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 (DHQP)

Healthcare Infection Control Practices Advisory Committee

June 4, 2020

Atlanta, Georgia

Record of the Proceedings

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Meeting Agenda

Healthcare Infection Control Practices Advisory Committee (HICPAC)

June 4, 2020
Centers for Disease Control and Prevention
Atlanta, GA
Teleconference

Thursday, June 4, 2020

Time	*Topic*	*Purpose*	*Presider/Presenter(s)*
1:00pm	**Welcome and Roll Call**	Information	Hilary Babcock (HICPAC Co-Chair) Lisa Maragakis (HICPAC Co-Chair) Mike Bell (DFO, HICPAC; CDC)
1:10	Division of Healthcare Quality Promotion (DHQP) Update	Information	Denise Cardo (DHQP, CDC)
1:20	COVID-19	Information	Mike Bell (DFO, HICPAC; CDC)
2:20	Healthcare Personnel Guideline Workgroup Update	Information	Hilary Babcock (HICPAC)
2:30	Federal Entity Comment	-	-
2:40	Public Comment	-	-
2:55	Summary and Work Plan	Information	Hilary Babcock (HICPAC Co-Chair) Lisa Maragakis (HICPAC Co-Chair)
3:00	**Adjourn**	-	-

List of Attendees

HICPAC Members
Dr. Hilary Babcock, Co-Chair
Dr. Lisa Maragakis, Co-Chair
Dr. Deverick Anderson
Dr. Kristina Bryant
Dr. Vineet Chopra
Ms. Elaine Dekker
Dr. Mohamad Fakih
Dr. Judy Guzman-Cottrill
Dr. Michael Lin
Dr. Jan Patterson
Ms. Michael Anne Preas
Dr. JoAnne Reifsnyder

***ex officio* Members**
Ms. Elizabeth Claverie-Williams, Food and Drug Administration (FDA)
Dr. David Henderson, National Institutes of Health (NIH)
Dr. Melissa Miller, Agency for Healthcare Research and Quality (AHRQ)
Dr. Daniel Schwartz, Centers for Medicare and Medicaid Services (CMS)
Ms. Judy Trawick, Health Resources and Service Administration (HRSA)

Liaison Representatives
Holly Carpenter, American Nurses Association (ANA)
Paul Conway, American Association of Kidney Patients (AAKP)
Karen DeKay, Association of Perioperative Registered Nurses (AORN)
Louise Dembry, Society for Healthcare Epidemiology of America (SHEA)
Kathy Dunn, Public Health Agency Canada (PHAC)
Kris Ehresmann, Association of State and Territorial Health Officials (ASTHO)
Ashley Fell, Council of State and Territorial Epidemiologists (CSTE)
Allen Kliger, American Society of Nephrology (ASN)
Chris Lombardozzi, America's Essential Hospitals (AEH)
Ronell Myburgh, DNV GL Healthcare
Silvia Quevedo, Association of Professionals of Infection Control and Epidemiology (APIC)
Mark Russi, American College of Occupational and Environmental Medicine (ACOEM)
Robert Sawyer, Surgical Infection Society (SIS)
Christa Schorr, Society of Critical Care Medicine (SCCM)
Ben Schwartz, National Association of County and City Health Officials (NACCHO)
Andrea Shane, Pediatric Infectious Disease Society (PIDS)
Pam Truscott, American Health Care Association (AHCA)
Margaret VanAmringe, The Joint Commission (TJC)
Valerie Vaughn, Society of Hospital Medicine (SHM)
Stephen Weber, Infectious Disease Society of America (IDSA)

CDC Representatives
Catherine Allen-Bridson
Laura Anderson
Matthew Arduino
Mike Bell
Andrea Benin
Stephanie Booth

Denise Cardo
Nora Chea
Koo Chung
L. Cliff McDonald
Ronda Cochran
Nicole Coffin
Kendra Cox
Michael Craig
Maggie Dudeck
Jonathan Edwards
Anthony Fiori
Kristi Gillis
Runa Gokhale
Nicole Gualandi
Kathryn Haass
Rita Helfand
John Jernigan
Cecilia Joshi
David Kuhar
Denise Leaptre
Fernanda Lessa
Sara Mallock
Devon Okasako-Schmucker
Christal Oliver
Apil Pangluri
Chris Prestel
Carol Rauch
Sujan Reddy
Kristen Roberts
Melissa Schafer
Erin Stone
Nimali Stone
Matthew Stuckey
Nicola Thompson
Amy Valderrama
Lauren Wattenmaker
Katie White
Marybeth White

Federal Agency
Elaine Mayhall, FDA
Brian Ortega, FDA
Gary Roselle, VA
John Weeks, FDA

Members of the Public
Brad Bolinger
Karol Cortez, CERH
Jill Culiner, Becton Dickinson
Valerie Deloney, SHEA
Loretta Fauerbach, Fauerbach & Associates
Chris Freedman
Liqun Gaho, REA
Maryellen Guinan, AEH
Kate Hare, ASTHO
Deborah Holden, VA Pacific
Joda Jamale, University of Kentucky Healthcare
Marion Kainer, Western Health
Chioma Kanu
Erin Laird, NACCHO
Rachel Long, Becton Dickinson
Ruth Morel, CDC Foundation
Martha Ngoh, ASTHO
James Prodofikas, Becton Dickinson
Dr. Rosie Lylie, Medline Industries
Puja Shaw, CSTE
Vianne Smith, Base Army Community Hospital
Brook Trainum, American Nursing Association
Kristy Weinshel, SHEA
Paul Zalko, Health Clinic
Miriam Zemudio-Corio, Levitt Partners

Executive Summary

The 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 teleconference meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) on June 4, 2020. The Designated Federal Official (DFO) and co-Chairs confirmed the presence of a quorum of HICPAC voting members and *ex officio* members, which was maintained throughout the meeting.

Dr. Hilary Babcock provided an update on the work of the Healthcare Personnel Guideline Workgroup. Drs. Michael Bell and Denise Cardo provided a report on the current status of the COVID-19 outbreak.

HICPAC stood in recess at 2:35pm on June 4, 2020.

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CENTERS FOR DISEASE CONTROL AND PREVENTION
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Division of Healthcare Quality Promotion
Healthcare Infection Control Practices Advisory Committee

June 4, 2020

Teleconference

Meeting Transcript

The United States 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 meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) on June 4, 2020, via teleconference.

Welcome and Roll Call

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the question and answer session please press “star” 1. Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I would like to turn the meeting over to Mr. Koo Chung. Thank you. You may begin.

Mr. Koo Chung: Good afternoon everybody. Thank you for joining the June 4 HICPAC teleconference. It is 1:06 and we'll go ahead and begin the call today. We'll start with first going over the HICPAC member roll call and disclosures. Once I call your name please state that you're present and disclose any conflicts. Thanks. We'll start with the co-chair, Hilary Babcock.

Dr. Hilary Babcock: Present. No conflict.

Mr. Chung: Thank you. Lisa Maragakis?

Dr. Lisa Maragakis: Present. I've received research funding from Clorox.

Mr. Chung: Thank you. Deverick Anderson?

Dr. Deverick Anderson: Here. No conflicts.

Mr. Chung: Thank you. Kristina Bryant? Okay. Vineet Chopra?

Dr. Vineet Chopra: Present. No conflicts.

Mr. Chung: Thank you. Nicholas Daniels?

Dr. Nicholas Daniels: Present. No conflicts.

Mr. Chung: Thanks. Elaine Decker? Mohamad Fakih?

Dr. Mohamad Fakih: Present. No conflicts.

Mr. Chung: Thank you. Judy Guzman-Cottrill?

Dr. Judith Guzman-Cottrill: I’m present. I have a consulting contract with Oregon Health Authority.

Mr. Chung: Thank you. Michael Lin?

Dr. Michael Lin: Here. I received research support in the form of product donation from Sage which is part of Stryker and otherwise, no conflicts.

Mr. Chung: Thank you. Jan Patterson?

Dr. Jan Patterson: Here. No conflicts.

Mr. Chung: Thank you. Michael Anne Preas?

Ms. Michael Anne Preas: Present. No conflicts.

Mr. Chung: Thank you. JoAnne Reifsnyder?

Dr. Joanne Reifsnyder: Present. No conflicts.

Mr. Chung: Great. Thank you. I'm going to check in with Kristina Bryant again.

Dr. Kristina Bryant: Yes. I'm here. I have received research funding from Pfizer for work on multi-center vaccine trials. And I've done consulting for (Meg) study.

Mr. Chung: Great. Thanks, Kris. And I'll check in with Elaine Decker. We'll go ahead and move onto the *ex officio* roll call. Tara Palmore, NIH? Melissa Miller, AHRQ?

Dr. Melissa Miller: Present.

Mr. Chung: Thank you.

Dr. David Henderson): I'm sitting in for Dr. Palmore until she can get to the phone, if she can. If not, I will be the NIH alternate representative today.

Mr. Chung: Thanks David. Good to have you back. Dan Schwartz, CMS?

Dr. Daniel Schwartz: Here.

Mr. Chung: Thank you. Judy Trawick, HRSA?

Ms. Judy Trawick: Here.

Mr. Chung: Thanks. Elizabeth Claverie-Williams, FDA.

Ms. Elizabeth Claverie-Williams: Present.

Mr. Chung: Thank you, Liz. Moving onto liaison representative roll call. Paul Conway?

Mr. Paul Conway: Present. No conflicts.

Mr. Chung: Thank you, Paul. Mark Russi, ACOEM.

Dr. Mark Russi: Yes. I'm here.

Mr. Chung: Thank you. Elizabeth Wick, ACS? Chris Lombardozzi, AEH?

Dr. Chris Lombardozzi: I'm sorry. I had trouble with the mute button. I'm here.

Mr. Chung: Thanks, Chris.

Mr. Chung: Pamela Truscott, AHCA?

Ms. Pamela Truscott: I'm here.

Mr. Chung: Thank you. Holly Carpenter, ANA? Alan Kliger, ASN?

Dr. Alan Kliger: Here.

Mr. Chung: Thank you. Karen DeKay, AORN?

Ms. Karen DeKay: Present.

Mr. Chung: Sylvia Quevedo, APIC? Kris Ehresmann, ASTHO?

Ms. Kris Ehresmann: Present.

Mr. Chung: Thank you. Ashley Fell, CSTE?

MS. Ashley Fell: Present.

Mr. Chung: Thank you. Ronell Myburgh, DNVGL?

Ms. Ronell Myburgh: Present.

Mr. Chung: Stephen Weber, IBSA?

Dr. Stephen Weber: Present.

Mr. Chung: Thank you. Benjamin Schwartz, NACCHO?

Dr. Ben Schwartz: Present.

Mr. Chung: Thanks. Andrea Shane?

Dr. Andrea Shane: Present.

Mr. Chung: Thank you. Kathy Dunn, PHAC? Krista Schorr, SCCM?

Dr. Krista Schorr: Present.

Mr. Chung: Thanks. Louise Dembry, SHEA? Valerie Vaughn, SHM?

Dr. Valerie Vaughn: Present.

Mr. Chung: Thank you. Robert Sawyer, SIS? Margaret VanAmringe, Joint Commission?

Ms. Margaret VanAmringe: I'm here.

Mr. Chung: Thank you very much. That is the end of roll call. And we have a quorum for this meeting. Just one mention - we will have public comments at the end of the presentation today. When the public comment period opens the operator will provide instructions for how members of the public may provide their comment.

Public comments should be limited to three minutes and we ask that you clearly state your name and organization for the record before providing your comment. Please note that the public comment is not a question and answer session.

Okay. Those are all the administrative updates for the call. I'll go ahead and kick it off with Dr. Bell, Dr. Maragakis, and Dr. Babcock to begin the agenda. Thank you.

Dr. Michael Bell: Thank you. Well, I'll hand it to our Chairs after saying I very much appreciate everyone's flexibility during this very challenging time and accommodating us by having a phone call instead of a traditional meeting. I'm also grateful for the work that's being continued despite having to deal with the pandemic that everyone is currently managing. Lisa and Hilary?

Dr. Babcock: Thanks, Mike. I just also want to welcome everyone and say thank you to everyone for being with us in this difficult time, with ongoing public health crises of COVID as well as the impact of structural racism that we continue to see across our country.

I would say that the expertise and knowledge represented by everyone on HICPAC and all of our liaisons and contributors and everyone calling in with interest in this area, I was thinking I would say that our expertise is more important than ever, but our expertise is really always exceedingly important but this time certainly highlights the critical importance of that expertise that we all have and that you all bring to work every day and to this committee.

I just really want to appreciate all the people here involved and calling in with interest in this area as well. So, thank you for being with us today. And I'll turn it over to Lisa and then Mike and then we'll embark on our agenda.

Dr. Maragakis: Thank you, Mike and Hilary. And I'll just add my welcome and thanks to everyone. I echo the comments that have already been made and I would just add that I think all of us in infection prevention see challenges daily, none of that can rival what we are currently experiencing.

But I think it helps me and I think it will help all of us to remember that in every crisis like this there are opportunities, and this is an opportunity to highlight as Hilary just said, the importance of the work that we always do. And to have the attention of our colleagues throughout healthcare and the general public, in a way that really can only be garnered by such a vivid threat.

And while it is daunting and overwhelming, I do think that it is an opportunity and I can see those around me in my organization and my community, really reaching out for the expertise - learning and taking to heart infection prevention. So just a small bright spot in what is otherwise a very challenging time. With that, I will turn it back to Mike if you have additional comments, or we can move to Denise's presentation.

Dr. Bell: Nothing more from me. You can start the presentation now. Denise?

DHQP Update

Dr. Denise Cardo: Thank you for joining this HICPAC meeting. As it was said before, it's a very challenging time but also an opportunity to really implement everything that we believe that can make a difference, not just in COVID-19 prevention and control but overall healthcare safety. I have slides and so if you go to the second slide, I will introduce some examples of what we are doing in our division as part of the COVID-19 response.

The emergency operations center (EOC) has been activated and we have been part of that since the beginning. And several DHQP staff are leading the Healthcare Systems and Work Safety Taskforce. The whole division is also participating in some fashion in the EOC. In addition to that, we work very closely with the National Response Coordinating Center (NRCC), which is also composed of FEMA and HHS.

And we are heavily involved in the healthcare work within the taskforce being co-led with ASPR. We'll continue to work with them in this capacity within the new HHS structure. I have some examples here, the traditional things that we do in terms of guidance and technical assistance.

Just to give you a flavor in terms of technical assistance it's not just by phone but also in-person as well. And since the beginning of the response, especially in nursing

homes, we've been sending deployers to the field and we have at least 40 people who have been deployed to the field during this response.

We have a lot, in terms of data, and I have two slides to give examples about what we are doing with NHSN. But I want to also mention that we are also the ones monitoring adverse events related to specific medications that are being used for COVID-19.

Our modeling groups are doing a fantastic job on this response. It has been a very, very important collaboration in this process. And I think it will continue to be important, especially as part of reopening and looking at opportunities to further prevent transmission.

In the beginning of the response, our labs played a critical role in surge capacity for testing and this activity continued for a long time. Our lab leaders continue to provide leadership and collaboration with many things that are happening in terms of lab activities for COVID-19.

Lately, the focus has been the prevention and control of infections in nursing homes and I have two slides about that. But I want to also highlight that it's not just a domestic response. We also have the international response.

One example is that we're doing this global infection prevention and control webinar in collaboration with WHO with simultaneous translation to several languages including Arabic, French, Portuguese, Russian, Spanish and with huge participation. It’s very important for sharing experiences and how implementation of infection control is being done in several countries.

Our Immunization Safety Office is also involved with activities related to vaccine safety, to be prepared for how to monitor vaccine safety when we start having vaccinations available. And finally, there is a new initiative led by Mike and he's going to say a little bit more about that, regarding training. And that is really recovering what CDC did many, many years ago. Many of you were not in the field yet, but CDC was the place where infection control training was being provided for the country.

Project First Line, it's a way not just to do that but an innovative way for training not only infection control professional but training any healthcare personnel using very interesting tools and Mike will talk more about this. The next slide includes just a list of some of the MMWRs related to some of our guidance documents. I know many people would get frustrated with updates, but we're learning as we speak and we have learned a lot since the beginning.

The next slide includes examples of data being collected in NHSN, which is the system that has been used for decades for healthcare associated infections and antibiotic resistance.

There was a need to collect information directly from hospitals, to look at hospital inpatient impact and hospital capacity. To address this need, we very quickly, with inputs from several experts, developed a module to collect information needed by hospitals, state/local jurisdictions, and also the White House taskforce and other federal agencies.

Even with NHSN being a voluntary system, we have 60% of general acute care facility voluntarily reporting data daily. We also have estimates of inpatient beds occupied and other important metrics not just nationally, but by state as well. We can also, and you're going to see on the next slide, look at the data by county.

Everything depends on participation by facilities, so we encourage hospitals to participate because the more participation we have, the more data we have that could help with allocation of PPE and testing that could be a very important tool during reopening because these are some of the metrics to see if things are moving in the right direction in terms of decreasing transmission of COVID-19.

This information is sent to HHS and it's combined with all the different information also from CDC and other groups. So HHS is not just looking at NHSN data, it's looking at this data combined with incidence, combined with a lot of other data elements to really help at the country-level to see what is going on and what the needs are, not just monitoring but also predicting what actions will be needed.

We share this daily with HHS, ASPR, but also with groups related to supply chain, and labs. The next slide shows the model that we developed for the long-term care. We work extremely closely with CMS, through multiple conversations, especially from the nursing home perspective.

As we all know, it's not a surprise that we see more transmission in nursing homes because of the infrastructure related to infection control. And what makes it worse is the residents have higher risk for complications, with a huge number of deaths occurring in those settings.

As part of our work with CMS, it was clear that there was no current way to collect information on what was happening in the nursing homes. So, we were able to do that and in less than two weeks, we had over 16,000 long term care facilities reporting to NHSN.

If you're familiar with how NHSN works, you know that this was huge between CDC and CMS. Particularly, because for many of the long-term care facilities, this was the first time they were reporting to NHSN. So now we have at least - and another thing that is interesting, the requirement from CMS - CMS is requiring that, is for skilled nursing facilities, but we also were seeing assisted living and other long-term care reporting to NHSN.

The number of facilities reporting at least one case is around 45%. When we look at the data in terms of not just what they have in terms of PPE today, but also what facilities think is going to be a problem for the following week in terms of PPE and this data has been extremely important for other groups in HHS and in the White House taskforce to decide how they can better focus their efforts on those specific nursing homes.

This data is required by CMS and CMS is making this data publicly available. The first report was on Monday and there's another data report today that CMS released. It is going to be once a week. The NHSN for hospitals is a daily information.

I want to say a few words more about nursing homes because we are working with CMS, especially in nursing homes and we are leading the workgroup for nursing

homes as part of the NRCC healthcare taskforce. So that includes all the federal agencies.

There are three pieces that are critical, especially based on what we've seen during the early outbreaks. We need to keep the infections out. Second, we need to really identify infections early, and then prevent transmission.

We learn that with the residents, many times being asymptomatic while positive, there was a need to do more aggressive testing. The domains that we have for implementation we're doing a lot of assessments and implementation support.

We do have a strategy for enhanced infection control that involves testing and a lot of activities related to training regulations with our work with CMS and guidelines. So we are really looking at how we can coordinate with CMS at the national level, but also locally with state HAI programs, CMS-funded surveyors, quality improvement organizations, to see how we ca really help these groups help the nursing homes and address the problem.

The next slide is an example of a deployment, where we sent people from our division to help with a long-term care facility. This deployment was to look at how effective a testing approach would help early identification of cases in nursing homes, but also transmission. We worked with two states and they selected the nursing homes and we did this assessment and developed tools to help moving forward.

And now it's our recommendation that is being used when you see one case that is positive that you test other residents and healthcare personnel from an infection control perspective.

The next slide, I already said about the initiative that Mike is leading and I know he's going to say more later. And finally, as I mentioned previously, the training for non-US healthcare settings in collaboration with WHO continue to occur. I really encourage people to join, because those webinars are very interesting and it's very good to see what is going on beyond the United States.

Just going back to the testing for nursing homes, so nobody gets confused. We do not recommend routine testing if you don't have a person with symptoms. As part of a study we conducted, we saw that when a resident is positive, if you test everybody, the likelihood of finding patients that didn't have symptoms is important. When you don't have any cases that are positive if you test everybody, you almost don't find any cases that are positive.

It's a very tailored approach, but we believe it's critical. I want to say thank you for all of your support and for your work. And we'll continue our work because the pandemic is not over and I do see that as an opportunity not to just improve infection control in settings like where you work, but improving infection control in settings like long term care facilities and is really going to help us also with antibiotic resistance, as well as an opportunity to increase the scope of what we collect for NHSN but also the types of facilities that are now able to join NHSN.

Dr. Maragakis: Thank you very much for that. All of you, that was really great to hear about all of the work that's going on and exciting to see the data coming in to show what you're all experiencing in terms of local variability and impacting PPE and things like that. I

will open it up first to the committee for questions for Denise. If anyone has a question, please chime in now.

Dr. Guzman-Cottrill: I just wanted to thank the DHQP for your support. Oregon's HAI program is grateful for the assistance that we've received so far. The CDC sent two epidemiologists to Oregon last month for a week-long visit for our specific request for technical assistance.

And this team, along with our local epidemiologists visited numerous affected long-term care facilities in our state, and the facility-level mitigation planning was so helpful for our local HAI program.

And we've been able to use what we learned and the experience to continue to work with affected long-term care facilities across our state. So, I just wanted to recommend that other states' HAI programs consider requesting this technical assistance when they're dealing with outbreak challenges in their jurisdictions.

Dr. Cardo: Thank you, and one piece that I didn't get into the details is also how we're improving the way for doing assessments and how we did what we call Tele-ICAR, and this is how to do infection control assessment a beautiful way and that has been very helpful.

And, Judy, thank you for mentioning that, and I will share that with the Division because we are working a lot and at the end, we don't see the impact of what we are doing, and we just hear when things go wrong. So, thank you for saying this because it's the type of recommendation that I really like to share with the whole Division because I think it's a critical. Thank you.

Dr. Babcock: Other questions?

Dr. Reifsnyder: Thank you for the presentation and thank you for your tireless work. I can't imagine how many hours. I just wondered if you could comment on staff testing in long-term care. You mentioned that CDC doesn't recommend routine testing and, that there's value if there's at least one positive case present in testing other nursing home residents in a screening. Could you comment on staff testing?

Dr. Cardo: Yes, as part of enhanced infection control, when we see one case, we recommend testing all healthcare personnel. In addition to that, as part of the reopening process, we know how critical it is to keep the infections out.

As part of the reopening, we do recommend that healthcare personnel be at least initially tested and then you should work with your state and locals to see how often they want healthcare personnel to be tested after that.

We know that in New York they were recommending testing healthcare personnel like twice a week. One piece that we always say, it's not just how frequent you have to do it but how fast you can have the results because, if you cannot have results fast to act, it becomes just a passive surveillance. So, we do have recommendations for healthcare personnel, and they are consistent with what CMS is also recommending. And I hope we'll be able to post that today.

Dr. Reifsnyder: Thank you.

Dr. Babcock: Other questions or comments?

Dr. Kliger: The half a million Americans on dialysis obviously are at increased risk, in part because they cannot socially distance three times a week during hemodialysis treatments. I want to first really thank CDC and the group in Washington state.

For example, one of the index cases of COVID-19 death in a dialysis patient nursing home resident was tremendously helped by your team that came there and was really helpful in sorting it out and helping to set up an overall strategy that was then useful around the rest of the country.

One of the current problems you mention testing, laboratory testing. One of the current problems that we see is in returning patients and staff to outpatient hemodialysis units. Particularly among patients, the incidence of persistently positive reverse transcriptase PCR testing is significant.

As many as 20 percent of our patients in some areas have had persistently positive PCRs for weeks, even months now, and the meaning of that probably is not at all clear. In these immunosuppressed patients, it's not clear that viral particles are necessarily no longer viable as apparently in small studies of other patients it has been shown.

So one of things we really need in terms of testing is some viral testing that we would hope the CDC might be able to help with to help answer the question about what do we do staff and, particularly, patients with long-standing persistently positive PCRs.

Dr. Cardo: So I will - with that answering and then I will turn to Mike if you have additional guidance. But thank you for mentioning dialysis. Since the beginning, we saw that it was a really - we saw nursing homes and dialysis settings as like very physical and is in - and like you said, it's a challenge not just how to prevent but how you deliver the care you need to deliver with respecting all this infection control, need to infection control to protect patients and healthcare personnel.

And so there's - we also are working closely with the group under the NRCC that is dealing with dialysis, and we have our staff from the DCP working with them and we work also very closely - work very closely with them. And also the dialysis is - the patients from nursing homes going to dialysis and then going back or other patients going to dialysis and then going back. So it's like also being in and out that is a big challenge.

So the recommendations for dialysis is similar to the nursing homes. They are not - they haven't been easy to implement, and I do thank you for all the collaboration to really work with us to see how those implementations will be feasible. We are learning a lot in terms of the tests, the different tests and how long they stay positive. Like you said, the meaning for that continues to be a question. Mike, do you want to say anything?

Dr. Bell: Yes, thank you for that. Just briefly, I do think - you know, we are gradually, although by gradually I should say very rapidly, given that this has been something that we've only, you know, known about for four or five months. We're seeing now what the natural history of this virus looks like, and it's becoming increasingly clear that with a few exceptions, people who are immunosuppressed, on medication maybe, who are severely ill and in the ICU perhaps - but in general, what we're

seeing is that, although the PCR test remains positive, the evidence shows infectious virus starts to go away after seven to ten days from the beginning of illness. This is getting more and more evidence underneath it and, as we become more confident, those cutoffs that we've drawn I think will become more and more helpful.

I think clearly we're at a point now where simply having a positive PCR, you know, two months after you've recovered is not meaningful from an infection prevention perspective. The patient is extremely unlikely to reflect ongoing infectivity. And so much of this information is being published week by week.

A lot of (unintelligible) about six or seven weeks, and I think that's been very helpful. So I don't think we're going to be stuck in a position where we have to deal with ongoing PCR positivity and to have to adjudicate whether they're infectious or not. I think we're going to be able to understand fairly clearly when that tails off.

The added piece of information here, in parallel with the ability to culture competent virus drifting down, as I said, after seven to ten days is that, as antibody status is confirmed, that too is correlating very nicely with the loss of infectiousness. So we're getting there. I would assume that another month or so will go by before we have, you know, firmer evidence that we can point at. But I think we're very, very close.

Dr. Kliger: So, again, thank you, Mike. I would just point out that the nephrologists around the country were concerned that dialysis patients may not have the renal competence of others and, given the fact that we'd be bringing back patients say two weeks after cessation of symptoms and exposing them to everybody else in the unit three times a week is a real concern. So if additional data are forthcoming, it would be nice to include dialysis patients among those that are being studied and cultured.

Dr. Bell: Yes, I think that's a great point. Again, dialysis is inherently a specialized situation for so many reasons, and you're exactly right that we don't have the luxury of postponing maintenance dialysis. And so that combined with the fact that we don't have the resources to bring everyone into an in-patient setting to do this we do need more information there,

Mr. Conway: This is Paul Conway. Can I make a brief comment also from the liaison bench? First, I'd like to thank Dr. Kliger for the work that ASN and he, in particular, have done in raising this issue. American Association of Kidney Patients and many of the other patient groups, I can tell you that the fear among patients is palpable. CDC was very generous with their time and did a webinar with us. That has - that on its initial signup crashed our system. We had over 5,000 patients register for that.

We've had over 10,000 views in the first two weeks of it, and this is the number one issue that people are calling about. Our concern and in this, to take to heart, our concern is that people will begin altering treatment or acting in a manner that they view would protect themselves and their friends who are fellow dialysis patients and alter their care.

So we're standing here ready to be a good partner in dissemination of factual information, as is Allen and ASN. But I think the patient fear factor thing, you folks just need to be aware of it. It is - it has not waned. In fact, we actually think it's increased. So I just wanted to put that out as a comment. Thank you.

Dr. Cardo: That's a very important point, and we're seeing is part of their response. It's not just how we prevent and control transmission of COVID-19 but how we make sure that patient care continues in the high level, and we need to address fear.

We need to address a lot of concerns that even healthcare personnel or the patients may have that can really have a negative impact in their treatment - ongoing treatment for the baseline conditions they have.

So it's something that we more and more we're seeing. We really need to look at this as how to deliver care in a way that we consider all this. So thank you. And if there's anything that you feel that we can do together, let us know. Thank you.

Ms. Ehresmann: As a liaison and for Minnesota Department of Health, just wanted to clarify. You said you don't recommend routine testing until you have someone, a resident or staff, in a facility that is symptomatic.

That's what our guidance in Minnesota currently says, although we also say if testing resources allow for a point prevalence survey, it might be warranted if the facility with no known residents is located in a high-risk area, in other words, close to other facilities experiencing outbreaks or if there's shared staff.

I'm kind of checking on that. And then the other thing is that we are getting a lot of pressure to test everyone in every facility. And if you could just say a little more about that, that would be great.

Dr. Cardo: Your recommendation is very consistent with ours, that you have to also see what is going on in your community and make public health decisions. But sometimes it's worth testing everybody because it's an area of high risk or sometimes it's also part of the reopening. As part of the reopening, although there are some recommendations that there will be an initial test for the healthcare personnel but also for the residents.

What we learn is that just doing point prevalence survey, when you don't have any cases or you're not in area that really would make it an important intervention, would probably not be the best use of testing capacity because the likelihood of finding a positive will be very low. But I know some places are trying to do that, especially as part of reopening.

What I say to everybody is not whether they should be testing or not testing, but it is critical what you do with the results. If people are testing on a regular basis and it takes longer, like testing every week, and it gets longer than a week to get results, you really need to see the value that testing frequency will bring in terms of protecting residents in a nursing home. if in the future we do have some data showing that best frequency. But, I think the important thing is what you do with the test results.

Ms. Ehresmann: Thank you.

Dr. Cardo: Also, flexibility is important. It varies where you are and because things change if you're in the process of reopening. The three things that I said for nursing homes is to keep it out, avoid any new cases, and detect early and act aggressively to limit transmission. If you're in the process of reopening, I think this is something that you need to really look at even more seriously than before.

Dr. Babcock: Thank you. Other comments or questions from Committee members, ex officio members or liaisons? I would just add a comment that I really appreciate the need for local adjustment, as your data has shown as well, that there is significant variability and prevalence of infection across different regions, even the different regions in counties. And so the guidance that comes out of that makes specific recommendation around pre-procedural testing, for example, and PPE use regardless of testing.

And we recently received a Joint Commission statement that recommended both, pretty much universal testing as well as universal COVID-19 PPE regardless of test results that we are kind of looking into and trying to evaluate. We currently, in the St. Louis metropolitan area, with our pre-procedural testing, have test positivity rate of around 0.06%. This guidance doesn't seem particularly suited to our area and to our current situation. So, to that extent flexibility reflecting local conditions, is helpful.

Dr. Cardo: Sometimes the recommendation will not be as tailored because the more we learn the more we can tailor it. But we're increasingly recommending that you work with your local and state health department authorities to really identify the best strategies for you. All the states are receiving funds for testing, and they need to submit a plan for how they are going to do testing.

I do encourage all of you to work closely with state and local health departments so whatever the recommendation is going to be or priority is going to be by the state or locals, it will reflect what you think will be the best for where you are.

Dr. Babcock: I like that. Any other questions or comments for Denise before we move on to some more COVID-19 discussion with Mike?

Dr. Shane: I also just wanted to echo everybody's appreciation. Especially in pediatrics, we really appreciate the time and efforts that CDC has devoted to developing guidance for summer camps and schools and some of these other pediatric-specific situations because we certainly are aware that when children need care that also has implications for the entire system for the adults that need to work and how they're taken care of. So that has been greatly appreciated.

And having pediatric colleagues on many of those committees and areas who have been developing that guidance is greatly appreciated. Sometimes children are not thought of in outbreak situations and especially with this virus that has predisposition for causing morbidity and mortality in older adults, understanding and paying attention to pediatrics and children is greatly appreciated. I wanted to express that personally and also on behalf of the Pediatric Infectious Disease Society.

Dr. Cardo: Thank you.

Dr. Babcock: Thanks. We'll go ahead and turn it over to Mike.

COVID-19

Dr. Bell: Great, thank you. Despite having just heard a lot about COVID-19, under the label of the DHQP update, I'm about to share a little more information about the outbreak. I

will say that what that reflects is the extent to which our Division has really been consumed by this national and global response.

When I think about what we're seeing with this pandemic, I think it's very clear that it's highlighting sort of the vast range of vulnerable populations in our country. We clearly saw at the outset the impact on older age groups, people with chronic health conditions, and I think what we're seeing is inherent challenges of managing respiratory infectious diseases.

I think we've had the luxury of having vaccines available for the control of many similar pathogens that otherwise would be challenging for us in very similar ways, things like measles and so on. We're in a state at this point where we are having to deal with what happens before we have a vaccine. Right now, we're seeing infection prevention and control being applied across many situations well beyond the traditional locations of healthcare.

We're seeing residential facilities, nursing homes and other communal locations. We're seeing prisons, work settings, tribal and rural communities, places where, in many instances, we're seeing multiple layers of factors that increase the risk of transmission, things like insufficient hygienic infrastructure, crowding, limited access to care and so on. These are things that have always been there and are simply being unmasked in a rather dramatic way by this pandemic.

In terms of where we are right now, it's very difficult to say. It's not clear whether we're 30 percent of the way through, halfway through, the numbers vary. What I can share with you, as of this week, is that we've got about 45,000 patients in the country hospitalized with COVID-19, and that compares to about 85,000 at its peak. So that's moving in a better direction. Right now 20 percent of ventilators are being used by COVID-19 patients.

At the beginning of April, it was 45 percent. That too has gone down. Unfortunately, 40 percent of facilities are still reporting that they're not able to obtain N95 respirators, and that hasn't really changed for the past several weeks. CDC and the National Healthcare Safety Network has been integral in terms of gathering this information, finding out what the needs and stresses are on healthcare settings across the country, and we continue to track this in partnership with the rest of government. It still remains to be seen what will happen with the natural history of this disease.

We don't know what the waves of transmission to follow are going to look like, how frequently they'll come, whether there's going to be a seasonal aspect to COVID-19. Those things do remain to be seen, and we're watching this very closely. The change in the pathogen and the virus host relationship is maturing and is something that we can expect, but it's not going to happen right away. Lastly, whether this becomes a vaccine-preventable disease also remains to be seen.

As encouraging as some of the news has been, those who have watched many medical products look great at the beginning and then run into challenges, are still waiting with bated breath, hoping for the best with the products under development right now. With a vaccine, I think we have a very efficient way of controlling this.

Unfortunately, if we don't have a vaccine, then there are some very real challenges. We have here, again, a respiratory pathogen that's affecting healthcare, and it's not the first time that an outbreak of this sort has demonstrated weakness in our healthcare delivery system.

We have made systematic decisions for generations now based on practical means, staffing limitations, financial imperatives. There are many things that go into designing how we deliver healthcare, including long-term care and ambulatory care, but many of them have downsides which, although they accommodate very important needs, end up causing problems during a time like this.

I think that there will be an opportunity to look at some of those factors and have another conversation about where we want to bolster the system so that we might be less vulnerable for future outbreaks.

Clearly there are limitations to what we can do as a nation and as a system, but I do think that we're going to be carrying forward some very important lessons learned. As I've brought up before, this won't be the last respiratory pathogen we have to deal with. We are increasingly able to diagnose and recognize respiratory pathogens. Things that were mixed in with non-specific viral respiratory illness in the past are now being identified with a great deal of efficiency.

As I have said before, this needs to be something that we're ready to respond to from the infection prevention and control perspective. We need to be, not only planning the response, but the occupational health response, the planning for appropriate PPE in the future and what that should look like.

The supply chain issue I won't talk about now but, clearly, there are issues there as well. And areas where I think we can have some new and potentially very beneficial cross-cutting conversation with regard to things like indoor air quality and air hazard.

I think that many facilities have prioritized different needs, whether it's climate control or building security or building efficiencies. In many places, air handling has created limitations on what we can do, and there may be an opportunity to rethink some of that for future construction. And lastly, I think that there is a strong need to revisit what we think are the expectations of infection prevention and control capabilities in place where patients are receiving care.

Probably the most notable thing right now is the vast gap between need and capability in many of our skilled nursing facilities. Places where patients are, in fact, receiving medical care but where the infection prevention and control governance structure is clearly falling short. Figuring out how we bolster that, how we can support its move in the right directions, I think is a very important topic. I need to mention a training initiative.

This is the "First Line" Initiative. This is a two-year investment to pilot our ability to reach healthcare systems across the spectrum of care. I think if we look historically at infection prevention and control training to-date, it has largely focused on infection control professionals, and to some extent, hospital epidemiologists.

But we really have not done a wholesale attempt at training everyone who actually puts their hands on patients. And I think about the impact of different aspects of

medical care delivery on infection control. As a clinician I can be helpful, diagnostically speaking, with upfront recommendations for appropriate treatment and checking-in on my patients.

Compared to the impact of nurses and environmental services staff's ability to implement infection control, my impact as an independent clinician is very limited. I think we need to recount all the people who are directly engaged in maintaining safety, minute by minute, hour by hour, for our patients and reach them with the information that they need.

What we're seeing also is that the type of delivery that we use today is likely insufficient. Moving past slide set presentations, moving past a lecture-type approach, that assumes that people have an hour or an hour and a half to spend to sit and listen to a slide presentation that is probably a very limited utility.

I also think that the content being tailored to be meaningful for each audience is an aspect where we will be investing heavily. What a dialysis technician needs to know and what makes sense to them versus what an ICU nurse needs to know are very different things. I think that tailoring the content to be as meaningful as possible to each audience is something that we anticipate doing.

The other piece of this is how it plans the way people live and work today. Most people don't have the luxury of spending an hour during or after a shift to listen to a divested presentation. Thinking about fast digestible portable ways of transmitting information either through smartphones or other methods is high on the list of what we're doing.

We're also thinking a lot about how we can create communities of remote mentoring so that people can share information, experiences, and strategies that have worked and propagate information across distances. This is especially true given our current remote learning reality. We certainly don't have the luxury of convened meetings and conferences at the moment and yet we very much need to get information out to people who need it.

Lastly, I'll say a little bit about innovation both related to training and related to medical practice. There is an opportunity here to further invest in understanding what constitutes as infection control and what the actual elements of the failure that we are experiencing. Are their design factors for devices and environments that can make things more failure proof?

And then things that I mentioned like air movement that we've not really paid much attention to in the past beyond negative pressure isolation and a couple of other exceptions. I think we can probably do a better job of that in healthcare and communal settings. I have a hunch that might have some very substantial benefits not only for COVID-19 but also for a variety of other respiratory conditions.

And then my favorite question is "what is the new normal?" I wonder whether we will ever go back to having waiting rooms the way they were. I personally very much hope not. I think that we've learned that there are better ways to have people arrive for care.

The fact that there is a lot of telephone-based arrival and scheduling that's happening now is very encouraging and that's something we need to promote. The

issue of human analysis came up and the layout and process of delivering care is something that is ripe for reconsideration and improvement.

It's completely unacceptable that anyone needs to be told to go into a place that they need to go to receive care. There are probably ways that we can reduce risk not only from COVID-19 but from seasonal influenza and a variety of other illnesses that put people at risk in those settings.

We've mentioned triage practices that go beyond remote triaging telehealth in general is an area that is receiving a great deal of attention. Understanding how that plays into reconstitution of a new normal health system is going to go a long way toward improving some of what we're able to do.

I mentioned the expectations of skilled nursing facilities. Long term care stands to benefit a great deal if we're able to take lessons learned and move from where we were to where we think we need to be with regard to anything ranging from environmental management, staffing, infection prevention and control training and capability and so on.

The last item I'd like to discuss is surge control. I think that we've shifted, as a culture in the United States, at least a little bit. I'm wondering whether surge control is going to become a routine reality and so are all parts of healthcare, perhaps seasonally, in our communities as well.

One thing that I didn't mention about the "First Line" Initiative is the scale. What I said about reaching everyone who delivered care I neglected to mention the sheer number of individuals that we're dealing with.

Thanks to the work of our team we have been able to estimate there are roughly 4 million nurses plus another 2 million related health staff who really do need to be trained. That is a huge list in terms of getting everyone trained up not just once but on a recurrent basis.

We're thinking a great deal about how this can be woven into certification, licensure, payment strategies and so on in a way that fosters an enduring cycle of training placement so that everyone across the field of medicine is on the same page when it comes to the basics of infection control.

There have been conversations for about a year now maybe a year and a half on how best to update the isolation guideline. I think that we are probably in a good place to start thinking through some of how the COVID-19 response will affect our approach to respiratory pathogens. Some things may change, some things may not, but I think it's a good time to be thinking through that.

Thanks to our very able colleagues in DHQP who are reviewing this information right now and we're looking through Appendix A of the isolation guidance as a starting point. We're going through it in a tiered manner taking care of some basics low-hanging fruit, for example, some recognized errors and some organizational pieces that can be improved right away. There will probably be a series of two or three layers of updates including corrections based on other guidelines that have been developed in the interim to harmonize.

There may be some new data, evidence, approaches, or technology that allows to make different recommendations for a few existing items. Then there are probably going to be pathogens and syndromes for which we don't have recommendations yet and we'll need to try and get to that. Thank you for letting me speak.

Dr. Maragakis: Thank you so much Mike for your presentation and also to Denise. Mike, I think you've touched upon so many important themes and ones that I have been thinking about a great deal. I'm very grateful in hearing healthcare leaders also note these things as organizations discuss plans for reopening and also thinking about what the future of healthcare delivery may look like, particularly what kind of lessons learned from this can we take to improve healthcare delivery from an infection control standpoint. I'm also thinking from an inefficiency and patient experience standpoint, thinking of telemedicine in particular, some of the benefits that this has brought to patients as well as providers.

I would echo so many of your comments about the physical space that we have touched upon in past conversations at these meetings including crowded waiting rooms and particularly the typical layout and workflows in ambulatory settings and emergency departments that make infection prevention at that point of entry so difficult particularly for pathogens that might be spread by airborne routes.

You didn't specifically mention eye protection, but I have been teaching a lot about eye protection and how this pandemic response has really highlighted the use and overnight transformed in the use of eye protection amongst healthcare providers in such a positive way.

I have a question, then I'll turn it over and ask the committee members and others to chime in with comments and questions. My question is about the phenomenon of non-COVID-19 related deaths and illness. I'm just wondering if we have data at a national-level on that.

It's certainly something that has been reported in other countries and that our communities, through reports from emergency management services are seeing a vast increase in the number of calls for cardiac events and the excess deaths that are being reported. Also, there is now an influx of patients who many of whom are waiting to seek care, because of their fear of the pandemic, and now are suffering worse consequences from their underlying medical illness. I wonder if you have any comments or any data about this.

Dr. Bell: I don't have data at my fingertips. It is something that CDC has been very concerned about. I'll ask Denise to comment as well since she's closer to this end of the response.

But I do know that there's been a huge effort made to encourage people to seek appropriate care and not delay care for chronic health conditions and acute conditions that warrant immediate attention. It's something that I feel very concerned about as a secondary harm related to COVID-19. But Denise do you want to say anything?

Dr. Cardo: No I don't think I have anything to add. It's a concern that we have and there's a lot of work to see how to really make sure that people who seek care and understand that everything will be safe. One thing that we don't know is the impact of COVID-19

on reporting of resistant infections and other healthcare associated infections because of reduced capacity of health department due to the pandemic.

We know that especially the HAI/AR and the lab networks were very busy with other things before COVID-19. So, we do anticipate a decrease in those infections because of lack of reporting. Also, another thing they are seeing is with food-related infections. It's a struggle to see how we are going to address these issues moving forward.

Dr. Maragakis: Thank you both. Do others have comments or questions?

Dr. Fakih: Great presentations from Dr. Cardo and Dr. Bell and we're so thankful for the CDC for all the support that they have given us over the last three months. Without the CDC I don't know what would've happened to us in healthcare.

I want to comment on Dr. Bell's presentation. I think he mentioned this, but I want to underscore it, if there's an opportunity for us to culturally stress the importance of protective and healthy behaviors that would not only help us with COVID-19 but also with other infections from regular colds to influenza to transmission of any bacteria.

We talked about MRSA with regular *Staphylococcus* aureus, CRE for gram-negative and if we embed in our behavior what we're doing right now with COVID-19, it potentially may have a huge impact on reducing transmission of any infection within the healthcare setting and within populations.

The issue that's even important for us to get out to the population is to first believe that the pandemic is a problem or any other infection is a problem and that they have the means to avoid being infected and also how to identify it if they may have the infection. And this applies for both healthcare workers that come to work with a fever and medicate themselves with Tylenol saying that they're not positive for SARS-CoV-2.

If someone has symptoms and are exhibiting healthy behaviors to reduce the risk of exposure to other, this is extremely important. However, if we don't have this cultural piece to change our behaviors, it is going to be extremely hard for us to spot infections and this pandemic.

One important suggestion would be to have some stability in how we screen for SARS-CoV-2. I know it's a very difficult and evolving process. However, with all the multiple small changes that we have as far as recommendations, the implementation and adoption piece has not been simple to operationalize. As Dr. Bell had said we need to educate not only our teams, but we need to educate different segments of healthcare. We need to educate the population and it takes quite a bit as far as adoption.

And the last thing I want to share is that we need to account for how we're addressing COVID-19 and screening and who this can impact diagnosis of other diseases. The non-intended consequences of what we do, and it's very hard to evaluate right now, but we may see in a few months from now, if a patient has a headache or chest pain, I'm thinking COVID-19, instead of heart disease, for example.

And the last thing I want to share regarding eye protection. I think eye protection is very important for COVID-19 and to HAIs but when we generalize it for every single encounter, you're adding another layer. And the compliance with other precautions that may be even more important may become much less evident, so more is not always better. Thank you.

Dr. Maragakis: Great, thank you for that comment. Does anyone else have a comment or a question?

Dr. Babcock: I wanted to mention that SHEA has also been interested in trying to expand on infection prevention principles and practices training outside of infection prevention specialists and healthcare epidemiologists and has recently launched a program that is called Prevention Check that is focused on front-line healthcare providers and education around common infection prevention challenges in that area.

It is still primarily focused in an acute care setting. There is some interest in trying to now look at expanding that into other settings and potentially into more resource limited settings. But I just wanted to mention that it's nice to hear us all thinking in the same direction.

I also want to echo what Mike said, and I know Lisa had mentioned this before as well, the new normal for waiting rooms and waiting room spaces around plexiglass separators and dividers to keep people more protected but the use of source control and different settings.

I do think it will be very interesting to see what the impact of a lot of these changes are on our seasonal flu season as we go into that and just to see what sort of what sticks in this sort of new normal.

Dr. Maragakis: Completely agree, Hillary. It'll be fascinating to see and with the use of mask and social distancing will have on seasonal flu. Okay I'm not hearing other questions or comments on this topic so, Hillary, shall we move forward than with the healthcare personnel guidelines workgroup update?

Healthcare Personnel Guideline Workgroup Update

Dr. Babcock: Sure. A quick update from the healthcare personnel guidelines. Just a reminder, the goal for this workgroup is updated the guideline for infection control in healthcare personnel. We published our most recent updated prior in 1998. Section 1 was the infrastructure and routine practices for occupational infection prevention and control services and that was published in October 2019.

And then Section 2 is the epidemiology and control selective infections transmitted among healthcare personnel and patients. That's where we look at specific pathogens and infections and has about 25 individual sections.

HICPAC has approved first drafts of pertussis, mumps, rubella, measles, and diphtheria. And then Group A streptococcus, varicella, parvovirus, and cytomegalovirus. And the first of these sections including meningococcal, diphtheria, Group A streptococcus, and pertussis went through CDC clearance and were posted to regulations.gov for public comment for a 60-day period that began February 27, 2020 and ended on April 27, 2020.

Usually our next step would be to incorporate these public comments into the document and bring back an updated draft to HICPAC for final approval and then post the sections online. We usually receive a pretty wide range of comments. This time only one public comment was received from one individual and it did not actually pertain directly to the content of this document.

Our plan is actually to hold and to resubmit the draft section for public comment at a later time when, hopefully, people can find some time to review and comment more thoroughly and then we can revise the document accordingly.

We do value the input of the public comments and don't want it to be where we are taking advantage of the current public health crisis to sort of slide this one through without a chance for input from colleagues to really give it the time and energy that they usually would. We will hold and plan to resubmit at a hopefully slightly calmer time.

And then the other sections slated for update includes S. *aureus*, conjunctivitis/adenovirus, rabies, vaccinia, scabies, pediculosis and viral respiratory pathogens -- very relevant. All of these are currently on hold as pretty much everyone is a little tied up at the moment.

I'm happy to take any questions or comments about the healthcare worker guidelines. Not that I gave you a lot you have questions about or comments. Shall we open for federal entity comments?

Mr. Chung: Before we begin the federal entity comments session, I wanted to give a quick primer for public comment that will happening just after the federal entity comment period. I will kick it off to the operator to give instructions on how to give public comment should you want to.

Again, please limit your public limit your public comment to three minutes and just to be clear, this won't be a question and answer session, but an opportunity for members of the public to give their comment about the topics that were discussed today.

Coordinator, can you please go ahead and give the instructions for how to give public comment and that as soon as she's is done, we will open the floor for any federal agencies that would like to give additional comment.

Coordinator: Thank you. We will now begin the public comment session. If you'd like to make a public comment, please press "star" 1. You will be prompted to record your name. To withdraw your request please press "star" 2. Again, for any public comment please press "star" 1.

Federal Entity Comment

Mr. Chung: Thanks. Hillary and Lisa, next will see if there are any comments from other federal agencies.

Dr. Babcock: Excellent. Please go ahead if any comments from another federal entity.

Public Comment

Coordinator: Again, as a reminder if you do have any public comments please press "star" 1 and record your name when prompted. Again, please press "star" 1.

Mr. Chung: We'll give it a few more moments and that will check in with the coordinator to see if we have any public comments on the line and then we will go from there.

Coordinator: Again, as a reminder if you do have any public comments please press “star” 1 and record your name when prompted. Again, please press “star” 1.

Mr. Chung: Do we have any public comments?

Coordinator: I show no public comments.

Mr. Chung: We’ll wait another two or three minutes and then go from there. But in the meantime, I don’t hear any other federal agencies that want to provide comment. Mike do you have anything else that you need to add or want to add?

Dr. Bell: No thanks, nothing for me.

Mr. Chung: Great. While we wait for the last few minutes for public comment Lisa or Hillary, would you like to go over the summary of today’s call as well as our potential work plan? It doesn’t look like we have anything to vote on today so no votes today.

Dr. Babcock: In summary from today’s meeting mostly I want to thank Denise and Mike for their comments and overview from all of the great work that is going on DHQP and the high level impact and perspective that Mike provided about what this may mean for our healthcare systems, infection prevention programs, and occupational health programs going forward.

We also want to take a moment to appreciate the hard work and dedication of everyone on this call, in terms of engaging with HICPAC and the ongoing work you’re doing in your local areas as well. Your comments and questions have been helpful for us and for CDC as well to have your input. Not a lot I think in terms of work plans.

Healthcare worker guidelines, isolation guidelines that Mike alluded to, and other workgroups that we have sort of in a holding pattern now, but we'll look forward to hearing more about their work as we are able to get started. Lisa anything that you would like to add?

Dr. Maragakis: No, thank you. I think you covered all of it. I just echo your thanks and appreciation for everyone and stay safe and keep doing the good work that you’re doing.

Koo, I guess we should check one more time and see if there are any public or federal entity comments?

Mr. Chung: Do we have any public comments on the line?

Coordinator: I show no public comments.

Mr. Chung: Great, thank you. I just have one last administrative update that I forgot to mention. The solicitation for HICPAC membership is now live. You can look for additional details on the Federal Register. If you just go to federalregister.gov and type “HICPAC” in the search box, one of the entries is for solicitation for nomination to the committee. More details are available there.

The deadline for applications is August 3, 2020. If you have any other questions or concerns about the solicitation for nomination to HICPAC you can always email us at

hicpac@cdc.gov. I think with no other federal entity comments are public comments and we can end this call a little bit early. Lisa, Hillary, Mike is that okay with you?

Mike: Thank you everybody for taking the time today this is very helpful.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing transcripts of the June 4, 2020, meeting of the Healthcare Infection Control Practices Advisory Committee, CDC are accurate and complete.

_____ _____

Date

Lisa Maragakis, MD, MPH
Co-Chair, Healthcare Infection Control Practices
Advisory Committee, CDC

_____ _____

Date

Hilary Babcock, MD, MPH
Co-Chair, Healthcare Infection Control Practices
Advisory Committee, CDC

Attachment #1: Abbreviations and Acronyms

Abbreviation/ Acronym	Expansion
AAKP	American Association of Kidney Patients
ACOEM	American College of Occupational and Environmental Medicine
AEH	America's Essential Hospitals
AHCA	American Health Care Association
AHRQ	Agency for Healthcare Research and Quality
ANA	American Nurses Association
AORN	Association of periOperative Registered Nurses
APIC	Association of Professionals of Infection Control and Epidemiology
ASN	American Society of Nephrology
ASTHO	Association of State and Teritorial Health Officals
ASPR	Assistant Secretary for Preparedness and Response
C. difficile	*Clostridioides difficile*
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
CRE	Carbapenem-resistant Enterobacteriaceae
CSTE	Council of State and Territorial Epidemiologists
CMS	Centers for Medicare and Medicaid Services
DFO	Designated Federal Official
DHQP	Division of Healthcare Quality Promotion
EOC	Emergency Operations Center
FDA	(United States) Food and Drug Administration
FEMA	Federal Emergency Management Agency
HAI	Healthcare-associated Infection
HHS	(United States Department of) Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
HRSA	Health Resources and Services Administration
ICU	Intensive Care Unit
IDSA	Infectious Disease Society of America
MMWR	Morbidity and Mortality Weekly Report
MRSA	Methicillin-resistant Staphylococcus aureus
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
NRCC	National Response Coordinating Center
PCR	Polymerase Chain Reaction
PHAC	Public Health Agency of Canada
PIDS	Pediatric Infectious Disease Society
PPE	Personal Protective Equipment
S. aureus	*Staphylococcus aureus*
SCCM	Society for Critical Care Medicine

Abbreviation/ Acronym	Expansion
SHEA	Society for Healthcare Epidemiology of America
SHM	Society for Hospital Medicine
SIS	Surgical Infection Society
Tele-ICAR	(Telephone) Infection Prevention and Control Assessment Tool
TJC	The Joint Commission
WHO	World Health Organization