Utah Department of Health & Human Services

Meeting Minutes

Laboratory and Surveillance Utah Healthcare Infection Prevention Governance Committee

Date: 2/5/2024

Attendees:
Susan Cheever, Alessandro Rossi, April Clements, Ashley Young, Camille Donkin, Giulia De Vettori, Jeanmarie Mayer, Kimberly Wilkerson, Linda Rider, Louise Saw, Mark Fisher, Rhonda Hensley, Sarah Rigby, Tara Ford, Bert Lopansri, Kristin Dascomb, Doug (VA), Rebekah, Heather Hutchinson, Lacey Kirby, Ashley Miller
Agenda Topics:
Introductions 1:00–1:05 Giulia De Vettori Action Steps/Plan 1:05–1:25 Angela Weil/Dr Rossi Situational Awareness 1:30–1:50 Giulia De Vettori Convene
Discussion:

Introductions - Giulia De Vettori

- Introductions - no new people
- Approve minutes - Alessandro Rossi moved for approval of the meeting and Kristin Dascomb seconded

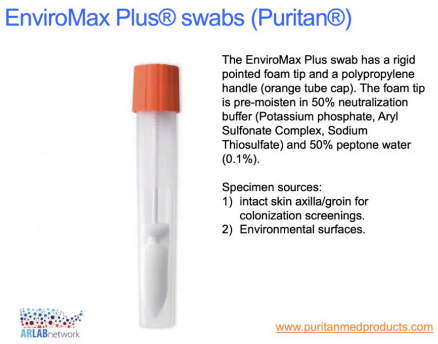
Action Steps/Plan - Giulia De Vettori/Angela Weil

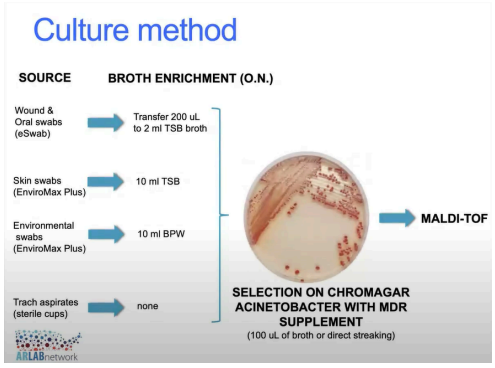
- C. Auris Awareness:
- Angela: shared letter sent to hospitals and vSNFs and LTACH
    - will be included with minutes
    - guidance about admission screening
    - includes background info about Candida auris
- Dr. Rossi: VIM-CRPA investigation-no new cases
    - no current local surveillance because we have not seen new cases in the last couple of months
    - no national updates recently from the CDC
    - We have submitted a paper about the work we did in this investigation
        - Has been submitted to the New England Journal of medicine
        - We were awaiting publication at the time of the meeting. Below is the article:
        - Multistate VIM-CRPA outbreak investigation
        - Our work on this investigation was successful because you submitted samples and allowed us to move forward on this work and prevent further morbidity
- Currently Lab has reduced capacity for colonization screening because of staffing shortages

- We are interviewing and trying to fill staffing shortages
- we expect to be back at capacity in one month

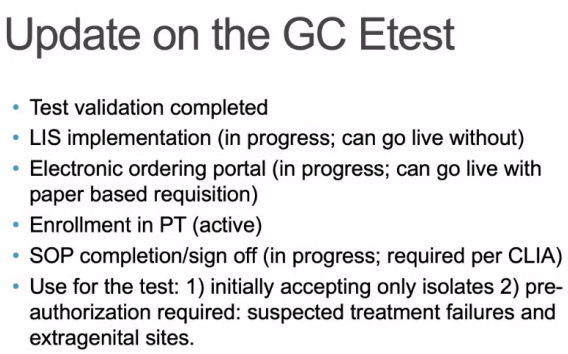
Colonization screening test	Current Capacity to test/week	Capacity/week when lab has 100% staffing
CRE-CRPA bu Cepheid CARBA-R	256	256
CRAB by Culture	30	100
C. auris by PCR	100	400

- We encourage facilities who can to do their own screening
    - at least for C. auris, ARUP and Intermountain are already self-sufficient
    - UPHL can provide validation support for labs that want to become more self sufficient
    - labs can order isolates free from the AR isolate bank and de identified clinical isolates from UPHL (C. auris and other Candida) to use for validation
    - UPHL can share residual Eswabs specimen for PCR validation
    - They will also share their SOPs and provide training, invite visits to observe workflow
- We may consider going to PCR testing in the future
    - for now we perform culture screening
    - may consider going to PCR because of the laboriousness of culture screening
- Survey sent to labs about who does colonization screening
    - only 3 received out of about 12
    - just sent Friday
    - we can share more results as we receive them
- Dr Mayer: Might want to call rather than survey
    - maybe talk to hospital IPs and ask what labs they use and how they order supplies for screening
- Mark Fisher and Dr Mayer: process:
    - new plan-when samples come in we set them up like we are screening for CREs, we validated acinetobacter-enrichment and CRE chromagar approach
    - ID the organism and verify carbapenem resistance
    - follow guidance from state
    - have validated with tracheal aspirate in ventilated, skin/wound, axillary
- Dr Mayer: at the University, risk is a strong factor in what screening is done
    - direct transfer from LTACH, v SNF, coming in from high risk state (CDC)
        - perirectal swab is easier to obtain than rectal for CRE test
        - For acinetobacter:
            - wound culture if wound
            - aspirate if trach
            - axillary inguinal
        - C. auris
    - We are starting to look at patients coming in from Washington state
    - If unexpected result-ring surveillance on a unit
- What do you do if you identify acinetobacter baumannii by culture?

    - If acinetobacter found, confirm by second method
        - chromagar is not susceptibility test
        - if confirmed as resistant
            - report to state
            - send isolate to UPHL for CP testing
    - We don't do surveillance for CRPA
        - If we find CRPA, we test for carbapenamase production to avoid miscommunication
    - 5 gene test on the sepiod
- Bert Lopansri:
    - No screening culture for acinetobacter
    - Do have screening culture for CRE
        - if anything grows, we work it up
        - from respiratory tract, we just have people send in a culture
- In Israel they use interesting method of sample collection for CRAB surveillance
    - increased surface is the key to increasing sensitivity
    - We recommend multiple source sampling
    - axilla/groin seems to be the best collection method
        - but using a conventional swab for collection does not provide enough sensitivity
    - For CRAB colonization there is no "gold standard", no commercially available test-everyone does things differently
        - within ARLN, there is a harmonization work group
        - UPHL uses these swabs
    - 

    - It would not be possible to collect a sample and immediately immerse it in a broth solution at the bedside like shown in the study from Israel
    - 

- UPHL assessed CRAB recovery using a field trial during point prevalence survey, testing 31 residents at a vSNF who consented to be swabbed with both the EnviroMax Plus swab and an eswab
    - 4 residents tested positive with EnviroMax Plus
    - only 1 tested positive with Eswab
- In a review analyzing 8 point prevalence survey screenings (axilla-groin, wound, sputum), average sensitivity:
    - axilla-groin 56.32%
    - sputum 83.67
    - wound 49.52%
        - So our results do not show the same sensitivity as claimed in the publication
            - maybe because we are swabbing a smaller surface area
- In the future we are looking to change to PCR testing to reduce turn-around time
- Dr Mayer: that sponge method was very complicated when I was trained on it
- Dr Rossi: The methods have changed- no longer use a stomacher
- A respiratory sample is a good sample, and increased collection sites increases sensitivity
- If we start to play with PCR, we can reconvene
- We are exploring a new testing platform for candida auris and maybe see if it will work for acinetobacter
    - Would allow faster turn-around time
- Dr. Mayer: It would be good to talk to facilities to find out where they send samples-what labs they use
- Dr Rossi: we do about 20 admission screenings each week
    - when we identify acinetobacter, we test for carbapenamase producing genes
- We are not quite ready to go live with the GC Etest
    - would require pre-authorization
    - initially we would only accept isolates



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- Bert Lopansri: we have probably seen 2-3 cases of disseminated GC
    - We do not do susceptibility testing
- UPHL will be a source for susceptibility testing with Neisseria Gonorrhoeae
    - Allesandro: Use GC based agar containing IsoVitaleX
    - right now we send it to Washington for resistance testing

Situational Awareness - Dr Alessandro Rossi/Giulia De Vettori

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Convene

- Next meeting May 6, 2024

Next Meeting Discussion/Questions
Every three months • 5/6/2024 Minutes will be posted to the HAI website • https://epi.health.utah.gov/uhip-governanceminutes/
Next Meeting: 5/6/2024