Reportable Diseases Advisory Committee Minutes, 11-01-2023

Meeting attendees:

Barrett, Nancy L. (DPH)
Wolujewicz, Karen (DPH)
Wong, Carlene; Quest Diagnostics (committee member)
Lambert, Matthew (DPH)
Phan, Quyen (DPH)
Razeq, Jafar (DPH)
Mitchell, Michael J; Quest Diagnostics (committee member)
Dembry, Louise; West Haven VA Hospital (committee member)
Kertanis, Jennifer; Farmington Valley Health District (committee member)
Melmed, Russell; Chatham Health District (committee member)
Robers, Amity; Hartford HealthCare (committee member)
Sosa, Lynn (DPH)
Landry, Marie-Louise; Yale New Haven Hospital (committee member)
Parry, Michael; Stamford Health (committee member)
Jones, Sydney (DPH)
Banach, David; University of Connecticut Health Center (committee member)
Linardos, Heather (DPH)
Ivanaviciene, Jurate; St. Vincent's Medical Center (committee member)
Pawlow, Dustin (DPH)
Petit, Susan (DPH)
Maloney, Meghan (DPH)
Vargas, Jennifer (DPH)
Soto, Kristen (DPH)
Aoun-Barakat, Lydia; Yale New Haven Hospital (committee member)
Jitendranath, Lavanya; Hartford Hospital (committee member)
Greenlee, Delores (DPH)
Cushman, Lara (DPH)
Glenn, Bailey (DPH)
Amihere, Bernadette (DPH)
CT-N

Dr. Sosa welcomed the group and facilitated introductions. Dr. Sosa also gave an overview of the reportable diseases statutes and regulations and reviewed the process for review, discussion and voting on proposals by the committee.

1. Negative HIV 1/2 Antibody/Antigen reporting — Heather Linardos gave a summary of the proposal and justification, including noting that unmatched negative results would be purged at a predetermined interval, such as 18–24 months after receipt.

   Discussion
   Dr. Sosa reminded the Committee that they had voted in favor of this proposal last year, however, the DPH Commissioner decided not to move forward last year to allow time to further develop implementation plans. Dr. Sosa noted that DPH would conduct a survey of laboratories to understand the volume of tests conducted and develop implementation plans, prior to initiating this surveillance July 1, 2024. Dr. Barakat spoke in favor of the proposal, which would enable DPH to calculate the statewide HIV test positivity rate and inform prevention efforts. Dr. Barakat asked about the expected burden on laboratories to report. Dr. Sosa answered that DPH expects that most laboratories doing this testing are already reporting in electronic format, which would mean reporting negative results should not be a significant additional burden. Nancy Barrett noted that there is also precedence for reporting of negative Hepatitis C RNA results to DPH, and that DPH is working on developing the matching process that could be used for multiple diseases, including Hepatitis C, syphilis, and HIV. Dr. Parry asked what proportion of acute HIV cases were detected very early, during the most contagious stage, e.g., within six months versus within one to two years. Heather Linardos responded that it varies broadly, with people who are frequently being tested more likely to be identified earlier in the acute phase. She also noted that upcoming changes to implement routine HIV testing in urgent care centers and other nontraditional testing sites may improve the ability to detect acute HIV cases. Russell Melmed asked if not implementing this reporting would put HIV surveillance funding from CDC in jeopardy. Heather Linardos answered no, but noted that DPH is evaluated annually by CDC on the completeness of HIV surveillance data, and currently only about 14% of newly diagnosed HIV cases in the state have date of last negative HIV test documented. Dr. Dembry asked about implications of this change for the American Red Cross, which does a lot of HIV testing of blood donations. Heather Linardos noted that the American Red Cross does report positive results already. Dr. Sosa asked who does the testing for American Red Cross. Heather Linardos answered that they do their own testing. Dr. Roberts asked how this surveillance change tied into a new initiative to offer HIV testing to all non-trauma emergency department patients older than 13 years of age without a previous test. Dr. Sosa answered that it would allow DPH to monitor the impact of that initiative and statute change. Dr. Banach asked how frequently these results will be evaluated to facilitate quick intervention. Heather Linardos responded that data are processed daily, and that a current challenge is the time it takes to follow up with providers to obtain information on date of last negative HIV test to identify acute cases; once acute cases are identified, DPH is focused on rapid intervention including prescription of antiretroviral medication and linkage to care. Dr. Sosa added that having these negative test result data would be an opportunity to improve identification and prioritization of acute cases by having results for the entire testing algorithm. Dr. Banach noted that this would be more impactful if results are used for quick intervention. Heather Linardos responded that DPH has an existing algorithm set up to try to detect such cases for prioritized follow up.

   Motion passed; 11/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting).

2. Invasive *E. coli* reporting — Meghan Maloney gave an overview of the proposal. Susan Petit summarized the proposal related to cases in infants and Meghan Maloney provided additional summary on surveillance of cases among persons older than 1 year.

   Discussion
   Dr. Mitchell asked how sterile sites would be defined for this surveillance. Susan Petit responded that DPH would use the same definition for sterile sites as used for other pathogens (e.g., *Streptococcus* and *Staphylococcus*). Dr. Sosa clarified that the proposal for submission of isolates from a subset of cases based on location of residence mirrors the approach already in use for other projects, such as surveillance of precancerous cervical lesions as part of HPV surveillance. Dr. Roberts asked whether laboratories would need to submit duplicate isolates for invasive *E. coli* and CRE surveillance. Meghan Maloney answered that laboratories would not need to submit twice, and nothing will change for submitting laboratories with the current CRE isolate submission process. Dr. Roberts asked if submission for isolates would be based on the location of the hospital or patient residence. Meghan Maloney answered that further instruction will be provided to laboratories once DPH receives confirmation of funding available for this work. Dr. Sosa noted that Connecticut has received funding from CDC as an Emerging Infections Program site for almost 30 years and is currently in a competitive renewal process for a new five-year funding cycle, with a decision expected from CDC in December 2023. She also noted that Connecticut is one of the few EIP sites that has not yet implemented surveillance of invasive *E. coli* in neonates, which is a high priority project, so funding is likely. Dr. Parry suggested that a narrower definition of sterile sites (including only blood and CSF) be used for surveillance in adult patients. Meghan Maloney answered that the definition of sterile site for isolate submission would be consistent across jurisdictions participating in this surveillance; however, the classification of cases would be carefully defined to exclude individuals with surgical or infectious complications. She also noted that laboratories often do not have clinical information about patients, so DPH will filter isolates as needed rather than asking laboratories to do that prior to submission. Dr. Mitchell asked DPH to confirm whether submission of isolates from cases older than 1 year would be based on patient or hospital location. Meghan Maloney answered that it would be based on patient residence location. Susan Petit reiterated that isolate submission would be statewide for cases in infants <1 year of age.

   Proposal: Add invasive *E. coli* in infants less than 1 year of age to the List of Reportable Diseases, Emergency Illnesses and Health Conditions.

   Motion passed; 11/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting).

   Proposal: Add *E. coli* isolated from sterile sites to the List of Reportable Laboratory Findings, including isolate submission for cases <1 year of age or upon request from DPH.

   Motion passed; 11/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting).

3. Histoplasmosis and blastomycosis — Meghan Maloney gave a summary of this proposal and justification.

   Discussion
   Dr. Banach noted that listed laboratory criteria did not include urine antigen testing, which is how a large proportion of cases are identified; would providers be expected to report cases diagnosed by urine antigen testing? Meghan Maloney answered that providers should report based on strong suspicion or diagnosis, regardless of laboratory findings, and acknowledged that DPH needs to better understand which tests are being used and how often to develop guidance for providers. Dr. Banach recommended that DPH clarify that providers are not limited to reporting cases with confirmatory laboratory criteria. Dr. Mitchell asked how pathologists would be made aware of reporting requirements given that histopathology findings are listed laboratory criteria and Connecticut is a low incidence area. Meghan Maloney answered that there are other diseases for which pathology findings are reportable, such as HPV. Dr. Sosa added that education of pathologists will have to be a part of implementation. Dr. Jitendranath noted that cases are very rare and most often reactivation cases with exposures outside of Connecticut; she asked how this surveillance will help with an epidemiologic survey in Connecticut. Meghan Maloney answered that DPH anticipates it will be rare, and the purpose is to characterize who in Connecticut are the rare cases, then that information can used to inform providers about whom to refer to Infectious Disease specialists for diagnoses. Russell Melmed asked what proportion of cases in the published Connecticut case series mentioned in the justification were exposed in Connecticut. Meghan Maloney answered that the case series was small and included a combination of people exposed elsewhere. She added that there is concern that the endemic region might be spreading for these pathogens due to climate change expanding the environmental range as well as evidence of spread of fungal spores during large scale climate events, such as large wildfires which can spread spores for hundreds of miles, which could allow the fungi to establish is new environments. Russell Melmed asked if there has been evidence of expansion in areas where surveillance is ongoing. Meghan Maloney responded that areas conducting surveillance are endemic regions where there would not be an area to expand, but they have identified new risk factors, such as a 2022 outbreak in workers at a paper mill. Dr. Barakat noted in the meeting chat that she echoed Dr. Banach's concern regarding clarity on expectations for provider reports. Dr. Sosa responded that laboratories would report only confirmatory laboratory criteria included in the relevant case definitions, whereas providers should report upon diagnosis or strong suspicion. Dr. Sosa further explained that given that since DPH is just starting this surveillance, it is preferable to use broad criteria for provider reporting, which can be refined over time as needed. Dr. Dembry asked if both conditions would be added to the provider reportable list. Dr. Sosa confirmed, yes; there was an error on the agenda. Russell Melmed asked if these were pilot projects. Meghan Maloney answered yes, in the context of the Emerging Infections Program. She noted that it is possible that after a period of surveillance, DPH may determine there are not enough cases to justify continued surveillance. Dr. Dembry asked if a time frame should be established for reconsidering this surveillance. Dr. Sosa answered that was possible if the Committee desired to add a time frame for reconsideration, and suggested at least 2 years to provide enough time to fully evaluate it.

Dr. Jones noted that Dr. Landry joined during the discussion; Dr. Sosa asked Dr. Landry not to vote on these items since she joined during the discussion.

Proposal: Add histoplasmosis to the List of Reportable Disease, Emergency Illnesses and Health Conditions as a Category 2 disease, and add *H. capsulatum* to the List of Reportable Laboratory Findings according to confirmatory laboratory criteria included in Histoplasmosis 2017 Case Definition | CDC.

Motion passed; 10/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting); 1/11 (Dr. Jitendranath) voted against.

Proposal: Add blastomycosis to the List of Reportable Disease, Emergency Illnesses and Health Conditions as a Category 2 disease and add *Blastomyces spp.* to the List of Reportable Laboratory Findings according to confirmatory laboratory criteria included in Blastomycosis 2020 Case Definition | CDC.

Motion passed; 10/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting); 1/11 (Dr. Jitendranath) voted against.

Dr. Dembry made the following motion: Revisit reporting of histoplasmosis and blastomycosis after 24 months of surveillance during the Reportable Diseases Advisory Committee meeting in 2026 to discuss continuation of surveillance in 2027 and beyond.

Motion passed; 11/11 committee members present voted in favor (Dr. Landry had not yet joined the meeting).

4. Anaplasmosis — Karen Wolujewicz gave a summary of the proposal and justification.

Discussion
Russell Melmed asked if anaplasmosis was being added to the list of provider reportable diseases because the case definition now includes a 60-day period from symptom onset? Karen Wolujewicz answered that since DPH removed anaplasmosis from the provider reportable list in 2014, we have seen a decline in response rate from providers. By adding it back to the provider list, DPH hopes to increase response rates from providers to better classify cases. Dr. Sosa clarified that the case definition has required clinical and laboratory information for a while. Dr. Barakat noted that anaplasmosis and Lyme disease are common diseases in Connecticut and with burnout among providers and expressed concern about further increasing the number of reportable diseases. Dr. Barakat asked why not only keep laboratory reporting for anaplasmosis. Dr. Sosa acknowledged Dr. Barakat's concern and noted that DPH is proposing to remove Lyme disease provider reporting for that reason, however anaplasmosis is far less common than Lyme. Karen Wolujewicz added that while DPH receives >8,000 Lyme disease lab reports annually, the Department receives <400 PCR anaplasmosis reports per year. Dr. Barakat responded that was likely due to clinical diagnosis without laboratory confirmation for anaplasmosis. Dr. Jitendranath agreed that for anaplasmosis, clinical correlation was important because antibody testing takes a long time and patients are often treated based on clinical presentation. Dr.

Jitendranath asked how IgG results will be handled given that the test is sometimes performed as part of a tick panel, and a positive IgG is indicative only of previous infection or exposure. Karen Wolujewicz answered that DPH would follow up with the provider that ordered the test and that studies have shown many people with positive IgG are asymptomatic. She said DPH is hoping to capture cases currently missed with only PCR being reported, but will not include asymptomatic individuals. Dr. Jitendranath expressed concern about overburdening providers with completing paperwork for IgG antibody results which may only indicate a history of exposure. Dr. Landry noted in the meeting chat that she assumed anaplasma IgG lab testing will be reported by the testing lab, which in Connecticut will only be a reference laboratory, such as Quest.

Motion passed; 11/11 committee members present voted in favor (Dr. Parry had to temporarily leave the meeting).

5. Lyme disease and *B. maynoii* — Karen Wolujewicz gave a summary of the proposal and justification.

   Discussion:
   Dr. Landry noted in the meeting chat that *B. mayonii* testing is also done only by reference labs such as Mayo clinic, so assume that only the testing lab will report.

   Motion passed; 11/11 committee members present voted in favor (Dr. Parry had to temporarily leave the meeting).

6. *Cronobacter* — Dr. Sosa gave a review of this proposal.

   There was no discussion on the proposal.

   Motion passed; 12/12 committee members present voted in favor.

7. COVID-19 — Kristen Soto gave a summary of the proposal and justification.

   There was no discussion on the proposal.

   Motion passed; 10/12 committee members present voted in favor; 2/12 (Dr. Mitchell and Carlene Wong) abstained.

8. RSV hospitalizations and deaths — Kristen Soto gave a review of the proposal.

   There was no discussion on the proposal.

   Motion passed; 12/12 committee members present voted in favor.