

**ANTIMICROBIAL STEWARDSHIP SUBCOMMITTEE
HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE**

Wednesday October 14, 2015

2pm-3pm

Teleconference

Attendance:

Members of Subcommittee:

Brian Lee, MD, Subcommittee Chair, Infectious Disease Specialist, UCSF Benioff Children's Hospital Oakland
Jeff Silvers, MD, Infectious Disease Specialist, Medical Director Quality Management, Sutter Eden Medical Center
Stan Deresinski, MD, Infectious Disease Specialist, Stanford University
Karen Anderson, MT, MPH, CIC, Infection Control, California Pacific Medical Center
Matthew Zahn, MD, MPH, California Association of Communicable Disease Controllers
Samantha Sweeten, PhD, MPH, San Diego County Department of Public Health

Absent:

Catherine Liu, MD, Infectious Disease Specialist, University California, San Francisco
OlgaDeTorres, PharmD, FASHP, BCPS-ID, Department of Pharmacy, O'Connor Hospital
Michael Butera, MD, California Medical Association
Dan Uslan, Associate Clinical Professor, Infectious Diseases at University of California Los Angeles
Conan MacDougall, PharmD, MAS, BCPS, University California, San Francisco

CDPH Staff:

Erin Epton, MD, Assistant Chief HAI Program
Lanette Corona, Associate Healthcare Program Analyst

ACTION TAKEN:

See Attached Minutes

ACTION REQUIRED BY HAI ADVISORY COMMITTEE:

ACTION REQUIRED BY ADMINISTRATION:

Brian Lee, MD, Subcommittee Chair

| TOPIC | DISCUSSION | ACTION/ OUTCOME | NEXT REVIEW |
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| I. Call to Order <i>B. Lee</i> | The Antimicrobial Stewardship Subcommittee meeting was held on Wednesday, October 14, 2015, via teleconference. | Dr. Lee called the meeting to order at 2:05 pm. | |
| II. Roll Call and Welcome <i>B. Lee</i> | Brian Lee, MD welcomed participants to the meeting, and invited all on the call to state their name and institution. | | |
| III. Review of minutes <i>B. Lee</i> | Minutes from May 20, 2015 and September 14, 2015 were approved as presented. | Minutes approved. | |
| IV. Update from CDPH: <i>Review of Bagley-Keene Open Meeting Act</i> <i>Presentation by Dr. Epton on CDPH's CRE definition and plan</i> | <p>Members were reminded of the Bagley-Keene Open Meeting Act 2010 rules. Specifically, to ensure all meeting agenda items are submitted within time to ensure they are included on the published agenda which must be posted 10 days prior of the actual meeting date. In addition, members are to ensure they are not discussing meeting information outside of public meetings with more than one additional member or member of the public to comply with the rules whether it is on the phone, via email or in person. Should members have additional comments or questions regarding meeting information after the meeting ends, they should contact the subcommittee chair directly to address their requests.</p> <p>Members were informed, the CRE definition the CDPH has adopted is the updated CRE surveillance definition that the CDC put forth earlier this year. This defines CRE as Enterobacteriaceae, specifically Klebsiella, E.coli and Enterbacter that is resistant to a carbapenem antibiotic using Clinical and Laboratory Standards Institute's lower breakpoints. It was noted, this is different from the previous CRE definition, which was that isolates would be non-susceptible to carbapenems, excluding ertapenem. There were also previous requirements for resistance to all 3rd generation cephalosporins tested which have now been removed from this current updated definition. The current updated CRE definition can also be met by demonstrating production/detection of carbapenemase enzyme by a recognized test (PCR, modified Hodge test, Carba-NP test). It was mentioned, this new definition arrived at in part through a CDC evaluation of CRE definitions, where they applied different definitions to a collection of isolates and then did mechanism testing to detect carbapenemase in those and</p> | | |

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| | <p>evaluated the sensitivity and specificity characteristics of all of the different definitions. The upshots are that the requirement for resistance to the cephalosporins was removed because it didn't enhance the specificity of the definition much and seemed to overly complicate things. The other upshot is that ertapenem was decided to be included in the updated definition because by excluding it they actually found that they did miss some actual carbapenemase producers. This was also meant to reflect an observation that many laboratories may only screen isolates for ertapenem susceptibility or resistance and so it was opted to allow and include this in the definition. The new definition is admittedly more sensitive, a little less specific in terms of detecting actual carbapenemase producing CRE however, actually doing mechanism testing to detect carbapenemase production is thought to offer the ability to actually identify carbapenemase producers and having a more sensitive initial screen and more specific test to actually detect carbapenemase is advantageous. A question was raised regarding, if additional testing is done and is negative, can we then say it's not CRE and not report it. It was noted, these isolates would still be considered CRE, but we would call them non-carbapenemase producing CRE. Many laboratories may not be performing additional testing to detect carbapenemase, however this is the direction we should all be moving towards. Discussion ensued regarding the benefit of carbapenemase testing would assist in distinguishing CREs that are not carbapenemase producers and take a different approach and prioritize those indeed that tend to be carbapenemase producers to determine where the resources are needed. A question was raised regarding how much carbapenemase testing must be done to confirm it is not a non-CP CRE; two enzymes and OXA 48? It was noted, the state's PH lab is currently able to do KPC and NDM and there is some discussion for the potential of adding additional enzymes. However, a tiered approach is recommended, all CRE patients in an acute setting would require contact precautions and a carbapenemase producer patient would require additional screening of patient contact. Continued discussion regarding the percentage of laboratories that have actually implemented the CLSI guidelines for lower breakpoints for Enterobacteriaceae. It was</p> | | |

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| <i>ASP Collaborative</i> | <p>noted a survey is currently underway to assist in determining this and the preliminary data will be available in the coming months. It was noted, the data collected from this survey will assist in determining the level of playing field for collecting and reporting CRE data from hospitals (i.e., how many have implemented the CLSI guidelines and how many are doing molecular testing).</p> <p>Members were reminded the next ASP Collaborative webinar is on 10/15/15 12-1pm on <i>“Tracking Antimicrobial Use”</i> with faculty/advisor discussant Conan MacDougall, PharmD. The following week are two Discussion Sessions; on 10/21/15 will be a panel of hospital staff to discuss strategies for practical application of tracking <i>“General Approaches”</i>. On 10/22/15, we will focus on the NHSN AU Module and review of the informatics survey that was completed over the summer.</p> | | |
| <p>V. Discussion Items: HAI-AC motion for AS subcommittee <i>“To begin to make a recommendation to CDPH to collect and report isolates and infections on the data of CRE as done with other HAIs”</i></p> <p>Toolkit for Hospital ASPs</p> <p><i>AS Pharmacy Advisory Group</i></p> | <p>Discussion ensued regarding the journal article <i>“Electronic Public Health Registry of Extensively Drug-Resistant Organisms, Illinois, USA”</i> related to useful implementation of CRE information. A question was raised whether this would be feasible for our state level. It was noted, this would be beneficial in discussing further. The purpose of such a registry is to help healthcare facilities be able to look up patients and see if the patient has been infected or colonized with CRE, not for the purpose of public reporting. This would still be interesting to explore and perhaps to borrow. A motion was made by Dr. Silvers and seconded by Samantha Tweeten; <i>“The Antimicrobial Stewardship/Antimicrobial Resistance subcommittee recommends the CDPH look into creating a PH registry to enable identification of CRE patients for healthcare facilities to use. Due to the difficulties in gathering accurate data we do not recommend pursuing public reporting of CRE at this time.”</i></p> <p>No discussion took place regarding the Toolkit for hospital ASPs.</p> <p>No updates provided.</p> | | |
| VI. Action items to bring to HAI-AC: | None discussed. | | |
| VII. Tabled Items | None discussed. | | |
| VIII. Next meeting | TBD | | |
| IX. Adjournment | A motion for adjournment was made. | Meeting adjourned at 3pm | |