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July 22, 2010

Ms. Julie Edelson
Influenza Coordination Unit
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
Attn: Prevention Strategies for Seasonal Influenza
in Healthcare Settings
1600 Clifton Road, NE, MS A-20
Atlanta, GA 30333

Dear Ms. Edelson:

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to comment on *Updated Guidance: Prevention Strategies for Seasonal Influenza in Healthcare Settings*, as published on June 22, 2010 in the Federal Register.

SHEA welcomes the updated guidance, with the range of evidence-based strategies, as appropriate to the current understanding of effective prevention of influenza, including infection caused by influenza A/H1N1 2009. The information that is now available regarding the transmission parameters and pathogenicity of influenza A/H1N1 2009 allow an approach consistent with that of authoritative sources of recommendations for influenza prevention, such as the Healthcare Infection Control Practices Advisory Committee (HICPAC).

Droplet Precautions

Droplet precautions have been consistently recommended (including in the 2007 HICPAC *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*) and used with general success for the prevention of influenza in healthcare settings for over 30 years. The proposed guidance reestablishes a recommendation for standard and droplet precautions for influenza control under routine circumstances, with special work practice, engineering and personal protective equipment recommendations for procedures that generate aerosols locally. SHEA supports this approach, but would encourage further

reflection on procedures, such as endotracheal intubation and cardiopulmonary resuscitation, from a practical patient care standpoint. Effective application of the recommended precautions for non-elective intubation and for CPR is not going to be possible in most instances and setting this as an expectation may result in untoward consequences (e.g., delayed life-saving, emergency care). Recommended precautions also highlight the need for research to determine the actual level of aerosol generation that occurs with various procedures under consideration.

The permissive recommendation “based on their local needs” for the use of higher levels of respiratory protection for routine (non-aerosol-generating) care is not consistent with the conclusion that standard and droplet precautions are sufficient and appropriate and has the potential to generate confusion.

Engineering controls for aerosol-producing procedures

SHEA has reviewed the section on *Transmission*, particularly the comments on airborne transmission and the lack of evidence demonstrating transmission of influenza from one patient room to another. It appears CDC wishes to continue its cautionary approach in recommending use of airborne infection isolation rooms (AIIRs) when *feasible* for the seven listed aerosol-producing procedures. The feasibility is greatest for planned procedures (sputum induction, bronchoscopy, autopsy), noting that bronchoscopies and autopsies are carried out in rooms already designed as negative pressure rooms. However, as noted earlier, unplanned procedures such as CPR, are highly unlikely to permit transfers to an AIIR or even to modify single rooms with appropriate equipment to effectively function as AIIRs. We therefore recommend the addition of explicit statements which acknowledge that moving a patient to an AIIR may not be feasible in many situations such as CPR, when sputum induction needs to be performed frequently, during endotracheal intubation and extubation and where closed suctioning protocols of airways have not been established. To further maintain important emphasis on effective engineering controls such as single rooms and other feasible barriers listed in the recommendations, SHEA suggests that AIIR design and operation details be incorporated into the appendix along with resources providing information on the *effective* use of portable HEPA filtration units. Both topics require more technical information than is possible to include in the overall guideline

Vaccination

Regardless of precautions applied in the prevention of influenza transmission, the best preventive measure is use of a safe and effective influenza vaccine. The importance of annual vaccination is stated, but only in terms of achieving high rates and improved levels of coverage. Now would be an appropriate time for a direct and unequivocal statement that every HCP without a valid medical contraindication to receiving influenza vaccine should receive an annual vaccination; if not as a mandate, then as a professional obligation not

dissimilar to the responsibility to apply hand hygiene and the other standard measures recommended in this guidance to prevent influenza. The recommendation for vaccination of HCP doing aerosol-generating procedures only has meaning in prospective terms.

As delineated in SHEA's 2010 position paper "Influenza Vaccination of Healthcare Personnel" (in press), SHEA views influenza vaccination of HCP as a *core patient and HCP safety practice* with which non-compliance should not be tolerated. The Society believes that it is the professional and ethical responsibility of HCP and the institutions within which they work to prevent the spread of infectious pathogens to their patients through evidence-based infection prevention practices including influenza vaccination. **SHEA endorses a policy in which annual influenza vaccination is a condition of both initial and continued HCP employment and/or professional privileges for the safety of both patients and HCP.**

While there may be more evidence for the benefit of HCP vaccination to patients in some settings than others, there is strong evidence that influenza vaccination reduces influenza, influenza-like illness and absenteeism in healthy personnel. The focus of the guidance should be on actually accomplishing universal vaccination, not just encouraging or tracking it. The uncertainties about the value of universal HCP influenza vaccination are less than the uncertainties related to some of the other measures being recommended. Universal, annual vaccination of HCP should be the foundation of a comprehensive strategy to protect patients and HCP alike. This is an opportunity that should not be missed.

Under visitor management, facilities should have a policy consistent with advising visitors to obtain information about influenza vaccination. Active promotion of influenza vaccination should be part of a comprehensive program for preventing influenza of everyone in contact with the healthcare delivery system across the entire spectrum of settings.

Healthcare Personnel Management

There has not been a standard work exclusion for HCP with known influenza or influenza-like illness. Although the recent use of an exclusion period of 24 hours after resolution of fever seemed to work well for general purposes with influenza A/H1N1 2009, there remains a concern about transmission of influenza virus (and other respiratory viruses) from HCP with continued respiratory symptoms. The continued presence of influenza virus in secretions after the recommended exclusion period makes strict application of respiratory hygiene necessary (as noted in the proposed guidance). In the healthcare setting, consideration of symptoms beyond fever is always warranted in terms of work exclusion, but theoretical risk of transmission must be balanced by patient safety concerns related to understaffing, especially in the care of patients in protected environments. Consideration should be given to a more symptom-based recommendation for HCP returning to work, such as resolution of fever AND significant clinical improvement, rather than a simple time frame.

This would provide protection after infection with any respiratory pathogen (rather than relying on influenza PCR testing) and could be combined with enhanced respiratory hygiene measures for those caring for patients at higher risk. This would need to include a recommendation for facility-based, employee health policies for evaluation of HCP status. It should be noted that effective universal vaccination will make the need to exclude HCP less common.

The use of viral RNA testing of respiratory secretions by rRT-PCR to allow HCP to return to care of higher risk patients is impractical and questionable, as it allows the return to work of HCP with other respiratory infections that may put these patients at risk. The focus should be on symptoms, how those symptoms may affect risk, and the measures necessary to prevent transmission of respiratory viruses from any HCP recovering from influenza and influenza-like illness.

A stronger recommendation for risk evaluation and early treatment with antivirals of HCP who do develop influenza might serve to raise awareness of the potential benefit of treating influenza as part of occupational health services. It is currently referred to in passing in several places and for HCP at high risk of complications of influenza in relation to consulting their healthcare provider. Enhanced attention to the potential benefit of treating employees with influenza can be incorporated into a comprehensive case-by-case evaluation of fitness for work dependent on symptoms, and not testing or fixed intervals.

Patient Isolation

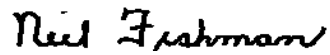
The minimum 7-day isolation and droplet precaution recommendation for patients differs from the 5-day duration of precautions in the 2007 HICPAC isolation guideline. What is the rationale for the recommendation for a longer duration of isolation in the case of patients?

Triage

During the experience of influenza A/H1N1 2009 in the community, many questions arose regarding patient triage in outpatient settings. This guidance provides good advice about such triage and cough etiquette/respiratory hygiene, but might emphasize and encourage more pre-presentation triage in a variety of settings, as in telephone consultation, that would not only minimize unprotected contacts, but would avoid delays in recognition of influenza-like illness on presentation.

SHEA commends CDC for addressing the need to match guidance to what we know about influenza in general and specifically what has been learned about influenza A/H1N1 2009. We appreciate that there has been, and continues to be, controversy attached to some of the proposed recommendations and appreciate the comprehensiveness and practicality of these evidence-based guidelines.

Sincerely,

A handwritten signature in black ink that reads "Neil Fishman". The signature is written in a cursive, slightly slanted style.

Neil O. Fishman, MD
President, SHEA