**Background:**

The NC Laboratory Response Forum is currently funded through the CDC Public Health Emergency Preparedness Cooperative Grant. The forum brings together laboratory directors or their representatives from Laboratory Response Network (LRN) facilities as well as hospitals which host Public Health Epidemiologists (PHEs) and allows a regular meeting to interface with state public health officials including the State Epidemiologist, CDC Career Field Officers, and other representatives as needed. The stated goal in bringing together these directors and public health officials is to strengthen both diagnostic capacity and public health response as well as facilitate productive communication from the federal level to the local level.

The meeting minutes presented here represent the seventh meeting of the group. The proceedings of the forum will now be distributed via Micronet and posted on the NC State Laboratory of Public Health Website. In most cases, comments and questions have been made anonymous to ensure productive discussion without fear of retribution. Please contact me to have questions posed to the forum or post them on the Micronet listserve. To be added to the listserve, please contact ____ at ____.
Present: ______

Opening Remarks – Signing In, Reimbursements, Parking, Fire Alarms, etc.

Presentation:
MMWR Review of Recommendations/Report Applicable to Clinical Labs
_____ – Presentation Attached (Attachment I)

Case Studies:
Case Studies #1: Summary
The presenter described multiple cases of malaria.
   Case 1: Smears appeared to be *P. falciparum*, and confirmed by PCR at CDC
   Case 2: Smears appeared to be *P. falciparum* and possibly *P. ovale*. CDC agreed that morphology was consistent with both species. CDC PCR confirmed only *P. falciparum*, negative for *P. ovale*. This case also infected with *Entamoeba*.
   Case 3: Another case was smears with a differential of *P. falciparum* vs. *Babesia* ssp. Specimens were sent to the CDC to rule out *Babesia* ssp. CDC confirmed by PCR *Babesia microti*. Recent travel history did not support the transmission of the organism.

Case Study #2: Summary
The presenter described a non-bioterrorism related case of tularemia which was difficult to detect clinically and resulted in an extended hospitalization. Infection was most likely zoonotically acquired via rabbit processing.

Case Study #3: Summary
The presenter described a suspected anthrax case and the subsequent response from the laboratory perspective:
The productive aspects of the response include:
   1) Because of back-up communication device, emergency communication was maintained, despite loss of primary after-hours communication link.
   2) Rapid turn around time, ~2.5 hrs from arrival in lab to preliminary PCR results
   3) Partners and chain of command fully informed.
The challenges posed during this response include:
   1) Collecting the best specimens for analysis
   2) Addressing safety concerns at the submitting facility
   3) Communication breakdown of primary after-hours contact due to equipment malfunction.
Presentation:
Molecular based detection and characterization of stx variants and other virulence factors associated with STEC positive stool samples in North Carolina from January of 2006 to January 2008
___, CDC/APHL Emerging Infectious Disease Training Fellow
Abstract Attached (Attachment II)

General Questions or Comments made during above sessions:
Question: How many of you are performing culture and susceptibility testing for Mycobacteria tuberculosis? Response: Vast majority responded they were performing both, culture and susceptibility.
Question: What biosafety level do you have in your lab for this task? Response: One lab has level 2 plus and the others have level 3.

Round Table Discussion

Update on NCEDSS, _____:
The NC Electronic Data Surveillance System (NCEDSS) is implemented with exception of syphilis and HIV/AIDS. We are live at state level reporting as of the first week of March and following week Mar11 – Wake Co was brought online as first local health dept (LHD) for all communicable disease reporting. The LHD’s do their own reporting other than syphilis and HIV.

Question: Is laboratory reporting going to be a part of NCEDSS? 
___: A keystone of NCEDSS implementation is having ability of electronic laboratory reporting (ELR). One of our requirements for moving into pilot phase for NCEDSS implementation was that we have an ELR feed from both the SLPH and LabCorp. For most of the diseases that are NCEDSS reportable at this time, those two laboratories provide the two greatest number of reports. That goal is going to be to implement ELR from other laboratories after the clinical data stream is functional and robust otherwise, the project would overwhelm our staff. We are still considering ourselves in the “pilot project” as we are getting feedback from LabCorp and NCSLPH.

The project overall has gone more smoothly than expected, due in part to work that was done on TB reporting counties (NCEDSS in place at some level for over one year – TB in 15 counties). HL7 messaging to ensure communication is smooth. There are hardware issues with regards to a feed from one institution, but we are working on that. We are working on ELR for LHDs and more users. In addition to Wake County, Pitt, Granville, and Vance online. Next week we roll out to Mecklenburg. It will be a big challenge due to the sheer volume.
Question: Will the lab be involved next week.
___: We are not dealing with Mecklenburg lab reporting at this time, so no lab involvement.

We at the state are dealing with a large volume of all the new data input. Users are dealing with data generation. It has been a change process for both state and local.

With regards to ELR, we are facing two choices: 1) Focusing first on getting the most data - from counties that have the highest lab volume; or 2) Going with HD labs that are more ready from an IT perspective – giving less data, but easier/smooother implementation.

First step is getting morbidity (clinical) reporting installed, after that, we will look at ELR.

Next counties after Mecklenburg are Johnson, Forsyth, Nash, Robinson, Wayne and New Hanover during month of May (last two or three weeks). We will be rolling out in 2-3 counties per week. We are working on very scarce resources. So we are focusing on each county and trying to ensure things are smooth and functional before going to the next county.

First 3-4 hours of the first day is dynamic (rough). It has changed dramatically in that a web site exists where the information is entered. Despite this initial difficulty, the response and feedback has been exceedingly positive overall.

This system has been designed specifically for NC, some adjusting will need to be done to maximize benefits.

___ ___ comment: The state is in the third year of this effort. We (Medical Consultation Unit) have spent 20% maybe 30% of our time to get this program running. The deployment is a dynamic time in that it requires many resources. We are using many resources for this effort and are dealing have several (5) vacancies in our small group. It has many strains, but is also exciting at this time for the rewards of our efforts in the data that is being generated.

Rules Change Regarding Prenatal/Labor HIV Testing, ___ ___

Rules change is complete. Language was changed from “third trimester AND labor/delivery” to “third trimester OR labor/delivery”. Question: was this a statute change. ___: No, it is a rules change.

Influenza in NC: Update, ___ ___

___ passed out report (attachment III):
The electronic report gets sent out every other week at beginning of season and every week during height of season. ___ sends out to Micronet in an extremely prompt manner.

This year we had 78 providers / 47 counties with number of different type of providers (private, student health, LHD, etc) in sentinel provider network. In years past, we only
had data from student health which left large holes in our data during the university/college breaks. Present system of providers is much more robust. Considering our population to number of providers, we are extremely well represented which leads to better data.

From NCSLPH, 560 positive results: 530 fluA, 30 fluB, one strain was partially missed in this season’s trivalent vaccine. Vaccine prediction starts in Feb, to allow for the millions of eggs to be produced and processed by start of flu season. So, predictions can be tricky. Cell line derived vaccines are being looked out.

**Question:** Does anyone know off hand from literature, how close we are to egg-free vaccine production? **Answer:** No

This year the epidemic was ~8 weeks to get to background. To the report, we show the previous four seasons for reference.

Looking at the graph from the past season, 2006-2007, a bimodal trend of ILI exists. The first ILI peak was actually an RSV outbreak (last weeks of Dec ‘06) whereas the second peak was caused by influenza.

**Question:** How many still doing rapid testing (as of 4-8-08)? **Response:** None.

**Comment:** Prevalence is low, so predictive value is low, now is the time for culture rather than rapid.

**Comment:** We make rapid tests orderable depending on prevalence, than a week or two ahead of time before turning it on, then when we reach low prevalence, we give a week before turning it off.

**Comment:** We have that policy, and have found the emergency department buys their own tests. **Reply:** we control test procurement, so ED would have to go through us.

__: We tried to control the high number of submittals from individual institutions keeping it to no more than 10/facility/week via a message sent out through Micronet. We still want submissions even this late in the season to achieve our broad spectrum of surveillance, but need it to be well represented regarding population in the state.

**Structure of the NC Laboratory Response Forum, _______**
The funding to NC from the Public Health Emergency Preparedness Cooperative Grant is most likely being reduced from $21M last year to $15M this year. I am exploring the possibility of different funding sources.

__ **Question:** Would adding different members help us accomplish our goal, i.e. subject matter experts or other institutional members? **Response:** This would be good on an as needed basis at this time.

Please give suggestions for funding and improvements for the forum.
Planning for Next Forum, ___ ___

It appeared that most of the audience was aware of the reports and lack of recommendations from the previous months’ MMWRs. Do we still want to keep this as a standing item? Answer: yes.

Ideas for next time? Suggestions: Flu planning and STD’s involving sexual abuse. One person volunteered to do a case report.