OREGON HEALTH AUTHORITY

Oct 28, 2025

Statewide Taskforce for Antimicrobial Resistance (STAR) Advisory Committee

Agenda

History, goals and objectives	
Membership housekeeping	
Epidemiology update	National, regional and local CPO National, regional and local CPO: from TN, PA, WA, OR Admission screening
Lab update	Lab capacity Whole genome sequencing and cefiderocol resistance (as time allows)
Funding update	

Introductions

- Name, organization and title
- *In the chat:*
  - the greatest challenge facing your organization/community as related to CPOs and *C. auris* right now?

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STAR

History, Goals, and Objectives

Statewide Taskforce for Antimicrobial Resistance (STAR)

History

Public health academic partnership
Initiated September 2012

Goals

Detect and contain high-priority antimicrobial resistant pathogens

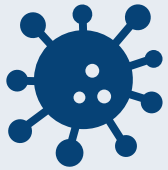
STAR

Objectives

Monitor Oregon antimicrobial resistant (AR) organism epidemiology and assess needs for prevention and response

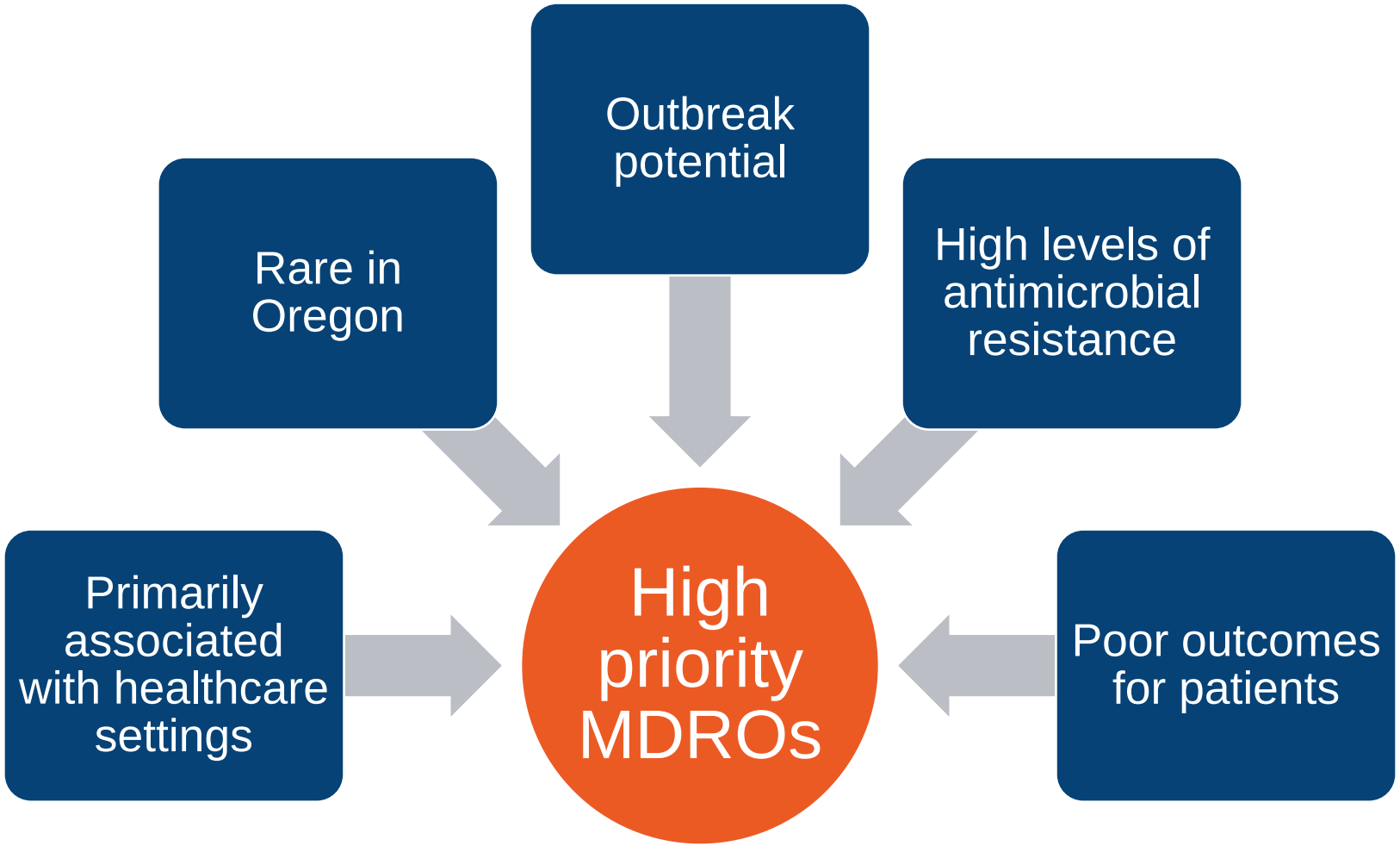
Coordinate statewide education about carbapenem-resistant and other AR organisms

Develop laboratory capacity and promote consistent laboratory practices for the rapid detection of carbapenemase-producing and other AR organisms



Provide outbreak assistance

STAR focuses on emerging pathogen threats



STAR focuses on emerging pathogen threats

Candida (Candidozyma) auris

Candida auris
source: CDC

Carbapenemase producing organisms (CPOs)

Carbapenem-resistant *Klebsiella pneumoniae*
source: CDC

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STAR

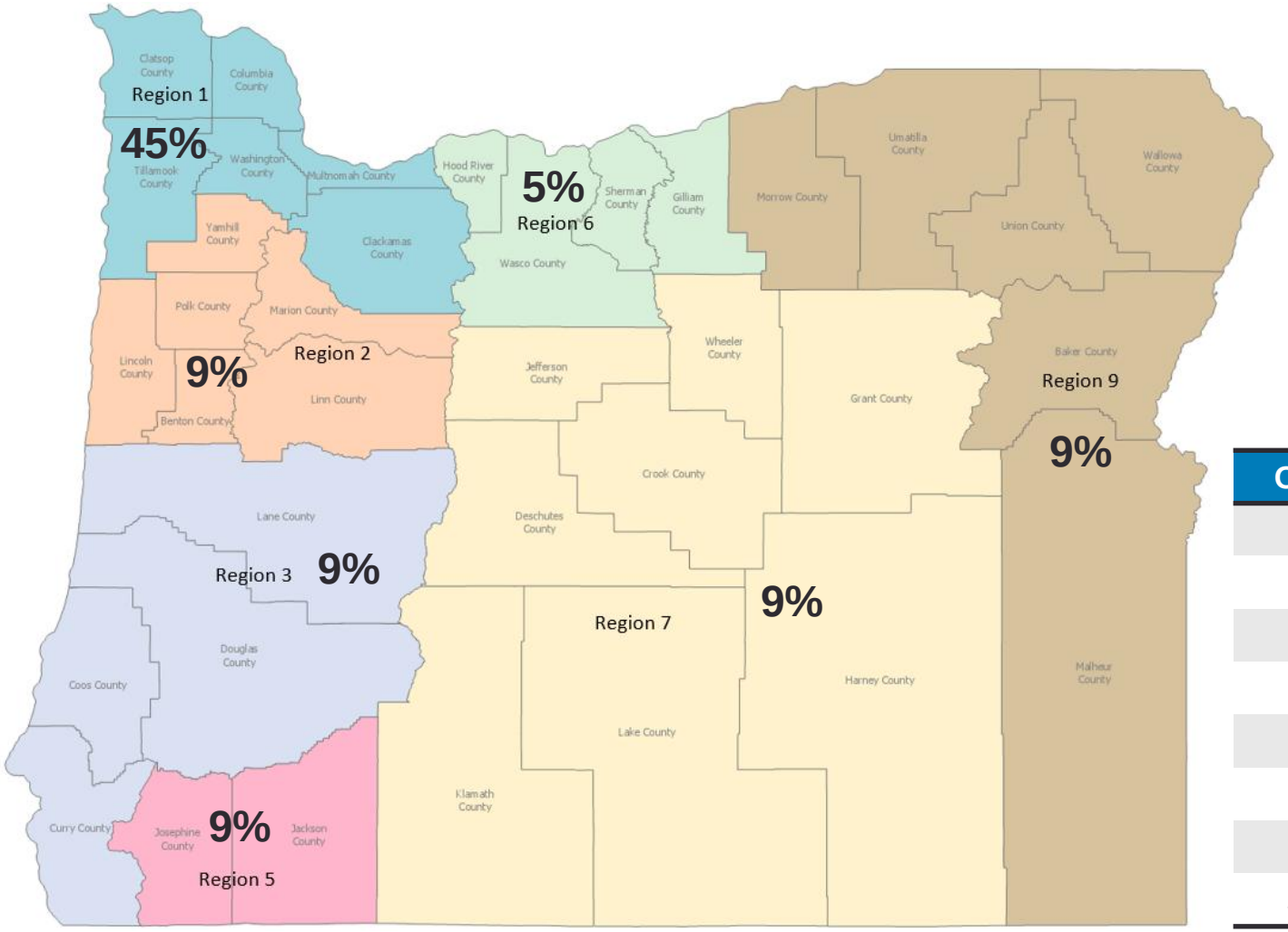
Housekeeping & Membership

STAR Advisory Committee Membership

- Minimum advisory committee commitment:
  - 1-2 annual meetings (virtual)
  - 2 years of participation
  - Contributions to resources, guidance documents, etc. as needed and available
  - Smaller group of OHA staff and consultants meets monthly to carry out this work

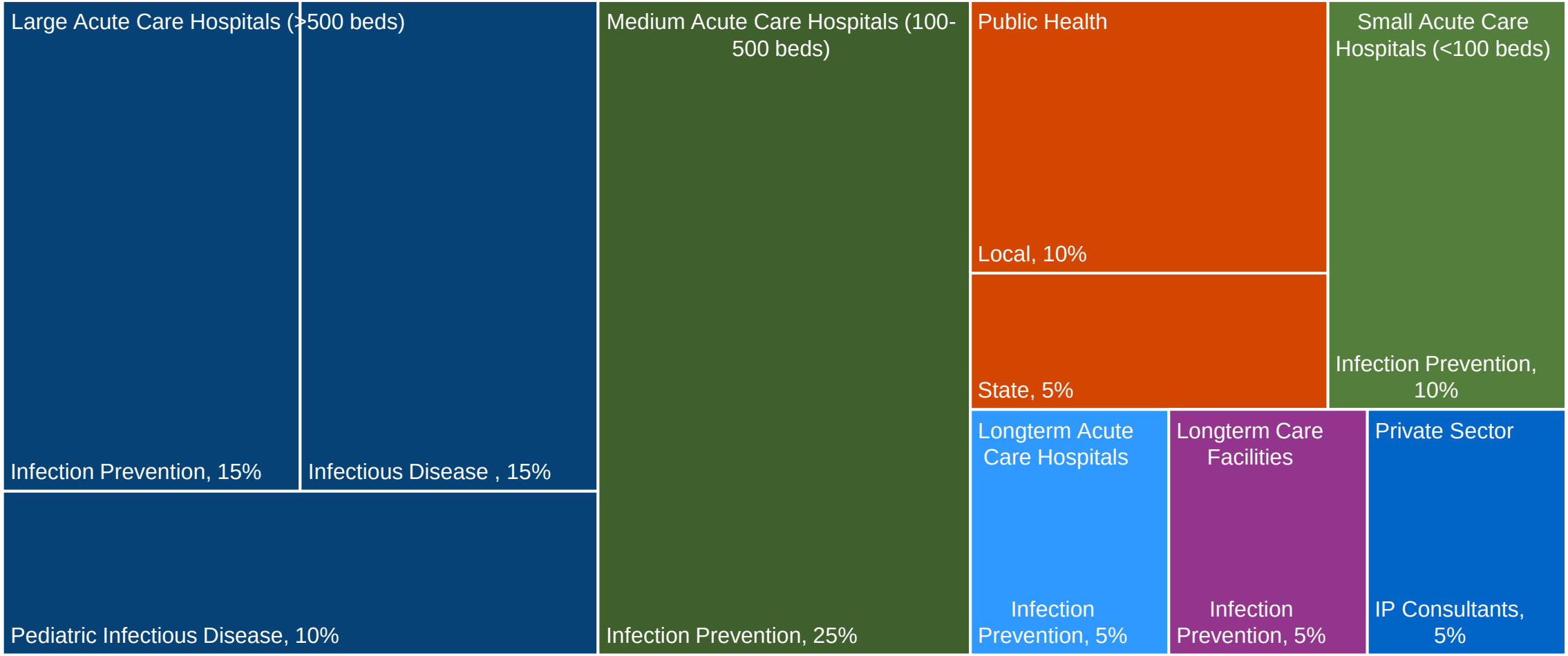
- 2027 = renewal year

Current STAR Advisory Committee Members



OR Region	% Members
Region 1	45%
Region 2	9%
Region 3	9%
Region 5	9%
Region 6	5%
Region 7	9%
Region 9	9%
Statewide	5%

Current STAR Advisory Committee Members

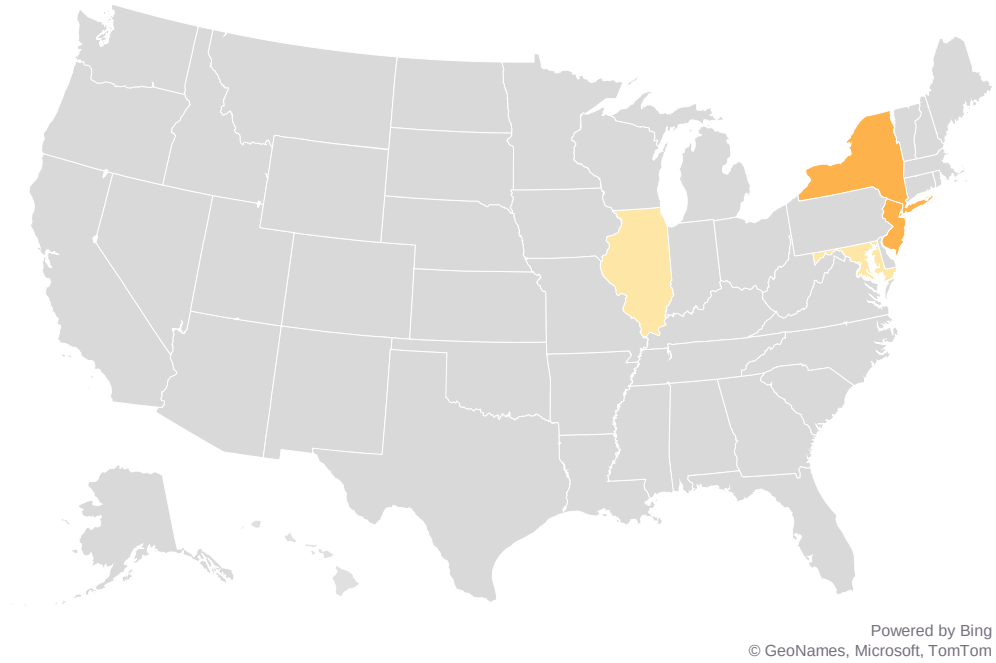


Epi Update

Candida (Candidozyma) auris

C. auris has spread quickly across the US

First reported clinical cases of *Candida auris* in the United States, 2013 - 2016



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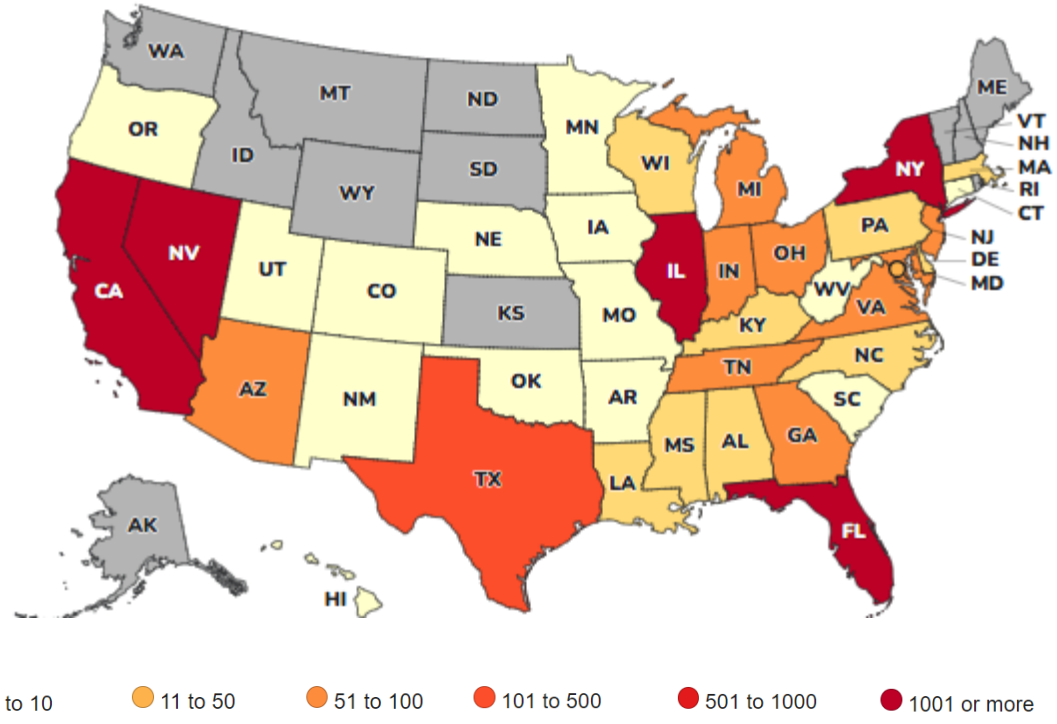

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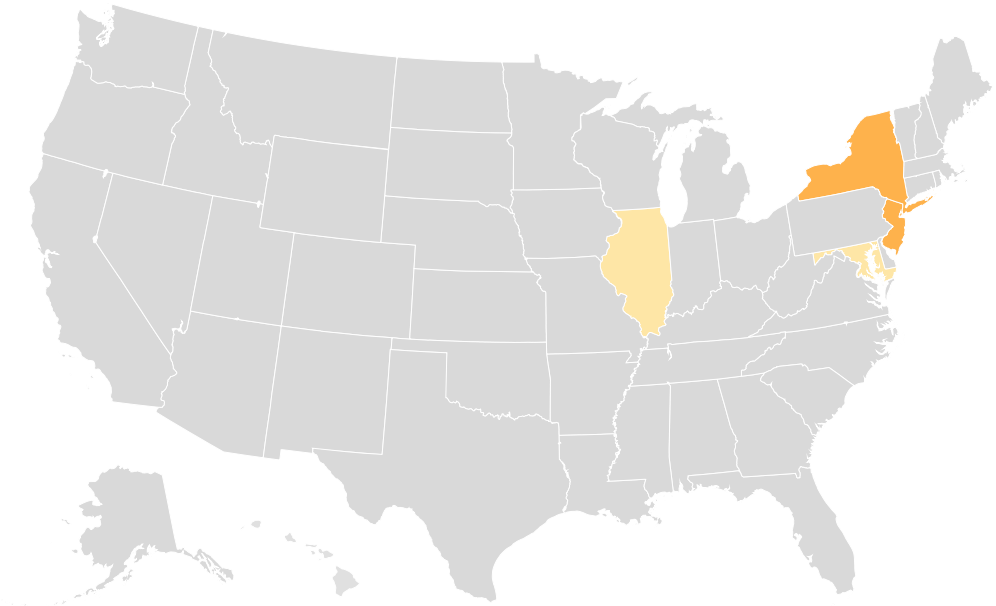

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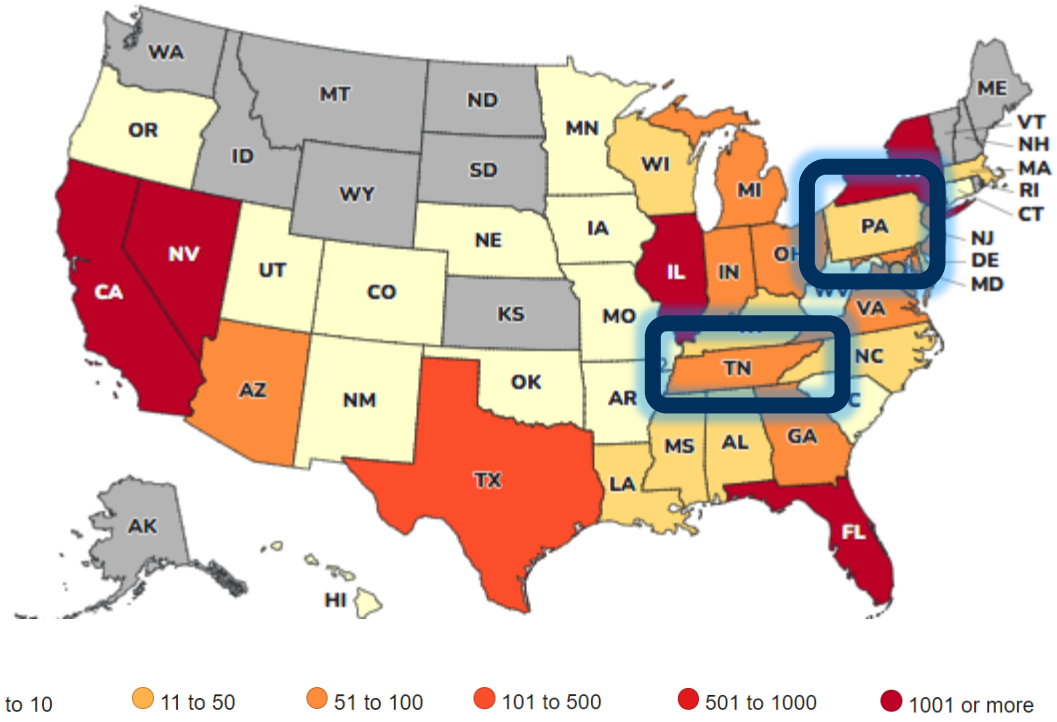
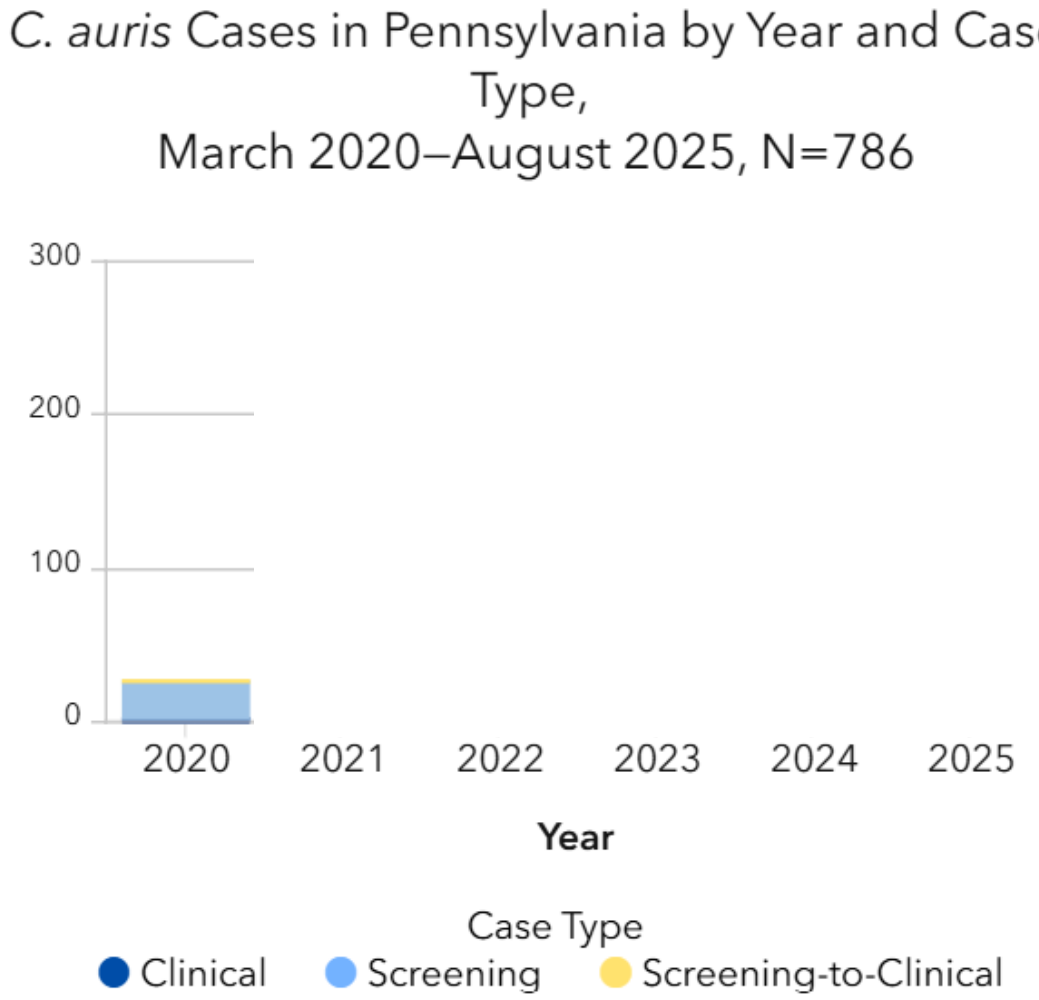


PA index case in 2020; 250+ cases in 2025



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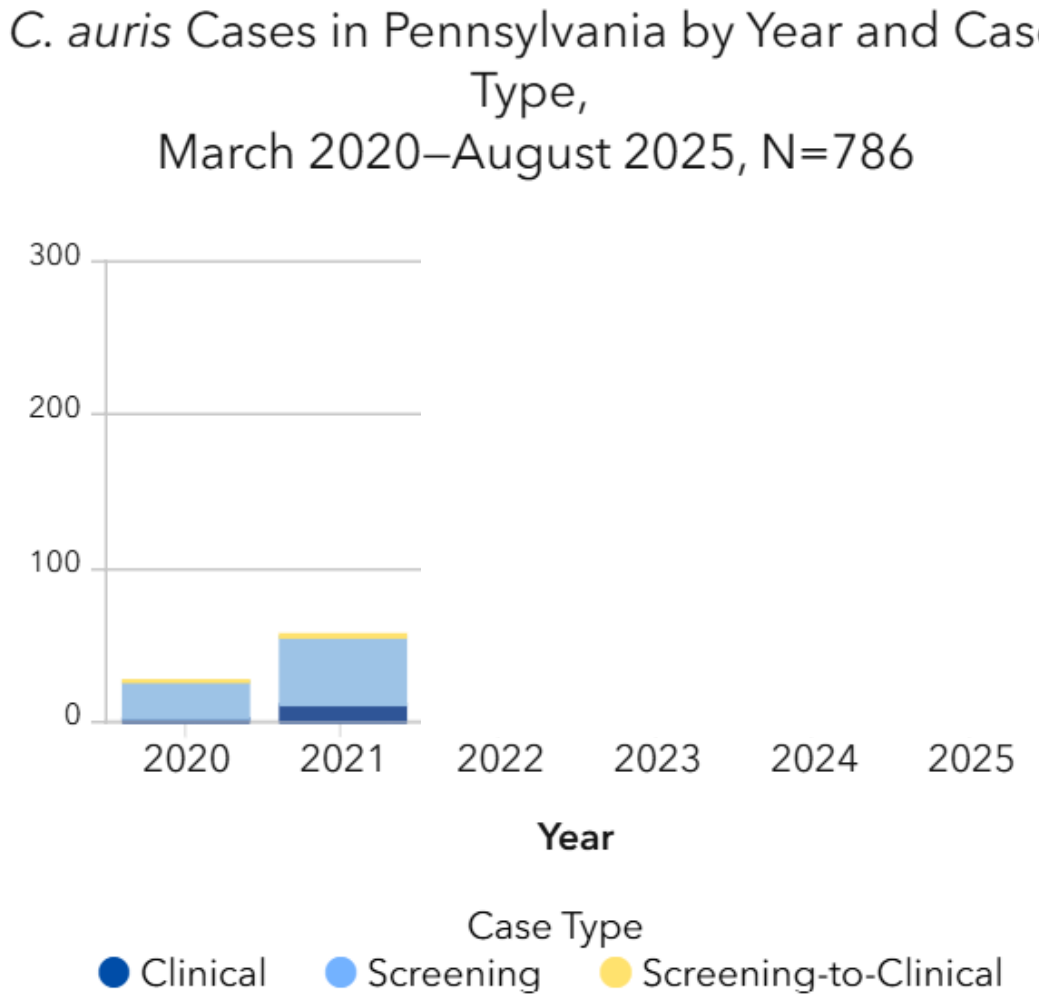

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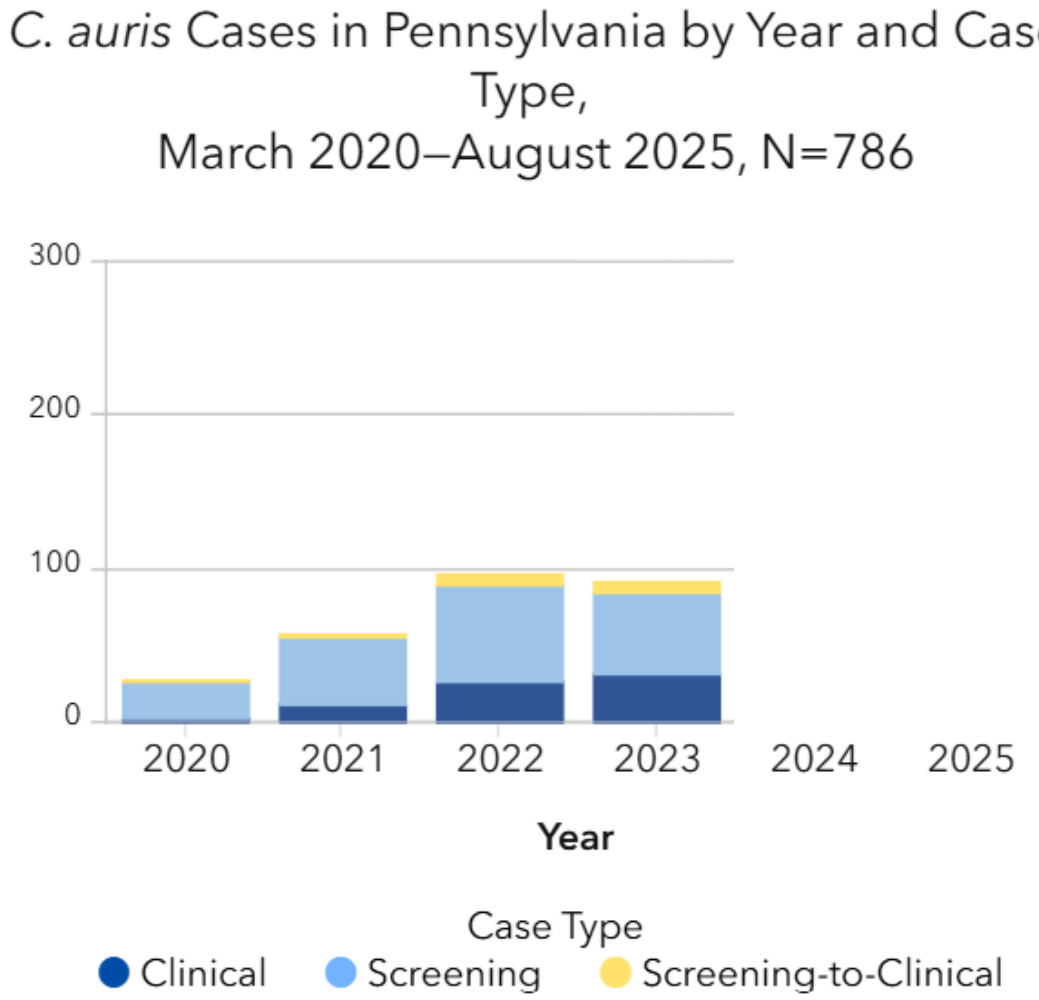

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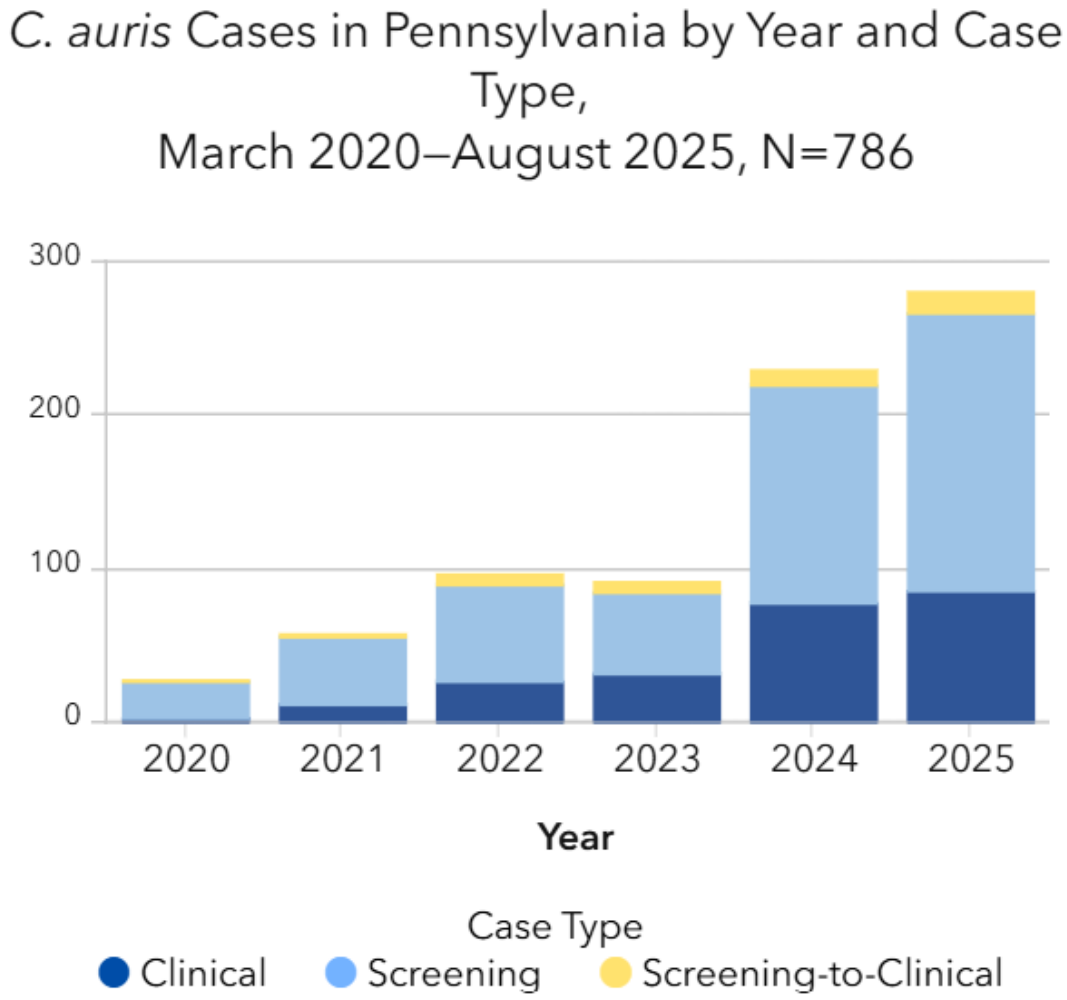

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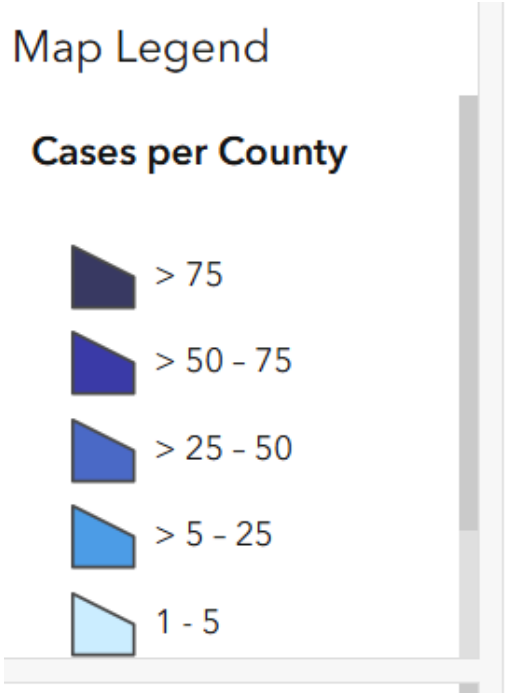
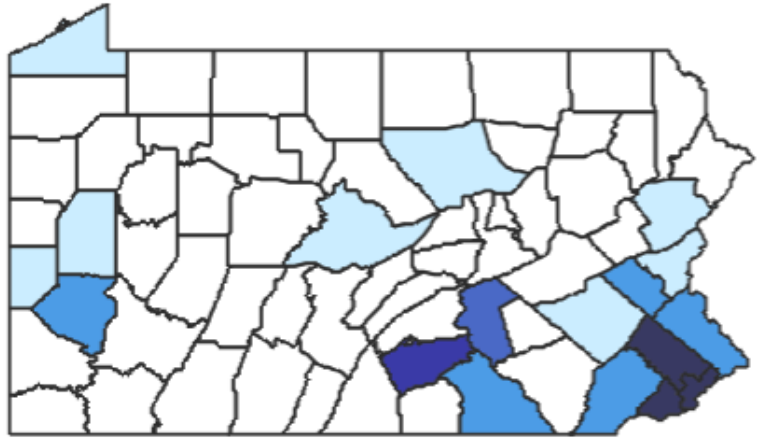
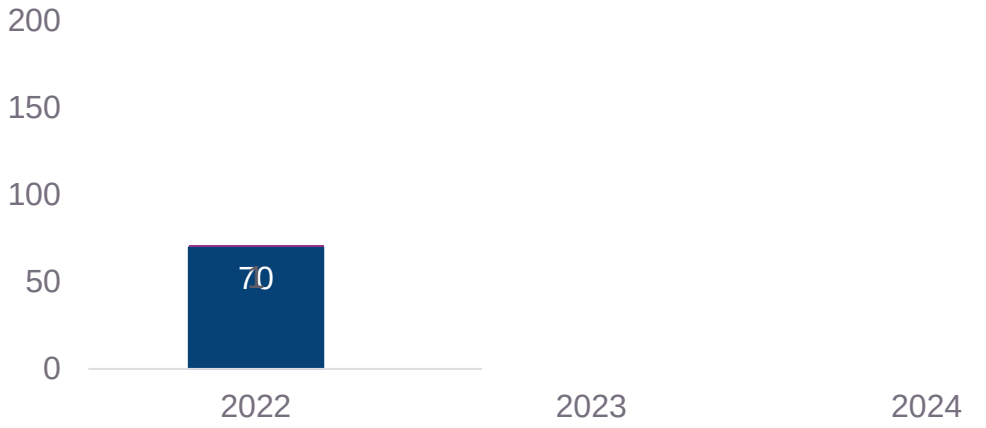
Clinical and colonization cases of *C. auris* in Pennsylvania, 2020 - August 2025



Clinical and Screening Cases by County of Healthcare Facility Where Identified, March 2020–August 2025, N=786



TN went from index case in 2022 to 400+ cases/year



https://www.tn.gov/health/cedep/hai/candida-auris-/candida-auris-dashboard.html

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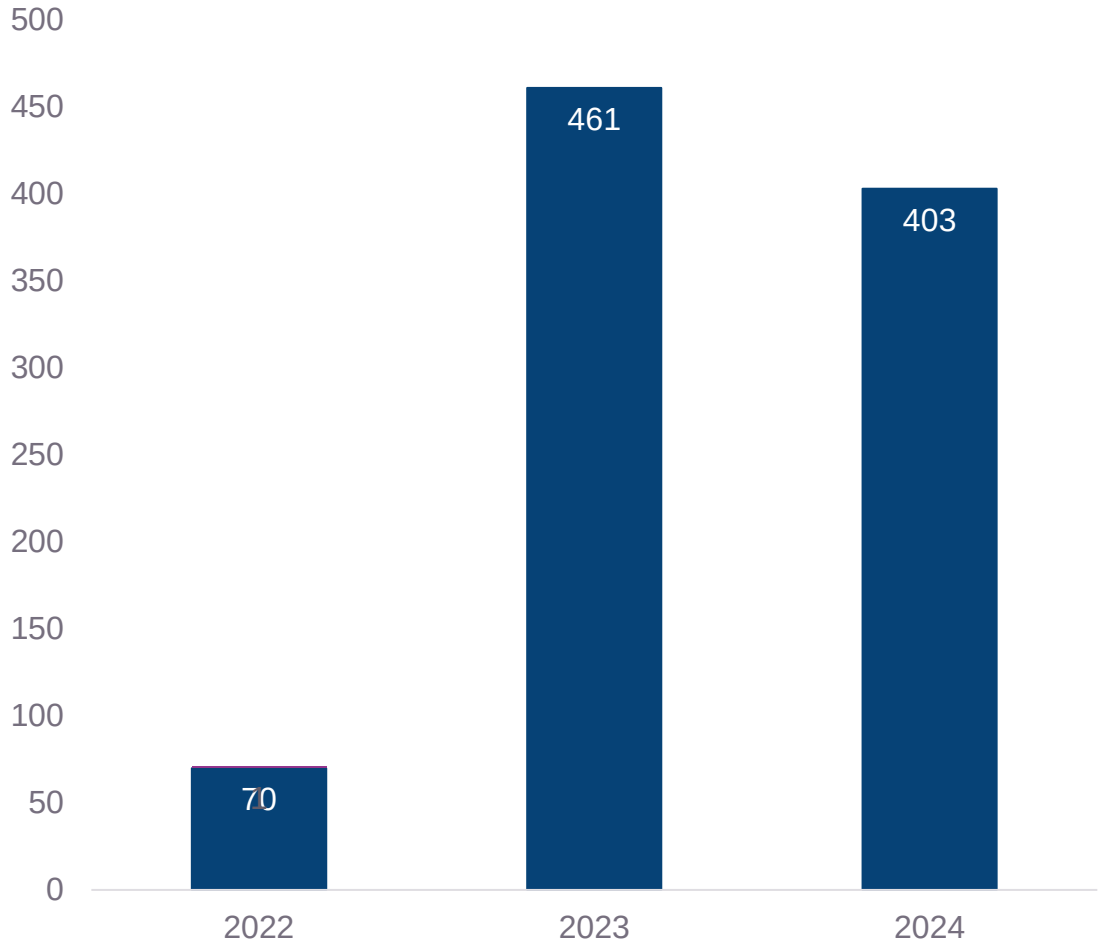

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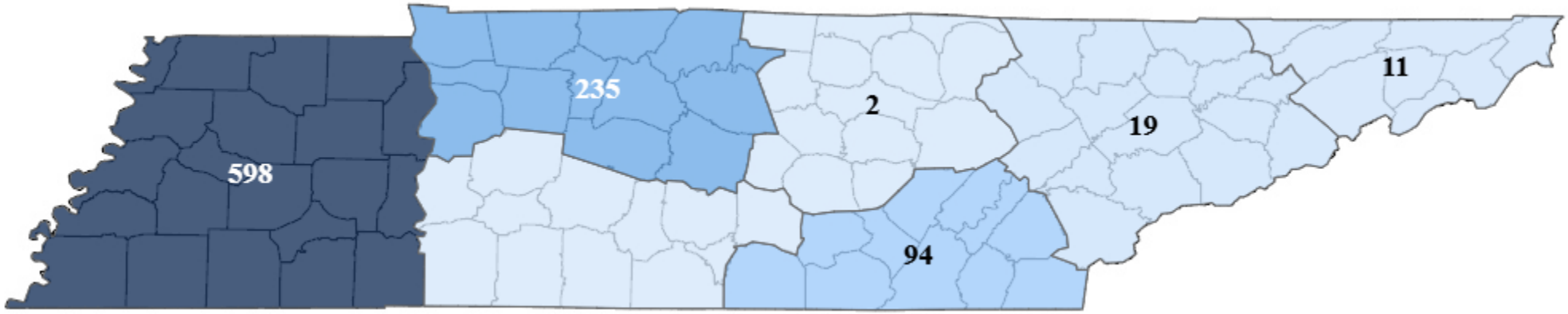
Clinical and colonization cases of *C. auris* in Tennessee, 2022-2024



Clinical and colonization cases of *C. auris* in Tennessee, 2022-2024

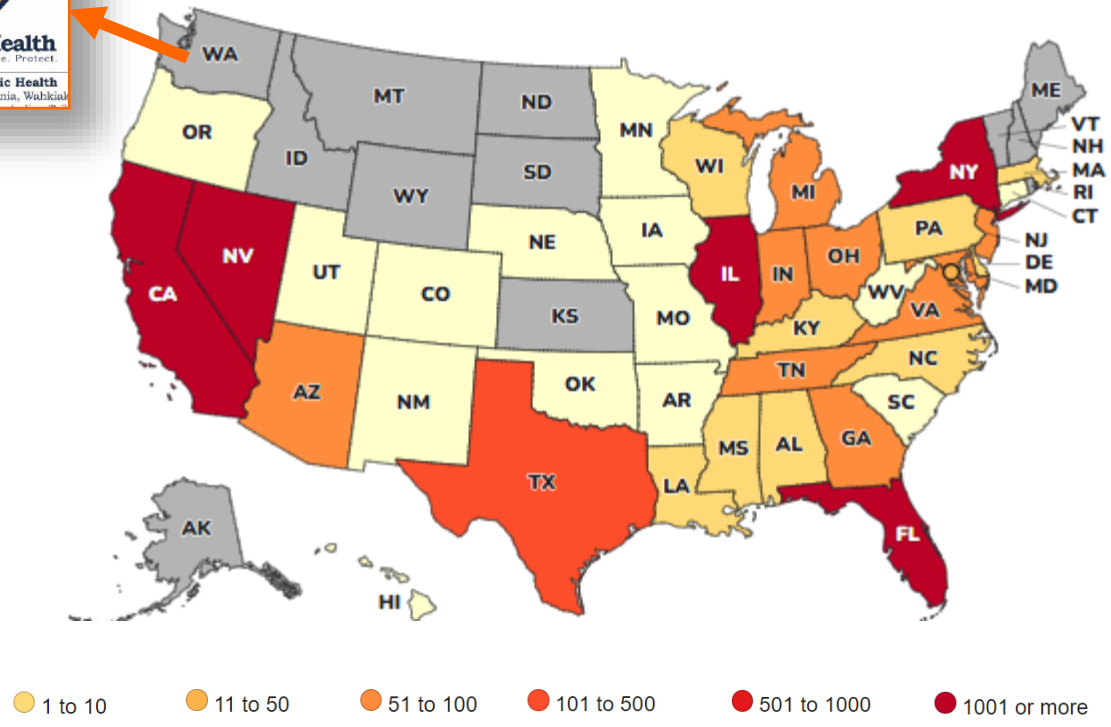
C. auris has spread quickly across the US

HEALTH ADVISORY
Aug. 5, 2024

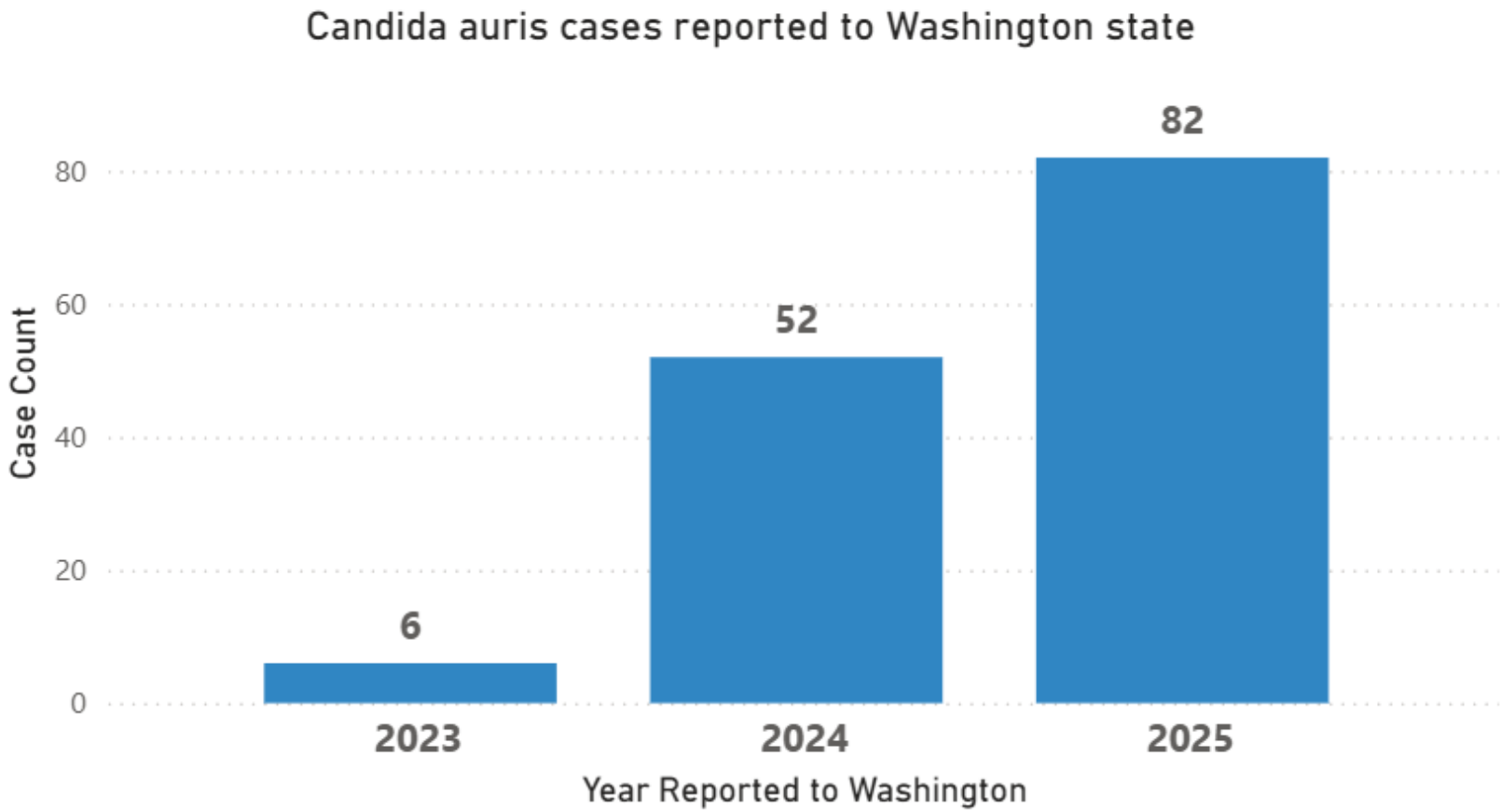
Ongoing transmission of Candida auris identified in Washington

Public Health
Prevent. Promote. Protect.
Region 4 Public Health
Clark, Cowlitz, Skamania, Wahkiak

Clinical cases of *Candida auris* reported in the United States, 2016 - 2023

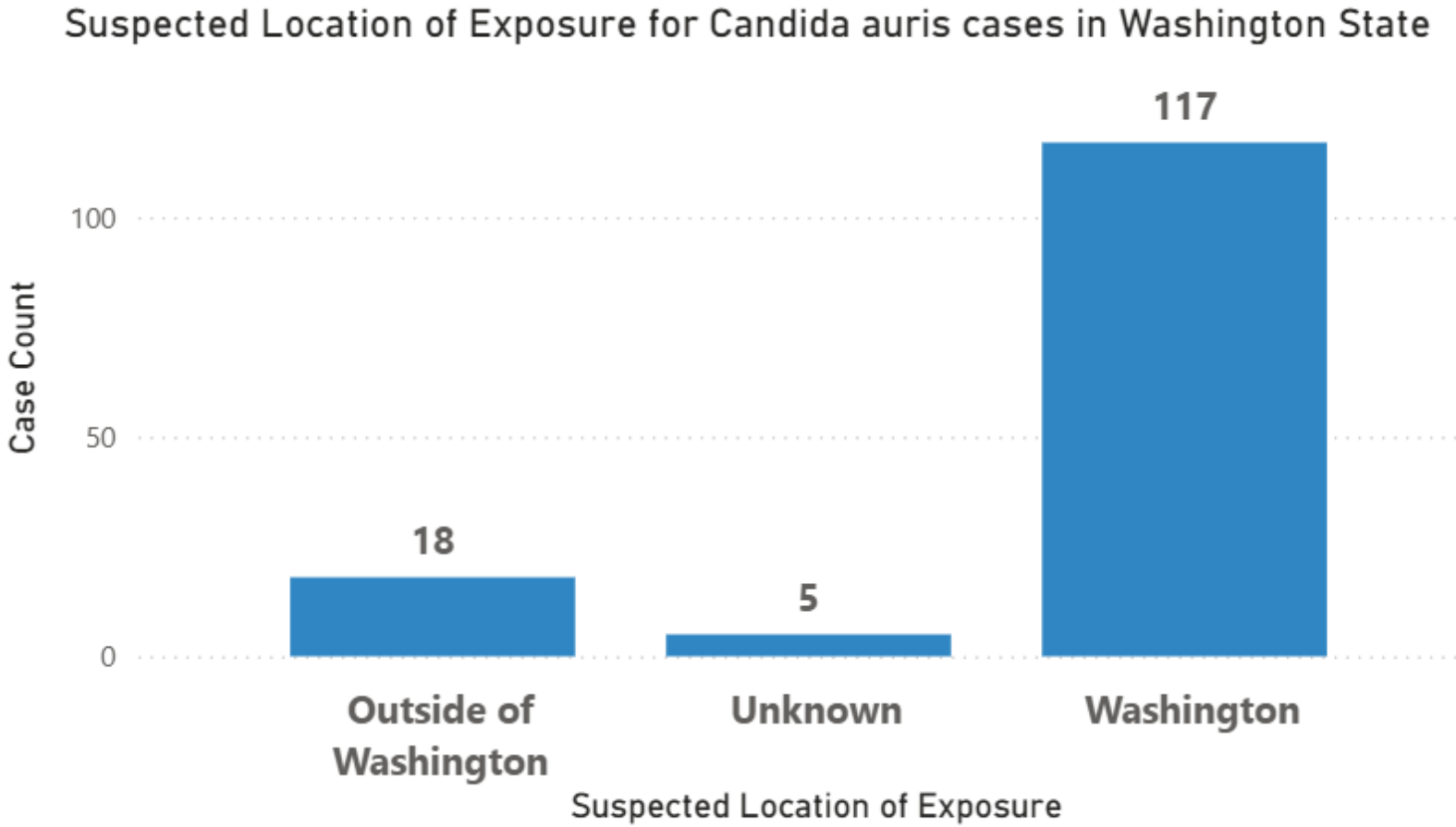


140 cases of *C. auris* reported in Washington state



This graph shows the number of positive *C. auris* cases reported to Washington. Surveillance for C. *auris* began in 2017. The first Washington case was detected in 2023. Data only shows one *C. auris* identification per case.

Ongoing local transmission in WA state



This graph shows the total number of positive *C. auris* cases reported to Washington since 2023 and their suspected exposure location.

WA cases across 8 counties, no OR border counties

Year

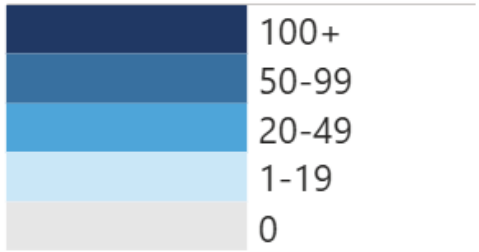
All

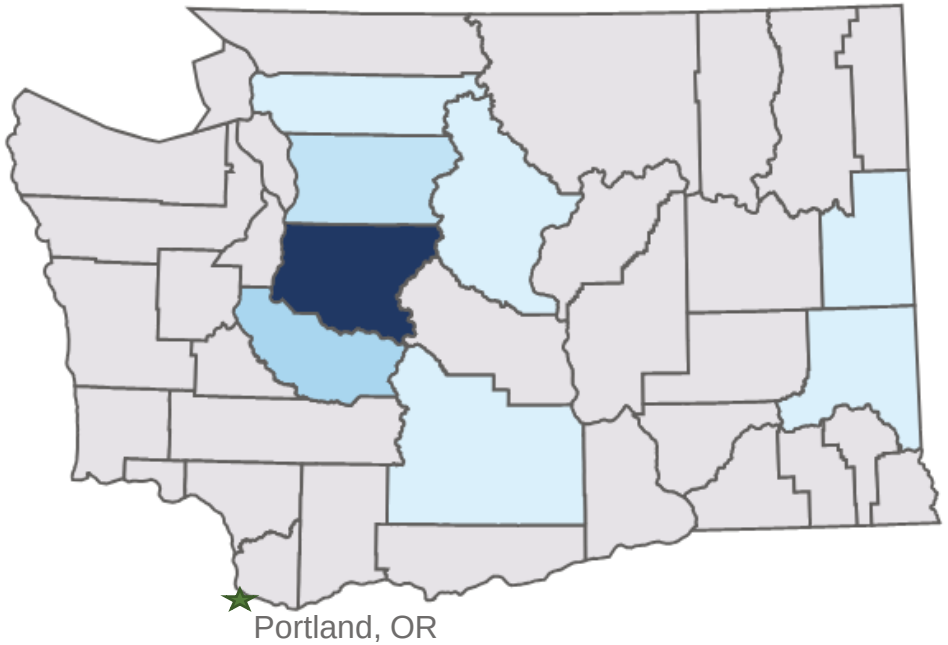
C. auris Cases in Washington State by County of Diagnosis

140

Cases Reported to Washington State

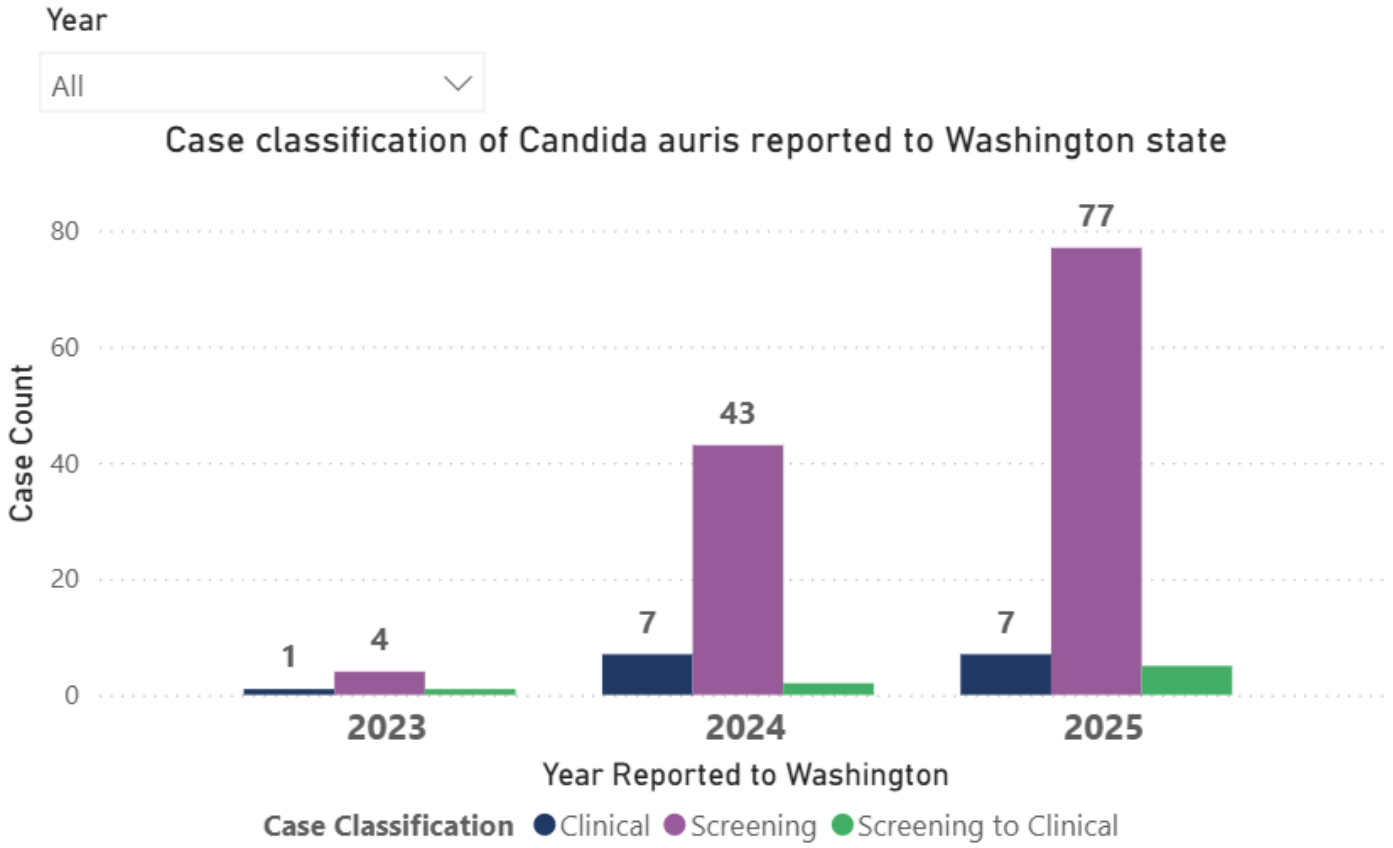
Map Legend





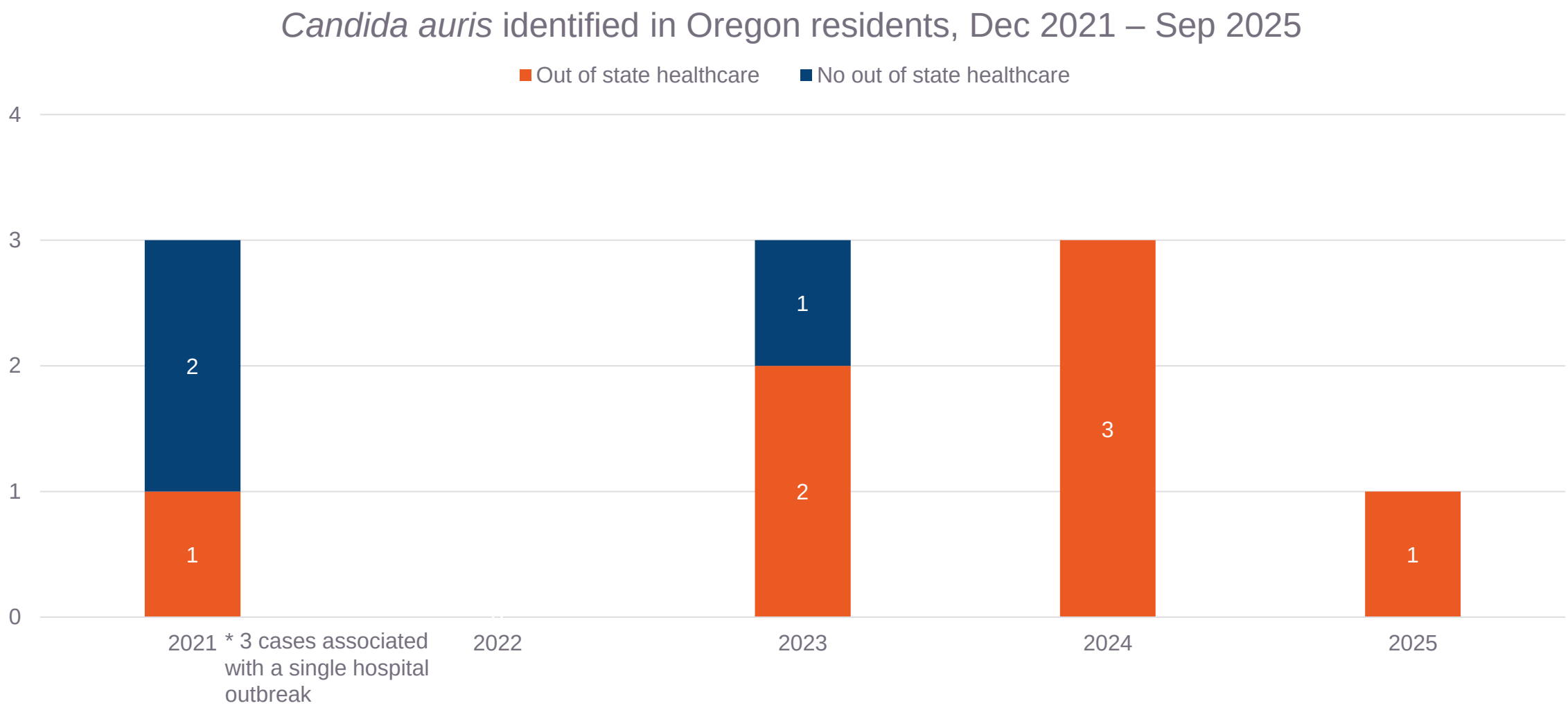
This map shows *C. auris* cases in Washington State since 2023. Data only shows one *C. auris* identification per case. Cases are displayed by county of collection facility at the time of diagnosis. If county of diagnosis is not in Washington, the county of residence is default.

Most new WA *C. auris* cases identified by screening



This graph shows the number of positive *C. auris* cases reported to Washington since 2023. Cases can be classified as either screening or clinical. Screening cases that later tested positive on a clinical culture are shown as "screening to clinical". Data only shows one *C. auris* identification per case.

In Oregon, *C. auris* remains rare for now



C. auris success so far

- Only outbreak limited to 3 cases in 2021
- Aggressive testing in response to new cases has not yet identified transmission
  - Strong IPC practices
- Some facilities now using List P at baseline, or moving towards this

Challenges based on recent *C. auris* epidemiology

Most newly identified *C. auris* cases have history of domestic healthcare outside Oregon	→	Admission screening of patients with domestic healthcare is more limited
Immunocompromised patients with chronic conditions present to ED frequently	→	Many opportunities for transmission
C. auris likely circulating at low levels in OR already	→	Many facilities do not routinely use list P products

Discussion

How can we maintain low *C. auris* prevalence?

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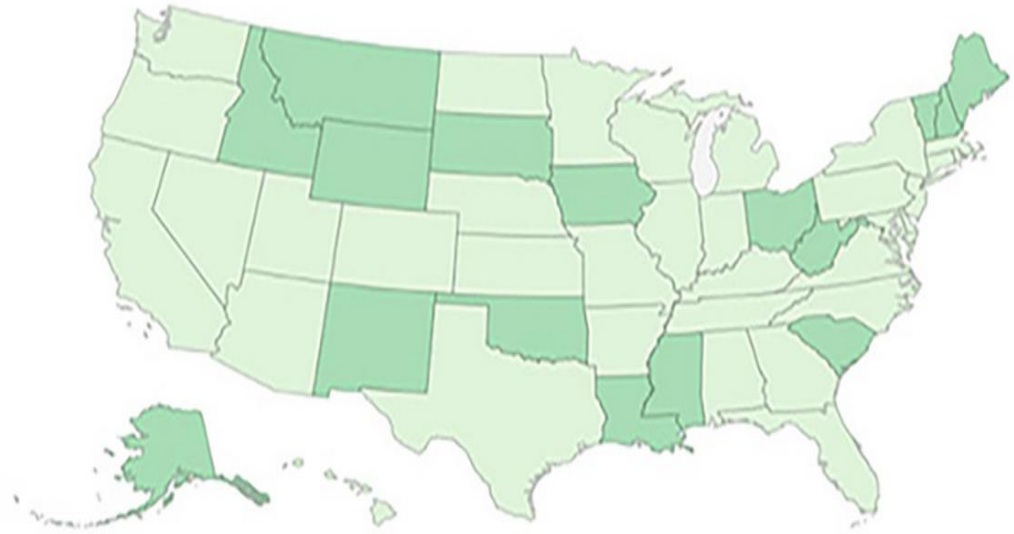
Epi Update

Carbapenemase Producing Organisms (CPOs)

Historically, KPC has been most prevalent in US

States reporting **NDM,** 2017



States reporting **KPC**, 2017

Not reported

Reported

National increase in CP-CRE

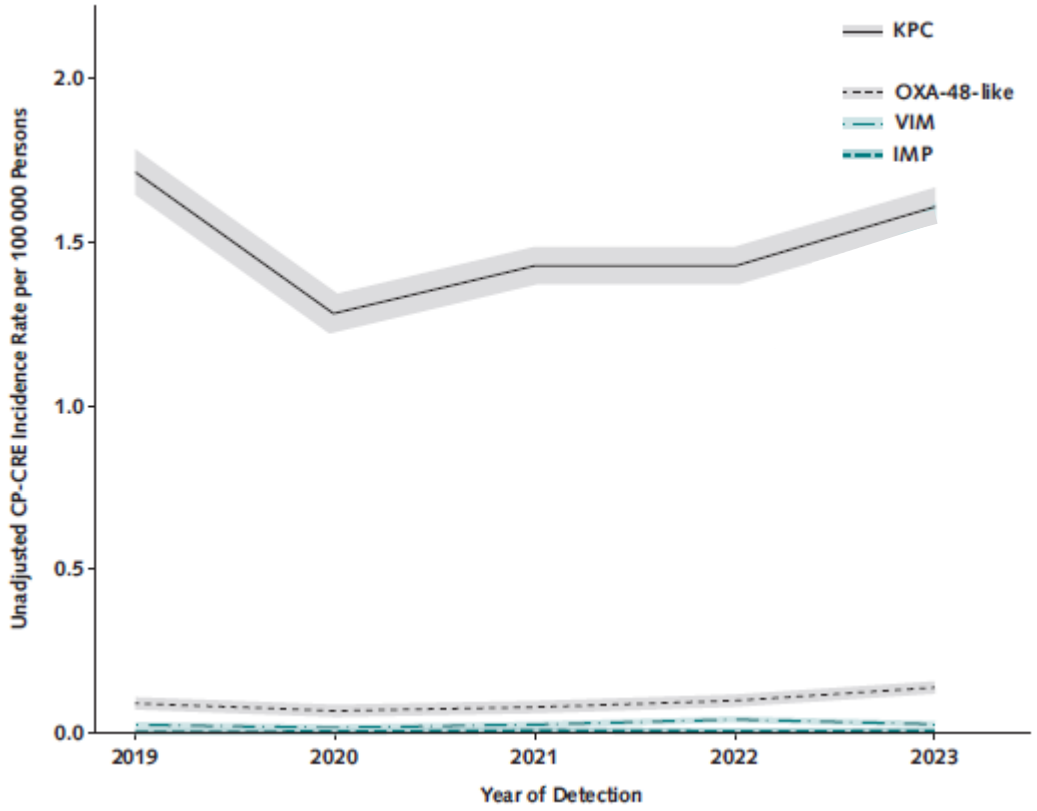


Figure. Unadjusted CP-CRE incidence rates per 100 000 persons across an open cohort of U.S. states with required CRE isolate submission, by carbapenemase gene (*top*) and by organism grouping and carbapenemase gene (*bottom*), 2019-2023.

https://pubmed.ncbi.nlm.nih.gov/40982973/

National increase in CP-CRE due to NDM

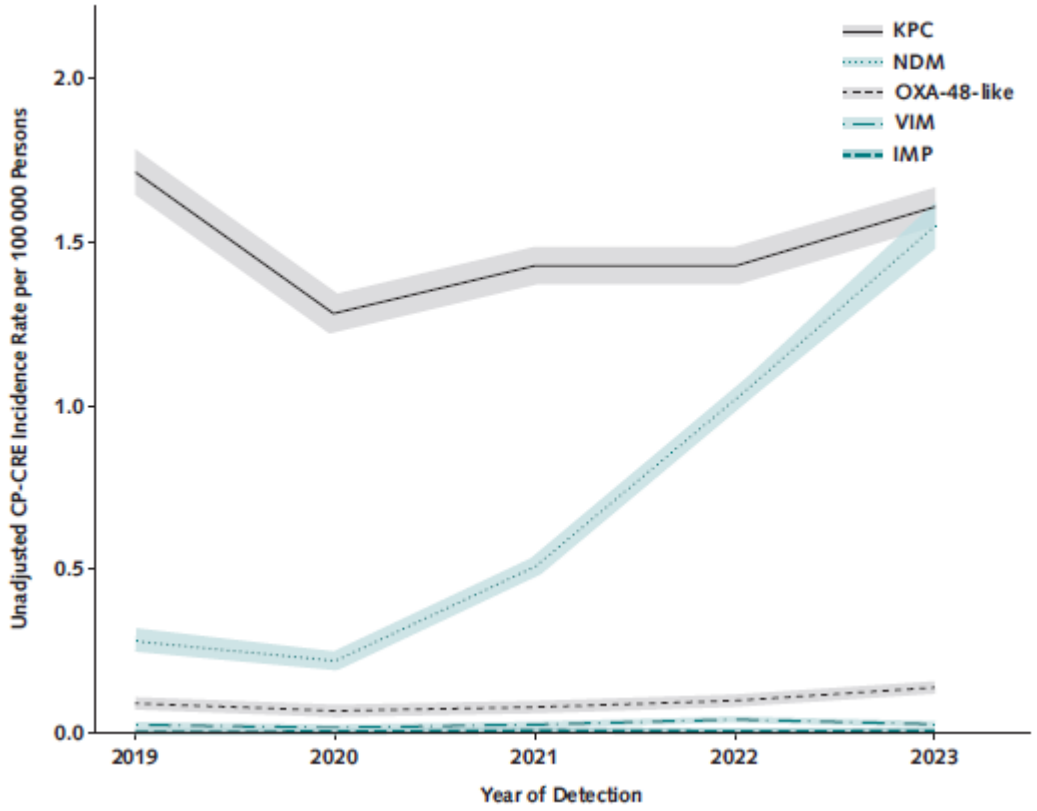
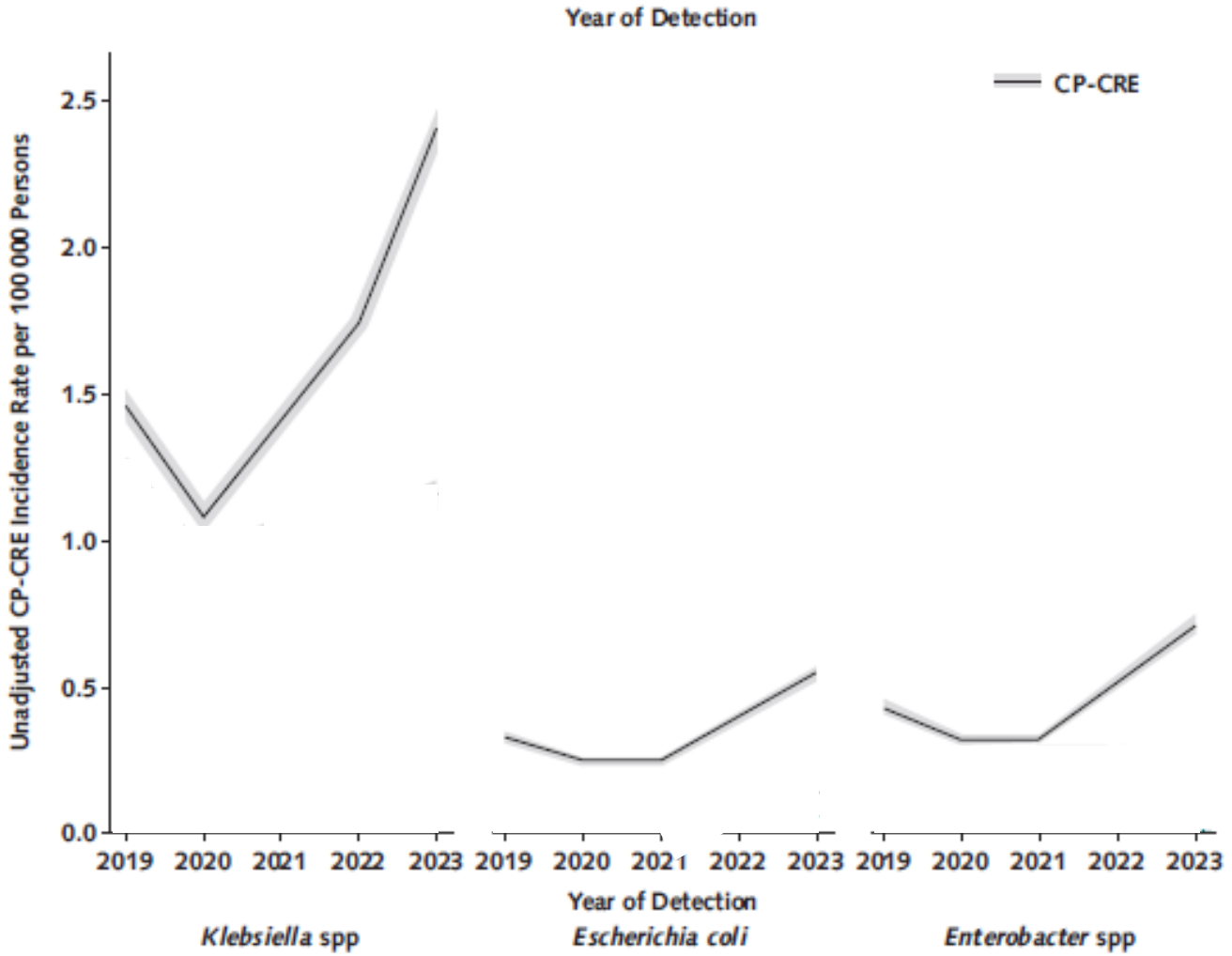


Figure. Unadjusted CP-CRE incidence rates per 100 000 persons across an open cohort of U.S. states with required CRE isolate submission, by carbapenemase gene (*top*) and by organism grouping and carbapenemase gene (*bottom*), 2019-2023.

CP-CRE rose across organisms, esp. *Klebsiella spp*.



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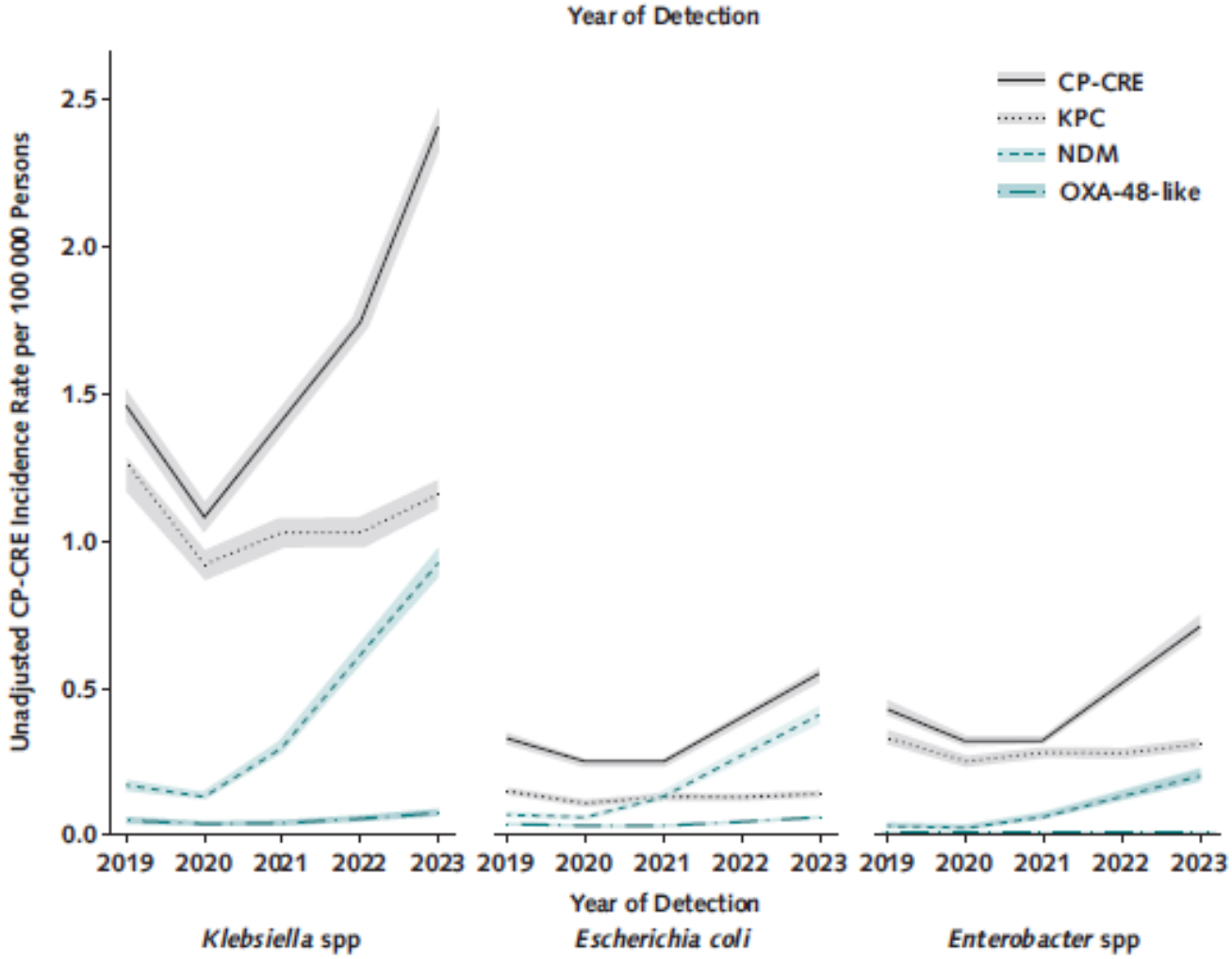
24% of *Klebsiella spp.* Isolates were NDM+ by 2023



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In OR: online dashboard to replace quarterly report

Previous: PDF Quarterly Report

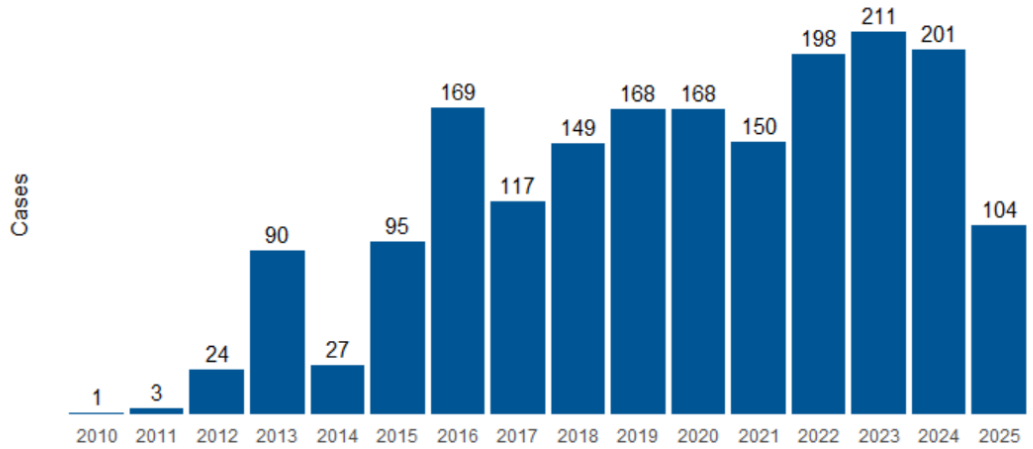
Public Health Division

Acute and Communicable Disease Prevention

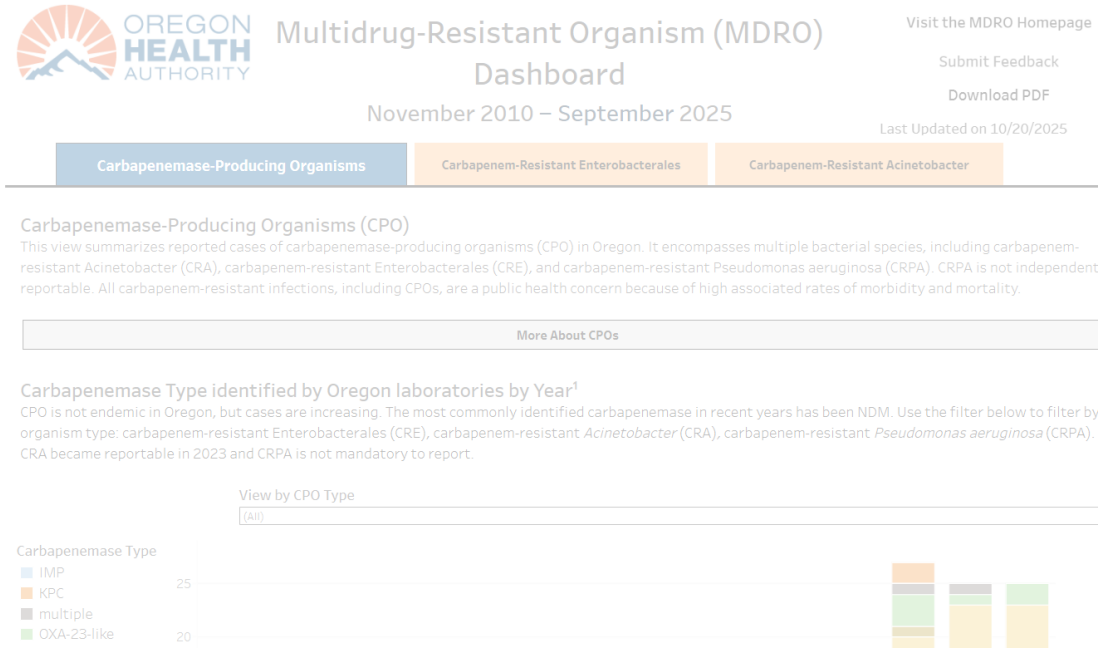
OREGON HEALTH AUTHORITY

Laboratory-based surveillance for Carbapenem-resistant *Enterobacterales* (CRE)

Figure 1. CRE cases of infection or colonization in Oregon residents by year, Nov 2010 - Jun 2025



Now: Tableau Dashboard



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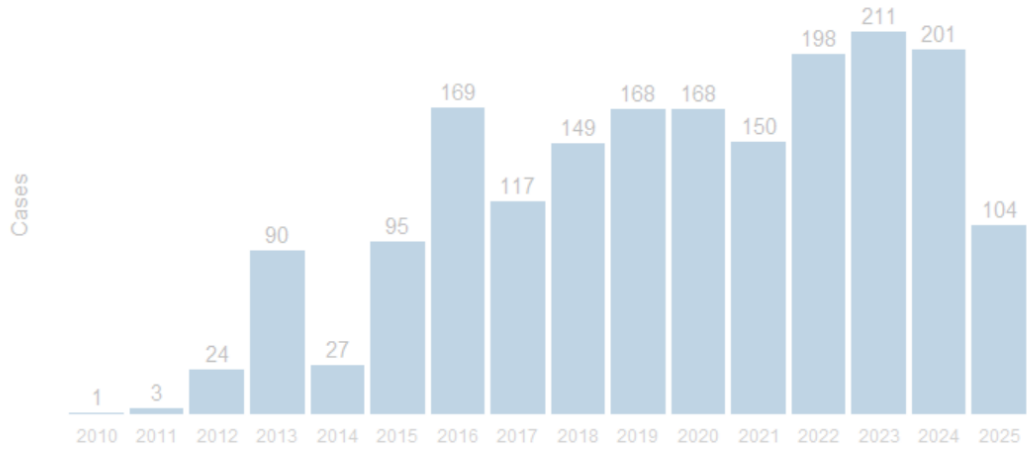

Now: Tableau Dashboard

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Multidrug-Resistant Organism (MDRO) Dashboard

November 2010 – September 2025

Visit the MDRO Homepage

Submit Feedback

Download PDF

Last Updated on 10/20/2025

Carbapenemase-Producing Organisms | Carbapenem-Resistant Enterobacterales | Carbapenem-Resistant Acinetobacter

Carbapenemase-Producing Organisms (CPO)

This view summarizes reported cases of carbapenemase-producing organisms (CPO) in Oregon. It encompasses multiple bacterial species, including carbapenem-resistant Acinetobacter (CRA), carbapenem-resistant Enterobacterales (CRE), and carbapenem-resistant Pseudomonas aeruginosa (CRPA). CRPA is not independently reportable. All carbapenem-resistant infections, including CPOs, are a public health concern because of high associated rates of morbidity and mortality.

More About CPOs

Carbapenemase Type identified by Oregon laboratories by Year[1]

CPO is not endemic in Oregon, but cases are increasing. The most commonly identified carbapenemase in recent years has been NDM. Use the filter below to filter by organism type: carbapenem-resistant Enterobacterales (CRE), carbapenem-resistant *Acinetobacter* (CRA), carbapenem-resistant *Pseudomonas aeruginosa* (CRPA). CRA became reportable in 2023 and CRPA is not mandatory to report.

View by CPO Type

(All)

Carbapenemase Type

IMP

KPC

multiple

OXA-23-like

25

20

Oregon interactive dashboard provides more data

Previous: PDF Quarterly Report

CRE

- case count by year and carbapenemase production
- organism and site of culture
- case count by age group and sex

Now: Tableau Dashboard

CRE

- case count by year and carbapenemase production
- case count and rate by Oregon county
- organism and site of culture
- case count by age group and sex

CR *Acinetobacter spp* (CRA)

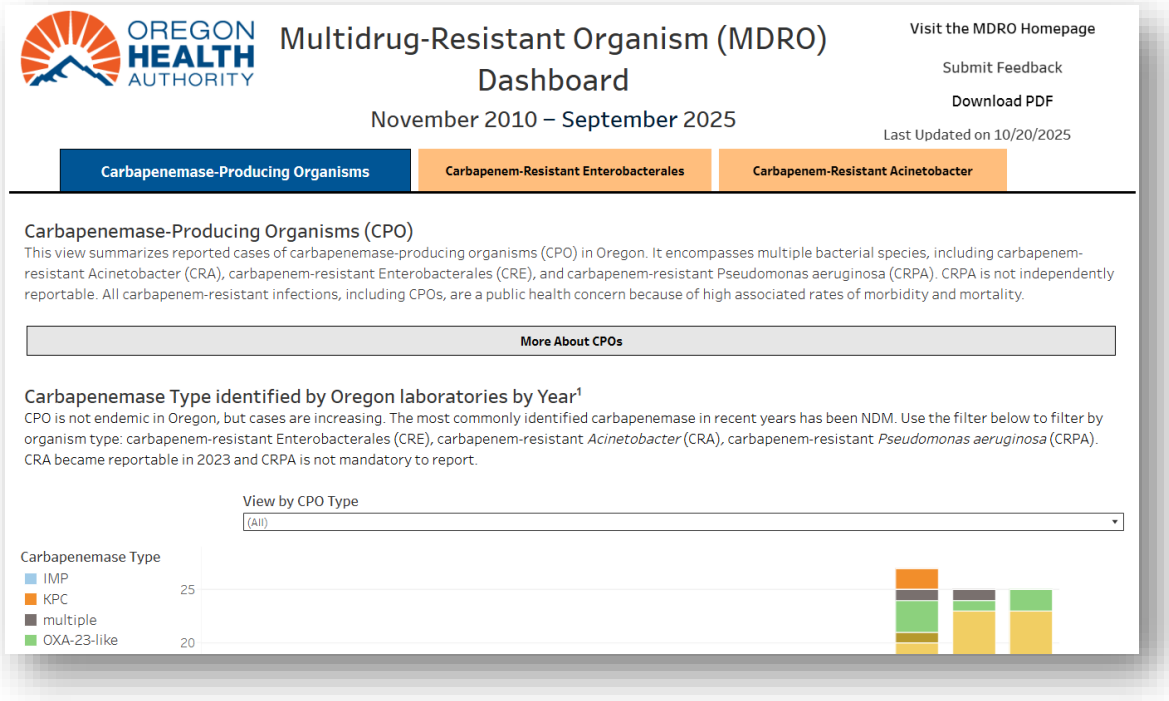
- case count by year and carbapenemase production
- organism and site of culture
- case count by age group and sex

CPO

- carbapenemase type by year
- clinical and colonization case counts by year
- case count and rate by Oregon county
- carbapenemase type by organism
- organism and site of culture
- case count by age group and sex

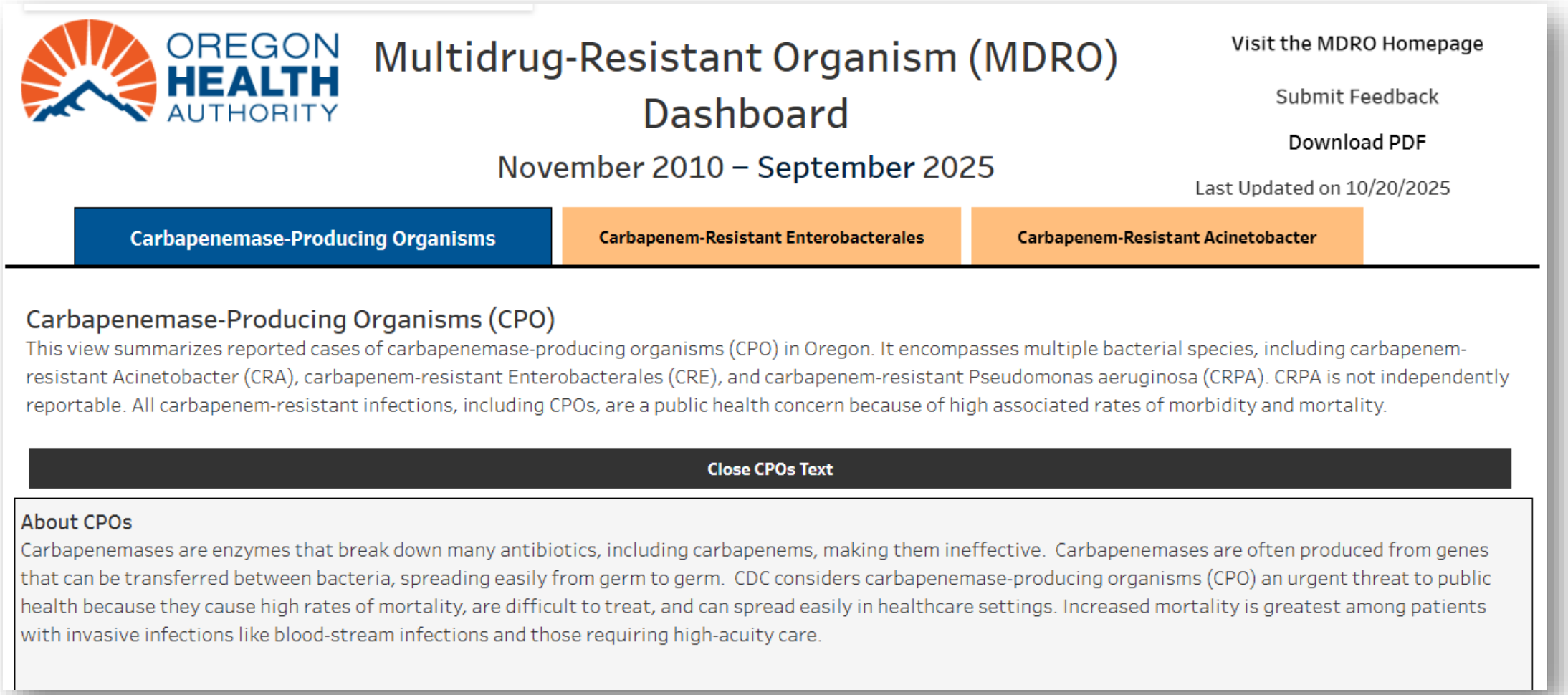
+ ability to filter by Oregon county and region across visualizations

Walkthrough of new CRO dashboard

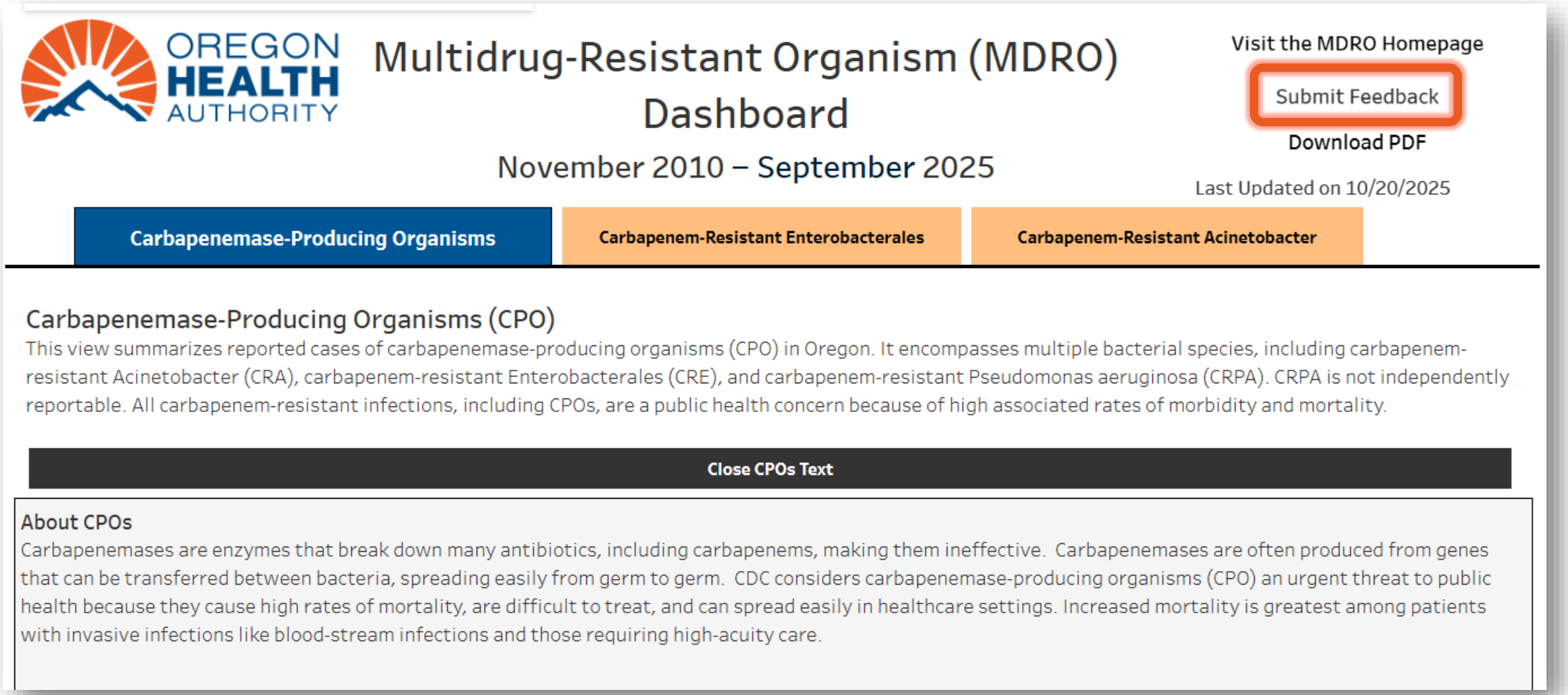


https://tinyurl.com/cpodashboard

Dashboard walkthrough: CPO tab



Dashboard walkthrough: CPO tab



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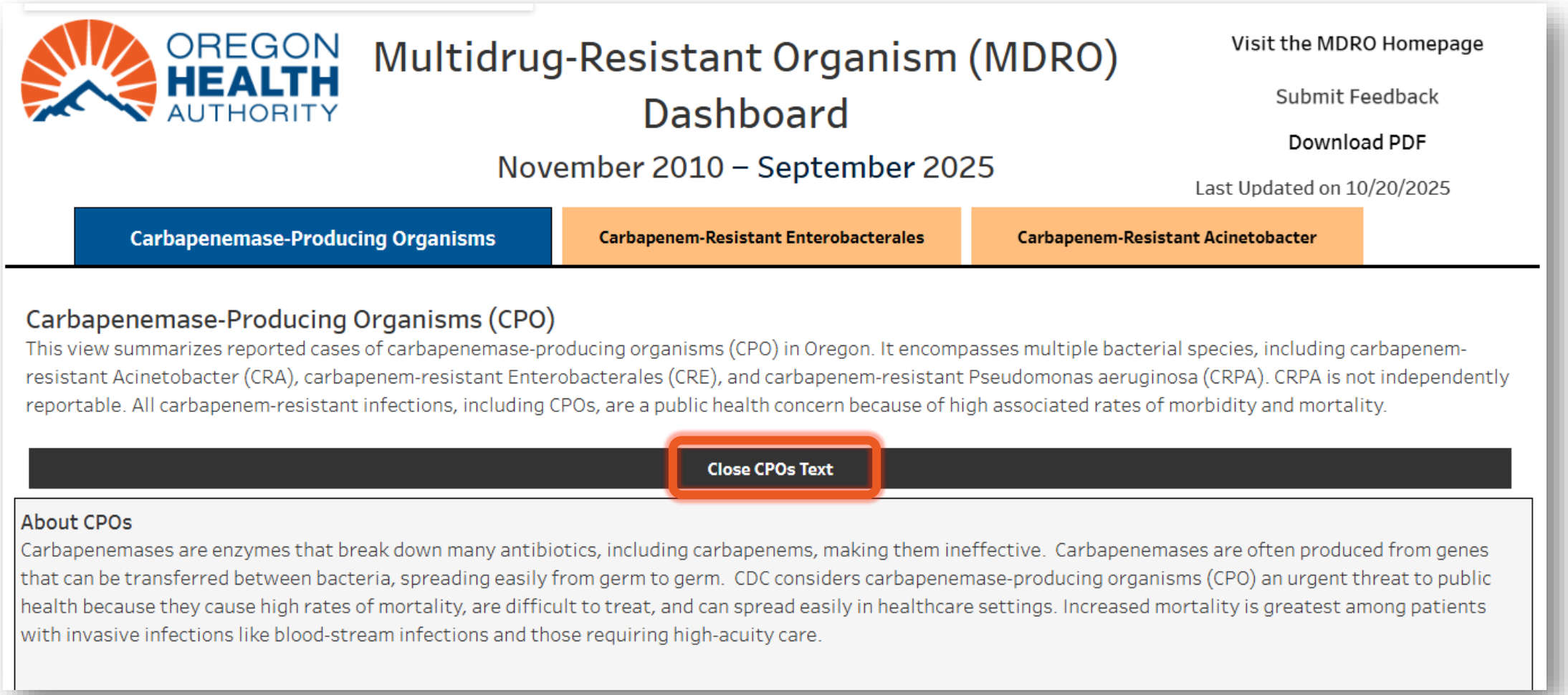

Dashboard: carbapenemase type by year

Carbapenemase Type identified by Oregon laboratories by Year[1]

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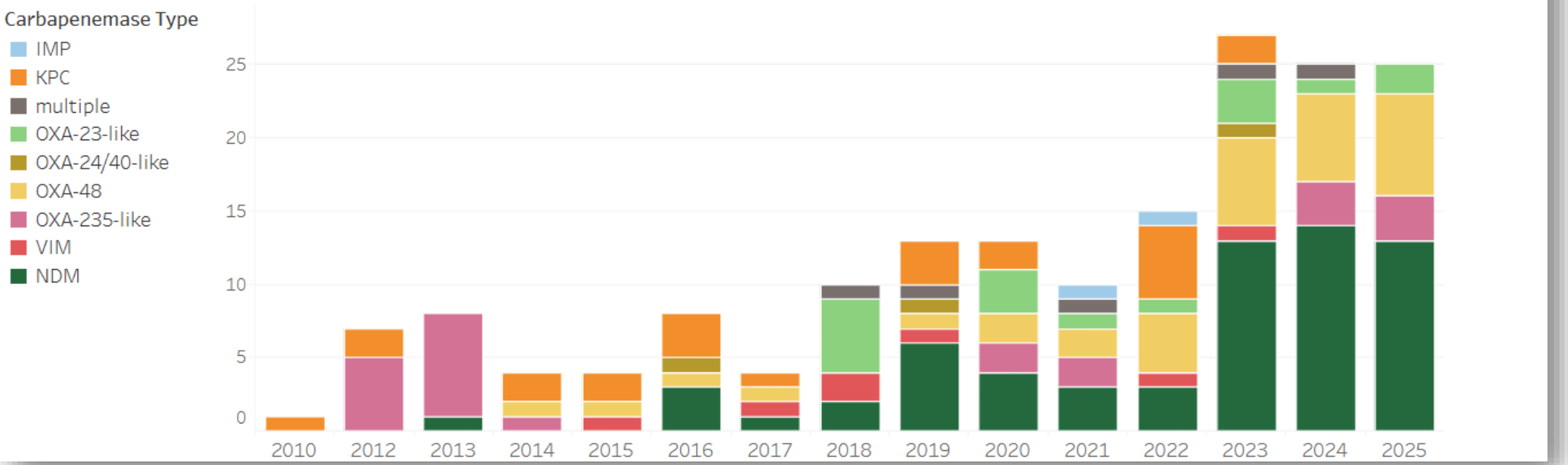
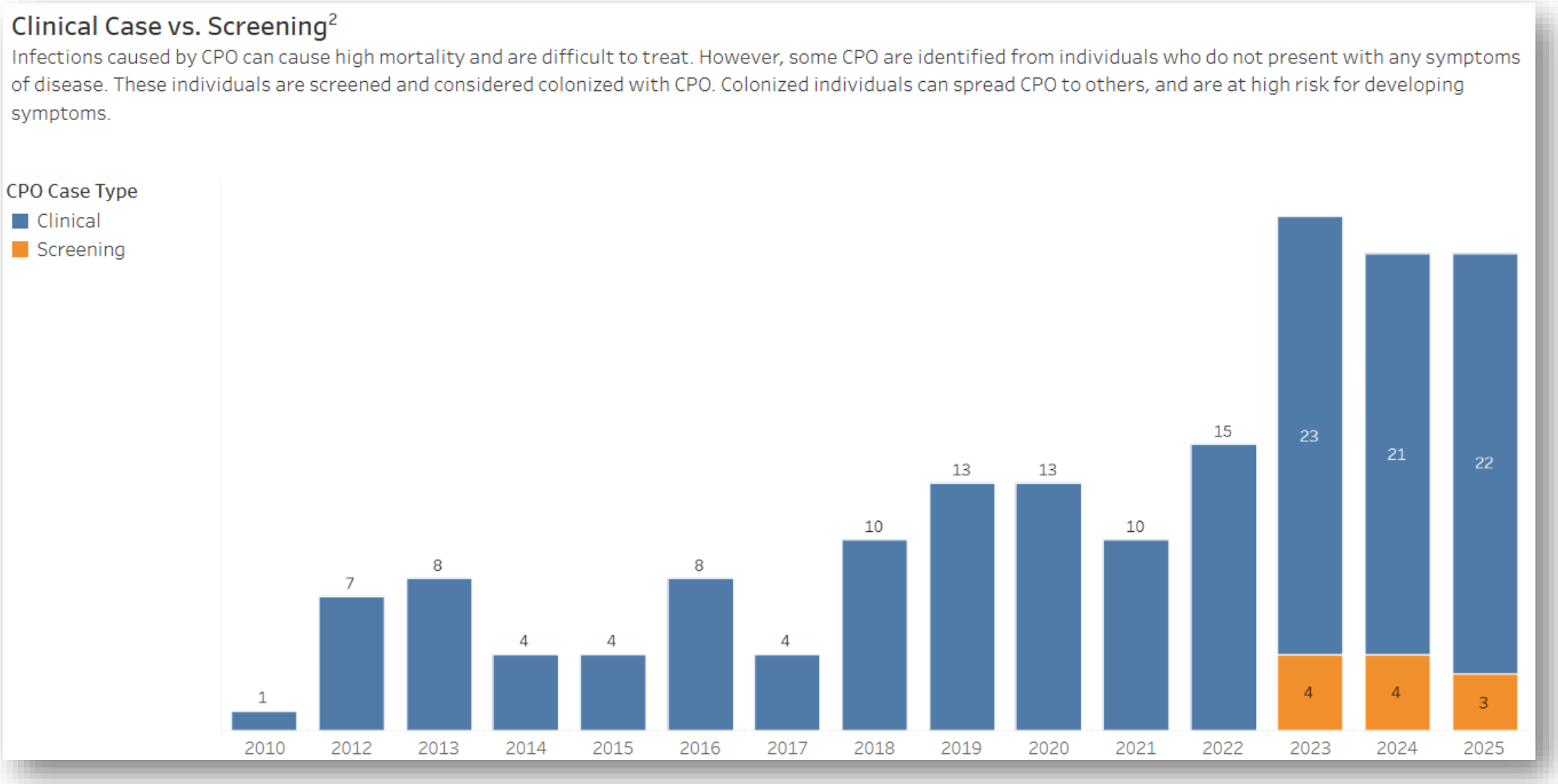
View by CPO Type

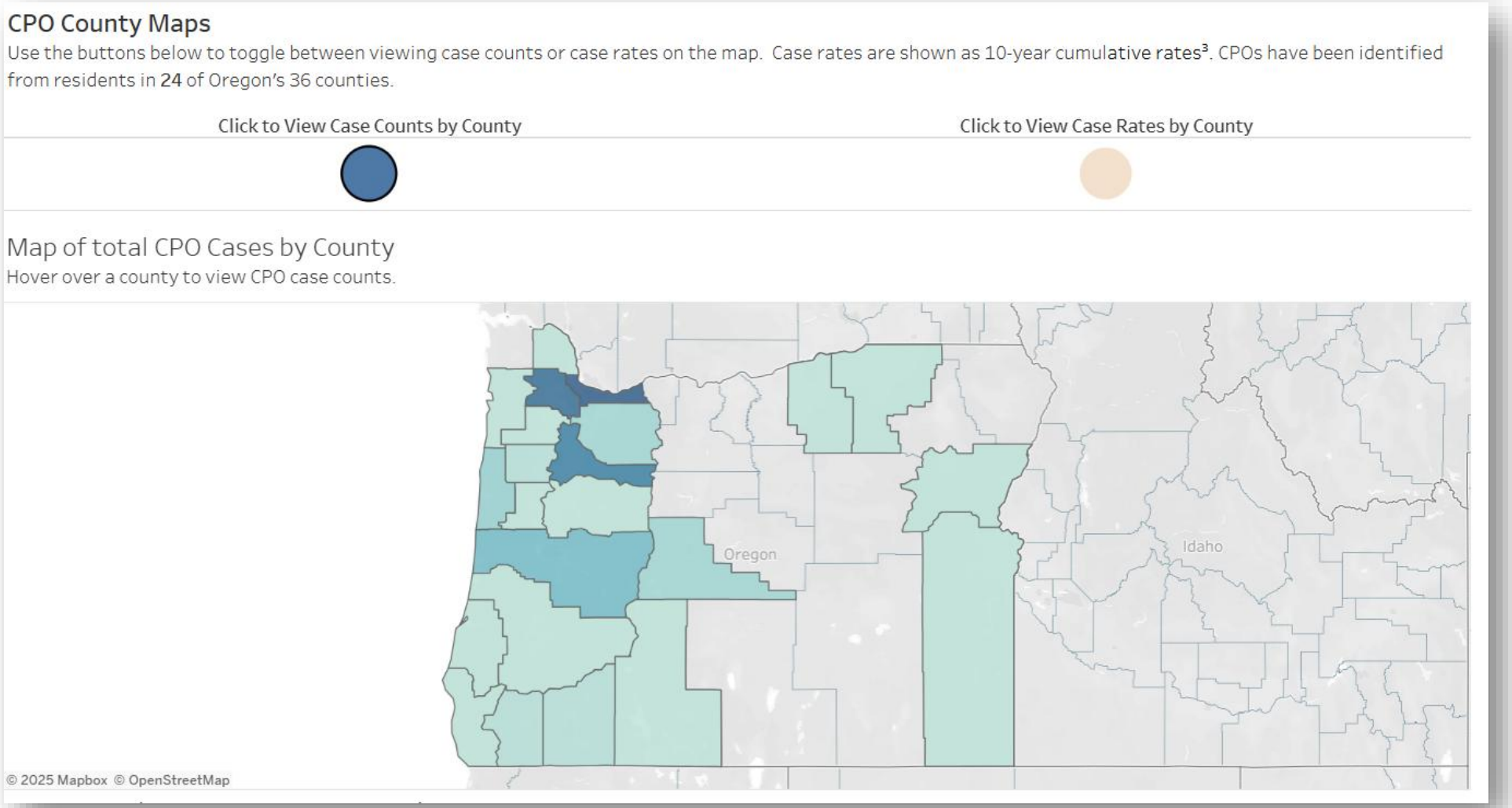
(All)



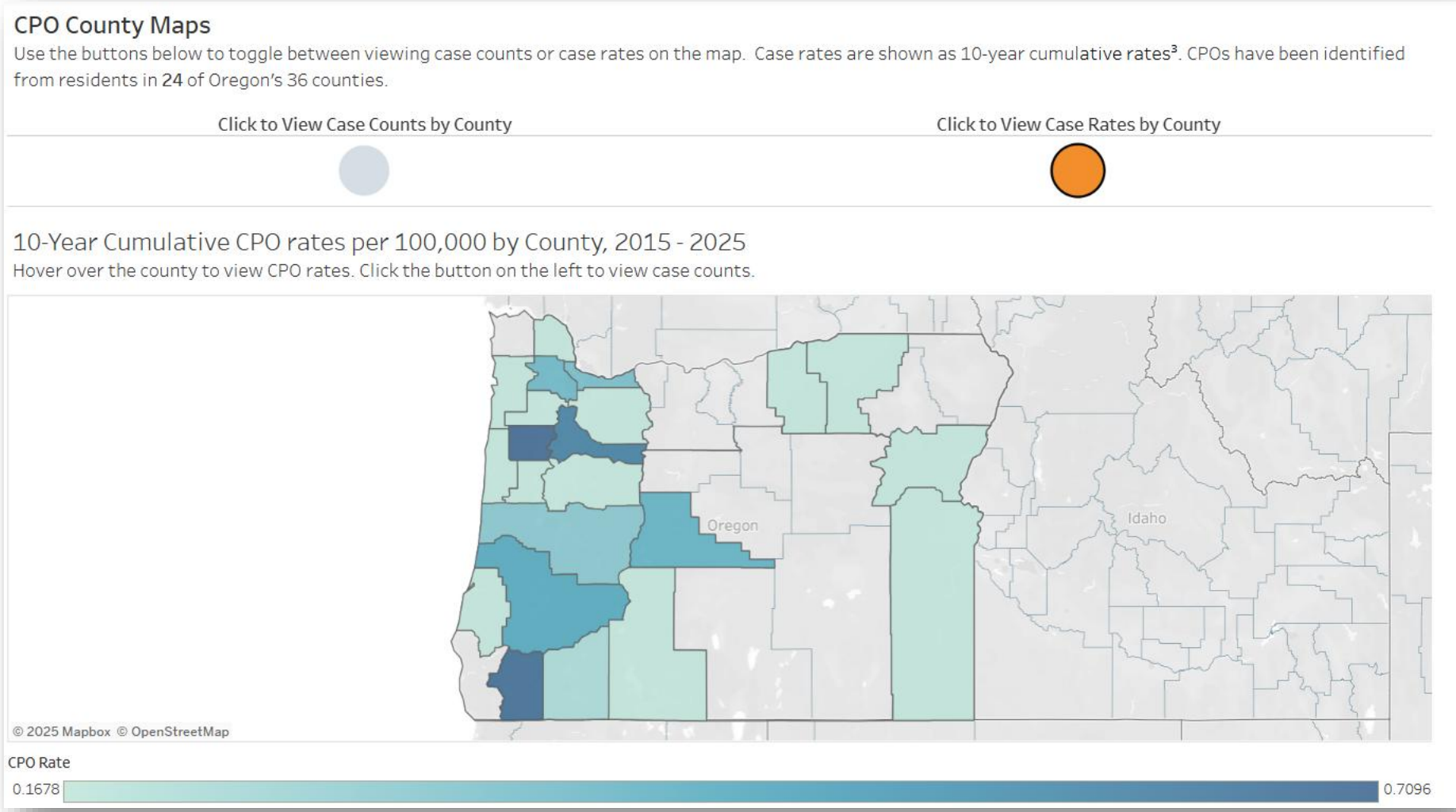
Dashboard: clinical vs screening cases by year



Dashboard: CPO case counts by county



Dashboard: CPO case rates by county



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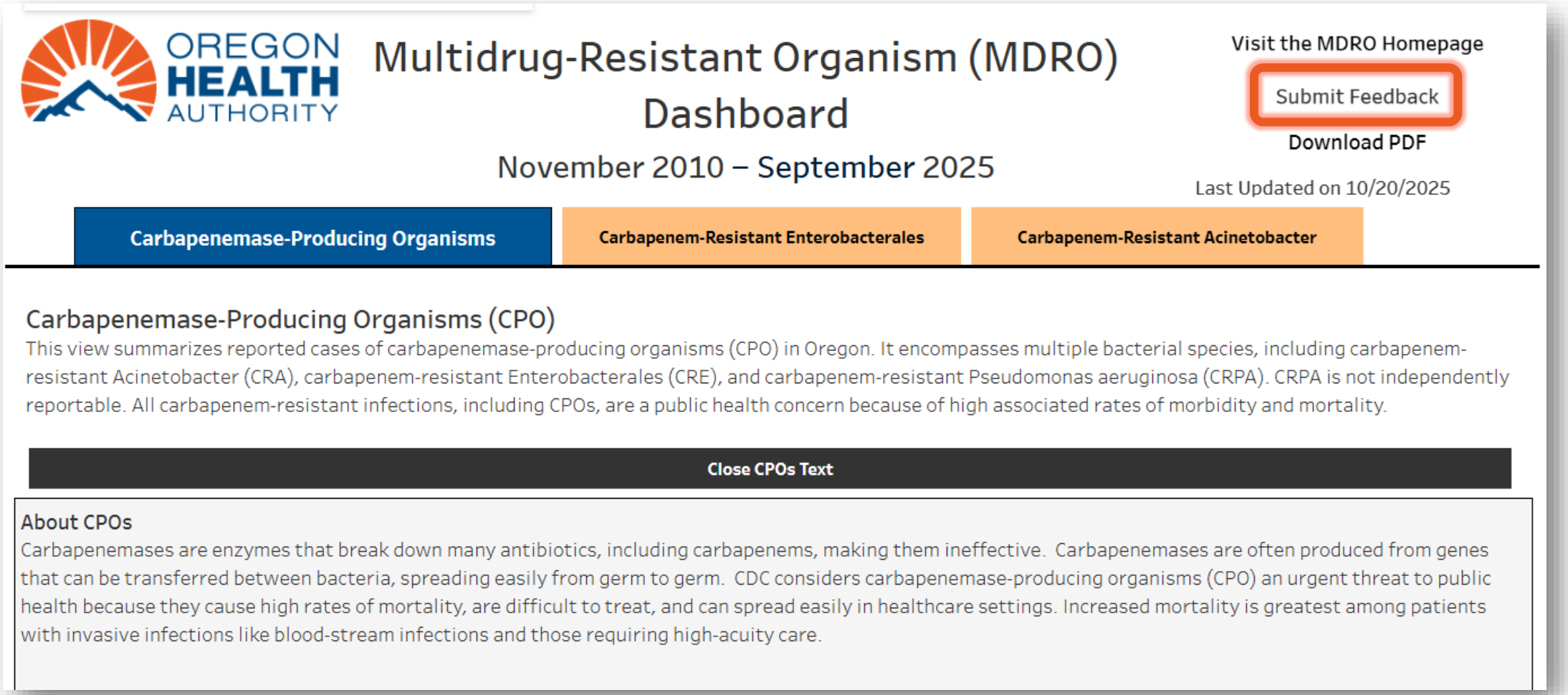

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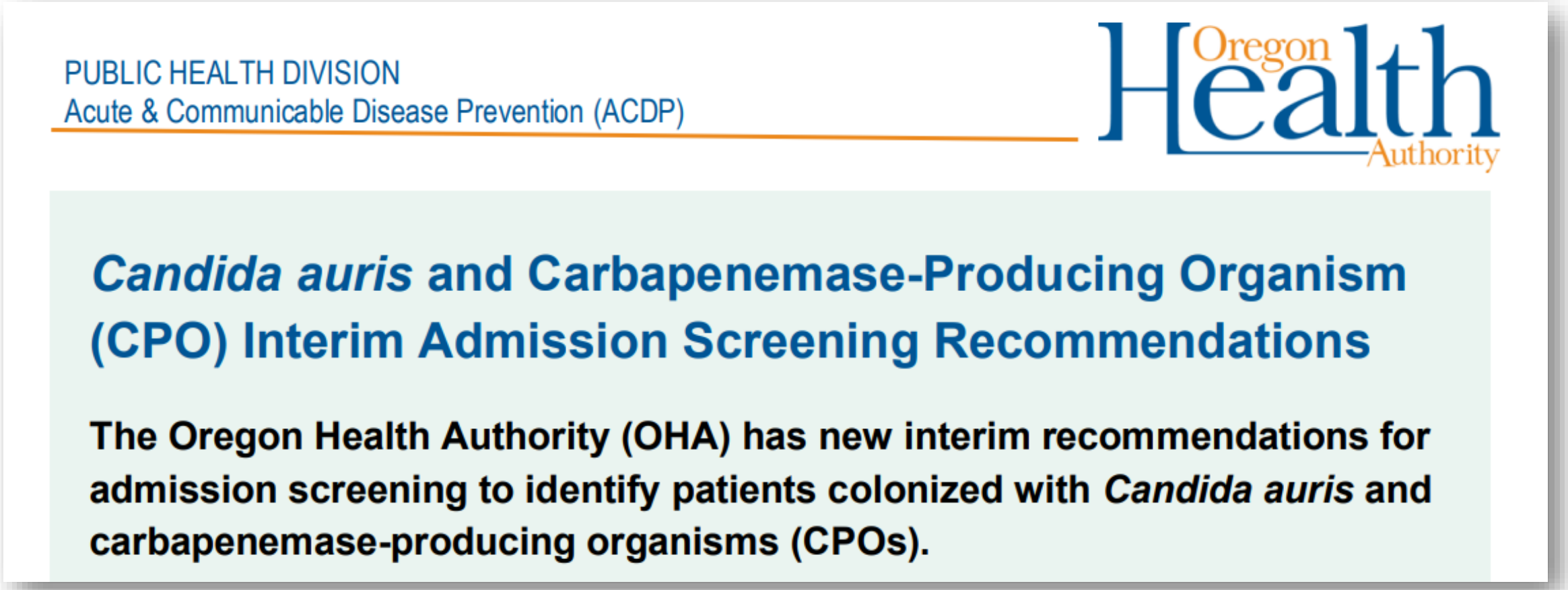
High-priority MDROs
Admission Screening

Oregon has interim admission screening guidance



https://rebrand.ly/AdmissionScreening

Oregon interim admission screening guidance

OHA *C. auris* and CPO Interim Admission Screening Recommendations

OHA recommends that Oregon hospitals, long-term acute care hospitals (LTACHs), and ventilator-capable skilled nursing facilities (vSNFs) test selected patients for *C. auris* and CPO colonization using one of the following strategies.

Strategy #1	Perform colonization testing on patients with the following exposures in the past 12 months: • spent the night in a healthcare facility (hospital or long-term care) **outside Oregon** (including outside the United States), or • outpatient surgery **outside the United States and Canada**, or • hemodialysis **outside the United States and Canada**
Designed to capture the highest number of cases while balancing simplicity and specificity. Ideal when pairing C. auris and CPO admission screening.	

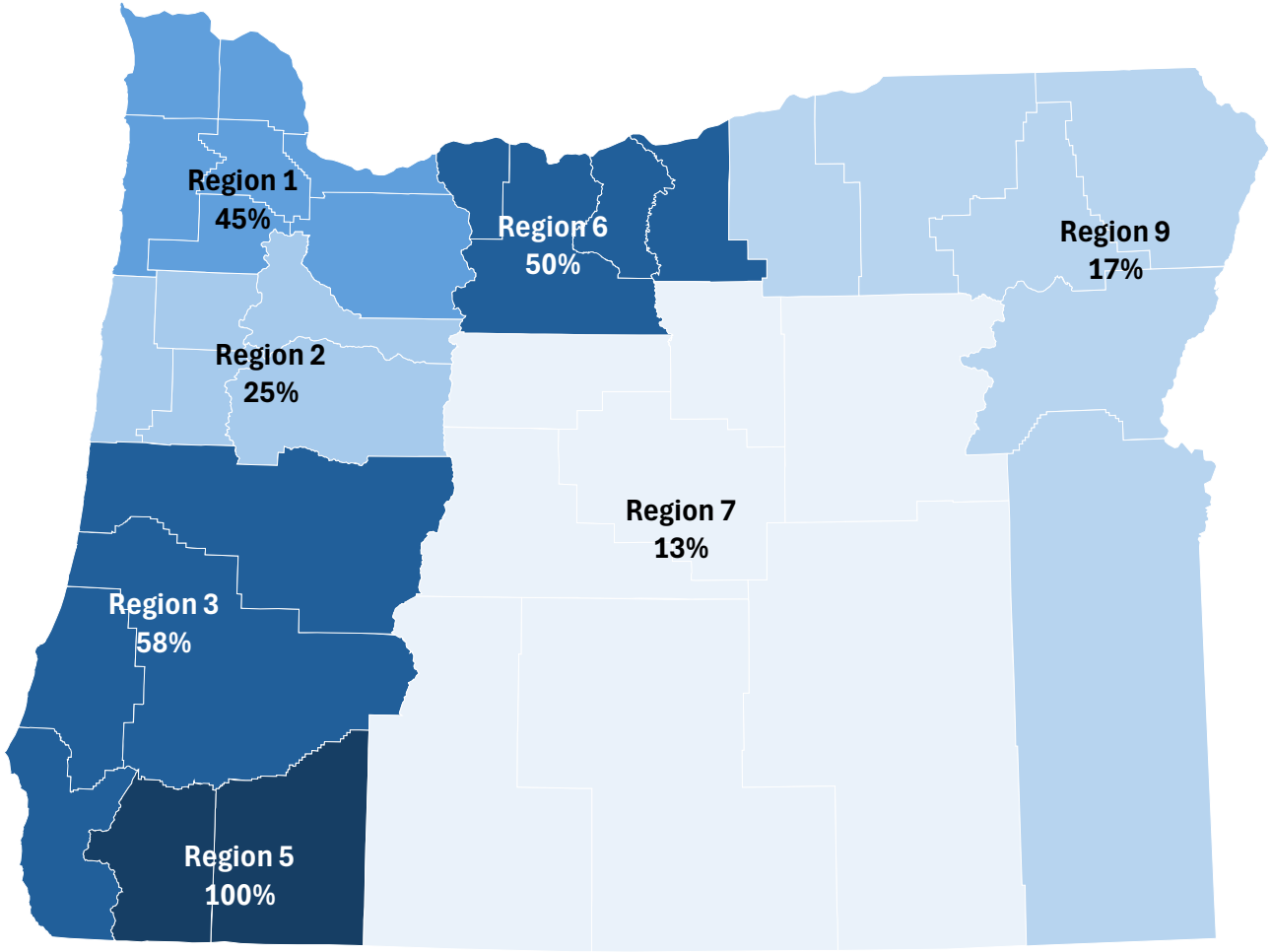
https://rebrand.ly/AdmissionScreening

19 Oregon facilities testing on admission

Facility	Year Started	Organisms Screened
Salem Hospital	2023	C. auris, CPO
Asante Rogue Regional Medical Center	2024	C. auris, CPO
Asante Three Rivers Medical Center	2024	C. auris, CPO
Providence Oregon (8 facilities)	2024	C. auris, CPO
Portland VA Medical Center	2024	C. auris, CPO
PeaceHealth - Cottage Grove	2024	C. auris, CPO
PeaceHealth - Peace Harbor	2024	C. auris, CPO
PeaceHealth - Riverbend	2024	C. auris, CPO
McKenzie-Willamette Medical Center	2025	C. auris, CPO
Vibra Speciality Hospital of Oregon	2025	C. auris, CPO

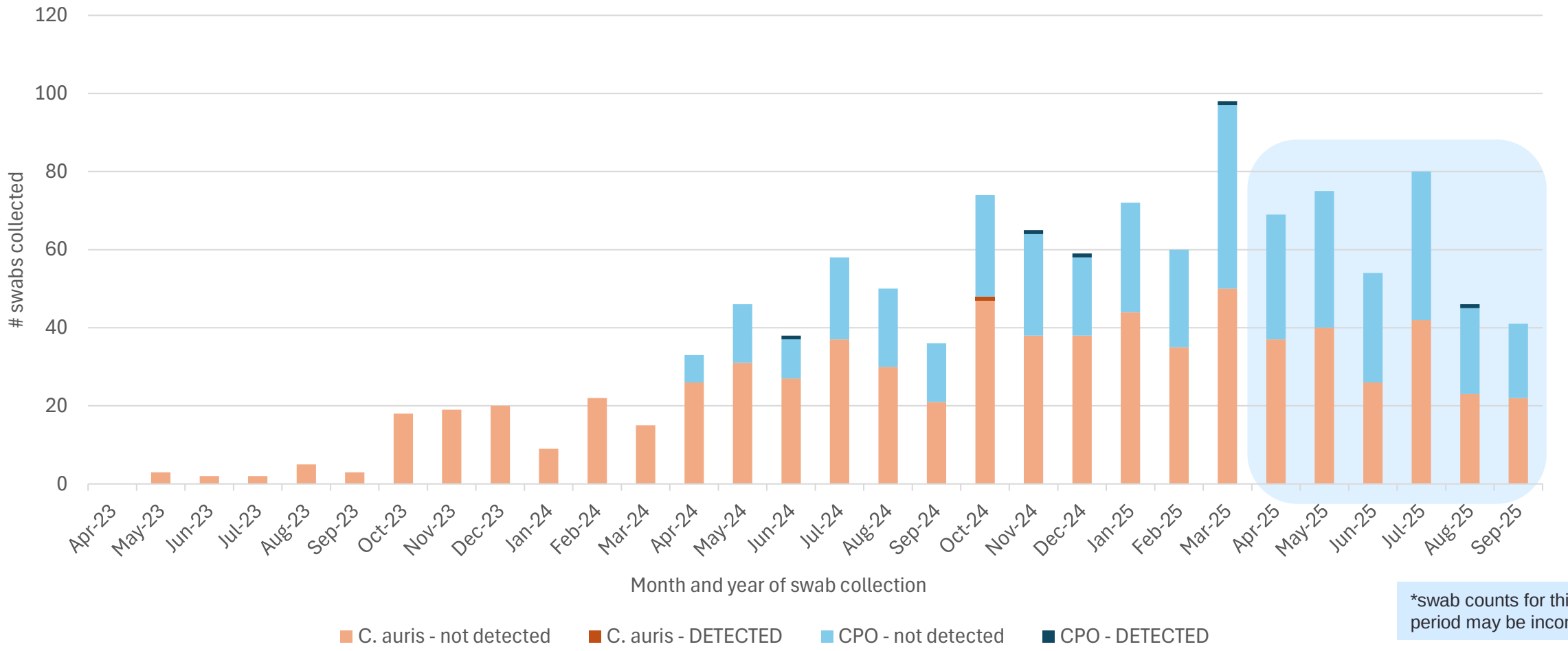
Routine admission screening at 19 of 65 facilities*

Percent of healthcare facilities* with routine admission screening (n=19) or working towards it (n=6)



* Acute care hospitals, longterm acute care hospitals, and ventilator capable skilled nursing facilities

6 cases identified via admission screening

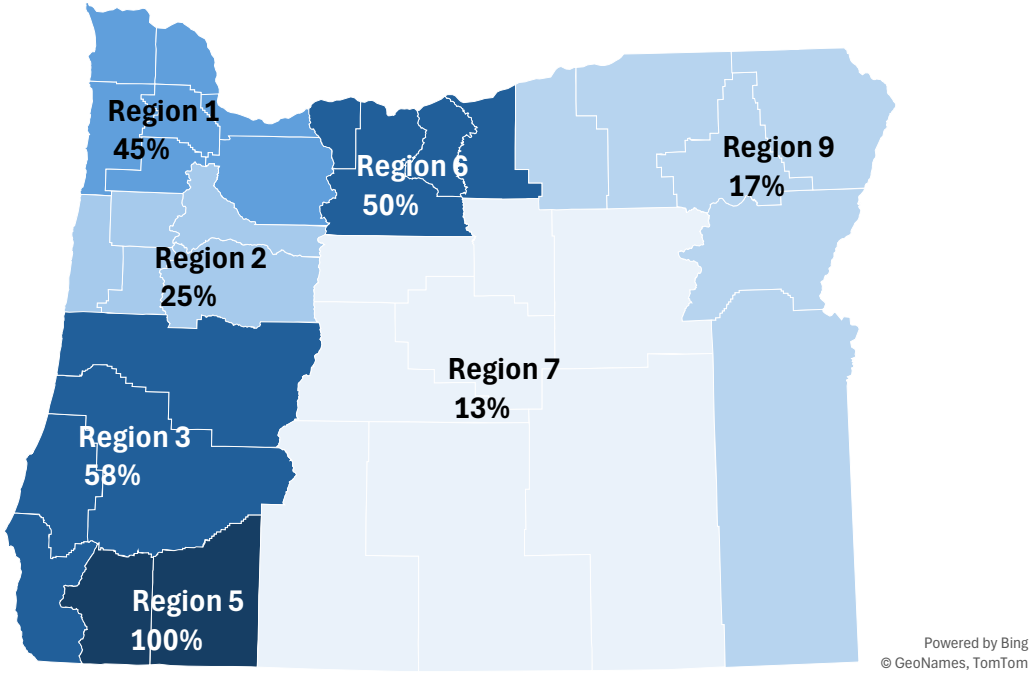


*swab counts for this period may be incomplete

*OHA relies on voluntary swab count reporting for non-public health labs. Swab counts may be approximate. Positive results are reportable.

Discussion

Percent of healthcare facilities* with routine admission screening (n=19) or working towards it (n=6)



For facilities with admission screening, how is it going?

- **Pros and cons**
- **Labs you are using for testing**
- **Changes and adjustments you've made over time**

OREGON HEALTH AUTHORITY

High-priority MDROs
Lab Capacity Update

Update on public health lab capacity

OSPHL new methods, faster results

OSPHL now providing CPO responsive + admission testing

ARLN regional reprioritization of resources, no anticipated impact to OR testing

Multiple methods for carbapenemase identification

Phenotypic
mCIM / eCIM
CarbaNP
CBD Pheonix CPO Detect
Genotypic
Carba-R
CARBA-5
OpGen Acuitas AMR Gene Panel
Biofire BCID2 Panel
Luminex VERIGENE

Example of a CARBA-5 genotypic test

12 clinical labs report carbapenemase testing ability

7 Nucleic Acid Testing (NAT) based detections from blood culture *(e.g., Verigene, Biofire)*

5 Carba-R PCR

3 Other methods *(CARBA-5, mCIM, etc.)*

Discussion

Pros and cons of doing carbapenemase testing at the clinical lab vs public health lab?

OREGON HEALTH AUTHORITY

High-priority MDROs
Funding Update

Discussion

How are federal or state-level changes impacting your work on AMR organisms?

Is there a gap that OHA can fill?

Closing

Is there anything else you would like to see from this taskforce over the next 12 months?

Thank you

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Sandra Hattan at Sandra.j.Hattan@oha.Oregon.gov or 971-673-1222 (voice/text). We accept all relay calls.

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OREGON HEALTH AUTHORITY