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

March 5, 2020

Atlanta, Georgia

Record of the Proceedings

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Meeting Agenda

Healthcare Infection Control Practices Advisory Committee (HICPAC)

March 5, 2020
Centers for Disease Control and Prevention
Atlanta, Georgia
Teleconference

Thursday, March 5, 2020

Time	*Topic*	*Purpose*	*Presider/Presenter (s)*
9:00am	Welcome and Roll Call	Information	Hilary Babcock (HICPAC Co-Chair) Lisa Maragakis (HICPAC Co-Chair) Michael Bell (DFO, HICPAC; CDC)
9:10	Division of Healthcare Quality Promotion (DHQP) Update	Information/ Discussion	Denise Cardo (DHQP, CDC)
9:15	NICU Guideline Workgroup Update	Information/ Discussion	Kristina Bryant (HICPAC)
9:30	Bloodstream Infection Guideline Update	Information	Vineet Chopra (HICPAC) Michael Anne Preas (HICPAC)
9:45	Healthcare Personnel Guideline Workgroup Update	Information	Hilary Babcock (HICPAC Co-Chair)
10:15	Long-term Care/Post-acute Care Workgroup Update	Information	Michael Lin (HICPAC) JoAnne Reifsnyder (HICPAC)
10:30	National Healthcare Safety Network Workgroup Update	Information	Lisa Maragakis (HICPAC Co-Chair) Deverick Anderson (HICPAC)
10:45	COVID-19	Information	Michael Bell (DFO, HICPAC; CDC)
12:00	Federal Entity Comment	-	-
3:40	Public Comment	-	-
3:50	Summary and Work Plan	Information	Hilary Babcock (HICPAC Co-Chair) Lisa Maragakis (HICPAC Co-Chair)
4:00	**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
Ms. Darlene Carey, Association of Professionals of Infection Control and Epidemiology (APIC)
Ms. Holly Carpenter, American Nurses Association (ANA)
Mr. Paul T. Conway, American Association of Kidney Patients (AAKP)
Karen deKay, Association of periOperative Registered Nurses (AORN)
Dr. Louise Demby, Society for Healthcare Epidemiology of America (SHEA)
Ms. Kathleen Dunn, Public Health Agency of Canada (PHAC)
Dr. Alan Kliger, American Society of Nephrology (ASN)
Dr. Chris Lombardozzi, America's Essential Hospitals (AEH)
Ms. Dana Nguyen, National Association of County and City Health Officials (NACCHO)
Dr. Jennifer Meddings, Society of Hospital Medicine (SHM)
Dr. Mark Russi, American College of Occupational and Environmental Medicine (ACOEM)
Dr. Robert Sawyer, Surgical Infection Society (SIS)
Dr. Christa Schorr, Society for Critical Care Medicine (SCCM)
Dr. Andrea Shane, Pediatric Infectious Disease Society (PIDS)
Ms. Margaret VanAmringe, The Joint Commission

CDC Representatives
Kristina Baister, DHQP
Michael Bell, DHQP
Andrea Benin, DHQP
Destani Bizune, DHQP
Brittany Booker, DHQP
Cedric Brown, DHQP
Koo Chung, DHQP
Angela Coulliette-Salmond, DHQP
Kendra Cox, DHQP
Janet Glowicz, DHQP
Rita Helfand, DHQP
Jamesa Hogges, DHQP
Leann Jackson, DHQP
Nalini Singh, DHQP
David Kuhar, DHQP
Preeta Kutty, DHQP
Kent Lemoine, DHQP
L. Clifford McDonald, DHQP
Tara Millson, DHQP

Latisha Powell, DHQP
Kristin Roberts, DHQP
Christina Sancken, DHQP
Devon Schmucker, DHQP
Srila Sen, DHQP
Erin Stone, DHQP
Sheri Chernetsky Tejedor, DHQP
Lauren Wattenmaker, DHQP
Todd Weber, DHQP
Katie White, DHQP
Cheryl Williams, DHQP

Members of the Public

Jacqueline Abel, Scarborough Health Network
William Archbold, DF Technical and Consulting Services INC
Anne Augustin, Public Health Ontario
Lynne Batshon, Society for Healthcare Epidemiology of America
Yin Chan, Advance Sterilization Products
Jill Culaner, DED
Melissa Delazier
Patty Dorton, Buchanan General Hospital
Sylvie Dwyer, North Bay Perry Sound Health Care District
Jeremy Edwards, American Council of Accredited Certification
Brittany Fisher, Essentia Health
Catherine Florence, NOVO Designs
Sara Gallinger, Alberta Health Services
Sylvia Garcia Houchins, The Joint Commission
Susan Garramone, Oxford Immunotec
Maryellen Guinan, Americas Essential Hospitals
Sheryl Harper, Alberta Health Services
Kim Houde, Alberta Health Services
Ami Hughes, Shirley Ryan Ability Lab
Bennett Jones
Doe Kley, The Clorox Company
Jill Kumasaka, University of Washington
Caroline Matilly, Cardinal Health
Scott Mccloud, NBC Medical
Mary McGoldrick, Home Health Systems Inc.
Melissa Miller, Public Health, Ontario
Aaron Milstone, Johns Hopkins University
Ronell Myburgh, DNV-GL
Janet Prust, 3M Company
Silvia Quevedo, APIC
David Rausch, Phoenix Controls
Jennifer Regier, Thompson General Hospital
Christi Robbins, County San Diego Public Health Nurse
Maria Rodriguez, Xenex
Christine Sherren, IWK Health Center
Sandra Sieck, Sieck Health Care
Linda Spaulding, INCO & Associates.com
Catherine Thorin, Novo Designs
Kristy Weinshel, SHEA
Nancy Wilde, Iowa Department of Public Health
Sandra Witek-Eames, Walter Reed
Emily Wunsch, Center for Family Health

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 March 5, 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. Kristina Bryant provided an update on the work of the Neonatal Intensive Care Unit (NICU) Guideline. Dr. Hilary Babcock provided an update on the work of the Healthcare Personnel Guideline Workgroup. Drs. JoAnne Reifsnyder and Michael Lin described the work of the Long-Term care/ Post-Acute Care Workgroup. Drs. Lisa Maragakis and Deverick Anderson provided an update on the National Healthcare Safety Network (NHSN) Workgroup. Dr. Michael Bell provided a report on the current status of the COVID-19 outbreak.

HICPAC stood in recess at 11:30am on March 5, 2020.

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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

March 5, 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 March 5, 2020, via teleconference.

Welcome and Roll Call

Operator: Welcome and thank you for standing by. At this time, all parties are in listen only mode until the public comment of today's call. If you wish to make a comment at that time, please press Star 1 on your phone and unmute your phone and record your name.

Today's call is also being recorded. If anyone disagrees, you may disconnect at this time. I would now like to turn the call over to Mr. Koo Chung. Thank you and you may begin.

Koo-Whang Chung: Good morning guys, this is Koo with CDC. In the room with me is the DFO, Mike Bell, as well as Denise Cardo, Director of DHQP, as well as David Kuhar and Melissa Schaefer. We're going to go ahead and get started pretty quickly here.

So I'm going to go ahead and get started with the roll call and Conflict of Interest Disclosures. And then I'll turn it over to Mike, Hilary and Lisa for a quick introduction. And then off to the races with the rest of the agenda. Okay?

Just FYI. It looks like there's been a quick shift in the agenda. The COVID 19 Session for 10:45 will be moved up in the session to just after Denise's 9:10 DHQP update. Okay?

So we'll go ahead and get started with the member roll call and Conflict of Interest Disclosure, okay? First off, the two Co-Chairs, Hilary Babcock.

Hilary Babcock: Here. No new conflicts.

Mr. Chung: Lisa Maragakis.

Lisa Maragakis: Present. No new conflicts.

Mr. Chung: Dev Anderson.

Deverick Anderson: Present, no new conflicts.

Mr. Chung: Kris Bryant.

Kristina Bryant: No new conflicts.

Mr. Chung: Vineet Chopra.

Vineet Chopra: Here, no conflicts.

Mr. Chung: Nick Daniels.

Nicholas Daniels: Nick Daniels, no conflicts.

Mr. Chung: Elaine Dekker.

Elaine Dekker: Here, no conflicts.

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

Judy Guzman-Cottrill: I'm here. No new conflicts.

Mr. Chung: Mike Lin.

Michael Lin: Here, no new conflicts.

Mr. Chung: Jan Patterson. Michael Anne Preas. JoAnne Reifsnyder.

JoAnne Reifsnyder: Here and no conflicts.

Mr. Chung: Okay. Moving onto the Ex Officios. Tara Palmore. Melissa Miller.

Melissa Miller: Here.

Mr. Chung: Daniel Schwartz.

Daniel Schwartz: Present.

Mr. Chung: Judy Trawick. Judy, you may be on mute.

Judy Trawick: You're correct. I'm here.

Mr. Chung: Thank you. Liz Williams.

Elizabeth Claverie-Williams: Liz Williams is here. Present.

Mr. Chung: Thank you. Moving onto the liaison representative roll call. Paul Conway, AAKP. Mark Russi, ACOEM.

Mark Russi: Here.

Mr. Chung: Elizabeth Wick, ACS. Chris Lombardozzi, AEH. Pamela Truscott, AHCA.

Pamela Truscott: Here.

Mr. Chung: Holly Carpenter, ANA. Alan Kliger, ASN.

Alan Kliger: Here.

Mr. Chung: Karen DeKay, AORN

Karen DeKay: Present.

Mr. Chung: Darlene Carey, APIC. Chris Ehresmann, ASTHO. Ashley Fell, CFTE.

Ashley Fell: Here.

Mr. Chung: Ronell Myburgh, DNV GL.

Ronell Myburgh: Here.

Mr. Chung: Stephen Weber, IDSA. Ben Schwartz, NACCHO.

Ben Schwartz: Here.

Mr. Chung: Andi Shane, PIDS.

Andrea Shane: Present.

Mr. Chung: Kathy Dunn, PHAC. Christa Schorr, SCCM. Louise Dembry, SHEA.

Louise Dembry: Present.

Mr. Chung: Valerie Vaughn, SHM.

Valerie Vaughn: Here.

Mr. Chung: Robert Sawyer, FIS

Robert Sawyer: Present.

Mr. Chung: Thank you. Margaret VanAmringe, Joint Commission. Great. Okay. We have and met quorum. Thank you very much. Just before we get started, I wanted to let you guys know that there's public comment scheduled for after the presentations. Currently it's scheduled for 12:15.

When public comment opens, the Operator will provide instructions for how to indicate that you would like to speak. 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.

Thanks guys. I'm going to kick it off to Dr. Bell and Dr. Babcock, and Dr. Maragakis to begin the meeting.

Dr. Bell: Good morning everybody. This is Mike Bell. Thank you very much for joining. And a quick thank you up front to everyone for being so flexible. The need to keep people in a place where they can continue to be a witness for their facilities underlies the last-minute change from an in-person meeting.

And huge thanks to Koo for making that pivot this past weekend. This is obviously a fast-moving situation. Let me hand it to our Co-Chairs briefly and then I'll say a quick word.

Dr. Maragakis: Thank you Mike. This is Lisa. I'd just like to welcome everyone and echo Mike's appreciation for your flexibility. It is a trying time, I think, for all of us and I'm looking forward to the discussion today and our ability to share lessons learned and really stand together in preparedness for the current situation.

Dr. Babcock: I'll just - this is Hilary - I'll just second what Lisa and Mike said and thank all of you for your flexibility and also for taking the time to come together and be able to share some of the work that is still going on, as other things do actually still keep going on in the background.

And also just to state up front - because I know all of you are working on the same things that we are all working on right now with Coronavirus - that I remain very impressed, as always, with all of the work that all of our people are doing to keep our patients and our colleagues and our community safe and really appreciate that work that everyone's doing.

Mr. Chung: Great. Thanks guys. I just want to make sure that I capture all the members in attendance. Michael Anne are you here? And if so, can you also give us your Conflict of Interest Disclosure, please?

Michael Anne Preas: Yes. Michael Anne here. I apologize for the late getting on. And I have no Conflicts of Interest.

Mr. Chung: I think that's it for me. I'm going to kick it off next to Dr. Denise Cardo. Thank you.

Denise Cardo: Good morning. I also want to thank all of you, not just for the flexibility and but taking your time to join us in this call today. And like all of you said before, it's amazing for me to see, not just the great work that all of you do, but the importance of the work that we do to prevent and controlling infections in healthcare settings.

And the importance of this work, not just to be limited to acute care, but also to post - acute care. Since we've been talking, doing all the presentations and HICPAC meetings, when we talk antibiotic resistance, we do say that it's a continuum of care and infections are transmitted when the patients are moved back-and-forth, depending on the needs of the patient.

And so as a division, we are not 100%, but very involved in the response. At the same time, like Hilary said, we continue to do other work because infections continue to occur and it will be very important to continue to get HICPAC involvement to see how we can do even better. And now I turn to Mike Bell who is going to provide details about the response and in special activities.

COVID-19 Update

Dr. Bell: Okay, thanks Denise. So good morning again everybody. Just a quick note. As you've seen on the agenda, this is a very compressed morning that we have. And although we have time attached to each of these things, you know, we will be going rather quickly and so there may be a shift in specific timing.

Our hope is to get everybody back to what they're trying to accomplish without absorbing most of your day. So in case you're telling somebody to show up for a certain session, realize that that might move forward just a tad.

So with that, let me start by giving you, first, a quick situation report of where we are with the COVID-19 outbreak. And then I'll give you a little bit more information about the response and what we're seeing on the horizon.

Here are numbers as of last night, there are 127 confirmed or presumptive cases in the United States. And that includes 23 cases that have arisen without direct relationship to travel or known contact with infectious people.

Those cases currently stand, Massachusetts, Washington State, California, Chicago, Arizona, Wisconsin, Florida, Georgia, Oregon, and Rhode Island. Normally when I read lists like that, they're in alphabetical order and I find that confusing, as opposed to geographic clustering. But that list had neither of the above and that's kind of interesting.

Anyway, notwithstanding, we've got many, many states now - and we will likely have more - that are seeing cases. This is in addition to the three evacuees that

were detected coming in from Hubei Province and the 46 evacuees that were positive coming in from the cruise ship in Japan.

Overall, internationally there have been 90,000 plus confirmed cases. As of yesterday, there were 74 countries effected. I think that's gone up by four or five already. And as we look at this, we are seeing a transition from focal outbreaks to a much more diffuse pattern. I'll say a word about that transition, in terms of our response.

I'm sure many of you are acutely aware that when we began this process, we took a very intentional containment approach. There are a couple reasons for that. First, we are fortunate to be in a country that can do some of this. Not everyplace has the resources both in terms of protective equipment and isolation capability. So we tend to make use of what we have upfront. That is a cultural thing, more than anything else.

There are plenty of places that try to take the opposite approach and there's nothing wrong with that either. I think the main issue is understanding the rationale. We tend to lean forward up front. And the rationale for containment, just as it is for extremely drug resistant bacteria or Candida *auris*, is to identify immediately, even a single case. Contain that case and make sure there hasn't been any secondary transmission. If there was, contain that secondary transmission and make sure that it doesn't take off into the community.

The reason for that in terms of this outbreak, is not that we expect to contain it in perpetuity, like we hope to do with many of our AMR pathogens. In this case, we know that it is going to ultimately get out into the community. But we're buying time. By taking an aggressive approach upfront we can do two things. We can suppress the peak of our epidemic curve. And, at the same time, we can delay the arrival of that peak.

That has the impact on the health system in terms of having a slightly slower, and hopefully, lower magnitude arrival of cases and the need to deal with that onslaught. And it also gives us more time in terms of identifying optimal care practices, as well as development of tests, immunization, and therapeutics. So that's the rationale - even though we know that this likely to affect the community - of attempting to contain the outbreak upfront.

Based on what I already told you about the number of countries and states affected, I think it's fair to say that we are rapidly moving to the mitigation phase. And just so you know, the folks here who have been drafting guidance, pretty much 24 hour - maybe 20 hours a day - every day for the past four weeks have been developing in parallel, not only an acute containment recommendations, but variations and adjustments on an almost hourly basis. This is a recognized transition. It's what we've done in previous outbreaks and we continue to do the things in this time.

When I talked about mitigation, a lot of what I'm thinking about is how we assist what is, in fact, an extremely brittle healthcare system to continue to function, despite the outbreak. We have, for whatever reason - and there are many good ones - designed the system based on very lean staffing practices.

Based on just in time supply chains and purchasing, and based on extending healthcare to less expensive locations, like nursing homes and outpatient settings - that makes sense during normal times but are really not well-designed to stand up to something like this outbreak.

And so we're seeing all of the predictable effects of that and a lot of what we're doing as we move to mitigation, is to try and accommodate those realities in a way that is safe for healthcare personnel, protects our patients, and allows it to keep the doors open to continue delivering care.

There are a few guidances that are in progress as far as shifting goes. And shifting is happening on a scale of 12 to 36 hours from now. We started out saying that patients who are recognized to have, or suspected to have COVID 19, should be cared for, ideally, in a negative pressure room, if you have one.

We've always said from the get-go, if you don't have one and there are none available near you, it's okay to use a private room with the door closed. But that is something that we lean toward a bit on up front. If you have them use them.

We also recommended for protective equipment a fit tested N95 respirator or better. Eye protection, gowns, and gloves so that we're managing this as contact precautions, with the addition of a respirator and eye protection.

That is focused on two things. One, we do not know the extent of contribution that environmental virus might pose. And so the glove and gown use is with an eye towards ensuring that we don't accidentally transmit infection that way.

Eye protection is something that we, I think, culturally for a generation or more, have been lax about. I think that's, frankly unacceptable in routine times, given that influenza spreads wildly across our community every year. And so this, as well as for routine practices, is an opportunity to firm up our use of eye protection.

It's not about there being necessarily target epitopes in the conjunctiva. It's the fact that our eyes drain into the back of our throats and if you're trying to keep respiratory viruses out of your throat, then protecting your eyes makes sense. Nose and mouth, similarly, need to be protected. We use respirators in this context because of the very likely possibility of a contribution of near range inhalation. This is something we've talked about with every concerning respiratory infection over the past 20 years.

And that is the idea that when we cough or breathe, we generate a range of particle sizes. Some of them are big and splashy and can land directly on us. But if you're not within line of sight or ballistic range - but within about six feet - it's conceivable that somebody can be generating small particles with infectious material in them, that could drift in and be breathed and entrained in what you're inhaling.

For that reason, a surgical mask that's a nice barrier against ballistic impact, isn't as good of a device. The fact that there's a half-inch gap on either side of your face really doesn't protect against inhalation. And so that's why we recommend respiratory protection.

There is - there's always discussion of the available published evidence and ongoing generation remedies, that question what is the relative benefit of a mask versus a

respirator. And I think the jury is still out. It seems to be fairly close, when we've compared respiratory infections across the board.

But then again, there's always a question of adherence. And what we see is that people are much more likely to adhere correctly to surgical mask use than to respirator use. So that behavioral component is a bit of a question mark.

We also are hearing early information about public issues that are upcoming that might show a lean towards maybe a little bit more protection with a respirator. So, I think we as a profession will continue to have to navigate that grey zone. But for the time being, that is the recommendation that we made during the containment phase.

The pivots that we're doing at this point, also have to accommodate the fact that we are amidst a global production shortage for protective equipment. Masks, respirators, gowns, and gloves are all manufactured in many other parts of the country including a large proportion in China, which as you recognize has had major impacts on their industrial capabilities. That has led to a very inconveniently timed reality that we are running short of much of this protective equipment.

We are working very closely with the Assistant Secretary for Preparedness and Response, that's ASPR and the Health Care Protection Program in states also managed by ASPR. ASPR is the owner of the Strategic National Stockpile. And so we are working closely with all of our jurisdictions and asking that they directly contact the HPP Programs in their states to request supplies.

The state programs are also attempting to coordinate with purchasing organizations and ensure that if there are supplies within a region that are needed desperately in one place or another, that that could be potentiated as efficiently as possible.

So recognizing that all of that work is being done to make the best use of what we have, this also includes some work by our NIOSH colleagues who have looked at expiration dates for protective equipment. As you've probably heard, some of what those Strategic National Stockpile is past “for use by” dates.

And for respiratory protection, understanding if the elastic bands are still going to provide a snug fit for the infiltration capacity as maintained, those are things that have been assessed by NIOSH and they have produced a chart to inform users if they are provided material from the stockpile, that is past use by dates.

There is actually a plan for figuring out which ones can still be used. That material is yet to be distributed. Everything that's distributed to date has been still within its “use by dates.”

So if a shortage issue is what's driving us to provide an alternative to the use of respirators for the care of all patients, we are seeing now that this is going to be finalized in the next day or so ideally today. We have negotiated intensively with our labor union colleagues and worked closely with NIOSH and OSHA, to get to a point where we can say that during times of shortage, we need to prioritize available respiratory protection. Whether that's N95, PAPRs, or anything else for the highest risk activities. So that healthcare personnel who undertake those activities still have protection.

That means that for routine things effecting patients and so on, without doing an aerosol generating procedure for example, can be done with a surgical mask, but with eye protection, gown, and gloves. That is a temporary state of affairs. The intent would be that once the supply chains resolve, we'd go back to recommending respiratory protection once it's available.

That is one pivot that we're making so that we are not painted into a corner. And also so that we don't wait until everything is gone and there isn't anything left for those high-risk procedures. So now is the time to do this. There are a couple of jurisdictions. I think Arizona and perhaps parts of Washington State, that have made that pivot on their own, which is totally fine.

But I think having the backing of the federal government is something that will be helpful for many other jurisdictions. So that's one thing that we're shifting.

Another thing that we're in the process of addressing is, the whole issue of how do you manage exposed healthcare personnel? As we look at the progress of this outbreak, there is going to be greater and greater numbers of individuals exposed. Not necessarily the extremely high-risk exposure that someone might have while doing induced sputum or something like that. But nonetheless, a non-negligible exposure.

And with the numbers that we're seeing - and as I said, with limitations in staffing - we're very concerned that if everyone gets furloughed for two weeks, we would shut down the healthcare system. We're in the process of releasing an updated document - and I think it went up last night - Melissa's nodding vigorously. It wasn't an easy task, but this went up last night.

And it basically now says that a low or medium risk exposure, a person who is asymptomatic, can come back to work - does not need to be furloughed. But should be working with Occupational Healthcare Visits for the facility and should be monitored before starting their shift to make sure that they don't have a fever or symptoms.

If they become symptomatic, obviously, they immediately stop working, put a mask on, notify their supervisor, and follow up with both Public Health and Occupational Health. I think that will make a large difference.

The issue of allowing symptomatic personnel to work is not something that is currently on the table. It is something though, that I think a great deal about, because during any cold and flu season, it is a reality that many healthcare personnel come to work with a minor sniffle or scratchy throat.

And, you know, realistically given that we're dealing with COVID which has a spectrum of symptoms ranging from nothing to minor to very severe, we ae in a situation where that kind of minor symptomatology could actually be bringing with it COVID into a facility.

It's a time to think seriously about whether we want to move to a situation - and this is something I'd like our member feedback on - where we recommend that if you have any mild symptoms, you wear a mask while you're at work. This is at odds with the very concrete statement that people like to make of don't come to work when you're ill.

If we could actually enforce that - and if people all had, you know, actual sick leave as opposed to taking time off - if we didn't rely on hourly staffing through contractors for environmental service and other care, that might be a realistic thing to suggest. But I'm afraid it really isn't. And so our committee, I think, is going to meet to weigh in. Not just for this outbreak. But going forward, do we want to see a change in our culture about how we manage symptomatic healthcare personnel with very mild symptoms.

This is related to what I brought up several times over the past five years about the growing availability of multiplex testing, where we're starting to get results of infection with previously undiagnosed nonspecific inverted commas, colds and as we do that, I think we're going to have to grapple with this even more seriously. So that is a bit of a digression, but the healthcare personal furlough thing has been adjusted and that is now up.

The last thing being posted today, if not tomorrow morning is the issue of how do we get people out of isolation? So to date, we have been using a negative RT-PCR test result with at least 24-hours of time in between them. The challenge we have there is, first of all, many people are being isolated at home.

From the very beginning, we recognized that the majority of people with COVID have very minor symptoms, if any. The minor symptomatology is 85%. And so with that in mind, keeping people in the hospital just because they have a diagnosis doesn't make a lot of sense.

We have, from the beginning said, that isolation can continue at home. Hospital care should be based purely on a need for medical care of that caliber. And once home, we've provided recommendations for home isolation. The problem is, deploying people around the community to do these two negative tests for all of these individuals is a logistic impossibility.

And the meaning of that test, I don't think is robust enough to make it as useful as we would like it to be for a "clearance test". As of yesterday, we have enough evidence, based on publications from China and Singapore, as well as the first 12 recognized cases in this country, which have been systematically assessed looking for not only RT-PCR signal, but also assessing what the cycle time is for those. How that cycle time, the CT value, maps to potential infectivity based on what we know about culture positivity.

And in a nutshell, we're looking at the fact that culture positivity from Chinese data, seems to cluster within the early part symptomatic infection. Those infections seem to be running their course in about two-and-a-half, three weeks. And thereafter, what we're seeing is an increase in CT values - in other words, requiring many more cycles to amplify the RNA signal, happens towards the end of the syndrome itself and during recovery.

The cutoff that we're seeing with the CT values appears to be around 30 or 32. Anything above that, doesn't map at all to the viability we've seen in culture studies published to date. And so that in combination with sort of, the practicality of home isolation, is being looked at to propose in the coming day, a time-based criterion for cessation of isolation. It will likely be a combination of number of days after onset of symptoms, plus a minimum number of days after resolution of symptoms.

There's still negotiation of what the resolution of symptoms should be. Whether it's fever and lower respiratory symptoms. You know, we want to be sensitive to the fact that people might have some residual cough after getting better. The thing that I think is important to takeaway, if you're not accustomed to thinking about RT-PCR, is that the test will amplify even scraps of RNA. So if there's debris from a recovering person that includes a little bit of viral RNA, that will ultimately get amplified.

It might take longer, which is why the CT values go up. But it doesn't really reflect "shedding a virus". It reflects release and detection of some pieces of viral RNA and it's a very different thing from what we think about with bacterial culture or viral culture or fungal culture, just to be fair to our mycologist colleagues.

So that is, guidance that should be up in a coming day or so. And with those three things, we hope to get people out of isolation. We hope to reduce the burden of testing for people who are recovering so that we can refocus the testing capabilities on the people who need to be diagnosed. And we are - we have fixed the healthcare personnel furlough thing for the time being. And we are pivoting on the use of respiratory protection in recognition of the shortage of supply.

One last thing about tests. There is a rapidly evolving landscape in terms of independent companies providing newly developed tests. Those have not been cross validated, as the international tests have not been cross validated. So just bear in mind that when we look at testing and the results, right now it's a little bit of a wild west situation, where many things have been devised. There's hasn't been time to iron out any inconsistencies or understand performance differences. And so as these tests come to market, just be aware that there will be ongoing assessment and additional information to help us understand how best to use those tests.

Lastly, I will just say that all of the other guidance that we have up there is likely to change in some way or another. And frankly, the time during which we are focused on healthcare is probably comparatively short. If you look at the progress of the outbreak in China, their vast outbreak peaked and started to resolve over the course of three or four months. We're now in month two.

And assuming we believe that that resolution is, in fact, happening, we probably have a couple, three more months of work to do in terms of accommodating this. So everything that we do, is about trying to be nimble. Making sure that what we've said so far, doesn't get in the way and being ready for what happens next week. That's kind of the timescale and time cycle on which we're working.

A huge thanks to the many staff members and divisions who have done nothing but work on this guidance. It's been a very rigorous process and one that's taking a lot of time. But we will continue to share.

And what I was saying about the healthcare system is that right now, we focus on it to protect a very critical asset for the nation. We will continue to do that. But at a certain point, healthcare personnel are going to be more likely to get this infection at the grocery store then they are at the hospital.

And when that happens, we will all need to be thinking about what the implications are both for healthcare personnel screening. What I said earlier about routine use

of surgical masks for anybody with mild symptoms, and what we think about in terms of testing, cohorting, and the like.

With that, let me stop there in the interest of time and turn it over to our chairs, Lisa, Hilary.

Dr. Maragakis: Thank you, Mike for all of that information. It is so useful to all of us and I think you explained it very well in, obviously, a compressed period of time. But certainly we, on the frontlines in healthcare, appreciate all that you and your colleagues are doing to get this guidance together.

And as you have described so well, react to the rapidly evolving situation and appreciate the need for flexibility, flexible approaches, that recognize the shortages that we are anticipating and the changing and evolving situations. Thank you for that.

Hilary, did you have comments?

Dr. Babcock: I also wanted to say thank you. We are looking at the updated Healthcare Worker Exposure Guidance as we speak and I think that the overall prescription is sort of the evolution of the process from the CDC's response and the rationale behind the various processes is also a good context for us to have.

I may have missed it, but I am interested in knowing, sort of, was the pivot you're describing in terms of PPE recommendations - that will be formally stated in the guidance at some point or is that already there and I kind of missed it?

Dr. Bell: No, that's going through the final negotiations today. You could imagine that between unions, OSHA and others - there's a lot of interest in this and it goes in both directions. And so we need to navigate that successfully if we don't want to have unnecessary consequences of that.

Just a word for where to find all this guidance if you're looking for it. www.cdc.gov/coronavirus is where all of this is sitting. And if you navigate down to the healthcare section, you'll find all of the latest…

((Crosstalk))

Dr. Babcock: Thank you for that. I think that it will be interesting to hear feedback, as well, from the full committee if that's the next step in our discussion. We, in Missouri - I'm knocking on wood as we speak - have not, as you noted, had a case yet, but of course, have been in full-on incident command prep mode for several weeks now and have had multiple patient's that we have had - been able to arrange testing for.

I think that the evolution of the guidance is both a challenge and a benefit. So we definitely appreciate, you know, responding to the changing conditions. And that's a real positive and a real benefit. It does make for communication, et cetera, a challenge for us on the ground. But not in any way meaning that it shouldn't be happening, just to reflect what that work looks like on our side.

And then I do think that testing capacity is really - has been a bottleneck and I know that there's a lot of work to expand that out. Our impression here and from others is that the Health Departments are really struggling to keep up with the numbers of requests and are still trying to do some triage and test control

And again, I think that's reasonable given their workflow, but does make it a little harder to feel confident in the case ascertainment that is going on. I think those are my two main comments and then if you might want to respond to those and then we can open to committee members if that's the next step.

Dr. Bell: Yes, the testing needs and bottleneck I agree, are challenging. Really what we're driving towards is a different modality protectant. RT-PCR is inherently a bad test for something that you want to turn around quickly, right.

We really don't want to wait for 24 or 36 hours for any test when we're trying to diagnose and isolate a transmissible respiratory virus. That's one of the reasons why everyone is working so hard to find a serologic answer.

And things like antigen tests also lean much more towards that rapid detection capability. Clearly the development pipeline does have its limitations, but I think what we're really saying is that we want a rapid test, just like we use for flu because that's the thing that helps us do what we need to do.

I would not, in any way, try to continue to rely on RT-PCR as a testing mode long-term. I just think that it's the first thing we can do because all we need is a little bit of a related virus to start sequencing and then once we sequence, we can do RT-PCR. So it's the first easy thing.

Whereas with serology and antigens, we need to grow the virus or we need to have acute and convalescent sera. And all of that happens later in the progress of an outbreak. Whereas sequencing and RT-PCR is something you can do pretty quickly.

So it's kind of a natural history of the arrival of a new pathogen. And it's very, very satisfying to me actually to see how quickly the labs across the country and internationally, have been able to do what they've done given, you know, if you think back to HIV for example, how long it took back then. So I think we are tooled up to do better, but I think that RT-PCR is just the first step and not the ultimate goal.

Dr. Maragakis: So is the next step to open to comments from the committee?

Dr. Bell: Yes, I think that's a great next step.

Dr. Babcock: Okay. Any committee members that would like to comment or ask questions, now is your moment.

Dr. Fakih: Good morning everyone. One of the issues we're facing - and I see it from my system - is how to evaluate patients with acute respiratory illness with moving to clinician discretion, of course, for COVID 19. I think it may miss the epidemiologic link that we had before in the past and therefore connected for every approach we do. In the past, we had the travel history or being exposed to COVID 19.

Or, even more recently, a couple days ago, it was related - if there's activity within your area, and I think it's fair - because we don't know the prevalence of the disease in the United States - so it's much harder to just have no - no way to prioritize who's going to be tested.

So similar to having that approach that maybe even maybe even mildly symptomatic healthcare workers that we're not testing for COVID 19 may be working. I think it's

very reasonable to think about how we will be testing our patients that will hit our EDs, our ambulatory, or call us from home. Do they even need to be tested?

So one of the things that I think is important to give guidance for - and we're trying to do that for our system - is that for those that have marked illness, it's - as soon as they show up they need to be on proper precautions. We deal with them like any other viral illness. We avoid exposure to healthcare workers. We send them home.

I think what I'm worried about right now is opening testing without clarity on how the clinicians will test. And not everyone is an expert in this. I think we're going to be hit with a huge number of people being stuck in EDs, being stuck in healthcare settings. And this is not even safer. This may be even more dangerous or potentially harmful to our institutions, because we won't be able to take care of someone with a heart disease or another event.

So what I'm pleading for here is for us to consider a category that is way more - I think it's probably 90 plus or maybe 99.9% of all population it's not COVID-19 that has upper respiratory illness. I don't know if I'm making sense to the committee members.

Dr. Bell: That is a very good estimation of where we're at essentially at this point. Without epi links, any sniffy nose is possibly COVID. There is a lot of work underway.

In fact, I believe today is the telehealth engagement that the agency is doing with a range of health informatics and IT platform companies and health systems to think through implementation of telehealth options so that we're not actually seeing people with minor disease that can be triaged away from the health system.

I think that's a major thing. I think that there's also an opportunity here to rethink how people arrive for assessment at acute care and ambulatory settings.

And then the last thing is understanding that the people who are severely affected to date, have not been children, or young healthy adults. They have, essentially across-the-board been older or with underlying chronic conditions.

And so I think there's also a role for clinicians to be thinking about how to target testing for the people who are at risk of greatest harm. That might be an added factor that could reduce the burden on the health system.

Dr. Fakih That's a great point. I mean it's just - I think the guidance is - what I'm trying to say is moving the guidance and keeping it open, I think may have unintended consequences that may harm our health systems. And right now, we don't have much testing available. So it's going to be a huge strain for health systems, for public health departments and also it's - there's going to be a bottleneck.

What do you do with someone you're suspecting - you're going to be stuck with that person? And one of the things that may need to be considered is to figure out how we can get the prevalence, but not test everyone, even if we're suspecting COVID-19 if they're mildly symptomatic. And you're way more knowledgeable than I am about this.

But would it make a difference if they go home and we say to them try to avoid people for a week, instead of making sure they're tested. I don't know the answer, but, it's just something to consider.

Dr. Bell: Yes, thank you.

Dr. Guzman-Cottrill: My comment and then I guess a question is - so as you know, here in Oregon, we've already identified three cases, which were all community acquired cases. I think - and I'm grateful to the CDC for staying on top of this 24/7 and then updating guidance as it's deemed necessary.

But from an infection prevention perspective in the healthcare setting, a question that I had or I think maybe just more of a comment is, judicious use of N95 masks, and PAPRs in the ambulatory areas. When I reviewed the updated guidance last night, it still does put medium risk category for healthcare workers who are wearing all of the recommended PPE with the exception of the surgical or procedure mask, instead of a PAPR.

I think the challenge - what we're having here in Oregon when trying to give guidance to the frontline healthcare workers in the ambulatory setting is a few specific procedures that are very common. Especially right now where we still have influenza, RSV, and (unintelligible) also a lot of Group A strep in the community right now - strep throat.

So based on the guidance the healthcare worker needs to be wearing an N95 mask or PAPR doing a nasopharyngeal swab for not just COVID-19, but also for influenza, or even right now we're saying a throat swab for rapid strep because that could induce a cough.

And most of these ambulatory centers do not readily have N95 masks or PAPRs available because they're all being used in an inpatient setting as well. So, they say are we lower risk because these patients aren't as sick?

Well we are also are keeping logs because we don't know the word of employees that are doing these procedures, even just a nose swab or a throat swab, because if that patient in the ambulatory setting ends up becoming sicker then gets tested for COVID-19 in the inpatient setting a few days later, then that healthcare worker would be considered exposed a few days prior.

So we're trying to maintain the workforce as I know you are too with your recommendations. But we're kind of thinking ahead since we don't know the community burden. And I think having more specific guidance on - which I don't know if there's any data even in the outbreak in Asia so far, that we can use to make an informed decision about nasopharyngeal swabs and throat swabs. If they are aerosol generated procedures, perhaps we should even put high risk and low risk aerosol generating procedures.

I'm not sure. This is one thing that we're really grappling with in the ambulatory setting when we don't know the burden in the community.

Dr. Babcock: I'm just going jump onto that comment for just a minute to say that, I agree completely that the ambulatory setting and the guidance for that has been a real challenge. Even here before we have cases, it means that our ambulatory settings are saying, essentially anyone that might be under consideration, they can't do any testing on. Like they can't flu swab them. They can't do anything because they don't have N95 there.

And I've been trying to remind people that we don't require N95 for flu testing, which also has a recommendation for N95 for aerosol generating procedures. And that we don't require that for doing nasal and oral pharyngeal swabs for flu. But it is fighting a little bit of an uphill battle.

Dr. Bell: So I will say when I think about this, it gets back to where we are in the timing of this arrival. We don't seem to have these concerns during flu season when we do rapid flu testing. And people do get severely ill. So I would ask ourselves, where do we want to go with this?

If we want to tighten things up for the COVID response in outpatient settings, I agree with you there. There are plenty of gaps in the armature, if you will. It is the reality of our health system. But then, whatever we do for this, I would expect to be done for flu. And, you know, that leads to scale issues that leads to implementation issues - and those I don't think are clearly worked out.

Again, I think it's important to keep in mind that we are in the third week-ish of a several month process. At a certain point, this will become very much like other coronaviruses. Think about what happened with MERS and SARS. You know, those were not short enough, but they didn't continue forever.

And so I would be thinking about what we do to sustain the health system through this process and not try to build something that is going to be long-lasting per se. Unless, like I said, with flu and whatnot, we really want to engineer an overhaul in what we're doing. Which may not be unwarranted.

Dr. Maragakis: You know, I guess I just wanted to bring up the issue - and I know there is some guidance online, but just a brief discussion I think would be helpful about the strategies to preserve the current respirators that we do have. So either PAPR hoods or N95 respirators. I just wonder if you want to say a word about that. We are trying, in our facility, to give sound guidance both as you've alluded to prioritizing settings, procedures, where they should be used. But also how long they can used and what we expect people to do with them.

And again, I know some of this is on the website, but I just wanted to make this worth a general discussion.

Dr. Bell: Thanks Lisa. Yes, I think that's an important thing. There is a document that NIOSH produced that runs through all of the ways to extend the usability and capacity for respiratory protection. You know, those things are always kind of challenging. It's not like we have rows of pegs for hanging respirators on the hallway walls outside of patient rooms. And so when we say hang them up, that's a kind of a difficult thing to implement.

I do think that there are some practical things they can do. One of them is thinking to where we place respiratory infection patients in a way so that it's efficient to leave respiratory protection and a face shield on from room-to-room and simply, you know, changing gowns and gloves, doing hand hygiene before going into the next room.

This is not meant to say that all respiratory type symptoms can be put into shared spaces. We still want private rooms. But as long as that's the case, moving from a COVID room to another undiagnosed respiratory infection room should be doable

without changing your respiratory or face shield. There're some admonitions about, you know, how you handle them and so on.

The extended use piece is probably the easiest to implement. There're probably more concerns about the reuse in terms of both contamination and secondary transition related persistent virus. You know, we're seeing that, at least on the laboratory test surfaces, stainless steel and so on, these organisms can persist in their infectivity for many hours. So with that in mind, you know, the extended use is probably better than the reuse option.

For devices like PAPR hoods, if they're going to be reprocessed between use for reuse, figuring out how to implement that is a major challenge. If you're using a wipe type approach, how carefully are you able to wipe and are there any residual tentacles that are of concern to the user. Ideally, you're not wiping the inside, but ideally, it's reused by the same person. We're not recommending reuse of something like that by different healthcare personnel.

The last thing, if you go to elastomeric, which a couple places have, I can tell you from personal experience that a clammy, damp reprocessed elastomeric respirator is extremely unpleasant to wear. And the throughput process of cleaning and disinfecting that respirator so you can put a fresh cartridge in, is logistically very challenging.

Dr. Babcock: I'll just add, we have also been having a lot of discussions about how to conserve our limited N95 respiratory capacity. I definitely see the benefit of extended use versus reuse and I think that when you get to a level where you have multiple patients or you maybe have a ward that is full of COVID patients, that then extended use is a better model and looks better and is probably safer.

I think it's a challenge in that earlier stage, if you have one or two patients and if you're lucky enough to stay at the one or two patients range then extended use does not really work as well. Because essentially you have to be able to take if off and put it back on between those two patients while you were doing other things. So I think we have struggled a little bit with that, but are trying to, sort of, tier that as well.

Do other committee members have comments or want to share any experiences with their conservation strategies or how that's going for them?

Dr. Bryant: Not sharing but, more of just a challenge. So with the change in the PUI definition, before the most current, that suggested testing people with severe acute respiratory illness with fever and known etiology, we have lots of questions from our hospitalists and our ICU physicians, about what does that mean? And should we not be wearing N95 respirator for things like intubation if we just don't know?

Now admittedly, I practice in a pediatric facility. There are diseases that could be less severe in kids. Maybe this will be really rare. So we tried to talk through this, but they're really worried. How do we know? Local epidemiology, how can we use that? I live in Kentucky where frankly we just haven't tested many people because of the lack of availability of kits.

So how do we advise or reassure clinicians who are intubating pediatric or adult patients? What should they do? And when should they wear an N95 respirator?

And if they intubate a patient who turns out to later have COVID 19, and they were only wearing a surgical mask with eye protection - that's moderate risk right? And so they can work if asymptomatic? Or they cannot?

Dr. Bell: Kris can you say that one more time? I think I heard you ask if exposed healthcare personnel can work if they're asymptomatic, is that correct?

Dr. Bryant: Well so two things. How do you advise wearing of N95 with intubation in a setting where we don't think we - we've not identified COVID 19 yet? And if ultimately the patient who's intubated turns out to be infected and the healthcare provider was wearing a surgical mask instead of an N95 mask for intubation, that's moderate risk, right? So what do we tell the healthcare worker about working?

Dr. Bell: So for a medium risk, that is now a - you can come back to work as long as you're not symptomatic. One thing about aerosol generating procedures - this is a topic for another multi hour discussion - and one that actually Washington University in St. Louis and Hilary and company should weigh in on as the experts, I think.

They've done more work than anyone I know of. Looking at what does it mean to say aerosol generating procedure? And all of these things that we always put in parentheses as sort of a holdover from the SARS experience, really turn out not to generate that many aerosols, including intubation and extubation.

So I'm thinking about this a lot of - on the one hand it's aerosol generating procedures. But also procedures during which respiratory and other infectious material are likely to be poorly controlled.

And when you think about the chaotic situation of the resuscitation that ended up resulting in transmission to the clinician in Toronto, you know that is the kind of thing that I think has less to do probably with aerosols and more to do with the chaos of the situation. But Hilary, do you want to say more about aerosol generating procedures?

Dr. Babcock: I would just say that in our work, which sadly I did not get published before Coronavirus got here, but we have spoken about extensively in public forum and in talks and we will try to get out as soon as possible - that we, obviously, were not able to capture a lot of intubation and extubations, as those are generally not planned very far in advance.

Those that we were able to capture did show a small increase in particle generation. Not much change in particle size. So I think there's a - there're sort of two things in talking about aerosol generating. Is there an increase in numbers of particles? But I think the real concern from a healthcare perspective is do those particles get smaller during this procedure, so that suddenly your surgical mask is not really effective anymore and you need the N95?

And we, even in procedures where we did see an increase in particle generation in number or map concentration, we did not see a shift in size of the particles to a smaller particle size. So I think that is reassuring, in general.

I do want to follow up on Kris's question though just - I think many of us are reviewing the items online, that you were referencing. And the medium risk categories from what came out yesterday, still says exclude someone for 14-days. I

think what's actually happened is that the procedures or the contacts that are called medium or low risk, are - have changed. So just for clarification based on what you were saying before.

And it looks to me that prolonged - for Kris's question, in the new guidelines that came out yesterday, prolonged close contact with a patient not wearing a facemask and the healthcare workers wearing all recommended PPE, except have a facemask instead of a respirator, would currently - well would be low, except for intubation would go up to medium. And for medium, actually is still work exclusion to Kris's point.

Dr. Schaefer: So the language that Mike was talking about is permissive to allow people with exposures to continue to work after consultation with Occupational Health Programs was moved up to, kind of, front and center at the top of the document where we're talking about updates.

So those first two paragraphs kind of talk about the current situation in the United States where we're seeing community transmission, recognizing that, kind of, everything that was listed below that you're referring to, may not be practical - or is not practical when we've got community transmission, as Mike was saying.

And so that language, those two paragraphs at the top, are where we have that permissive language. And so if that is not clear, we can see about working with our communication and web folks to maybe highlight that a little bit more or pull that out so it's not missed.

Dr. Babcock: So essentially the table looks the same but you added comments that say we don't always have to follow the table if we can't?

Dr. Schaefer: Right. So we made some clarifications in the draft of the document before we had some language about self-monitoring with delegated supervision that was requiring a check-in when they showed up at work every day. We made that a little bit more permissive. We received feedback on - the original table was a little bit confusing, so we took that into consideration and tried to kind of make it more clear about if source controlling the patient was present or absent and then the kind of categories of PPE that were worn.

So for facilities that elect to follow the stricter guidance because they haven't had it in their community and they work to do a stricter approach, they can still follow to that language, but recognizing that the situation in the United States has changed and there is community transmission and so in order to get this up quickly, instead of doing a complete overhaul of everything, we added that language at the top to give some flexibility there.

Dr. Babcock: Okay. So that's - I'm sorry to be really detailed about it, but just to be clear - so that's the paragraph right before the word background?

Dr. Schaefer: Yes. The two paragraphs before background talk about the community transmission, make the case that doing this - devoting a lot of resources to contact tracing and all these retrospective risk assessments, are going to devote resources from more critical infection prevention and control activities.

And so we're shifting emphasis to more routine procedures without having healthcare personnel report whenever recognized exposure, regularly monitor themselves for symptoms, don't report to work when they're ill, and then that paragraph spelled out that the asymptomatic can work in consultation with Occupational Health and some other considerations.

Dr. Cardo: As all of you are saying and as Melissa just said - we recognize that there are different levels of community spread in the United States. So we are now - it's not that we're changing completely our recommendations - like Mike said, the basic recommendations continue, but we are being realistic in terms of how to make those things work and also continue to provide quality care to the patient.

And so we are going to see that the language that can really help us guide facilities that are facing that problem, to really…

((Crosstalk))

Dr. Cardo: …provide options in implementing the recommendations. The same thing is applicable for this N95. So we are - it's not that we're saying we're changing COVID, we are really looking at how this can be applicable to the different realities that we are facing.

Dr. Maragakis: I really appreciate that explanation and that approach and I think that as someone mentioned earlier, maybe there's a way to present in the guidance documents that are in the website, so that it's very clear, like under ideal circumstances, you know, if whenever possible there's a recommendation.

If there's a shortage of Personal Protective Equipment supplies, here's a more permissive approach and as Mike said earlier, we've got to go back - you know, if we get a supplier we can go back to the recommendations.

Or with local community spread and surge here's the modified approach that can be taken. We're sort of thinking about that in our health system and trying to have different strategies as we've been discussing this morning as the situation evolves.

But I think you're right. It's not a change of the recommendation, it's an adaptation to circumstances and really what is feasible.

Dr. Cardo: And Lisa, thank you for the comment. Everything you are saying is included in all the recommendations. So suggestions, not just in how we can highlight that, but also how you, as experts in the field, can help with that message. I think it was critical.

And because it is embedded in the beginning of all the recommendations when you look at what we are drafting for, like N95s and with good eye protection, everything that is said is included. But it would be great if you guys can help us in how to deliver the message that you just mentioned.

Dr. Babcock: I'm sure it is, Denise. And, I didn't mean to be critical and all that it's not, I'm sure it is. I think people are having trouble digesting it and it's so I found that even within an organization so difficult to control the message, get it to the people who need it and I can just say that yesterday, I was very busy in meetings and my team came to me and said the CDC has changed their guidance and now it's droplets.

And I had to work backwards. I mean - I was shocked because I didn't think that was true and so I had to work backwards to really undo a lot and say, no - this is not what happened, that has not changed. So the word choice and the way that it's explained - it's just critical.

Dr. Cardo: Yes, and that's what I'm asking. Because I can help in delivering that. I didn't think you were critical, I'm just saying you'd be great if you, as professionals and also your associations can help and we can even - I don't know how we want to continue to have updates, but we can help you with the, like Mike did, with the rationale and while you were doing and what are we expecting.

And I think it'll be fantastic, because we're facing the same - getting the same confusion that you were getting and I think it's something that we all should be helping with the message, that is critical.

Dr. Russi: I think the challenge a lot of us - is in the ambulatory setting and again - and others have commented on this who don't have negative pressure isolation and generally have not had N95s there. We also want to be careful with the N95 supply and continue to prioritize it for inpatient care.

And looking at the new guidance - and Mike, from what you said, it sounds as though we regard an encounter with a non-masked patient where everything's in place except the N95, but there's a face mask as being a low-risk encounter. I think we've tried to do a lot of planning around making ambulatory encounters nothing more than brief triage sort of behind a closed door.

I mean, even using a cell phone to do the interview. And then if someone needs further evaluation, moves them to a site where there's negative pressure isolation in order to have things like a respiratory sample done.

So it kind of gets down to, you know, I mean, as we transition to this being much more prevalent in the community and people much more frequently coming into ambulatory sites and the thresholds for testing now being lower than they were before - is it going to be acceptable?

And if so it’s kind of needs to be spelled out that it's acceptable for ambulatory sites to employ contact precautions, eye protection and face masks in order to have an ambulatory encounter during which a nasopharyngeal swab is gotten.

Dr. Schaefer: Yes, thanks for that comment Mark. That is what we're attempting to address with the updated guidance, but we are - as Mike said, things are still pending. But we have heard that feedback, appreciated it. We'll be doing our best to address it.

Dr. Bell: In terms of - ambulatory is a huge and important thing. The other things that I didn't get into and I'll try to keep it brief - are things like dialysis facilities and skilled nursing facilities. Places where respiratory protection programs are not traditionally provided. Respiratory protection is not normally used. And yet, during in the context of this outbreak, we've need to do some things that are different.

At the same time, we don't want all of these people to be shipped over to acute care facilities for routine dialysis or for non - you know, noncomplex care. And so navigating that piece is equally important, as is ensuring that our ambulatory services can be sustained.

Ms. Preas: I was just going to share with respect to the PPE that we walk such a fine line in assuring that PPE is readily available at the point of use for standard precautions, correct?

And as much as we're messaging - and I just want to share this with the group and I 'm sure many folks feel the same way - as much as we're messaging that wear the proper PPE when you're in droplet and contact precautions, wear it appropriately - our PPE is flying off the shelf and this is without regard to the N95, which you're - you know, it feels as if you have to practically lock up and, we know, we can't necessarily do that.

Our burn rate is so much higher than our actual need rate because of the public perception that everyone is going to die. I mean there's this perception amongst our healthcare worker force that COVID-19 is going to be their demise. And then while we know that transmission is higher in healthcare settings, we definitely just need some help with this messaging around how the overwhelming majority of people do well. And there's the small subset of people who are ill and require care.

So that we can hopefully talk some folks off the ledge and - or we need a supply chain as quickly as possible. I'll just stop there. Some big challenges for the hospitals and definitely for our extended ambulatory areas to also have the same fear.

Dr. Babcock: Yes, I agree completely.

Ms. DeKay: We are also getting the same concerns from our members that they don't have enough masks or gowns to do procedures.

Again, they can use non disposable gowns and reprocess them, but the concern is about the mask. So again, some guidance would be great.

Dr. Bell: Well, I think the guidance available - is out there. I think what you're describing, the fear and consternation, is also a reflection of how our healthcare personnel are trained and educated. We have major gaps in infection transmission training and teaching, ranging from medical schools, to nursing schools, to even before.

And I hate to say it, but what we're seeing now is the results of a very long process of neglecting that part of our education. And so it's fine to try messaging, but when you're messaging to people who really don't have the background information, then the path is much, much more difficult. I think that, you know, many things that we're seeing here, alongside the brittleness of a health system, warrants strong consideration as opposed to trying to deal with it on the back end during a crisis like this.

I think we need to be asking ourselves what should we be doing for our existing staff and also for the people coming through the process to make sure that for the next one of these, and there will be a next one of these, we don’t have as much of a heavy lift to do.

Ms. Preas: I agree with that sentiment. I think that we - and we've certainly in HICPAC discussed this in the past and this may be an unintended positive that comes out of this experience for the risk healthcare system around training and education and also around basic infection prevention practices.

We talk a lot in our facility right now about -- I call it "going old school" -- going traditional that, you know, separation. You can't wedge a whole bunch of people in a waiting area. You can't put your infusion chairs so close together.

And, the rationale for all of those things that we know are embedded in our framework that people bypass because there's this perception that nothing bad is going to happen. So I agree with your comment.

Dr. Patterson: I just have a couple of comments. One is with regards to the aerosol generating procedures. We've told our clinician that for aerosol generating procedures they should be using N95s and eye protection anyway. It's not something that they've routinely done, but it is actually our policy.

And so we've just reminded people about that because we don't have ready access to testing right now either. And, the other comment I was going to make - or, question I guess to comment -- is I believe CDC has some guidance about (unintelligible) use of masks or respirators.

I am reminded of my time in Toronto during SARS in 2003. During which, when there was community transmission that hospital transmission was not a problem. And, that they did masking for the care of all patients. And, at least surgical masks for the care of all patients for a period of time.

And, I'm not saying we should do that. But I'm just saying that it is possible that that may need to be considered at some point in time. And so could you comment on the guidance for intended use of masks?

Dr. Bell: So yes. Jan, thanks for that. So, isolation masks/surgical masks are a little more prone to sogginess. And, that makes their persistent use a little more difficult. But we do use them for several hours during surgical procedures. So you know, it can be done.

I think the caveats would be identical to what we say for extended use of respiratory protection. In that, you know, we wouldn't want to see people reusing them after that extended use. But if they are able to move from one room to the next room with eye protection and surgical masks in place and just change their gowns and gloves, that should be permissible.

Dr. Patterson: Thank you.

Dr. Daniels: My question is - has there been any asymptomatic transmission of COVID-19? And if so, is that an area of concern?

Dr. Bell: Hey, Nick. Yes. The documentation is still limited to PCR signal. And so with all the caveats that I mentioned earlier this morning. But yes. People without recognized symptoms apparently have had positive PCR detection of RNA.

Does that mean they were infectious -- hard to know? The relative contribution of symptomaticity to infectivity we tend to assume exists. But that obviously has not been proven. I think that, you know, the reality is there's nothing actionable we can do about asymptomatic transmission. It's the same thing as kids with influenza passing it around at school and coming home. That's something that we really can't harden our society against.

And, certainly, there's nothing to do for it in a healthcare study. That is, once again, a reason why we really lean towards vaccines for highly transmissible infections. Especially, with non-specific symptoms like measles. You know, those are things that we don't want to have to deal with from an occupational health or an infection control perspective. We want to deal with it as a community mitigation perspective.

Okay. Thanks guys for this great discussion on COVID. I think for the sake of time we'd like to try and move on to the next sections of the agenda. Lisa and Hilary if that's okay with you can we begin with the NICU guideline update given by Kris?

Neonatal Intensive Care Unit Guideline Workgroup Update

Dr. Bryant: I hope the committee notices my striking lack of slides because for the last couple of meetings I've held you captive with many slides with many, many words on each one. A brief update this time.

The Workgroup work on S. *aureus* is complete. And, we hope to have that published on the website by summer. The CLABSI part of the guideline is preparing to go through CDC clearance and hopefully public comment. You will see that again, if not June, at the fall meeting. And, as you probably remember, respiratory infections will be a systematic review.

And, work is progressing a little slowly -- but progressing on that. I'll be happy to answer any questions.

Dr. Babcock: Thank you, Kris. That's really exciting to have those things moving forward. Any questions from committee members or liaisons or *ex officio* for Kris and the NICU group?

All right. Hearing none, should we go on to the bloodstream infection update.

Bloodstream Infection (BSI) Guideline Workgroup Update

Dr. Chopra: I can provide an update for the group on behalf of Michael Anne and myself. And, I guess I'm just going to start also by thanking those of you on the call from CDC and from stakeholders just for your leadership during these difficult times. I just came from a COVID-19 meeting and we are ramping up here. And, I appreciate all the guidance and support.

So with that, I would just say that our CLABSI Workgroup has really been very active. Michael Anne and I have had a call with the team. And, I want to actually call out the team members who have been doing all the heavy lifting.

So our Workgroup DFO, Shannon Novosad, and our incredible CDC and DHQP support team. Kendra Cox, Chrystal Oliver, Kristin Roberts, Devon Schmucker, Erin Stone. And, our librarian, Joanne Taliano, who has spent a lot of time looking at the literature and putting our searches together.

The BSI Workgroup, as many of you know, are working on a series of focused questions. And, the first question that we're currently working on is based upon chlorhexidine bathing. The question is what is the balance of benefits and harms associated with daily chlorhexidine bathing compared with either no bathing or bathing with another agent on CLASBI rates on adult and pediatric ICUs, adult and pediatric wards, long-term acute care facilities [LTACs], or skilled nursing facilities.

The Workgroup team has defined an extensive literature search strategy at which we discussed in our first Workgroup call that happened several weeks ago. The search has revealed the following. We have about 33 articles that are chlorhexidine bathing only. Eight of these have been extracted and the work is ongoing to extract data from the additional articles.

I will point out that we have about 21 of these in the adult ICU setting. Two that include adult ICU and other wards. Six that include wards such as LTACs and skilled nursing facilities. And, unfortunately, only 3 studies that include pediatric settings including pediatric ICU settings.

We are looking specifically at whether some of these studies are chlorhexidine bathing alone, or chlorhexidine bathing in the context of other multi-strategy interventions, hoping to separate signal of the bathing intervention from the additional stuff that goes on typically with these multi-modal strategies.

Our current efforts are focused on extracting the data and starting to look at each individual study to determine how best to synthesize and report our findings. Because a lot of these are randomized controlled trials that we have actually been thinking about even a meta-analysis of the data to provide some quantitative estimates of benefit in these individual groups. So more to come there.

I want to point out also that one of the conversations that we're having was around who should be included in the process in terms of the Workgroup members. We do want to seek representation from SHEA, IDSA, APIC, SHM, the American Nursing Association.

And, of course, HICPAC. We have suggested names and certain organizations as a starting point. But I would welcome additional suggestions from this committee in terms of who should be looking at base products and who should be involved with the process.

So that is the update. And, on behalf of Michael Anne, and myself I'm happy to take questions.

Dr. Babcock: Thank you for that, Vineet. Any questions or suggestions about organizations that should be represented?

Ms. Carpenter: My call dropped and I just heard that ANA should be involved in something. And, I missed what we should be involved with. I'm so sorry.

Dr. Chopra: That's okay, Holly. I was just giving the group the update on the Bloodstream Infection Guideline. And, we identified having a voice from the American Nursing Association being important in the Workgroup and thinking about the recommendations. So I will certainly reach out - or somebody from our Workgroup will reach out to you to see if we can get you engaged and involved.

Ms. Carpenter: Thank you so much.

Dr. Bryant: Vineet, that's really exciting work. And, it's great that there is broad input into this. I know you have pediatric representation and you're looking at pediatric ICU settings which is fabulous. Could PIDS be included as well?

Dr. Chopra: That's a great suggestion, Kris. I don't see why not. Michael Anne?

Ms. Preas: I totally agree. That's fantastic.

Dr. Bryant: Thank you both.

Dr. Chopra: Thank you, Kris.

Healthcare Personnel Guideline Workgroup Update

Dr. Babcock: Other comments, questions, suggestions? Okay. I think - oh, I'm next. The Healthcare Personnel Guideline update is next. I actually do have slides, but only a couple of slides. And, I'll be able to go through them fairly quickly.

The usual disclaimer and background which I will not force you all to listen to me read on the phone today. Status report. The Section 1, as we know, was published at the end of last year. So that is terrific. We have the sections noted on the slide for pertussis. And, some of these other ones as well are posted -- oh, sorry -- are completed.

And then posted for public comment, we have the Diphtheria, Group A Strep, Meningococcal Disease, and Pertussis. So those are open for public comment. If you want to go look at them and comment or suggest that other people take a look and comment, we would appreciate that. And, that public comment is open through the end of April.

We are working on Conjunctivitis/Adenovirus, Rabies, and Scabies and Pediculosis. And, next up, some bloodborne pathogens then Herpes and TB. No changes to our methodology and process noted here that we've reviewed before. This Slide 6 shows again what we are working on and what our upcoming pathogen plans are.

Just a very high-level update on Conjunctivitis. We did note that there was a disconnect in the guidance that was previously published in the HICPAC guidance against what some people were doing and what some of the recommendations were.

So if you look at slide number 8, the 1998 recommendation was to restrict personnel with epidemic keratoconjunctivitis or purulent conjunctivitis from patients care and the patient's environment for the duration of symptoms. That meant if their symptoms went on for a long time, that it was probably a good idea for them to see an ophthalmologist.

We learned from our group that in practice some places are using a 14-day exclusion regardless of symptom duration. And, the *Red Book* has that as a recommendation. We reached out to the CDC subject matter experts. They were unaware off the top of their heads of literature to support this change to a 14-day exclusion.

We decided to do a literature review for his question. Is there any data to help us make a decision about duration of symptoms as a work restriction, compared to a 14-day work restriction? We have done - I will not go into all of the details of that today. But a quick overview just to say that from the summary of the evidence overall, it looks like there is really not going to be evidence on which to base a change in recommendation.

And so it is likely that the recommendation will stay the same. Obviously, everyone is a little busy at the moment. So we have not had formal review back through the subject matter experts at CDC or through our group. But that - just as the preview looks like. We will not be changing the HICPAC recommendation.

So next steps on Slide 10. We will be developing draft recommendations for Scabies and Pediculosis. And for Conjunctivitis and Rabies. And then, after the public comment closes on the pathogens that are listed here then we'll bring - we'll review those, incorporate changes, and bring updated drafts back at an updated meeting. And then, as mentioned, we will be moving on to the Bloodborne Pathogen section.

Just as a reminder -- on Slide 11 -- Of our great team of dedicated people who have been working on this document for a long time and continue to work on this document -- which is a big one and needs a lot of attention. And, I really appreciate the dedication of this great group.

So I will stop there and I'm happy to take any questions or comments.

Dr. Maragakis: Thank you, Hilary. And, to the whole group for all your great work on this epic project. Does anyone have any questions or comments for Hilary? Okay. Hearing none, thank you very much Hilary. And, I think our next agenda item is to get an update from the Long-Term care and Post-Acute Care Workgroup. Mike Lin and JoAnne?

Long-Term Care/Post-Acute Care Workgroup Update

Dr. Riefsnyder: Michael Lin and I are co-chairing this group. As a reminder, I'm a newer HICPAC member and I am the Chief Nursing Officer for Genesis Healthcare.

We've just kicked off this Long-Term care/ Post-Acute Care Workgroup. So there's not a lot to report, but we'll let you know where we are. And, there is a slide deck that details this presentation as well.

So the goal of the Long-Term care/ Post-Acute Care Workgroup is to inform HICPAC on optimal strategies to prevent healthcare-acquired infections in long-term care and post-acute care settings. The charge to the Workgroup is to initially to provide recommendations to HICPAC on care of people living in nursing homes. And, the implementation and scope, specifically of enhanced barrier precautions (EBP). Mike will talk a little bit more about that in a moment.

We've included a list of our Workgroup members. As I said, Mike and I are co-chairing this group. And, we're really pleased with the stakeholders and subject matter experts who are joining us to work on this really important work. Mike, do you want to talk a bit about EBP and what we're focused on?

Dr. Lin: I'll start with the technical staff from CDC. Kara Jacobs-Slifka and Nimalie Stone who have been really helpful in guiding the direction of our Workgroup.

And then, the Workgroup members. Deborah Burdsall from APIC. Erin Epson from California Department of Public Health. Robin Jump from SHEA. Vivian Leung from CSTE. Lona Mody from University of Michigan. David Nace for AMDA, Society for Post-Acute and LTC Medicine. Mary-Claire Roghmann, University of Maryland. Pamela Truscott form AHCA. And, Denise Winzeler from American Association of

Post-Acute Care and Nursing. So we really appreciate all the work that the members have signed up for in essence.

So, on to Slide 6. Enhanced Barrier Precautions is the focus of our Workgroup. And, just as a reminder. Enhanced Barrier Precautions expands the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated. And, refer to the use of gown and gloves during high-contact resident care activities and provide opportunities to transfer MDROs to staff gowns and clothing.

So things like dressing in the morning. Bed, baths, and things like that. So morning routines are all things that can lead to transfer MDROs. And, currently, the way the enhanced barrier precautions guidance is written it only applies within the context of a containment response to novel and emerging antibiotic resistant pathogens such as carbapenemase-producing organisms and Candida *auris*.

So the main question that we are tackling is what is the role of enhanced barrier precautions in nursing homes outside of a MDRO containment response. On the next slide -- as JoAnne mentioned -- our Workgroup was recently established. It was November of 2019 and we had our first meeting in February 13, 2020. You can see with the introductions of the Chair and members.

We discussed this background to get everyone on the same page with enhanced barrier precautions guidance. And, members had a chance to share initial thoughts about the approach to how to answer the question.

And so we are going to be planning bi-monthly calls -- every other week calls -- by a teleconference to get to our product. So I'll stop there and thank JoAnne and all the Workgroup members in our CDC leadership for putting this together.

National Healthcare Safety Network Workgroup Update

Dr. Maragakis: Thank you both so much for that update and all your work on this Workgroup. And, to the whole team. Does anyone have any questions or comments for Mike and JoAnne? Okay. Hearing none, we will continue to move forward in the agenda. And, up next is an update from the National Healthcare Safety Workgroup. So I co-chair that Workgroup with Dev Anderson who's also on the line. Dev, I can start briefly and then please chime in.

Our Workgroup has had several calls. And, most recently on January 29 had a call. And, we have had presentations really largely on our Workgroup calls by the CDC subject matter experts. In particular, Andrea Benin and Kathy Bridson.

And on our last call we really I think dug into the meat of a discussion about CDI testing in healthcare settings. And, the issue that there is an NHSN interest to revise the CDI metric.

And so our Workgroup was briefed on this goal and reviewed the fact that the existing metric is based on laboratory results -- the LabID. Which I believe most of us are familiar with. That is a rate that is -- excuse me -- the LabID per 100,000 patient days. And, it uses the standardized infection ratio, or SIR, methodology.

The proposed revised metric that was presented to us is LabID plus the use of an antimicrobial agent or other therapy considered as treatment. And, the rationale being that that would be a proxy for a clinically significant infection.

And so our Workgroup really had a vigorous discussion about this. We reviewed data - the CDC SME group reviewed data that had informed this proposed approach. And, I think our Workgroup gave a lot of feedback from the healthcare facility and clinician standpoint. And, expressed some reservations about the proxy approach just from a clinical standpoint in questioning about antimicrobial use as a proxy for significant disease. Knowing as we do, the antimicrobial use patterns can vary, and they're not always truly correlated with what is significant disease.

Anyway, those discussion will be ongoing. We have monthly calls. And, I think for the foreseeable future we will probably be tackling this issue of the CDI metric. Dev, do you have additional thoughts or comments about that?

Dr. Anderson: Not much to add. Thanks, Lisa. I think the other thing potentially to add is that one of the components of the presentation at our last call was I think what looks like a pretty nicely outlined strategy for trying to gather data as to what the implications might be -- the use of the - and altered CDI metric like this. And, I think that's something we'd all probably would welcome and look forward to seeing some results from.

Dr. Maragakis: Great. Thank you, Dev. Any questions or comments from anyone about the NHSN Workgroup?

Dr. Schwartz: I'm in Fairfax County and was talking with one of the infection preventionists at one of our hospitals who talked about settings where he thought a specimen should have been tested for C. *difficile*. And, where is the decision of the hospital was not to do the test.

And, I think that a couple years ago there was a lot of emphasis on not over-testing and not doing tests on specimens that truly did not need to be tested. But I'm wondering if the pendulum has swung too far and whether there are specimens that should be tested that are not being - where that's not being done.

And so I'm wondering whether your group has thought about any guidance in terms of what would be the expected number of specimens to test that might indicate an adequate surveillance system.

So just like they do globally with polio surveillance. They look at isolation of non-polio enteroviruses as a way of assessing weather surveillance is adequate. And, I was wondering if the group had any thoughts about assessing whether surveillance for C. *difficile* that is ongoing in hospitals also is adequate.

Dr. Maragakis: Thank you for that question. Does anyone have any comments in response either from the CDC? Or, Dev, any thoughts about that?

Dr. Benin: Lisa, it's Andrea. Do you want me to comment on that?

Dr. Maragakis: Sure, that'd be great. Thank you, Andrea.

Dr. Benin: Hi, Ben. Thanks for that comment. You know, we are starting to hear things about both testing without treating and treating without testing. And, part of the work

that Dev described is for us to understand how those things interact with the surveillance metric. How treating without testing and testing without treatment interacts with what would hopefully be a revised metric that we're looking to develop.

So I think that those are good questions. The other angle that you bring up there are the issues about diagnostic stewardship. And, there are a number of active projects going on how to the division around helping organizations to develop diagnostic stewardship so that we're testing the right patients.

And so there is a body of work on that. And, I think lots of folks are working on that given the impetus to, you know, both kind of improve on the metric but also do the right thing by all of the patients.

And so I think that's the most important part that - you know, from our perspective is that diagnostic stewardship is really about what's the right thing clinically and for the - for any given patient. None of us want C. *difficile*. And, none of us want our C. *difficile* missed. But I'll see if Mike Bell wants to add anything or no.

Dr. Bell: I'll just underscore what Andrea said. Which is that the first and foremost thing is that we do the right thing for patients. So this is a clinical quality of care decision. And then, we will make do with whatever data those decisions generate -- not the opposite direction.

We would never want surveillance needs to necessarily drive clinical practice. We also want to make sure that what we're surveying doesn't lead to unintended impacts on clinical practice. And, that's part of the diagnostics to which you commented. That conversation as well.

Dr. Schwartz: Okay. Yes, thank you.

Man 1: I think the only other thing to add to that would be - I think as the area in the field of kind of this notion of diagnostic stewardship emerges, I think it's reasonable for us to continue to think about the idea. you know, having that pendulum swing too far where we are not doing appropriate testing. I would have to say obviously I don't know the scenario that you describe within section prevention.

But I would still say in general, Mike, (unintelligible) That there is significant over testing of C. *difficile* despite multiple strategies in place to try and find the right mix. So I think your comment is a good one and I think it'll be great to see some data as the different definitions come down the pike.

Mr. Chung: It seems as though we've powered through this agenda pretty quickly. But before we get to federal entity comment I just wanted to see if the operator was available to give her instructions on public comments so we can line those up now as we go through the federal entity comment should there be any. And then, will move into the public comment period as well. Is that okay with you Lisa, Hilary.

Dr. Maragakis: That sounds great.

Public Comment

Mr. Chung: Sandy (operator), Is it possible if you can give your instructions for the public commentary please?

Operator: Yes, that's possible. if you'd like to make a comment over the phone, please press “Star 1”. Please ensure your phone is unmuted and record your name to make a comment. Again, that is “Star 1”.

Mr. Chung: Thanks, Sandy. I guess if there's any other last-minute questions or concerns within the NHSN Workgroup update - sorry, I hijacked that end of the conversation there. But is there any work, about that please feel free to continue. But if not, we'll go ahead and move on to the federal entity comment. Thank you. Lisa, Dev any final comments on the NHSN Workgroup update?

Dr. Anderson: Nothing from my side.

Mr. Chung: Great. Thanks so much. I think Lisa may had to have jumped off the call for another meeting she needed to attend. But we finished the majority of the agenda. But I wanted to give you a few moments here for any federal entity comments that we may have on the line. If you do, please let us know.

Operator: just one moment. We do have some comments.

Federal Entity Comment

Mr. Chung: Great. Great. Will give it a few more moments for public comments. But if there's any other federal entity comments please go ahead and chime in. Thanks.

Dr. Schwartz: Hi, this is Dr. Schwartz from CMS. Can you hear me?

Dr. Maragakis: Yes, go ahead.

Mr. Chung: Yes.

Dr. Schwartz: Yes, good morning. We've been working very closely with our colleagues at CDC in the department. I just want to call your attention to a series of memos there have been recently - going back - and by the way, I read the titles of the memos so you can Google these. There on our website, but the link is quite lengthy.

So starting on February 6, 2SO 20-9-A was a memo we put out just to alert healthcare facilities concerning coronavirus. And, that memo basically Just reminded everybody to go to the CDC website for further information and just emphasize the basic infection control methodologies that should be used.

And, specific highlighting and hygiene. then yesterday we released a series of memos about the survey process. 2SO-20-12-A basically says that CMS is suspending non-emergency surveys across the country so our surveyors can focus on the most serious health and safety threats like infectious diseases.

And, our colleagues in the accrediting organizations will learn to put this and will follow this policy as well. It doesn't mean we're not going to be doing surveys, but the surveys will be prioritized. And, just to point out a couple of them. So all immediate jeopardy complaints will be investigated. Complaints alleging infection control concerns including facilities with potential (unintelligible) all the respiratory illnesses will still occur.

And, other facilities that have had serious infection controls deficiencies in the past three years. And surveys facilities, hospitals, dialysis centers that have a history of infection control deficiencies at lower levels of immediate jeopardy are still in line

for surveys. So this went out yesterday. it's in effect immediately and for the foreseeable future. we also put out another memo yesterday -- QSO-20-13-hospitals. It deals obviously with hospitals and it's more of a Q&A.

And, we also put out yesterday (unintelligible) 20-14-NH for nursing homes. Which is Similarly focus on nursing homes and again is in the form of FAQ. So I just wanted to alert you to those memos. Thank you.

Mr. Chung: Thank you so much for that. any other federal entity comments before we move on to the public comments?

Dr. Roselle: This is Gary Roselle, The Department of Veteran Affairs (VA). As you might imagine, we've been spending most of our lifeforce on COVID-19. And, there are endless documents out for the VA on their website. Two big issues that I think are coming up. One is testing since we've heard from Washington then everybody could have a test if they wanted it and it's not clear that that is the case. But it is an issue.

The second is preservation not only of respirators but also the gowns because we're probably going to have a bigger shortage there than the respirators. So we are doing a bunch of mitigation strategies to preserve both so that we will have enough -- as time goes by -- enough based on what we think now, you know -- in the future.

And then lastly, I think The CDC guidance for COVID-19 has actually been very good. better than some of the outbreaks in the past. So I'm actually pleased that it seems - I mean, you're not going to fix the problem in the world, but I think the guidance has been very useful. the people who are working 20 hours a day should get credit for that. That's it.

Dr. Maragakis: Totally agree. Thank you very much Gary for that comment.

Mr. Chung: Thanks Gary. Thank you for that comment as well. Okay. if there's no other federal entity comment. (Sandy), I think we'd like to move on to the public comment phase of the teleconference. Can you please announce the first public comment and move down the list? Thank you. Just as a quick reminder folks. Those giving public comment please limit your public comment to three minutes. Thank you so much. (Sandy)?

Operator: Thank you. The first question comes from Keith Saint-John. Please give your affiliation. Thank you.

Mr. Saint-John: This is Keith Saint-John and I'm with Professional Disposables International. I actually have a question to Dr. Bell. Does the CDC have a list of regional pandemic preparedness sites that they could provide us?

Dr. Bell: Oh. Hey, Keith. Thank you for calling in. We don't maintain that system. The regional sites are under ASPR -- the Assistant Secretary for Preparedness and Response. And, if you look up HPP -- the Healthcare Preparedness Program -- on their website there should be a listing.

Mr. Saint-John: Thank you very much, Mike.

Operator: Our next call comes from Gary Evans. You may go ahead and please give your affiliation.

Mr. Evans: Hi, this is Gary Evans with Hospital Infection Control and Prevention. I don't know if I'm breaking protocol here. I just wanted to ask Dr. Bell if anyone could comment on measures that are being taken to prevent COVID-19 in nursing homes in long term care facilities.

Dr. Bell: Hey, Gary. So the documents that we have for nursing homes around the same website that I mentioned -- cdc.gov/coronavirus. So you can take a look there. if you want a discussion of that with, Martha Sharan, our press officer and we'd be happy to set up a time to talk.

Mr. Evans: Okay. Thank you. Thanks a lot.

Mr. Chung: Hey. This is Koo by the way. Just a quick update guys. The public comment period is not intended as a Q&A. If you have a public comment related to something we've discussed today during the teleconference, this is your opportunity to spend about three minutes to discuss your public comment. Again, not intended as a Q&A. Thank you. And, if we have any other public comments please proceed.

Operator: The next one comes from Kevin Kavanaugh. You may go ahead and please give your affiliation.

Dr. Kavanaugh: This is Kevin Kavanaugh from Health Watch USA. I have two comments. One's regarding the COVID-19 in the shortage of PEE with gowns and masks. Along with surgical masks reuse an extended use guidance. According to the Chinese CDC, the fatality rates curve is highly dependent upon age sparing the very young. Fatalities in healthy children appeared to be not almost nonexistent.

So is there any consideration of having young - I would say less than 30-40 years old healthcare workers assigned to COVID-19 treatment activities and not those healthcare workers who are much older? I think that this may be a strategy which would be good to get into place. The next comment is regarding enhanced barrier precautions in regards to the CDC's urgent and serious threat. And, in our opinion we feel that these relax precautions compared to contact isolation and our concern regarding their effectiveness.

And I would like to recommend that they at least be shown to be effective in controlling outbreaks first and have good data on this before recommending and implementing them on a national basis. Thank you.

Dr. Maragakis: Thank you very much for your comment. Do we have other public comments?

Operator: we have one more. The next one comes from Lisa McGiffert. Can you please state your last name and your affiliation?

Ms. McGiffert: Yes. this is Lisa McGiffert. I'm with the Patient Safety Action Network. And, I just wanted to make the comment that I am heartened to hear some discussion here about strengthening training including in the education system as well as on going in facilities by employers of healthcare workers to strengthen the laxed attitude that I think we've had for a long time in infection control. And, it's a problem that the patient advocates have been concerned about for many years.

So I hope that this will be an unintended part positive -- as someone said -- in moving forward plain old infection control period I would love to see CDC or maybe others to put out some of these old school practices and infection control strategies

that frankly a lot are about common sense that the healthcare system has forgotten. So I encourage you to do that. Thank you.

Mr. Chung: Thank you Lisa for the comment. Sandy (operator), are there any other public comments?

Operator: No, there are no further comments at this time.

Call Summary

Mr. Chung: Okay, great. we will let public comment come in for a little bit longer. As we go through the last part of the agenda, Hilary - I was wondering if we could go through the summary and workplan for this call.

Dr. Babcock: Sure. So to review for this call, we had a welcome and an update from Denise Cardo. We had an excellent summary of current status an upcoming changes and items under consideration for the COVID-19 outbreak from Dr. Bell, with robust discussion from the committee and committee members. We received the NICU Guideline updates from Dr. Bryant, noting that several items are ready for publication, and several are moving toward public comment.

We heard from the Bloodstream Infection Guideline updates, and the progress that they have made in their data extraction, and some very interesting data available. And, they are also reaching out to include additional Workgroup members. So if people have suggestions later about other members that might be valuable additions to that Workgroup, then please pass them along.

And, we heard from me for the Healthcare Personnel Guideline update, we have some items in public comments right now and are working through the Conjunctivitis work. So we will be bringing that back at next meeting. And, it was great to hear about the work getting kicked off by the Long-Term Care/ Post-Acute Care Workgroup and some of the areas that they are addressing.

Definitely, looks like a very great group assembled to work on that. And then, we continue to hear updates from the ongoing work at the NHSN Workgroup, which is addressing a lot of important issues and we definitely appreciate all their attention. We're not having any formal votes on anything today. Or, any informal votes on anything today.

Primarily, an information sharing meeting. I just want to say again from myself and from Lisa we really appreciate everyone taking the time to have this time together. Definitely, appreciate our CDC colleagues and all the work that they're doing. And, them taking time out of that work as well to share with us and to be here with us for this meeting. I have nothing further to add. Koo, are there other - or, Mike, do you want to say any few closing words?

Dr. Bell: Yes, Hilary. thank you for that. I have to say it means a tremendous amount to all of us working here to have your input and your collegiality available. To have our liaison colleagues, our public advocates, our patient advocates, everyone being willing to talk with us and give us your thoughts. I very much appreciate people taking the time during what is a crazy few months. And, we'll look forward to hearing from you again at a hopefully less chaotic moment.

Operator: There is one more public comment.

Mr. Chung: Great. I was just about ask about any final public comments.

Operator: Yes. It is Yesinia Khattak. Please give your affiliation. Thank you. Ma'am, please check your mute button.

Ms. Khattak: Okay. Hi. Sorry about that. This is Yesinia Khattak from Pomona Valley Hospital Medical Center -- infection preventionist. My comment would be in regards to the healthcare worker guidelines in interim revisions by CDC on novel coronaviruses such as COVID-19. Because we residing in California, often times we find ourselves in limbo as to what to follow -- national versus state regulations.

And, often times we find ourselves having to follow state regulations only because it is the higher standard. So if during any changes of healthcare worker guidelines, if the states could also be spoken or talked to so that we can find a mutual supporting effort on having the same message. Both, federal and state. That would be helpful. Thank you.

Dr. Bell: Thank you for that. As you know, states have the authority to make any decisions they want. We do have very close relationships with state health officials, the governor, the Council of State and Territorial Epidemiologists, the State HAI Programs, which we fund directly, the state public health laboratories, and the state hospital associations.

All of these people are engaged. But what a state ultimately decides to do is up to them. So we will continue to make that outreach. But recognize very much that you are required to follow your local jurisdictions and their regulatory requirements. Thank you.

Mr. Chung: Sandy, this is Koo. Any last final public comments before we say our goodbyes?

Operator: No, there are no further comments.

Mr. Chung: Great. Well, on behalf of CDC I would like to thank everybody for joining the call today. And for pivoting on such short notice to a teleconference. I think we were lucky enough to give you guys back one hour and 45 minutes of your day. I know many of you need that. So thank you again for calling in. Hilary, any final comments?

Dr. Babcock: No. Thanks to everyone.

Dr. Maragakis: Thank you, everyone.

Dr. Bell: Thank you everybody. Bye.

Operator: You may now disconnect. That concludes today's conference. Thank you all for participating.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing transcripts of the March 5, 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
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
BSI	Bloodstream Infection
C. difficile	*Clostridioides difficile*
CDC	Centers for Disease Control and Prevention
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare and Medicaid Services
DFO	Designated Federal Official
DHQP	Division of Healthcare Quality Promotion
FDA	(United States) Food and Drug Administration
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
NACCHO	National Association of County and City Health Officials
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
PHAC	Public Health Agency of Canada
PIDS	Pediatric Infectious Disease Society
S. aureus	*Staphylococcus aureus*
SCCM	Society for Critical Care Medicine
SHEA	Society for Healthcare Epidemiology of America
SHM	Society for Hospital Medicine
SIS	Surgical Infection Society