

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion**



Healthcare Infection Control Practices Advisory Committee

October 28, 2021

Atlanta, Georgia

Record of the Proceedings

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Attendees

HICPAC Members

Hilary Babcock, MD, MPH, Co-Chair
Lisa Maragakis, MD, MPH, Co-Chair
Deverick Anderson, MD, MPH
Nicholas Daniels, MD, MPH
Elaine Dekker, RN
Mohamad Fakih, MD, MPH
Judith Guzman-Cottrill, DO
Michael Lin, MD, MPH
Michael Anne Preas, RN
JoAnne Reifsnyder, PhD, MBA, MSN
Sharon Wright, MD, MPH

Ex Officio Members

Melissa Miller, MD, BSN, MS, Agency for Healthcare Research and Quality (AHRQ)
LCDR Matthew Ellis, USPHS; MPH, CIC, REHS, Indian Health Service (IHS)
LCDR Scott Steffen, PhD, CQIA, CQI, Food and Drug Administration (FDA)
Judy Trawick, Health Resources and Service Administration (HRSA)

Liaison Representatives

Holly Carpenter, American Nurses Association (ANA)
Paul Conway, American Association of Kidney Patients (AAKP)
Patti Costello MT-CHEST, MT-CSCT, American Hospital Association (AHA)
Eve Cuny, MS, Organization for Safety, Asepsis, and Prevention (OSAP)
Karen DeKay, MSN, RN, CNOR, CIC, Association of periOperative Registered Nurses (AORN)
Ashely Fell, MPH, Council of State and Territorial Epidemiologist (CSTE)
Keith Kaye, MD, MPH, Society for Healthcare Epidemiology of America (SHEA)
Alan Kliger, MD, American Society of Nephrology (ASN)
Chris Lombardozi, America's Essential Hospitals (AEH)
Lisa McGiffert, Patient Safety Action Network (PSAN)
Ronnell Myburgh, RN, MBA, DNV GL
Mark Russi, MD, MPH, American College of Occupational and Environmental Medicine (ACOEM)
Robert Sawyer, MD, Surgical Infection Society (SIS)
Christa Schorr, DNP, MSN, Society for Critical Care Medicine (SCCM)
Benjamin Schwartz, MD, National Association of County and City Health Officials (NACCHO)
Jennifer Selkirk, Public Health Agency of Canada (PHAC)
Andrea Shane, MD, MPH, Pediatric Infectious Disease Society (PIDS)
Sarah Smathers, MPH, CIC, FAPIC, Association of Professionals of Infection Control and Epidemiology (APIC)
Pamela Truscott, MSN, RN, American Health Care Association (AHCA)
Margaret VanAmringe, MHS, The Joint Commission (TJC)
Stephen Weber, MD, ScM, Infectious Disease Society of America (IDSA)

CDC Representatives

Michael Bell, DHQP	David Kuhar, MD, DHQP
Sydnee Byrd, DHQP	Jill Kumasaka, DHQP
Jim Chatfield, DHQP	Preeti Kutty, DHQP
Zeshan Chisty, DHQP	Ruoran Li, DHQP
Koo Chung, DHQP	Stefanie McBride, DHQP
Kendra Cox, DHQP	Hanako Osuka, DHQP
Camden Gowler, DHQP	Melissa Schaefer, DHQP
Rita Helfand, NCEZID	Zachary Smith, DRM
Heather Jones, DHQP	Christine So, DHQP

Erin Stone, DHQP
Ashley Styczynski, DHQP

Marwan Wassef, DHQP
Laura Wells, DHQP

Members of the Public

James Arbogast
Cetera Baker
Jordan Bastian
Emily Bludnicki
Deborah Burdsall
Pam Falk
William Fritsch
Sarah Hatcher
Stephanie Henry, Cambridge Communications &
Training Institute
Jill Jumasaka
Linda Lefrak
Betty McGinty
Silvia Quevedo, Association of Professional of
Infection Control and Epidemiology (APIC)

Ann Marie Pettis
Janet Prust
Gary Roselle, Department of Veterans Affairs
(DVA)
Sarah Rhea
Patrick Ross
Jane Siegel
Keith St. John, Professional Disposables
International
Endah Sulistijo
Lisa Tomlinson, Association for Professionals in
Infection Control and Epidemiology
Erin Winkler

Executive Summary

The United States (US) Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) Division of Healthcare Quality Promotion (DHQP) convened a virtual meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) on October 28, 2021, via Zoom for Government. The meeting was called to order at 12:06 PM Eastern Time (ET). The presence of a quorum of HICPAC voting members and *Ex Officio* members was confirmed, which was maintained throughout the meeting.

Dr. Lisa Maragakis, HICPAC Co-Chair, announced with great sadness that this would be the last meeting for her dear friend, colleague, and HICPAC Co-Chair, Dr. Hilary Babcock. Dr. Michael Bell, HICPAC Designated Federal Officer (DFO) and DHQP Deputy Director, emphasized that not only had Dr. Babcock's time with HICPAC been extremely enjoyable and much appreciated, but also her work has made a notable imprint on the field at large. Dr. Babcock stressed how much she has enjoyed the time that she has spent with HICPAC's current and prior members, as well as all of the CDC support staff who keep this work moving forward, and what an honor and privilege it has been to serve on HICPAC for such a long time.

During this meeting, HICPAC heard an update from their DHQP colleagues Drs. Bell and Srinivasan. Dr. Bell provided a COVID-19 update, reiterated the ways in which the trends for COVID-19 are improving, highlighted healthcare-associated infection (HAI) challenges that remain and those that have emerged during the pandemic, and challenged everyone to learn from and incorporate lessons from the pandemic in order to return to a "new normal" that is even better from an infection prevention standpoint. He also provided an extensive update on the Afghanistan evacuee response and the work that has been underway to control infectious disease transmission in this vulnerable population. This success story has a direct bearing on HICPAC's work with infectious disease and multi-drug resistant organisms (MDROs). In addition, Dr. Bell announced the kick-off of the *Isolation Precautions Guideline* Workgroup (WG) to be chaired by HICPAC members Dr. Sharon Wright and Dr. Michael Lin. Also, as part of the DHQP update, HICPAC heard an update from Dr. Srinivasan about resources that will be made available in the coming months and years to support long-term care facilities (LTCFs) and address some of the many longstanding challenges in that setting, with resources and initiatives to support preparedness, staffing, and infection control infrastructure on the horizon.

HICPAC heard an update from Dr. Babcock on the *Guideline for Infection Control in Healthcare Personnel* (HCP) work and the *Staphylococcus aureus* (*S. aureus*) key questions. HICPAC provided input on the key questions, which will be taken back to the larger Workgroup. HICPAC will be updated during future meetings on the other sections of the guideline as they move into clearance and are posted on the website. HICPAC also heard a brief update from Dr. Guzman-Cottrill who reported on the Central Line-Associated Bloodstream Infection (CLABSI) section of the *Guideline for Infection Prevention in NICU Patients*, which is moving into final CDC clearance, as well as the respiratory illness work that is under review. Federal entity comments were provided by Dr. Gary Roselle from the Department of Veterans Affairs (DVA) with regard to the Methicillin-Resistant *Staphylococcus aureus* (MRSA) section of the HCP guideline. A public comment was provided via email the day before the meeting from Deborah Burdsall proposing a discussion about the modification of transmission-based precautions, especially in long-term care. She also suggested a modification to Appendix A, Table 2 for respiratory infections in congregate care with the current standard of practice for the care of persons suspected or confirmed with COVID-19, to include Contact/Droplet, N95 or higher with eye protection.

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Healthcare Infection Control Practices Advisory Committee (HICPAC)

**October 28, 2021
Atlanta, Georgia**

Minutes of the Meeting

The United States (US) Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) Division of Healthcare Quality Promotion (DHQP) convened a remote meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) on October 28, 2021.

Call to Order / Roll Call

**Sydnee Byrd, MPA, Program Analyst
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention**

Ms. Byrd called to order the October 28, 2021 HICPAC meeting at 12:06 PM Eastern Time (ET), thanked everyone for joining, and reviewed housekeeping items. She then called the roll, establishing that a quorum was present. Quorum was maintained throughout the meeting. HICPAC members disclosed the following conflicts of interest (COIs):

- Dr. Guzman-Cottrill has a consulting contract with the Oregon Health Authority.
- Dr. Michael Lin receives research support in the form of contributed products from OpGen, LLC and Sage Products, which is now a part of Stryker Corporation. He previously received an investigator-initiated grant from CareFusion Foundation, which is now part of BD.
- Dr. Lisa Maragakis has received research funding from the Clorox Company.

Ms. Byrd indicated that public comment was scheduled following the presentations. She explained that when the comment period opened, the Coordinator would provide instructions for how members of the public may provide comments, that public comments would be limited to 3 minutes each, and that commenters should state their names and organization for the record before providing their comments. She noted that the public comment period is not a question-and-answer session.

Welcome / Member Announcements

Lisa Maragakis, MD, MPH

HICPAC Co-Chair

Senior Director, Healthcare Epidemiology and Infection Control, The Johns Hopkins Hospital and Health System

Associate Professor of Medicine and Epidemiology, Division of Infectious Diseases, The Johns Hopkins University School of Medicine

Dr. Maragakis welcomed everyone to the HICPAC meeting and thanked them for their patience in using the Zoom platform, emphasizing that it was a hopeful and optimistic time in that there were beginning to be improvements in the pandemic. After reviewing the agenda, she made the following announcements pertaining to HICPAC Members, *Ex Officio* Members, and Liaison Representatives:

HICPAC Members

- Dr. Maragakis lamented that it was a sad day because this would be the last meeting for her dear friend and colleague, Dr. Hilary Babcock, as HICPAC Co-Chair. She emphasized that she could not imagine serving on this committee without Dr. Babcock, and that everyone would miss her tremendously and hoped that she would stay connected and help HICPAC with its work moving forward:
 - Dr. Bell said that he could not emphasize enough how much Dr. Babcock's efforts have been appreciated. She joined HICPAC in December 2013. In the early days, she helped characterize the process for developing recommendations. HICPAC's early "Products and Practices" approach is largely attributed to Dr. Babcock. She has been a very vocal member of the National Healthcare Safety Network (NHSN) Working Group, which hopefully she will continue. Most notable has been her work on the healthcare personnel (HCP) document, which has been a very large undertaking for which steady progress has been made that will be a valuable effort. All of that to say that Dr. Babcock's time with HICPAC has been not only extremely enjoyable and much appreciated, but also has made a notable imprint on the field at large. The universal "we" is very thankful to her for that. It is hard to overstate how much Dr. Babcock is appreciated.
 - Dr. Babcock thanked Drs. Maragakis and Bell for the nice comments, and said that she was sad to have this be her last HICPAC meeting. She stressed that she has enjoyed the time that she has spent with HICPAC's current and prior members and all of the CDC support staff who keep this work moving forward, and that it has been truly an honor and privilege to work on HICPAC for such a long time. She assured everyone that she was leaving them in amazing hands with Dr. Maragakis as Chair and was excited to see where HICPAC would go in the future. She reminded everyone that she has been involved with the HCP guideline for about 10 years and definitely would see that through to the end, and expressed her hope to be engaged in other workgroups as well.

Ex Officio Members

- Tara N. Palmore, MD no longer will serve as the *Ex Officio* for the National Institutes of Health (NIH). Her replacement is pending.
- Megan Hayden, RN, MS, CNS, CIC, CPH no longer will serve as the *Ex Officio* for Centers for Medicare and Medicaid Services (CMS). Her replacement is pending.

Liaison Representative

- Patti Costello, MT-CHEST, MT-CSCT is representing the American Hospital Association (AHA). Ms. Costello is the Executive Director of the Association for the Health Care Environment (AHE), which is a professional membership group of the AHA. She has been with the AHA for 27 years as the Director of Education at the American Society for Health Care Engineering (ASHE) and Director of Meetings and Program Development for the American Society for Healthcare Central Service Professionals (ASHCSP) before advancing to Executive Director of the AHE in 2001. She has published works in healthcare, hospitality, and commercial food service safety and also has served as a contributing author and subject matter expert (SME) for environmental hygiene, food service, and sterile processing training manuals, with an emphasis on taking the science to the appropriate setting and defining the “why” behind the work. She has facilitated over 400 hands-on workshops and seminars at the national level for member organization chapters covering topics such as employee engagement and retention, food service sanitation, safe alcohol service, healthcare environmental services, infection prevention, and staffing.

Division of Healthcare Quality Promotion (DHQP) Update

Michael Bell, MD

HICPAC Designated Federal Officer

Deputy Director, Division of Healthcare Quality Promotion

National Center for Emerging and Zoonotic Infectious Diseases

Centers for Disease Control and Prevention

Dr. Bell said that while Dr. Cardo was unable to join the meeting, she wished everyone well. She and Dr. Bell both continue to be very grateful for the time everyone invests in joining these meetings. It is a very challenging time and they understand everyone is making a special effort to step away from busy practices and busy healthcare facilities to join the HICPAC meetings. Dr. Bell stressed it is important now more than ever to maintain these efforts for a number of reasons. The COVID-19 pandemic certainly underscores the importance of everything they do for healthcare safety for patients and HCP, as well as the backsliding that has occurred in some traditional metrics as a nation. This illustrates how much health systems rely on infection control and prevention and the efforts that everyone applies day in and day out. Working together to continue to press forward is the only option to do what is necessary to protect patients and make sure health systems are as reliably safe as they possibly can be.

To provide a quick update on COVID-19, everyone is painfully aware that this pandemic response is approaching two years. There is some good news. Vaccine availability is better than it has ever been. The widening approval for utilization is also very helpful, and there have been very reassuring trends in terms of safety profiles. The overall national trends in incidence, number of hospitalizations, and nursing home impact have all been moving in the right direction. However, this is not a uniform pandemic. There are still areas across the country that are experiencing high rates, some facilities have been extremely stressed, and HCP across the board are worn out. That is a challenging reality without an easy solution, but everyone is

working very hard to support the response effort. CDC continues to track trends in terms of hospitalizations, vaccine effectiveness (VE), and data related to pediatric vaccination as that becomes increasingly taken up. Monitoring also is underway on the impact of the cold and influenza season and of the winter season in general, during which events, activities, travel, and holidays can all increase the opportunities for transmission within groups. Even though CDC is frequently asked when they plan to send up the “all clear” signal and let everyone go back to “normal,” that is unlikely to happen as an on and off switch type event, especially for healthcare in terms of source control; there might also be a lower threshold for staff to stay home when ill. The countermeasures in place are good and probably will not cease. How they are implemented and adjusted from month-to-month, season-to-season, and event-to-event is likely to be locally determined. There is a dotted line to all of this to elements such as staffing pipelines, supply chains, and training support where there is a notable brittleness in healthcare systems that have been enduring the pandemic. This is an area that is likely to be a focus for the coming several years in terms of thinking about how to make health systems more resilient. The bottom line is that it would be wrong to go back to 2018 “normal” and there will likely be a “new normal” instead. Dr. Bell emphasized how excited he was to have the support of HICPAC as CDC thinks about what that should and can look like.

In terms of the Afghanistan evacuation situation, over 60,000 individuals were evacuated abruptly from Afghanistan. The situation there was extremely dire, and people were given minutes to decide whether to leave, which means many people ended up in temporary shelter situations in Europe and the Middle East for months with only what they happened to have with them at the moment. Those people have been moved systematically to “safe havens” at 8 military bases in the US. These facilities were stood up very quickly to harbor individuals and provide a base for establishing identity, health needs, et cetera. That processing has been extremely systematic and robust, but this is happening in a background of very low vaccination rates. Afghanistan still has endemic polio, with wild-type and vaccine strains. There is an active measles outbreak that has been ongoing in Kabul for a number of months. That, combined with very austere conditions and a great deal of crowding, has led to significant concerns for infectious disease transmission within and across these groups.

The good news is that thanks to Department of Defense (DoD) colleagues, over 90% of those 60,000 people have been successfully vaccinated. Measles, mumps, & rubella (MMR), inactivated polio, and COVID-19 are among the vaccines that have been delivered. This is all occurring as a preamble to relocation to final residences, which the Department of State continues to work on actively. The other standard immigration health community catch-up is also being done. This includes screening for tuberculosis (TB), et cetera. Approximately 50 cases of measles have been identified in the 60,000-person population from Afghanistan since transport. That is a strikingly low number and a very impressive testament to the effectiveness of the MMR vaccine. The estimated number of measles infections was anticipated to be about 5000, given the density of the population and the duration of time they have spent together. That 5000 would have meant about 500 hospitalizations and 10 or more deaths. Some mumps, COVID-19, and influenza cases have been identified within the expected range. Hepatitis A, Hepatitis B, enteric diseases, leishmania, malaria, TB, and syphilis also have been identified within these groups. This also is a testimony to the importance of the immigration public health screenings and effective medical processes that are being implemented in the US. TB, syphilis, and Hepatitis B are sleeper diseases that, if not identified intentionally, may not show themselves like an outbreak of measles with any promptness, but can spread within communities and create a persistent burden on local jurisdictions.

DoD colleagues have documented the prevalence of multi-drug resistant organisms (MDROs) in the immigrant population over the course of many years. The Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA) have both helped CDC with outreach to clinicians to remind practitioners of the importance of obtaining appropriate culture susceptibility testing, especially among people who have arrived from elsewhere. There is an existing recommendation for people who have accessed healthcare internationally in the previous month, that careful consideration be given to susceptibility testing where appropriate. There are similar outreach activities in local jurisdictions in public health departments as part of resettlement activities. This is occurring through CDC's Global Migration and Quarantine (DGMQ) whose job this is on a daily basis. They have close relations with the Department of State and the Office of Refugee Resettlement (ORR). The ORR has ongoing relationships with multiple regional and local resettlement organizations that overlap in terms of jurisdictions. There is a steady process of describing what the needs are for a certain population or individuals. Many are medically fragile, so identifying appropriate places for placement is done in concert with local resettlement organizations, which take turns accepting people and distributing them to appropriate locations.

In terms of medical fragility, many within immigrant populations have a number of chronic medical conditions (e.g., diabetes, hypertension, et cetera). A large proportion of individuals are pregnant, some of whom are in various extremes of third trimester pregnancy. All of these issues have added to the complexity of the process. It is anticipated that the safe haven sites will be vacated within a few months. That said, thousands of additional individuals are negotiating with the Department of State to find their way to the US. That process is being managed in parallel to ensure that all health screenings and appropriate vaccinations are completed.

Another very exciting effort is the kick-off of the *Isolation Precautions Guideline* process. Dr. Bell clarified this is not a new edition of the 2007 document. DHQP/HICPAC are no longer producing textbook-type guidelines. The efficiency of that type of guideline production is not adequate to keep pace with the movement of evidence. By the time a 6-year text-writing process is completed, it is essentially time to start over. This will be a very directed update. Most importantly, it will be an update that reframes much of what has traditionally been used as the framing for how infections are transmitted. This has been needed for a number of years. One of the "silver linings" of the COVID-19 pandemic is the considerable amount of information that has been generated to allow systematic evidence analysis to support updated framing. Over the past 12 to 15 years, for each emerging respiratory infection, we have made interim recommendations, e.g., for Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS)-1, and pandemic influenza. That has been done on an ad hoc basis based on professional judgment. At this point, the more robust evidence base can be used to systematize this into something more longstanding. Dr. Bell expressed his gratitude to Dr. Sharon Wright for agreeing to Chair this effort.

Arjun Srinivasan, MD (CAPT, USPHS)
Associate Director, Healthcare-Associated Infection Prevention Programs
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

Dr. Srinivasan reported on some of the work underway in the long-term care sector. As everyone knows, long-term care facilities (LTCF) have been hugely impacted by COVID-19. COVID-19 remains a continuous challenge for them. The COVID-19 pandemic has brought forward a host of issues, problems, and challenges. Everyone who knows anything about long-term care, already knew some of these longstanding issues in nursing homes, assisted living facilities, and other types of LTCFs. As part of the American Rescue Plan Act (ARPA), Congress authorized \$500 million for what they termed nursing home “Strike Teams”. ARPA was broadly written as an effort to help nursing homes and nursing facilities prepare for, and respond to, COVID outbreaks. CDC is distributing the \$500 million to state health departments through CDC’s Epidemiology and Laboratory Capacity (ELC) funding mechanism. Given the way these funding mechanisms work for the pandemic, the states have received those funds and are now in the process of working on their plans to spend those funds.

CDC has developed broad guidance¹ on how these funds should be spent. The guidance provides as much flexibility as possible for CDC’s state partners to work across multiple domains of partnerships. CDC recognizes that this is not something that resides just within the healthcare-associated infections (HAIs) and antibody-resistance part of the state health department. There is a need for states to think much more expansively within their state, in terms of who needs to be involved (e.g., state immunization programs, state Medicaid programs, state survey agencies, state preparedness programs, et cetera). In addition to several different partners in the LTCF, there are many partner organizations that are very active in this space. CDC thinks these partners will be critical in terms of helping spend these funds in ways that are most needed at the state level. The CDC guidance is flexible enough to allow states to support individual homes that have specific needs (e.g., staffing, testing, vaccinations, supplies, Personal Protective Equipment (PPE), et cetera), but also, it is intended to allow the nursing home communities in states to better prepare and bolster their infection control infrastructures and staffing infrastructure plans.

CDC recognizes there are huge and longstanding issues that need to be addressed, and it has assembled a broad coalition of partners. Dr. Srinivasan extended sincere gratitude to the John A. Hartford Foundation, which has stepped forward to convene a broad spectrum of public health and nursing home partners. An initial webinar was scheduled to be convened the week following this HICPAC meeting. It will include all of these partners and the states, and it will provide an opportunity for individuals to talk about their visions for how these funds can be used to best support the nursing home community. Dr. Srinivasan emphasized there would be a lot more to come on this, and he would be happy to present again as the state plans begin to take shape

Discussion Points

HICPAC pointed out there is a lot of variability in state health department infrastructure and inquired as to what the support mechanisms are for states that do not have as much

¹ <https://www.cdc.gov/nceizid/dpei/pdf/guidance-nursing-home-ltc-facility-strike-team-and-infastructure-508.pdf>

infrastructure and capacity, as well as what metrics, milestones, and expectations are in place that states must achieve.

Dr. Srinivasan responded that CDC has tried to bring many partners together to help states connect with local groups like some of the nursing home organizations. They recognize that some states may not have the bandwidth, likely do not have all of the expertise that is necessary, and those states will need to partner with these organizations to fill these gaps. The agency is working on guidance to help define who the partners are in a state, inside and outside of the health department itself, that could be helpful. Given the speed with which this has to be done, it is not realistic to think that someone can be hired to do this. While some people may be hired, CDC believes that working on and leveraging partnerships will be an expeditious way to get this work underway. In terms of milestones and metrics, there are numerous domains states can use for this funding. Some of the milestones and metrics will depend upon what the states are choosing to do. A major early milestone is going to be getting, allocating, and tracking the funding so that the states are able to spend it. CDC also will work to understand the priorities in each state. For instance, if staffing is a priority and activity, the agency will want to know what is being done and what needs to be monitored to make sure that progress is being made.

Isolation Precautions Guideline Workgroup Update

Sharon Wright, MD, MPH
Isolation Guideline WG Chair
Chief Infection Prevention Officer
Beth Israel Lahey Health

Dr. Wright emphasized that the *Isolation Precautions Guideline* is important and impactful work on which she is excited to get started, and that it is a privilege to co-lead this work with Dr. Michael Lin. They will be working to form the membership of this group over the coming months so that they can get started.

Healthcare Personnel (HCP) Guideline Workgroup Update

Hilary M. Babcock, MD MPH
Chair, HCP Guideline Workgroup
Medical Director, BJC Infection Prevention and Epidemiology Consortium
Medical Director of Occupational Health (Infectious Diseases)
Barnes-Jewish and St. Louis Children's Hospitals
Associate Professor of Medicine, Infectious Disease Division
Washington University School of Medicine

Dr. Babcock provided an update on the *Infection Control in Healthcare Personnel (HCP)* guideline. As a reminder, the original guideline was published in 1998 and has been under revision for about a decade. The HCP Workgroup's charge is to focus on pathogen-specific issues for Infection Control in Healthcare Personnel. Where information is out of date, the Workgroup has been making updates using evidence-based methods when evidence has been available. In terms of the status report, **Section 1: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services** was published in October 2019.² **Section 2: Epidemiology and Control of Selected Infections Transmitted Among HCP and Patients** is in progress. Content is with the web team, who is getting it ready to be posted. This

² <https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html>

includes the Diphtheria, Group A *Streptococcus*, Meningococcal Disease, and Pertussis sections. HICPAC has approved Measles (August 18); Mumps, Rubella (May 18); Varicella (August 19); Parvo, Cytomegalovirus (November 19); and Rabies (August 21). These are in the process of being updated and moving through clearance, and they will eventually be posted. The *S. aureus* key questions will be discussed during this session. The areas the Workgroup hopes to get started on next include Respiratory Viral Pathogens, Conjunctivitis/ Adenovirus, Scabies, and Pediculosis. “On Deck” are Hepatitis A, Hepatitis B, Hepatitis C, Herpes, Human Immunodeficiency Virus (HIV), and Tuberculosis. Dr. Babcock reviewed the prior *S. aureus* recommendations from the 1998 version, followed by the new draft updated recommendations.

1998 *S. aureus* Recommendations

17. Staphylococcal infection or carriage

- a. Obtain appropriate cultures and exclude personnel from patient care or food handling if they have a draining lesion suspected to be caused by *S. aureus*, until the infections have been ruled out or personnel have received adequate therapy and their infections have resolved (Table 3). **Category IB**
- b. Do not routinely exclude personnel with suspected or confirmed carriage of *S. aureus* (on nose, hand, or other body site) from patient care or food handling unless it is shown epidemiologically that they are responsible for disseminating the organism in the health care setting (Table 3). **Category IB**

The Workgroup spent a fair amount of time structuring key questions to try to update this guidance in a way that is relevant for health programs and patient protection. This is probably close, and the Workgroup is happy to take additional input.

Draft Updated Recommendations

Section 2: Updated Draft Proposed *S. aureus* key questions

1. For asymptomatic healthcare personnel, does routine (non-outbreak) screening for methicillin-resistant *Staphylococcus aureus* (MRSA) followed by decolonization, or decolonization alone prevent colonization or infections in patients?
2. For asymptomatic healthcare personnel, does screening for *S. aureus* in an outbreak followed by decolonization, or decolonization alone prevent colonization or infections in patients?

The plan is to capture data from identified articles to try to address potential sub-analyses, such as the need for non-outbreak screening in higher risk settings. Also, if HCP are decolonized, how long should they be restricted from work while being decolonized, should HCP be screened for clearance of colonization, and is there anything that can be gleaned from the identification of characteristics or activities that are associated with transmission from HCP to patients. The Workgroup is hopeful these questions will lend themselves to recommendations that will be helpful, practical, and useful. This document is structured around specific identified and diagnosed infections, but often, someone presents with a rash, wound, lesion, respiratory illness, gastrointestinal (GI) illness, or something else that is unknown. Therefore, the Workgroup has been discussing the potential for including syndromic guidance before the actual diagnosis is known. That is separate from the proposed draft questions.

In terms of next steps, the Pertussis, Meningococcal Disease, Diphtheria, and Group A *Streptococcus* sections will be posted soon to the CDC Infection Control Guideline Website, and

the Rabies section will be submitted to CDC clearance. For *S. aureus*, the Workgroup is reviewing the framing of key questions, updating the literature search as needed, and beginning to write the narrative. The Workgroup has engaged in discussion with *S. aureus* SMEs within CDC to get their input. They have reviewed the draft questions and provided input about the potential sub-analyses that the Workgroup might be able to look into while collecting data. They are beginning to write some of the background and narrative for this. SMEs are being identified for the respiratory viral pathogens.

Dr. Babcock indicated that since she will be rotating off of the general HICPAC committee, she can no longer chair the Workgroup. Therefore, Dr. Colleen Kraft will take over as chair of this Workgroup. Dr. Kraft's willingness to serve in that role and her leadership are greatly appreciated.

Discussion Points

HICPAC generally thought that Questions 1 and 2 could be extremely useful for everyone involved in infection prevention in the acute care setting.

HICPAC requested that Dr. Babcock comment on some of the differences between Question 1 and 2, particularly with regard to the idea that Question 1 focuses on MRSA and Question 2 in a different setting focuses on methicillin-susceptible *Staphylococcus aureus* (MSSA) and MRSA:

- In terms of prioritization and infection control, it is not clear whether the focus should be on antibiotic-resistant organisms or look more broadly at antibiotic-resistant organisms and some of the common infections caused by non-antibiotic-resistant organisms such as MSSAs.
- It was suggested that perhaps MRSA and MSSA could be included in both Questions 1 and 2 and the gaps in the literature/science could be shared.
- It was noted that of invasive disease with *S. aureus* in some hospital systems, 60% to 70% are now MSSA. The impact of MSSA is not negligible and it is well worth it for whomever is going to conduct research on this to start thinking about it.

Dr. Babcock indicated that the Workgroup did an environmental scan around these questions. There is some interest in universal screening for MRSA of HCP, which has been done or considered as a potential intervention in specific settings. There has not been universal screening for MSSA in the absence of an outbreak among HCP. It is known that a good swath of the population is colonized with MSSA at any given time. The Workgroup did not feel that looking for/trying to decolonize for that in the absence of an outbreak would be an area for which much literature could be found. In addition, they did not feel that this would be a very practical or value-added solution. MSSA is included in the outbreak setting because it is known that as part of an actual outbreak evaluation, this may provide value as there are reports about that. In no way is the Workgroup trying to imply that MSSA is not important. There is value in calling out gaps in the research.

HICPAC asked whether there is any value in assessing whether there is risk to patients from MRSA colonized but asymptomatic HCP. Question 1 seems to jump right to the idea that the answer is "yes" and the focus seems to be what to do about it.

Dr. Babcock clarified that the goal of Question 1 is to assess the broader question of whether there is a role for this type of screening and if it would interrupt anything. It does incorporate the question of whether there is something to interrupt. The Workgroup is cognizant of the question regarding whether there is a risk to address. They recognize that most of the literature around

this is largely outbreak-centric. In general, potential transmissions have been identified in outbreak settings. Given that multiple strategies have been used in many of these outbreaks to try to interrupt the outbreak, the role of any one of them is difficult to figure out. The Workgroup is going to try to look broadly to ascertain the impact of decolonization or screening and decolonization as part of that bundle, versus interruption without using that technique as part of the bundle to determine the main driver.

HICPAC noted that both questions focus very much on the outcomes of colonization and infections and wondered whether the Workgroup also would be assessing the potential unintended consequences of decolonization in terms of resistance for some of the products used for decolonization. In addition, perhaps the “non-outbreak” setting needs to be broadened to include sensitive *S. aureus*. Especially with the staffing issues occurring in the healthcare setting now, when widespread screening is done without necessarily having an epidemiologic link, there is a potential for staffing to be worse.

Dr. Babcock responded that the Workgroup did not include that as an outcome of interest for this particular recommendation. Most of these are fairly focused recommendations rather than being for the whole population, although Question 1 could end up being a more whole population-focused question if benefit is found. The Workgroup can think further about this question in terms of whether data are available. Based on the data available, perhaps this could be addressed in the narrative as considerations for usage recommendations around a potential risk for resistance if using mupirocin, for example, for decolonization.

Neonatal Intensive Care Unit (NICU) Guideline Workgroup Update

Judith Guzman-Cottrill, DO
NICU Workgroup Chair
Professor of Pediatrics
Division of Infectious Diseases
Oregon Health & Science University

Dr. Guzman-Cottrill reported that the *Guideline for Infection Prevention in NICU Patients* for CLABSI in NICU patients is in final clearance and is expected to be posted on the website in early 2022. The second update is for the NICU Respiratory Illness Guideline. The NICU Workgroup is conducting one final review of all the studies retrieved in the updated, recent literature search. The goal of that update is to ensure consistent inclusion and exclusion of all the studies that were included for respiratory illnesses in the NICU setting. Once that is complete, the Workgroup will update the narrative summary with the conclusions of the draft document. The revised version will then be sent to the full Workgroup for final review.

Federal Entity Comment

Gary A. Roselle, MD
National Director
Infectious Diseases Service
Veterans Health Administration
Department of Veterans Affairs

I was glad to hear in the MRSA section that looking at screening employees is really important because anything you do with employees is very tricky. It's even harder than with patients, so a real recommendation based on real data would certainly make it easier to make something happen if it needs to. It's not a small thing. Now I'm assuming you're only talking about nasal swabs, because it gets even trickier if you're talking about swabbing other places, like for carbapenem-resistant Enterobacteriaceae (CRE)—it can be a big deal. You have to call an ethicist in order to start thinking about that. This is a good thing and I will eagerly await the results because it's important and having real guidance will make things much more effective.

Public Comment

No public comments were provided in-person during this meeting. However, the following comment was submitted in writing the day before the meeting from **Deborah Burdsall**:

I would be interested in discussion about modification of transmission-based precautions, especially in long term care. My suggestion is to modify Appendix A, Table 2 for respiratory infections in congregate care with the current standard of practice for care of persons suspected or confirmed with COVID-19, to include Contact/Droplet, N95 or higher with eye protection for the following reasons:

- Unknown airborne/microdroplet transmission of multiple respiratory viruses including influenza
- Easiest to operationalize and monitor
- Staff familiarity
- Viral tests are neither 100% sensitive nor specific
- Standard Precautions are interpreted by LTCF HCP as “the person is not on isolation,” rather than use gowns/gloves/eye protection as needed
- There is also a concern with multiple transmission routes of transmission.

The emphasis is on children requiring a higher level of transmission-based precautions, but as we have learned with COVID-19, adults probably spread more effectively, and it seems the rationale was that children cannot control secretions. Persons with dementia have a difficult time with that as well.

Table 2 of the HICPAC guidance has this syndromic guidance that seems relevant to congregate care even if they do emphasize children.

<https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf>

With multiple viruses circulating, each with slightly different guidance for transmission-based precautions, the Table II Appendix A guidance seems most pragmatic combined with respirators.

THANK YOU!!!!

Summary and Work Plan

Dr. Maragakis thanked everyone for taking time out of their busy schedules. She summarized that during this meeting, no votes were taken. HICPAC heard a wonderful update from their DHQP colleagues. Dr. Bell provided a COVID-19 update, reiterated the way in which COVID-19 is improving, highlighted HAI challenges that remain and have emerged during the pandemic, and challenged everyone to learn from the pandemic in order to return to a “new normal” that is even better from an infection prevention standpoint. He also provided a great update on the Afghanistan situation in terms of the terribly challenging conditions, the very successful vaccination campaign, and all of the work that has gone into controlling infectious disease transmission in this very vulnerable population. This is really a success story that has direct bearing on HICPAC’s work with infectious disease and MDROs. In addition, Dr. Bell announced the kick-off of the *Isolation Precautions Guideline* work to be chaired by Drs. Wright and Lin. Also, as part of the DHQP update, HICPAC heard an exciting update from Dr. Srinivasan about resources that will be made available in the coming months and years to support LTCFs and some of the many longstanding challenges in that setting, with resources and initiatives to support preparedness, staffing, and infection control infrastructure. She expressed again how sorry she was to see Hilary go, thanked her for her service, emphasized what a honor and privilege it had been to serve as Co-Chair with her, and looked forward to continuing to work with her.

Dr. Babcock recapped that HICPAC heard an update from her on the *Guideline for Infection Control in Healthcare Personnel (HCP)* work and the *S. aureus* key questions. The Workgroup very much appreciated the input from HICPAC on the key questions. HICPAC will be updated during future meetings on the other sections of the guideline as they move into clearance and are posted. HICPAC also heard a brief update from Dr. Guzman-Cottrill who reported on the CLABSI section of the *Guideline for Infection Prevention in NICU Patients*, which is moving into final CDC clearance, and the respiratory illness work that is under review. Federal entity comments were provided by Dr. Gary Roselle from the Department of Veterans Affairs (DVA) with regard to the MRSA section of the HCP guideline. She emphasized once again what an honor and privilege it has been to work with HICPAC members and CDC staff, and expressed appreciation for the collegiality, smart people, and all of the work they have been able to accomplish together. She looks forward to participating in the Workgroups as HICPAC’s work continues.

Adjournment

Dr. Bell and Ms. Byrd thanked the HICPAC members, Co-Chairs, *Ex Officios*, and Liaison Representatives for their participation. They also expressed gratitude to Dr. Babcock for all that she has contributed to HICPAC and emphasized how much she would be missed.

With no additional business raised or comments/questions posed, HICPAC stood adjourned at 1:14 PM ET.

Attachment #1: Acronyms Used in this Document

Acronym	Expansion
ACOEM	American College of Occupational and Environmental Medicine
AEH	America's Essential Hospitals
AHA	American Hospital Association
AHCA	American Health Care Association
AHE	Association for the Health Care Environment
AHRQ	Agency for Healthcare Research and Quality
ASHCSP	American Society for Healthcare Central Service Professionals
ANA	American Nurses Association
AORN	Association of periOperative Registered Nurses
APIC	Association of Professionals of Infection Control and Epidemiology
ARPA	American Rescue Plan Act
ASHE	American Society for Health Care Engineering
CDC	Centers for Disease Control and Prevention
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare and Medicaid Services
COI	Conflicts of Interest
CRE	Carbapenem-Resistant Enterobacteriaceae
CSTE	Council of State and Territorial Epidemiologists
DFO	Designated Federal Officer
DGMQ	Global Migration and Quarantine
DHQP	Division of Healthcare Quality Promotion
DoD	Department of Defense
DVA	Department of Veterans Affairs
ELC	Epidemiology and Laboratory Capacity
ET	Eastern Time
FDA	(United States) Food and Drug Administration
GI	Gastrointestinal Illness
HAI	Healthcare-Associated Infection
HCP	Healthcare Personnel
HHS	(United States Department of) Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IDSA	Infectious Diseases Society of America
IHS	Indian Health Services
LTCF	Long-Term Care Facilities
MDRO	Multi-Drug Resistant Organism
MERS	Middle East Respiratory Syndrome
MMR	Measles, Mumps, & Rubella
MRSA	Methicillin-Resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-Susceptible <i>Staphylococcus aureus</i>
NACCHO	National Association of County and City Health Officials
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health

Acronym	Expansion
ORR	Office of Refugee Resettlement
OSAP	Organization for Safety, Asepsis, and Prevention
PPE	Personal Protective Equipment
PHAC	Public Health Agency of Canada
PIDS	Pediatric Infectious Disease Society
PSAN	Patient Safety Action Network
SARS	Severe Acute Respiratory Syndrome
<i>S. aureus</i>	<i>Staphylococcus aureus</i>
SHEA	Society for Healthcare Epidemiology of America
SIS	Surgical Infection Society
SME	Subject Matter Expert
TB	Tuberculosis
TJC	The Joint Commission
US	United States
VE	Vaccine Efficacy / Effectiveness
WG	Workgroup