

**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**



2007 Isolation Guideline Update Listening Session

October 10, 2023

Atlanta, Georgia

Record of the Proceedings

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Attendees

CDC Representatives

Michael Bell, MD
Sydnee Byrd, MPA
Nicole Coffin, MA
Mandy Cohen, MD, MPH
Beth Golshir, MPH
Brianna Holiday, MPH
Debra Houry, MD, MPH
Heather Huntley, JD
Daniel Jernigan, MD, MPH
Alexander J. Kallen, MD, MPH
Aaron Kofman, MD
Laura Wells, MS
Seth Kroop, MPA

Members of the Public

Lisa Brosseau, ScD, CIH: Industrial Hygienist Consultant, Center for Infectious Disease Research & Policy (CIDRAP), University of Minnesota
Melissa McDiarmond, MD, MPH, DABT: Professor of Medicine; Professor of Epidemiology and Public Health; Director, Division of Occupational and Environmental Medicine; University of Maryland School of Medicine
David Michaels, PhD, MPH: Epidemiologist and Professor in the Departments of Environmental and Occupational Health and Epidemiology, Milken Institute School of Public Health, George Washington University
Donald Milton, MD, DrPH: Physician, Occupational Medicine; Professor of Environmental and Occupational Health, University of Maryland School of Public Health, with a secondary appointment in the University of Maryland School of Medicine's Department of Medicine
Peg Seminario: Industrial Hygienist; Occupational Safety and Health Leader and Expert; Retired Director, Occupational Safety and Health, AFL-CIO
Jane Siegel, MD: Pediatric Infectious Disease Specialist; Involved in the Update of the 2007 *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*; Public Health Medical Officer, California Department of Public Health (CDPH)
Raymond Tellier, MD: Physician; Medical Microbiologist, Provincial Laboratory for Public Health of Alberta, Canada; Associate Professor Division of Infectious Diseases, McGill University in Montreal, Canada
Stephanie Wallace, PhD, MS, Cambridge Communications & Training Institute (CCTI)

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Minutes of the Meeting

The United States (US) Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) Division of Healthcare Quality Promotion (DHQP) convened a Listening Session pertaining to the update of the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* on October 10, 2023.

Call to Order / Welcome

Daniel Jernigan, MD, MPH
**Director, National Center for Emerging and Zoonotic Infectious
Centers for Disease Control and Prevention**

Dr. Jernigan welcomed everyone and thanked them for taking time to join the October 10, 2023 2007 Isolation Guideline Update Listening Session at 2:00 PM Eastern Time (ET). He indicated that CDC has been receiving many comments since starting the process to update the *2007 Guideline for Isolation Precautions*. While they have heard frustration that some opinions are not being taken into consideration, he emphasized that CDC values everyone's expertise and insights. Along with the Healthcare Infection Control Practices Advisory Committee (HICPAC), CDC is committed to developing guidelines that are effective and feasible and will work with commenters to ensure that their perspectives are heard.

Mandy K. Cohen, MD, MPH
Director, Centers for Disease Control and Prevention
Administrator, Agency for Toxic Substances and Disease Registry

Dr. Cohen thanked everyone for taking the time to join, pointing out that she wanted to ensure that she heard input directly as she is learning herself.

Michael Bell, MD
Deputy Director, Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

Dr. Bell welcomed everyone. He emphasized that he, CDC, and the HICPAC deeply appreciated and recognized the participants' efforts throughout the COVID-19 pandemic and the expertise that they were sharing during this session. As HICPAC and CDC are approaching the update to the *2007 Guideline for Isolation Precautions*, they are very much interested in the insights of others, which will inform the process and content and are critically important to the

process. HICPAC and CDC recognize that many of the participants have familiarity with working with federal advisory committees and how they operate. He assured everyone that the input from this session would be incorporated with all of the other input that has been or will be received. Additional opportunities are part of the established mechanisms. Given that this was not a public HICPAC meeting, Dr. Bell pointed out that CDC representatives would not be able to engage in dialogue, but within the laws of the Federal Advisory Committee Act (FACA), would listen and provide the feedback received to HICPAC.

2007 Isolation Guideline Update Listening Session

Overview

David Michaels, PhD, MPH
Epidemiologist & Professor
Departments of Environmental and Occupational Health and Epidemiology
Milken Institute School of Public Health
George Washington University

Dr. Michaels expressed gratitude to the CDC for the opportunity for this group of members of the public to provide input and share their views regarding the update to the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. These foundational guidelines have been looked to widely by healthcare providers (HCP), professionals, and public health authorities as the basis for infection control standards and practices that are critical for ensuring that patients and healthcare workers (HCW) are protected from healthcare-acquired infections (HAIs). These members of the public support CDC's efforts wholeheartedly. Since those 2007 guidelines were issued, enormous knowledge and experience have been gained in terms of how infectious pathogens are transmitted and how to control them. The COVID-19 pandemic added a great deal of knowledge as well. It is known that certain populations, including the elderly and those with existing comorbidities, are at much higher risk of infection. It also is known that current existing environmental conditions and infection control practices in healthcare settings are inadequate to protect patients, HCW, and the public. Millions of people in healthcare settings have been infected and hundreds of thousands have died during the COVID-19 pandemic. Other HAIs also have increased.

Stronger and more protective practices and control measures are urgently needed. Strong, protective, updated isolation precautions guidelines are necessary to achieve this goal. The updated guidelines must rely upon and reflect the full body of scientific evidence, knowledge, and experience and they must provide clear and strong recommendations that will protect HCWs and patients from preventable infectious diseases and death. These updated guidelines should be designed to provide a high level of protection to HCWs and patients in all healthcare settings—not just a basic minimum level of protection. Particular attention needs to be given to protecting vulnerable populations who are at high risk of serious harm from infections. Everybody in this group of members of the public who joined this 2007 Isolation Guideline Update Listening Session are experts with deep knowledge and experience concerning infectious disease prevention and control, including aerosol transmission, respiratory protection, ventilation, occupational medicine, occupational health, epidemiology, and infection control.

This group opted to use its time during this session to address several key issues and concerns and make some recommendations for strengthening the guidelines and the guideline development process. Their input covered the following 3 key points:

1. Proper characterization of aerosol transmission
2. Respiratory protection and why it is not appropriate to rely on randomized controlled trials (RCTs), excluding other sources of evidence to evaluate the need for and the effectiveness of control measures
3. Ventilation as a key component of control of aerosol transmission and a first and foremost recommendation

Key Point #1: Aerosol Transmission

Donald Milton, MD, DrPH

Professor of Environmental Health

University of Maryland School of Public Health

University of Maryland School of Medicine's Department of Medicine

Dr. Milton observed that early in the COVID-19 pandemic, there was a lot of confusion about modes of transmission. It is understandable that CDC would like to simplify messaging to communicate clearly. However, the new term “air transmission” misses the mark. The lack of infectious air biology and aerosol science representation on the committee may be responsible. Dr. Milton highlighted a few major research findings to explain why this misses the mark. First, people generate a range of particle sizes when breathing, talking, singing, and coughing. Multiple studies of exhaled aerosols from influenza and COVID cases, including studies by CDC’s National Institute for Occupational Safety and Health (NIOSH), show that there is a high concentration of infectious particles in these exhaled particles and that this concentration is highest in the smallest particles. These particles are small enough to be inhaled and deposited in the respiratory tract anywhere from sinuses to the distal intrathoracic airways. Second, experimental and modeling studies show that the concentration of infectious aerosols is highest closest to the source, including studies from NIOSH. Therefore, it is now widely recognized that the traditional notion that close proximity equals transmission via sprays of ballistic drops called “droplet transmission” was wrong. Poor ventilation compounds the problem and extends it over larger distances. Research studies demonstrating an important role for sprays of infectious drops (e.g., droplet transmission) of influenza virus and SARS-CoV-2 are lacking, yet there is considerable and mounting evidence that aerosol transmission occurs. Sprays of ballistic drops and inhalation of aerosols are distinct physical processes and there is no scientific basis for combining them under one name of “air.” Finally, to revert to outdated emphasis on personal protective equipment (PPE) designed for supposed droplet transmission fails to recognize that there is a significant risk associated with inhalation near a source within a shared space, particularly in poorly ventilated spaces.

Key Point #2: Respiratory Protection

Melissa McDiarmond, MD, MPH, DABT
Professor of Medicine
Professor of Epidemiology and Public Health
Director, Division of Occupational and Environmental Medicine
University of Maryland School of Medicine

Following from what Dr. Milton explained about aerosol transmission, Dr. McDiarmond pointed out that the key exposure route for aerosol transmissible diseases like influenza, SARS-CoV-2, and others is by inhalation. This means that respirators are necessary to provide adequate protection from inhalation exposure. They also are capable of providing a high degree of source control. Surgical masks are not respirators and are not approved for use as respirators. They may offer some degree of source control but likely do not prevent the emission of the many smaller exhaled particles due to the surgical mask's low filter efficiency and poor fit. Returning to the theme of the evidence review of respirator performance that was conducted by the committee, this review used pragmatic RCTs. As a sole source of evidence, they are misleading because it gives the appearance of rigor to these trials that suffer from substantial sources of confounding that completely undermines their validity. The pragmatic RCTs relied on Isolation Precaution Workgroup (WG) evidence reviews and are fundamentally flawed because for some and most, there was no control (e.g., a no mask group). Thus, it was not possible to say whether masks and respirators were equally effective or equally ineffective. The interventions were not worn continuously during all possible exposures. Community transmission discussed for the recent RCTs by Loeb during COVID-19 was not accounted for and unlike studies were combined. In other words, the comparisons were not apples-to-apples. The review ignored the only well-conducted study, the MacIntyre study, with a control group and continual use of respirators that found a clear benefit of respirators over surgical masks in preventing infectious respiratory illness in HCW. Dependence on RCTs alone ignores the types of studies used by the various regulatory agencies that approve and certify respirator performance. Finally, the Cochrane Reviews process itself has been widely criticized by the National Institute of Environmental Health Sciences (NIEHS), Environmental Protection Agency (EPA), and World Health Organization (WHO) for using RCTs as the preferred evidence for resolving occupational and environmental health issues for which respiratory protection would qualify.

Key Point #3: Ventilation

Lisa Brosseau, ScD, CIH
Research Consultant
Center for Infectious Disease Research & Policy (CIDRAP)
University of Minnesota

Dr. Brosseau pointed out that the "Hierarchy of Controls" is a core principle that governs the selection of interventions. That is true in infection prevention and control and occupational and environmental health. The hierarchy for infectious aerosols is best characterized by first considering and prioritizing source controls, meaning interventions that eliminate or minimize the pathogens of the source. The next intervention is pathway controls, which are basically controls that interrupt the pathway from the source to the receptors, on which Dr. Brosseau focused. She has been using the Hierarchy of Controls approach throughout the pandemic because it helps people better visualize the hierarchy of starting with source controls, then working on pathway controls, and last working on receptor controls. That includes PPE and other interventions as well. While there is attention to ventilation in healthcare, there needs to be

more. That was illustrated throughout the pandemic in hospitals and other types of healthcare settings. The lack of ventilation in a number of shared spaces, such as break rooms where transmission occurs from worker-to-worker, illustrates that more careful and thorough thought must be given to ventilation throughout a healthcare setting. General ventilation is needed to dilute and remove infectious aerosols from shared spaces, such as break rooms. For locations where there are high concentrations, more thought needs to be given to local exhaust ventilation solutions. Industrial hygienists are very good with local exhaust ventilation solutions. There were some attempts at that in healthcare settings throughout the pandemic, some of which were published, but this needs more attention. There may be other methods in addition to the movement of air, such as ultraviolet light that may be useful in a high-risk area. While it might not be possible to build as many negative pressure rooms as may be needed, especially during a pandemic, the purpose of a negative pressure room is to ensure the direction of airflow such that it does not transfer particles from the patient to the rest of the facility. That remains important for all aerosol-transmissible diseases. It is important identify more inexpensive, effective, and rapidly deployable solutions for cutting off or preventing the movement of infectious aerosols from patients and workers to other patients and workers. *CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings* and the revised *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* have to address the role of ventilation in terms of both general and local exhaust in protecting HCW and patients from aerosol transmissible diseases. The WG and HICPAC need to consult with and include more people with expertise in ventilation design and standards in their reviews of the guidelines.

Discussion Points

Dr. Siegel clarified that anything she said during this meeting was a reflection of her professional experience and expertise and was not a reflection of CDPH policy.

Dr. Michaels pointed out that from a regulatory point of view, this guidance is not formally regulatory. However, it impacts behaviors by employers and workers. No regulatory agency would rely only on pragmatic RCTs to make decisions without assessing the breadth of evidence, including observational studies that show clearly that respirators are more effective than surgical masks. Frankly, he thinks that CDC should be embarrassed and would be looked upon with great question if they conclude that surgical masks are equally as effective as respirators. The agency should consider this extremely seriously.

Dr. Seminario pointed out that CDC houses the “respirator specialists extraordinaire” through NIOSH, particularly in terms of the National Personal Protective Technology Laboratory (NPPTL). While a couple of representatives from NIOSH serve on the HICPAC Isolation Precaution Guideline WG who are terrific, Drs. Marie de Perio and David Weissman, the problem is that transmission and control engineers are not involved. NIOSH was central to tuberculosis (TB) guidance in the early 1990s. That was a much more inclusive approach that included the people who knew the science and engineering. While CDC is involving NIOSH as part of the review, they should be part of the process to begin with because they have the expertise within CDC on the issues of respiratory protection and ventilation.

Dr. Michaels stressed that the “Hierarchy of Controls” is the time-tested fundamental way workers are protected. Healthcare facilities are no different from factories or construction sites. PPE is not the first resort. It is the last resort. CDC is not even talking about PPE. Masks are not PPE. Respirators are PPE. Thought must be given to engineering controls as part of this. It is discouraging that Occupational Safety and Health Administration (OSHA) has not been part of

this process. OSHA has experts on engineering controls. The California Infectious Disease Standards, Aerosol Transmissible Diseases (ATD) standard, requires engineering controls *before* PPE. The CDC guideline will be discordant with the law in California and OSHA's basic principles. That will be a problem for healthcare employers, which must be taken into account and addressed. While the engineering controls have to be feasible, not to recognize that they need to be part of the solution is problematic. CDC's guideline needs to advocate for this basic public health principle.

Dr. Siegel emphasized the importance of ventilation for long-term care facilities (LTCFs). LTCFs generally do not have requirements for ventilation though they certainly have the greatest burden of COVID-19 outbreaks. There are some straightforward interventions that can be implemented to improve airflow and ways to see direction of airflow that would be very important to those facilities. This does not require a million-dollar replacement of a heating, ventilation, and air conditioning (HVAC) system.

Dr. Jernigan asked the group whether there are important more general research questions that still need to be answered as soon as possible to address some of the issues raised.

Dr. Milton said that while there is always more research that can be done, there are enough data to make some decisions and solid recommendations. NIOSH had done a lot of work on portable air cleaners and respiratory protection, and it is known that these interventions can make a major difference in exposures. There is a role for new studies that try to determine the right combination of integrated controls in various types of healthcare environments. Infants, emergency departments (EDs), and LTCFs are very different places and probably there are some nuances about what will work best. It is known that ventilation and filtration are very important and can make a huge difference. It is now known that the carbon dioxide level in the air is not only a measure of ventilation, but also is a strong predictor of how long a virus will survive in the air. Thus, it is a doubly important aspect to control in the environment. Additional research is not needed to make new policy on this.

Dr. Seminario stressed that NIOSH has done a lot of work for decades, particularly in the healthcare field and in terms of PPE and respirators. They have a lot of deep experience and knowledge. They also have done a lot of work in terms of engineering over the years. It would be extremely useful to speak to the engineering experts within NIOSH to find out what exists and to get their input in order to have a basic understanding of the engineering aspect of this.

Dr. Cohen apologized for having to step away, but noted that she was able to hear all 3 presentations and expressed her appreciation for the group's thoughts and feedback. She emphasized that she would be learning more as CDC works through this process.

In terms of Dr. Jernigan's question regarding research, Dr. Siegel said she thought it would be beneficial to have more data from LTCFs about ventilation. Preparation for outbreaks in LTCFs now involves more than just influenza and SARS-CoV-2. More information would be beneficial about the routes of transmission for respiratory syncytial virus (RSV), enterovirus (EV), rhinovirus (RV), adenovirus, human metapneumovirus (HMPV), human parainfluenza viruses (HPIVs), and other respiratory viruses.

Dr. Tellier commented that there are extensive data on the important role of aerosol transmission for influenza A and now for emerging coronaviruses. Aerosol transmission played a major role in transmission of SARS-CoV-2. These are viruses of proven pandemic potential and there will be future pandemics with these viruses or closely related viruses. This is enough

to justify aerosol precautions in terms of the potential impact. An important concept that Dr. Milton introduced in infectious disease is that of anisotropy; that is, all of these agents can be transmitted by more than one route. The infectious dose and the severity of the disease associated with the route of transmission are not always the same. There are strong data for influenza to suggest that much less virus is associated with more severe disease if acquired by the aerosol route. Even if a random number of only 10% to 20% of cases of influenza are caused by aerosol transmission, if they are the 20% most severe, they are well worth taking care of. More data certainly are needed for other viruses, but some data are available in the literature. For adenoviruses, there were experiments in the 1960s with aerosol transmission of viruses to human volunteers that showed that a smaller dose is required than by nasal installation and is associated with more severe illness. It is known from epidemiological studies in military barracks that adenoviruses can give rise to explosive outbreaks. It also is known that ventilation is very important in LTCFs. During the COVID-19 outbreak in Quebec, a ventilation system broke down in a LTCF for the elderly with underlying illness in Montreal for 2 weeks. The attack rate for the residents there was close to 100%, with very high mortality. This is not just theoretical. There are more dangerous viruses lurking that will have a strong aerosol component.

Dr. Bell expressed interest in how Dr. Michaels would frame his use of the word “feasibility,” especially given the array of health systems that have to be addressed, the variety of ages of buildings, and other targets with respect to engineering and structural improvements.

Dr. Michaels responded that OSHA has systems in place through which they deploy engineers to introduce interventions and ascertain costs. This typically involves the interface of economics and technology. It turns out that once a standard is issued, it becomes much more feasible because engineers figure out ways to implement the standard more cheaply and better. The California Infectious Disease Standards ATD just states “feasible.” There certainly are precedents to inform this. Employers have to show why an intervention is not feasible and what their equivalent would be, which also could be included in the CDC guidance.

Dr. Siegel added that this is how Cal/OSHA addresses this. If a facility is not making ventilation changes, then they have to demonstrate what they are doing to mitigate the risk of transmission. She recalled hearing many arguments historically about the infeasibility of wearing gloves, which now is not questioned. It is necessary to evolve with what has been learned.

Dr. Milton recalled when dentists thought people would shun them if they wore gloves, but now he thinks the opposite is true.

Dr. Seminario emphasized the importance of the feasibility issue because it is a real consideration and always has been defined legally in the context of OSHA standards. The OSHA standard, which should be the same for CDC, is the requirement to provide a high level of protection to the extent feasible. OSHA is in the process of developing infectious disease standards and they are looking to what CDC is doing in this area, but the point of OSHA standards is not to codify existing practice. It is to protect people, assess the feasibility, and give people time to implement interventions. The goal is to change practice as happened with bloodborne pathogens. Given that the CDC guidelines are foundational to the conditions in healthcare facilities, it is important to think about the goal of what CDC is trying to do. It should not just be about simplifying the guideline so that people can read it on their cell phones. It should be about improving protection and what is needed to do that. There are numerous difficult issues (e.g., healthcare capacity, various risk factors, structural issues, types of populations, et cetera). She was struck during the last HICPAC meeting with patients who

spoke one after another about how they would not and could not seek healthcare because they are at high risk and are very afraid of going into healthcare settings. It is not just affecting whether people are infected. It is the basic medical care that some people sacrifice because they do not feel safe. There is a lot of interest in the CDC guidelines, which could have a major impact. CDC could do some tremendous work moving forward with the updated guidelines.

Recommendations

David Michaels, PhD, MPH

Epidemiologist & Professor

Departments of Environmental and Occupational Health and Epidemiology

Milken Institute School of Public Health

George Washington University

In terms of specific recommendations from this group, Dr. Michaels recapped that the updated guidelines need to be designed to provide a high-level protection of HCWs and patients in all healthcare settings, with particular attention to vulnerable populations. The guideline should be based on the full body of scientific evidence of infectious disease transmission and control measures, not simply the pragmatic RCTs. The guideline should fully and properly recognize, characterize, and address aerosol transmission. The guideline should recommend the use of NIOSH-approved respirators by HCW to limit exposure to aerosol-transmitted diseases where exposure presents a hazard, as is required for all inhalation by OSHA's Respiratory Protection Standards. The CDC guideline should include requirements for ventilation, which must be a key control for aerosol-transmitted diseases. In addition, this group strongly recommended that CDC open up the guideline development process to fully involve experts in other disciplines and stakeholders, including HCW and patient groups. Finally, CDC should delay any HICPAC vote on these guidelines until there is a complete and proper review and consideration of all of the science, and there is an opportunity for meaningful involvement and input from other key experts and stakeholders. Leaving public comment input until after a HICPAC vote is too late for meaningful impact. The publication of proposed guidelines that are incomplete, weak, and without scientific basis will greatly undermine CDC's credibility and the public's trust in the agency. Dr. Michaels emphasized that this group was grateful for the opportunity to meet with CDC to share these comments and recommendations, which they hope will be helpful. They are eager to provide any further input and assistance to help CDC with the revision of these guidelines.

Discussion Points

Reflecting on the question that Dr. Jernigan posed earlier regarding research needed, Dr. McDiarmond pointed out that one of the take-home messages was that there is a lot of actionable evidence and science that is settled that did not seem to be discernably represented in the planned activities of the next version of the guidance. Notably, this is based on seeing slides that have been made available publicly versus seeing the full draft.

Dr. Seminario added that there are many people who want to help and participate in this process who have extensive experience, expertise, and perspectives. CDC would benefit by figuring out how to engage these individuals through not only written comments, but also by talking to people. That is where they will gain insights from people and find out more about what is actually occurring. This also will help to restore trust in CDC that the agency is open and accessible to them and care about what they have to say.

Dr. Seminario emphasized that there is concern about the guideline going from very clear and specific to general and minimal. It is not clear what CDC is recommending to healthcare facilities during the transition process in terms of whether they still should use Appendix A or do the basic minimum.

Adjournment

Michael Bell, MD

**Deputy Director, Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention**

Dr. Bell expressed his gratitude, emphasizing that CDC heard loud and clear about the aerosol transmission issue, the need to think about respiratory protection, and the importance of ventilation. In terms of next steps, CDC is challenged by some protocol issues. In order to share a draft, the WG must present it to the HICPAC in public by law. HICPAC must then vote to share it with CDC. Only then is CDC at liberty to publish it for public comment. There are 2 layers of voting. One is the voting that gets it to CDC, which must happen in order to get input on an actual draft. The second is that based on public input and a final version that comes from that, there is a final vote to present the recommendation of the contents back to CDC. While this is somewhat byzantine, it is the requirement by law.

He also pointed out that the revised guideline would not be a replacement of the entire 2007 guideline, which is a 200-page document that is not realistic to maintain in this day and age because it is difficult to access. The goal is to do this in segments, the first of which addresses transmission pathways. The bigger job ahead of HICPAC and CDC is to go through what currently is labeled as "Appendix A." This is the section that recommends a package of PPE and other controls for each and every pathogen. This is where the asterisk beside "when inhalation presents a hazard" becomes very important and offers tremendous opportunity for involvement of other people. The reality is that all respiratory pathogens are not treated the same. A child with a runny nose from a rhinovirus is different from a child with COVID-19 or other pandemic-prone diseases. Figuring out how to navigate going through each pathogen in a practical way is going to require a lot of input and is likely to take about 2 years. That is where this type of dialogue can be very helpful.

In terms of the transition process from the existing to the updated guidelines, Dr. Bell emphasized that the goal is not to leave a giant gap. Pieces of documents have been updated through the past decade when there is new evidence or a change is needed. The update or change is flagged in the electronic document with a rationale. Appendix A will remain in effect with a flag at the top indicating that some of the categories are renamed and how to cross-translate. None of the recommendations and none of the proof available to address infectious diseases have changed. CDC is just taking the opportunity to be clearer. The draft will be presented during the HICPAC meeting on November 2-3, 2023 so that people can provide additional comments. Approval of that draft for sharing with CDC will allow the agency to get the document to public review. Dr. Bell emphasized that the public review during that meeting would be an important component of the process.

With no additional business raised or comments/questions posed, the Listening Session HICPAC stood adjourned at 2:53 PM ET on October 10, 2023.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 10, 2023 2007 Isolation Guideline Update Listening Session are accurate and complete.

Date

Signature

Attachment #1: Acronyms Used in This Document

Acronym	Expansion
ATD	Aerosol Transmissible Disease
ATSDR	Agency for Toxic Substances and Disease Registry
CCTI	Cambridge Communications & Training Institute
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CIDRAP	Center for Infectious Disease Research & Policy
DHQP	Division of Healthcare Quality Promotion
ED	Emergency Department
ET	Eastern Time
EV	Enterovirus
FACA	Federal Advisory Committee Act
HAI	Healthcare-Acquired Infection
HCP	Healthcare Personnel
HCW	Healthcare Workers
HFE	Human Factors Engineering
HHS	(United States Department of) Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
HMPV	Human Metapneumovirus
HPIVs	Human Parainfluenza Viruses
HVAC	Heating, Ventilation, and Air Conditioning
LTCF	Long-Term Care Facilities
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NIEHS	National Institute of Environmental Health Sciences
NIOSH	National Institute for Occupational Safety and Health
NPPTL	National Personal Protective Technology Laboratory
OSHA	Occupational Safety and Health Administration
PPE	Personal Protective Equipment
RCT	Randomized Control Trial
RSV	Respiratory Syncytial Virus
RV	Rhinovirus
SARS	Severe Acute Respiratory Syndrome
TB	Tuberculosis
US	United States
WG	Workgroup
WHO	World Health Organization