepted “Gold Standard”



## qPCR

(QUANTITATIVE POLYMERASE CHAIN REACTION)

Rapid method used to detect & quantitate bacteria, used as a positive or negative screen



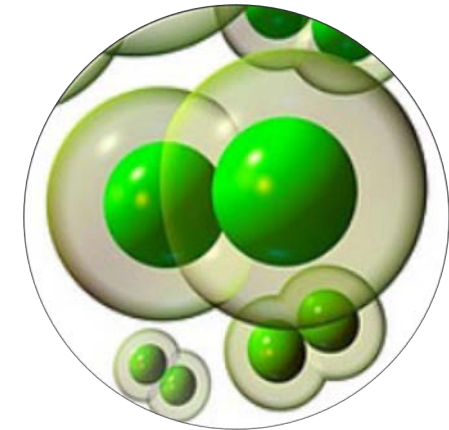
## OTHER RAPID METHODS

Emerging methods that may have limitations to detect low levels and limited to one or a few species.

# OUTBREAK FULL INVESTIGATION

## Part 6 • Remedial Procedures – Potable Water Systems

- Outlet Cleaning Procedure
- Outlet Flushing Procedure
- Superheating & Flushing Procedure
- Hyperchlorination



# OUTBREAK FULL INVESTIGATION

## Part 7 • Determining the End of the Outbreak

- No new cases of Legionnaires' Disease
- No detection of *Legionella* in post-remediation environmental samples

THE  
END

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>

# OUTBREAK FULL INVESTIGATION

## Part 8 • Environmental Sampling Following an Outbreak

- *Legionella* can regrow following remediation events if conditions are right
- Follow up sampling approach, as described in HICPAC Guidance
  - Collect Environmental Samples for culture at 2-week intervals for 3 months
  - If *Legionella* is not detected after 3-months, collect cultures monthly for another 3 months
  - If *Legionella* is detected
    - Review & modify Water Management Program
    - Perform additional remediation
    - Implement new 6-month post-remediation environmental monitoring follow-up sampling

SOURCE: CDC, <https://www.cdc.gov/legionella/health-deps/epi-resources/outbreak-investigations.html#remediation>



# AFTER AN OUTBREAK

## Future Preventive Measures

- Have an effective Water Management Program in place
- Implement a continuous Environmental Sampling Plan



# WATER MANAGEMENT PROGRAM

## Risk Management



### AT-RISK WATER SYSTEMS



Potable Water Systems

56%



Cooling Towers & Evaporative Condensers

22%



Whirlpools or Spas

7%



Ornamental Fountains & Other Water Features

4%



Aerosol Generating Misters, Atomizers, Air Washers & Humidifiers

4%

# WATER MANAGEMENT PROGRAM

## Pathogen Analytical



- Testing plans are a method to **validate** the Water Management Program is working to control the hazard
- Proactive measure to
  - Identify potential growth & transmission sources
  - Confirm efficacy of remedial procedures
  - Manage and reduce risk

# WATER MANAGEMENT PROGRAM

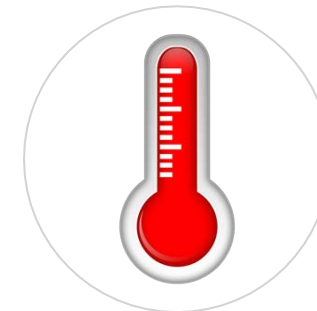
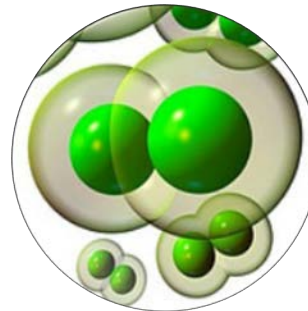
## Short-Term Remediation Strategies



- Contingencies to regain control
- Reactionary measures – **Does not resolve root cause!**



Remedial Cleaning & Hyper-chlorination  
Disinfection



Thermal  
Disinfection



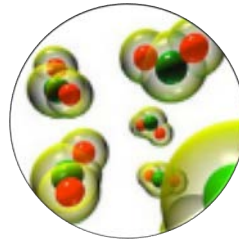
Point-of-Use  
Water Filters

# WATER MANAGEMENT PROGRAM

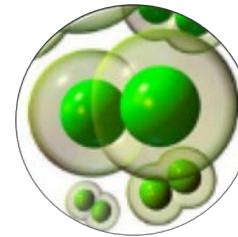
## Long-Term Control Strategies



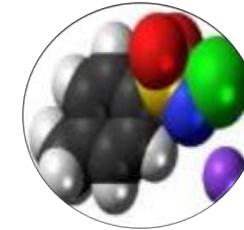
### ■ Supplemental Disinfection



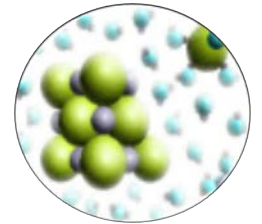
Chlorine Dioxide



Chlorine



Chloramine



Cu-Ag Ions

### ■ Point-of-Use Filters



# SUPPLEMENTAL DISINFECTION STRATEGIES

## CHLORINE DIOXIDE

- EPA approved
- On-site generation using sodium chlorite + chlorine + acid
- On-site generation from sodium chlorite

## CHLORINE

- EPA approved
- Liquid Chlorine
- On-site generation (higher stability)

## CHLORAMINE

- EPA approved
- On-site generation using liquid chlorine + liquid ammonia

## COPPER-SILVER


- Regulated as a contaminate by US-EPA under FIFRA\*
- Cu-Ag ions from Cu-Ag electrodes

\* Federal Fungicide, Insecticide, & Rodenticide Act

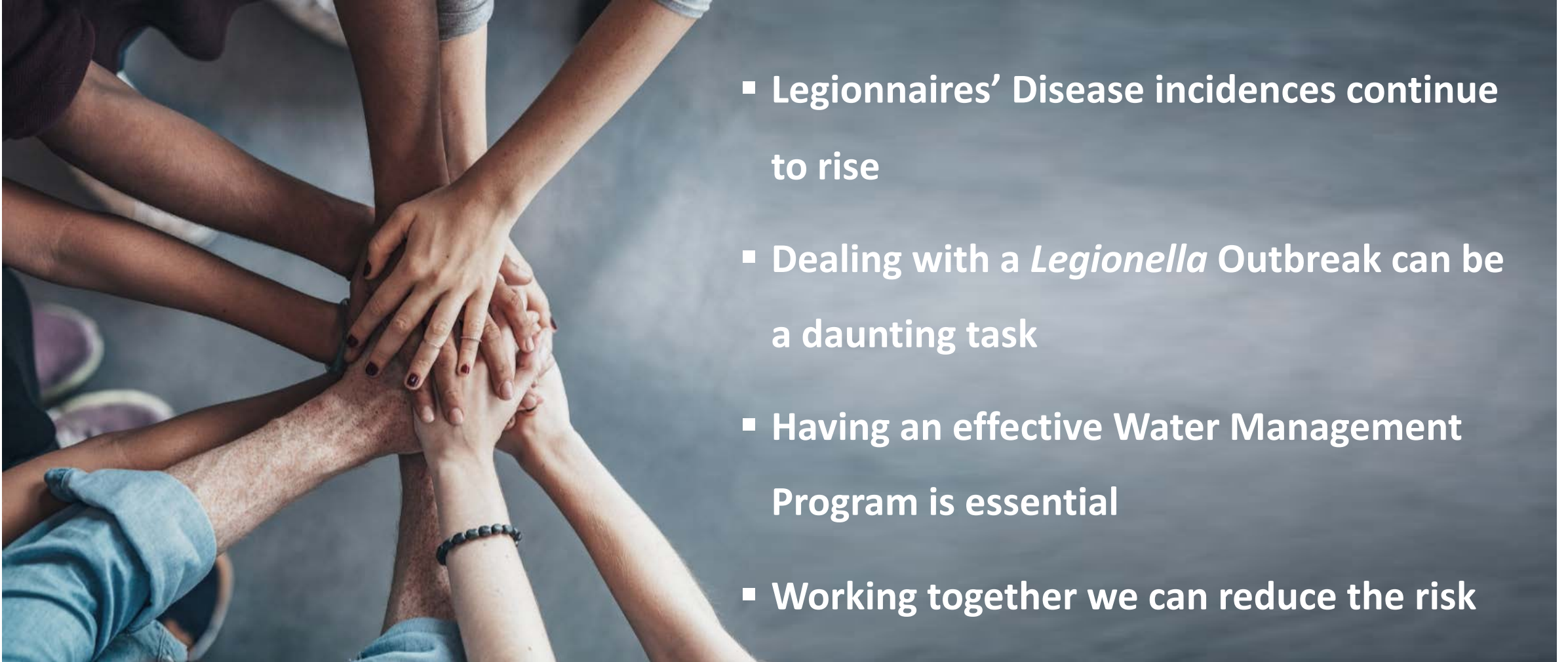


# WATER MANAGEMENT PROGRAM

## Supplemental Disinfection Permitting

- 
- Safe Drinking Water Act
  - Each State may have their own requirements
  - The permit & permitting process is owned by the building owner

# IN CONCLUSION...



- Legionnaires' Disease incidences continue to rise
- Dealing with a *Legionella* Outbreak can be a daunting task
- Having an effective Water Management Program is essential
- Working together we can reduce the risk

**ECOLAB**<sup>®</sup>

**NALCO** Water



**We have boots on the ground everywhere.**

Local service delivered worldwide.



Global Experts in Water Safety

**25+ years**



Our *Legionella* lab is a charter member of the CDC-ELITE proficiency program, ELAP Certified and follows ISO 11731 procedures.