Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens
Member Conference Call
Friday, May 11, 2018 | 2:00 p.m. – 3:00 p.m. ET
Dial-in: 866-740-1260 Passcode: 5273136
Webinar Link: https://cc.readytalk.com/r/si80vlh84tt1&eom

AGENDA

Welcome and Governance Committee Remarks – 15 minutes
Gerd Clabaugh and Marion Kainer
Membership Updates

- Association of Public Health Laboratories (APHL) – Jafar Razeq, MD
- The National Association of County and City Health Officials (NACCHO) – Hillary Hanson, MPH
- Association of State and Territorial Health Officials (ASTHO) – Kris Ehresmann, RN, MPH

New Workgroups

- Laboratory and Policy Workgroups *(WG charge documents attached)*

Workgroup Product Presentation/Updates – 30 minutes

- Workgroup A -- *Workgroup Co-chairs*
  Feedback and Comments *(all members)*
- Workgroup B -- *Workgroup Co-chairs*
  Feedback and Comments *(all members)*

Results of the Scabies Product Vote – 5 minutes

CORHA Meeting Overview – 5 minutes

Closing Remarks – 5 minutes
Gerd Clabaugh and Marion Kainer

CORHA Voting Member Roster

Name	Affiliation	Representing Organization	Other
Gerd Clabaugh	Iowa Department of Public Health	Association of State and Territorial Health Officials (ASTHO)	Governance Committee Co-chair
Marion Kainer	Tennessee Department of Health	Council of State and Territorial Epidemiologists (CSTE)	Governance Committee Co-chair
Joe Perz	Centers for Disease Control and Prevention (CDC)	Centers for Disease Control and Prevention (CDC)	Governance Committee Member
Dawn Terashita	Los Angeles County Department of Public Health	National Association of County and City Health Officials (NACCHO)	Governance Committee Member
Kristen (Kris) Ehresmann	Minnesota Department of Health	Association of State and Territorial Health Officials (ASTHO)	
Joseph Miner	Utah Department of Health	Association of State and Territorial Health Officials (ASTHO)	
Wendy Bamberg	Colorado Department of Public Health and Environment	Council of State and Territorial Epidemiologists (CSTE)	Workgroup A Lead
Erin Epson	California Department of Health	Council of State and Territorial Epidemiologists (CSTE)	
Elizabeth Mothershed	Centers for Disease Control and Prevention (CDC)	Centers for Disease Control and Prevention (CDC)	
Hillary Hanson	Flathead City- County Health Department	National Association of County and City Health Officials (NACCHO)	
Jafar Razeq	Connecticut State Public Health Laboratory	Association of Public Health Laboratories (APHL)	
Linda Greene	Highland Hospital; Affiliate University of Rochester Medical Center	Association of Professionals in Infection Control and Epidemiology (APIC)	
Patricia Meier	Centers for Medicare & Medicaid Services (CMS)	Centers for Medicare & Medicaid Services (CMS)	
Julia Marders	Food and Drug Administration (FDA)	Food and Drug Administration (FDA)	
Waleed Javaid	SUNY Upstate Medical University	Society for Healthcare Epidemiology of America (SHEA)	Workgroup B Lead

CORHA Laboratory Workgroup Charge: Outbreak Detection and Response *(Draft)*

Workgroup purpose:
The Laboratory Workgroup of CORHA seeks to promote and support improvement of laboratory response to healthcare-associated infection outbreaks. The primary objective is to define public health, clinical, and commercial laboratory best practices to support outbreak detection and response. The workgroup will assist laboratorians as well as public health and clinical partners by developing guidance, identifying best practices, and improving collaborations with healthcare facilities and state/local public health departments.

The workgroup is tasked with the following activities:

1. **Contribute knowledge and support activities that lead to improving laboratory test methods in support of HAI/AR outbreak response activities.** The workgroup will:

1.1 Promote implementation of techniques to detect specific pathogen strains (e.g. CP-CRE) helpful for outbreak response.
1.2 Determine what laboratory test methods are practical for HAI/AR outbreak response

2. **Identify and promote best practices for laboratory data collection and data sharing in relation to HAI/AR outbreak response.** The workgroup will:

2.1 Determine what laboratory data would be most valuable for outbreak identification/investigation.
2.2 Make recommendations on reporting roles and methods for different types of laboratories, including clinical, commercial, research, and public health laboratories, to relevant stakeholders.

3. **Support effective interactions between laboratories, healthcare facilities, and state/local health departments in the context of HAI/AR response activities.** The workgroup will:

3.1 Identify best practices for how laboratories can assist epidemiologists and other partners with identifying potential outbreaks and investigating routes of transmission.
3.2 Identify best practices for outbreak response from a laboratory perspective and determine the roles of each stakeholder during an investigation.
3.3 Foster relationships with laboratory stakeholders

CORHA Policy Workgroup Charge *(Draft)*

Workgroup purpose:
The CORHA Policy Workgroup seeks to address the legal and policy considerations related to outbreaks of healthcare-associated infection (HAI), including those caused by antimicrobial-resistant (AR) pathogens, and make recommendations to policy makers at all levels to improve the detection, reporting, investigation, control and prevention of HAI/AR outbreaks.

To address these priorities, the Workgroup will work in sequence to address the following focus areas:

1. **Improve reporting of HAI/AR outbreaks and exposure events**
   Outbreak Reporting, Notification, and Disclosure.
   For the purposes of this workgroup, *outbreak reporting* is defined as activities that occur when a facility reports a possible outbreak to public health, *notification* occurs when patients potentially affected by an outbreak are informed, and *disclosure* is defined as activities that occur to inform individuals beyond the patients potentially affected by an outbreak.

   To address outbreak reporting, notification, and disclosure, Policy Workgroup members will conduct the following activities in Phase I:
   - 1.1. Assess current state laws relating to HAI outbreak reporting, notification, and disclosure practices;
   - 1.2. Assess current federal requirements relating to HAI outbreak reporting, notification, and disclosure practices;
   - 1.3. Explore and describe common HAI outbreak reporting, notification, and disclosure burdens;
   - 1.4. Define and describe levels of HAI outbreak public disclosure;
   - 1.5. Describe ethical and legal issues related to HAI outbreak reporting, including but not limited to timeliness of reporting, notification and disclosure;
   - 1.6. Highlight examples of promising or effective tools for HAI outbreak public reporting and disclosure practices; and
   - 1.7. Identify key resources to improve and support standardized approaches to HAI outbreak reporting, notification, and disclosure to public health and relevant stakeholders.

2. **Explore options to enhance legal authority and policy options to support best practices**
   To address the legal authorities and other policy options associated with HAI outbreak reporting, notification, and disclosure, Policy Workgroup members will conduct the following activities in Phase II:
   - 2.1. Describe and codify best practices for HAI outbreak reporting, notification, and disclosure options, as identified through the Phase I activities described above;
   - 2.2. Describe legal issues related to HAI outbreak reporting, notification and disclosure;
   - 2.3. Promote best practices, supporting examples, and recommendations on legal issues and policy options relating to HAI outbreak reporting, notification, and disclosure; and
   - 2.4. Develop or promote model legislation or policy language to support best practices for HAI outbreak reporting, notification, and disclosure.

All Policy Workgroup activities will occur in coordination with CORHA workgroups focused on promoting standardized approaches on outbreak detection and reporting, and investigation and control.

Priority Pathogens for the Policy Workgroup include:
TBD

Policy Workgroup Members should consider representation from the following perspectives:
1) Experts on state law relating to reporting and disclosure practices (attorneys general, health department legal counsel, etc.), 2) ad-hoc contributors from federal and/or accreditation agencies with knowledge of their respective agency HAI outbreak reporting requirements 3) IC staff at the state and local levels, 3) communication staff, 4) hospital and facility staff knowledgeable of day-to-day workflow, data collection and reporting effort, 5) experts who are able to speak to ethical issues relating to HAI outbreak reporting, notification, and disclosure, 6) patient advocates, 7) persons knowledgeable of optimal pathogen-specific intervention timelines to guide discussion of timeliness of reporting.

Indicate that a future phase may focus more specifically on legal authorities related to investigation activities.

Proposed Investigation/Reporting Thresholds and Outbreak Definition for Carbapenem Resistant Enterobacteriaceae (CRE) *(Draft)*

<Draft>, <Date>

The thresholds and definitions below are intended to be a guideline and are based on expert opinion except as noted otherwise. States and local jurisdictions may have their own requirements for reporting and outbreak definitions.

	Acute Care Hospitals	Long-Term Acute Care Hospitals and Long-Term Care Facilities with Ventilated Patients	Long-Term Care Facilities (LTCF)	Critical Access Hospitals	Dialysis Facilities	Outpatient
Threshold for facility to do additional investigation	*In regions with high prevalence CRE and/or endemic KPC*[1]*:* • ≥1 non-KPC CP-CRE (NDM, VIM, IMP, OXA-48 type) • ≥2 KPC-CRE or • ≥2 CP-CRE (unknown mechanism) or • ≥2 CRE (non-CP or mechanism testing not performed) of same organism in a 4-week period in patients on the same unit*. *In a region with lower prevalence CRE*[2]*:* • ≥1 CP-CRE (KPC, NDM, VIM, IMP, OXA-48 type, or positive by phenotypic test) • ≥2 CRE (non-CP or mechanism testing not performed) of same organism in a 4-week period in patients on the same unit*. *In regions with very low CRE prevalence*[3]*:* • ≥1 CRE (CP, non-CP, or unknown CP)			≥1 CRE (CP, non-CP, or unknown CP)	≥1 CRE (CP, non-CP, or unknown CP in patient not previously known to be infected or colonized)	

Threshold for reporting to PH	*In regions with high prevalence CRE and/or endemic KPC*[1]*:* • ≥1 non-KPC CP-CRE (NDM, VIM, IMP, OXA-48 type) • ≥2 KPC-CRE or • ≥2 CP-CRE (unknown mechanism) or • ≥2 CRE (non-CP or mechanism testing not performed) of same organism in a 4-week period in patients that are epidemiologically-linked[#] with confirmatory laboratory testing. *In regions with lower prevalence CRE*[2]*:* • ≥1 CP-CRE • ≥2 CRE (non-CP or mechanism testing not performed) of same organism in a 4-week period in patients that are epidemiologically-linked[#] with confirmatory laboratory testing. *In regions with very low CRE prevalence*[3]*:* ≥1 CRE (CP, non-CP, or unknown CP)	≥1 CRE (CP, non-CP, or unknown CP)	≥1 CRE (CP, non-CP, or unknown CP in patient not previously known to be infected or colonized)
Outbreak definition	≥2 CRE of same organism (or mechanism, if mechanism testing performed) in a 4-week period that are epidemiologically-linked[#] or determined to be genetically related by laboratory testing[$].		

CP=carbapenemase-producing; non-CP = non carbapenemase-producing; KPC=*Klebsiella pneumoniae* carbapenemase; NDM = New Delhi Metallo-β-Lactamase; OXA-48-type = oxacillinase; VIM = Verona-Integron encoded carbapenemase; IMP = active-on-Imipenem Metallo- β-lactamase

[1]Regions with high prevalence or endemic CRE are defined as areas where CRE are routinely identified (e.g., on average, acute care facilities in high prevalence regions would have more than one CRE case per month and those in endemic regions would have one or more CRE cases per week).

[2]Regions with lower prevalence CRE are defined as areas where CRE are identified with some regularity (e.g., on average, acute care facilities in these regions would have more than a few cases per year to one case per month).

[3]Regions with very low prevalence CRE are defined as areas where CRE are seldom identified (e.g., on average, acute care facilities in these regions have one or a few CRE cases per year).

*At minimum, patients admitted to a common unit should be investigated, but additional factors that might indicate a common exposure, such as invasive procedures, could also be used. Patients do not need to have overlapping stays to meet the threshold for additional investigation.

[#]Epidemiologically-linked = Including but not limited to the following examples: residing on same unit (or within same facility if facility is smaller), transferred from same outside facility, assigned to same primary or consultative service, facility staff in common, had same procedure, seen at same facility, etc.
[$]Laboratory testing methods commonly used for assessing genetic relatedness include pulsed field gel electrophoresis (PFGE) and whole genome sequencing (WGS).

Points for consideration:

- CRE numbers include both colonized and infected patients.
- Prevalence definitions are intended as examples based on the average facility in a region. The CRE prevalence may vary among facilities in a region due to facility bed size, patient population, whether a facility conducts admission screening or active surveillance, and other factors. Some facilities might fall into one prevalence group for CP-CRE and a different prevalence group for CRE.
- CRE prevalence is highly heterogeneous in the United States. For this reason,
    - In high prevalence or endemic areas, the threshold for investigation of 2 CRE on the same unit was selected for greatest sensitivity. For some facilities in KPC endemic settings, this threshold might prove too burdensome. In this case, facilities should know their baseline CRE prevalence and choose a threshold for investigation that represents a rise above the baseline and that carefully balances sensitivity with specificity. Facilities in these regions might have a lower threshold for investigating non-*K. pneumoniae* CRE, which could carry less common carbapenemases, compared to carbapenem-resistant *K. pneumoniae.*
    - Some facilities may have a prevalence that differs from other facilities in the region. For example, for a ACH in a lower prevalence region that receives patients from facilities in higher prevalence regions, the higher prevalence thresholds might be more appropriate than those for the lower prevalence region.
    - Facilities should consult with public health for guidance about which prevalence threshold they should use. If the prevalence threshold is unknown, a facility should start with the thresholds for very low CRE prevalence and modify as more information becomes available.
- Mechanism testing for CRE is available at 50 state public health laboratories and 7 local health departments. Facilities that do not regularly send isolates for mechanism testing should request mechanism testing for CRE that meet the following criteria 1) isolated from patients with a history of hospitalization outside the U.S. in the 6 months prior to culture collection, 2) resistant to all antibiotics tested at the clinical laboratory, 3) part of a suspected outbreak (i.e., 2 isolates that meet the criteria for further investigation by a facility).
- Non-KPC CRE remain rare throughout the U.S. Identification of any non-KPC CP-CRE, or KPC CRE in non-endemic areas, should result in a public health investigation as described in the CDC Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms.
- Screening tests to identify asymptomatic carriers are available free of charge through the Antimicrobial Resistance Laboratory Network.

CORHA Spring In-Person Meeting Agenda *(Draft)*

Meeting Objectives: To review progress made towards meeting CORHA and workgroup strategic goals and objectives and continue development of CORHA's product offerings.

May 23, 2018			
8:00 AM	*Breakfast available*		
8:30 AM	Introductions and Orientation to the Meeting • Introductions of meeting participants • Review of meeting materials in folder • Review of CORHA's Strategic Map and implementation priorities • Updates from the Governance Committee • Presentations from Workgroup A and B Leads		Council Co-Chairs
9:30 AM	CORHA High-Level Outbreak Investigation Guidance and Feedback		Governance Committee
10:30 AM	*Break—refreshments provided*		
10:45 AM	Medical Product investigations—advice to WG A/Lab/Consumer perspective		
11:45 AM	High-Level Outbreak Investigation Guidance Small Group Meetings/Outline Development • Groups will be split to focus on developing outlines for upcoming chapters		Facilitators TBD
1:00 PM	*Lunch*	Emory Conference Center Dining Room	
2:00 PM	Existing Workgroup Meetings • Workgroup A • Workgroup B		Facilitators TBD
4:00 PM	New Workgroup Meetings • Laboratory Workgroup • Policy Workgroup		Facilitators TBD
5:00 PM	Full Council discussion and Report Back		
5:30 PM	*Adjourn*		
6:00 PM	Optional Group Dinner		

May 24, 2018			
8:00 AM	*Breakfast available*		
8:30 AM	Welcome and Overview of the Day		Council Co-Chairs
8:45 AM	Workgroup Meetings		
10:45 AM	*Break—refreshments provided*		
11:00 AM	Report Outs and Prioritization of Future Activities		Council Co-Chairs
12:30 PM	Next Steps and Wrap Up		
	Adjourn		
1:00 PM	Governance Committee Business Meeting		