Updates to Guidelines—IRID

Lesley Brannan, MPH
IRID Team Lead
512-776-6354
Lesley.Brannan@DSHS.Texas.gov

Minor Changes

- Amebic meningitis:
  - Edits to case criteria to align with ECCG
  - Updated NORS reporting info
  - Minor edits to sentence structure
- Group A Streptococcus, Invasive
  - Added info on requesting PFGE at state lab for clusters
- Group B Streptococcus, Invasive
  - Added notification for HAI team for healthcare-associated outbreaks
  - Added info on requesting PFGE at state lab for clusters

Streptococcus pneumoniae

- Updated vaccine information
- Added notification for HAI team for healthcare-associated outbreaks
- Provided instructions on sending specimens from sterile sites to DSHS for serotyping for children < 5 years of age

Pediatric Flu Deaths

- Updated case investigation checklist
  - Tracking down vaccination history
  - Specified timeframe for case notification/investigation form sent from LHDs→Austin
  - Requesting specimens
- Added Texas Medical Board rule
- Updates to specimen submission guidelines for respiratory specimens and autopsy/tissue specimens

Novel Influenza

- Made changes to case investigation checklists to be compatible with case definitions
- Incorporated new pandemic plan references
- Added Texas Medical Board rule
- Updated close contacts definition
- Updated specimens submission guidelines

Meningococcal – Part 1

- Basic epi
  - Clarification about communicability and antibiotics
- Definitions
  - Updated lab criteria/case classifications
  - (Re)Moved cluster and outbreak definitions
- Case Investigation Checklist
  - Significant changes (mostly reordering items)
  - Added messaging for cases identified in schools/institutions
  - Added instructions for tracking down vaccination history, lab specimens
- Control measures
  - Aligned IG with Red Book close contact definition and prophylaxis info
  - Specified window for prophy of close contacts
  - Added Texas Medical Board rule
  - Added serogroup B vaccine info

Meningococcal – Part 2

- Managing special situations – lots of changes!
  - Aligned recommendations with CDC VPD Surveillance Manual and earlier version of DSHS guidance
  - Added attack rate calculations and definitions for case classifications and population at risk
  - Added instructions on PFGE clusters
- Laboratory
  - Updated specimen submission instructions for newest submission forms
  - Added statement on contacting DSHS if your isolate is dead
- Flowchart
  - Added PCR as confirmatory lab test

Novel Coronavirus

- New chapter!
- It's huge!
- I'm sorry! / You're welcome!
- Note:
  - Case definitions in EAIDB IG don't match the Epi Case Criteria Guide (ECCG is meant to cover novel coronaviruses generally)
  - Most up-to-date information will be available on the CDC website
  - Pandemic plan incorporated into guidance
  - If CDC changes their guidance we will change ours

Legionellosis – Part 1

- Basic epi
  - Minor edits/clarifications
- Definitions
  - Removed “community acquired” case category
- Case investigation checklist
  - Recommended getting full address of facility
  - Recommended interviewing patient whenever possible
  - Added instructions to see Managing Special Situations when case reports facility exposure or travel
- Prevention and control
  - Separated guidance for cases, contacts, and general public; and healthcare providers and facilities
  - Added water birth guidance
  - Incorporated some Task Force recommendations

Legionellosis – Part 2

- Managing special situations
  - Differentiated recommendations for single case and multiple cases
  - Incorporated relevant CDC guidance, Task Force guidelines, and lessons learned from recent outbreak investigations
  - New addition: Actions when one possible healthcare-associated case is identified (from Task Force guidelines)
  - Added recommendation for facility to report to regulatory as appropriate
  - Added recommendation that other “closed” facilities (e.g., correctional) follow healthcare facility guidelines
  - Recommended notifying other facilities (e.g., gyms) of associated cases
  - Added new section: multiple cases associated with a community

Errata/clarifications

- Page 109: HD should recommend active surveillance for 1 possible facility-associated case, but HD does not need to monitor facility's compliance
- Page 110: Retrospective surveillance should be conducted for a minimum of 60 days from initiation of the investigation (6 months is ideal if resources are unlimited)
- Pages 111, 113: Environmental sampling should be done if there is evidence of ongoing transmission

Legionellosis – Part 3

- Reporting
  - Added info to this section for notifying DSHS within 1 business day for healthcare-associated or travel-related exposures
  - Added info on notifying facilities of associated cases
  - Changed timeframe for sending investigation form to DSHS Austin--ASAP! (b/c of exposure history)
  - Updated NORS information
- Clinical Laboratory Procedures
  - Updated instructions related to changes in submission forms

Legionellosis – Part 4

- Environmental Sampling and Testing – NEW!
  - How, when, where to sample; how many
  - Storing and shipping samples
  - Testing samples
- Sampling Resources – NEW!
  - Sampling supply list
  - Sample collection procedures for different sites (e.g., faucet, showerheads, cooling towers, hot water tanks, etc.)
  - Additional resources (training and water sampling resources)

Changes made to all IRID chapters

- Send investigation forms as soon as they are complete
  - For immediate or 1-day notifiables, DSHS Austin may need notification earlier than this

What else does the IRID Team want you to know?

S. pneumoniae Serotyping

- What is it?
  - DSHS wants S. pneumo specimens from sterile sites for all kids < 5 years of age
  - Serotyping performed at Minnesota PHL
  - Purpose: Identify serogroups currently circulating in Texas, inform vaccine initiatives
- How you can help:
  - Recruit children's hospitals and other hospitals in your area
    - You can use our form letters
- What DSHS Austin has done/is doing:
  - We sent letters to previous submitters and children's hospitals in May 2014
  - We will talk to the Texas Pediatric Society

Meningococcal

- New
  - PCR is now a confirmatory test
  - Got dead isolates? We can work with that!
  - Sexual risk factor questions
  - Draft investigation form – review and comment
- Reminders
  - Make sure lab sends isolate to DSHS (serotyping, PFGE)
  - Please obtain vaccination status – check multiple sources!

Legionellosis

- New
  - Draft investigation form – review and comment
  - Notify DSHS Austin within 1 business day of travel or healthcare exposures
  - Send case investigation forms ASAP
  - Follow up with still ill/hospitalized patients to determine outcome
  - Let us know if you're seeing Legionella PCR testing in your area
- Reminders
  - Please interview the patient/surrogate!
  - Fill out a Respiratory Outbreak Summary Form if you have an "outbreak"
  - Urine antigen results are reportable even if no species, serogroup named by test

What's Next?

Legionellosis Improvements--National

- States have asked CDC for 

- CDC is working on:
  - Videos (environmental sampling, environmental assessment, premise plumbing)
  - Best Practices document
  - Website update
  - First set of tools/resources should be available in summer 2015
- CSTE position statement for reporting/classifying healthcare-associated cases and travel cases

Legionellosis Improvements--Texas

- Short-term:
  - Texas is comparing major guidance documents
  - DSHS Austin will review new CDC tools, documents and update Investigation Guidelines
  - Adding investigation form questions to NBS (investigation and reports)
- Mid:
  - DSHS Austin will update and combine Task Force/Guidelines documents into new draft
- Long-term:
  - Multidisciplinary Legionella Task Force will be assembled to review draft, make recommendations, finalize document

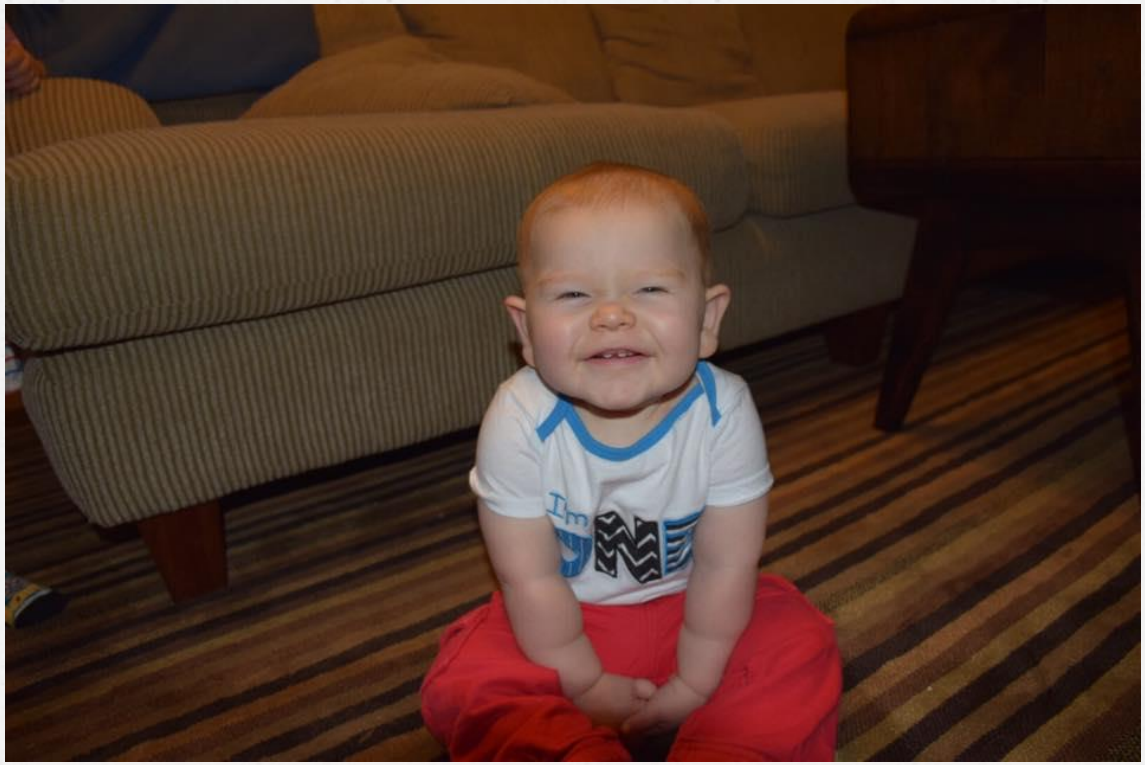
Adult Influenza Death Reporting

- At the 2014 Influenza Surveillance Workshop, there was unanimous approval for reporting of flu deaths in adults
- A workgroup (local, regional, state) has been formed and is currently pursuing this
- Reportable no earlier than 2016-2017 season

Updates to Guidelines—VPD

Rachel Wiseman, MPH
VPD Team Lead
512-776-2632
Rachel.Wiseman@DSHS.Texas.gov

Who remembers last year's breakout session?



No or Minor Changes

- Diphtheria
  - larynx added to case definition to match CDC
- Hepatitis A
  - Updated links, fixed exclusion criteria in checklist, minor polishing
- Hepatitis B, acute and perinatal
  - Updated perinatal follow up instructions, minor language polishing, re-organized sections
- No change
  - Tetanus
  - Polio

Case Definition Changes Only

- *Haemophilus Influenzae, type B*
  - Type B is still the only notifiable H.flu
  - PCR is now a confirmatory test
    - Must be from a sterile site
    - Consistent with CSTE/CDC case definition

Laboratory Updates Only

- Mumps and Rubella/CRS
  - Mumps PCR available at DSHS
  - Rubella PCR available through MN via DSHS
  - Mumps and rubella culture NOT available through DSHS
- Instructions for mumps/rubella follow the measles instructions
  - Check the correct box
  - Swab the cheek, not throat, for mumps

Hepatitis C, Acute

- Case definition updated
  - Now consistent with CDC/CSTE
  - Removed perinatal/suspect case definition pieces
- Cleaned up Checklist and Investigation/ Surveillance (made a little more comprehensive)
- **AND! Hep C is no longer with VPDs—Kelly Broussard on the HAI/MDRO team is handling! YAY!**

Measles

- Added information on serology interpretation
- Added information on measles risk factors (exposures)
- Cleaned up “Recommendations for Prophylaxis, Quarantine and Monitoring of Measles Contacts” table
- Added section on IG administration
- Added school/daycare and healthcare facility exposures to “special situations”
- Updated lab section to reflect PCR availability at DSHS
- General polishing
- Fixed flow chart on case classification

Pertussis

- Added section on other *Bordetella* species
- Removed non-CDC language from case definition (provider dx language)
- Updated close contact language
- Added information on following up on lab results, including prioritizing serology results
- Updated DSHS-provided PEP info and added info on new rules on prescribing abx to contacts
- Expanded HCW exposure follow up piece

Varicella

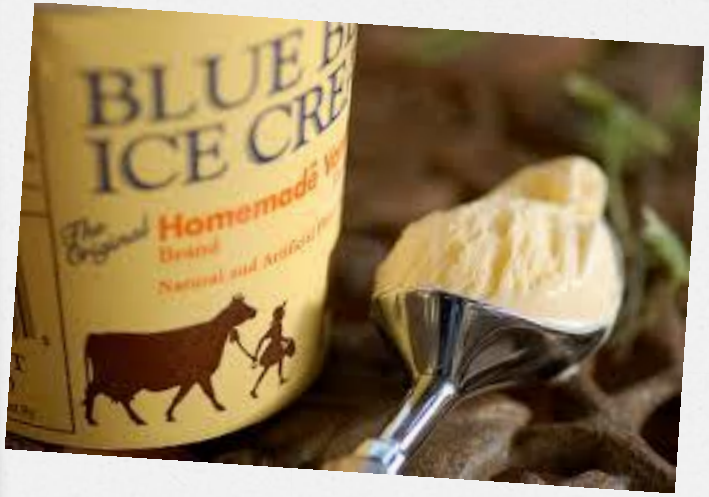
- Updated information on following up ELRs
  - All ELRs need to be investigated
  - EXCEPT in people over 50, IgG in 20-50 year olds
- Updated outbreak definition and what information to collect
  - Now there's a form!
- Expanded lab section to include CDC and MN testing information

Appendices

- Updated Appendix A, purpuric lesion added to sterile site flow chart
- Polished Appendix B, Exposure Notifications
- Updated Appendix C, Laboratory Resources
- Updated Appendix E (now D), Resources
- Removed D (policies for requesting vaccine for PEP as they are in flux)
- Removed Appendix F
  - VPD Communication Toolkits are available on line
  - Links available in Resources (appendix D) and Measles, Hep A and Pertussis chapters

Guidelines, whoopty doo.

What's the real scoop?



Varicella

- In the near future, varicella will likely require investigation. Feel free to start now.
- Severity (# of lesions) is required by the CDC. Please collect it, if it is not included on report.
- Most VZV labs need investigation to *establish diagnosis.*
  - Do NOT make an ELR a case without contacting provider/patient to verify patient had varicella!
- CDC is asking for more info on outbreaks, so we made a form! Please submit on cpox outbreaks.

Varicella Labs—we did a study!

- Pulled VZV ELRs, asked the ordering provider for dx
- Analyzed volume of tests, type of test, age of patient, and diagnosis.
- Most chickenpox cases had IgM testing
- Can reduce ELR follow up ~50% and still find >90% of chickenpox cases
  - Investigate all VZV labs for pts <20
  - Investigate all VZV labs except IgG for pts 20-50
  - No f/u for VZV labs for pts>50
- Red items are being swept from NBS documents requiring review queue.

Pertussis

- CDC wants to make serology confirmatory
  - Start investigating serology results now (you already should be)
  - Prioritize the PT (pertussis toxin) IgG and PT/FHA IgG results
- Cases with only serology results are still only probable cases.

School Outbreaks of Pertussis

- CDC's pertussis objective: Protect infants
- But this is a school…
- http://www.cdc.gov/pertussis/outbreaks/guidance-letter.html
- Only high risk children receive PEP.
- Implement case finding ASAP.
- Coughing kids  doctor ASAP.
- If multiple cases, inform local MDs.

Perinatal Hepatitis B

- DSHS is identifying pregnant women from Hep B sAG+ ELRs
  - Quest/LabCorp have flags for peri labs
    - Not visible in lab screen in NBS
    - Visible by pulling lab report out of NBS
    - Kayla pulls them each week, gives to Peri Program
  - Kayla calls remaining providers to ascertain pregnancy/delivered status
    - Refers peri cases to Peri
    - Refers acute cases to LHDs

Acute Hepatitis B

- Did you know that ~65% of our cases have no risk factors for hepatitis B?
- Why do you think that is?

Let's talk about the lab…

DSHS Lab MMRV Musts

- Tell the VPD team the specimen is coming
  - Preferably the day before
  - This ensures the lab has the appropriate staff/time/reagents to do the testing
  - It makes the lab like you. And me.
- Obtain the tracking number for VPD team
  - If the specimen gets lost, this is critical info
  - Tracking specimens also allows the lab to plan appropriately

Lab Paradigm Shifts

- Measles, mumps, rubella culture no longer available
  - We do PCR! (Or send rubella to MN for PCR!)
  - PCR specimens can be genotyped
- Measles IgM may not be available much longer
  - Only available at CDC, we can forward to them
  - Do PCR instead, if within appropriate time frame
- Embrace urine (not literally!)
  - MN and CDC can do PCR on urine for MMR for us
  - No VTM needed!
  - Virus is shed in urine longer

What about those VPD QA measures?

CDC has expectations!

- All VPDs investigated and reported to CDC (with complete info!) within 30 days!
- Vaccine history, vaccine history, vaccine history!
- Severity for varicella (# of lesions)
- Proof that measles cases are imported
  - PCRs are a must for this one, so get viral samples!
- CDC wants serogroups and serotypes
  - Need mening, H. flu, and S. pneumo (<5 yo) isolates sent to our lab

DSHS has measures!

- For Immunization contracts:
  - Every quarter—DSHS measures LHD turn around time
  - Every quarter—LHDs should address low TATs
- After data close-out, each jurisdiction gets a “report card”
  - Turn around times by VPD
  - Vaccine history capture by VPD
  - May or may not come with suggestions
- Now you can measure yourself! Instructions for NBS reports are available. Email Eric Garza.

Know Your Vaccine History

- Ask the patient/parent of the patient
  - Even if patient is an adult—Mom knows best!
- Ask the diagnosis provider
- Ask the patient's primary provider
- Ask the patient's school
- Ask the patient's employer (select jobs only)
- Check ImmTrac
- Is the patient the appropriate age to have received the vaccine?

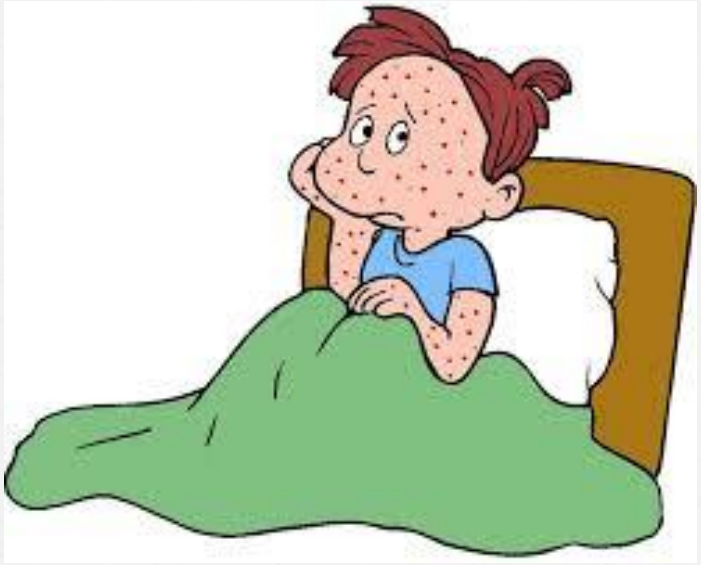
VPD Scenarios

You're reviewing the NBS documents requiring review queue. A hepatitis B surface antigen appears. You click on it. The patient is 22 months old.
Pop quiz, Hotshot. What. Do. You. Do?

A doc reports an IgM+ patient with parotitis. Doc does not think it is mumps and wants PCR. It is 9 days since onset.

What do you do?

Meet Peter



- Peter had his 2nd MMR 2 weeks ago.
- Now he has a fever, spots, and cold symptoms
- The PA reports to your LHD that Peter has measles
- The PA wants to know what lab test to run

What do you do?