Update to the *Guideline for Infection Control in Healthcare Personnel, 1998* “Section 2”

HICPAC Infection Control in Healthcare Personnel Workgroup

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HICPAC Presentation, May 2019
Disclaimer: The findings and conclusions herein are draft and have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy.
Infection Control in Healthcare Personnel Workgroup

• **Workgroup:** *Guideline for Infection Control in Healthcare Personnel, 1998*

• **Goal:** To provide updated information on Infection Control in Healthcare Personnel (HCP), Section 2

• **Workgroup Charge:** The workgroup will focus on pathogen-specific issues for Infection Control in Healthcare Personnel. Where information is out of date, the Workgroup will make updates using evidence-based methods *where evidence is available.*

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Status Report

Section 2: Epidemiology and Prevention of Selected Infections Transmitted Among HCP and Patients

- Approved sections: Pertussis (Feb 2018); Mumps, Rubella (May 2018); Measles (Aug 2018); Meningococcal Disease (Nov 2018)
- Nov 2018 HICPAC meeting: “Draft” draft Diphtheria, Group A *Streptococcus* presented
- Today: Presentation of Varicella, Diphtheria, Group A *Streptococcus* sections (vote); “draft” draft Parvovirus, CMV recommendations; Conjunctivitis and Polio discussion
- In Progress: Respiratory Viral Pathogens, *S. aureus*

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Section 2 Pathogen Update: Methodology

• Different from prior guideline updates
• For each pathogen, the 1998 text and recommendations are being reviewed by the workgroup for elements that can be deleted, updated or continued.
• Specifically, the workgroup looks for
  • Outdated recommendations already updated elsewhere, e.g. ACIP
  • Areas with significant gaps between 1998 recommendations and current practices
  • Areas with new data/literature that can inform updated recommendations
  • Areas of need where 1998 guideline does not address a common issue or area of concern
• CDC pathogen-specific SMEs are also engaged to provide feedback on gaps, needed updates, and available literature
• Depending on that review process, either a Systematic Review or an Informal Review is conducted, and new literature is incorporated.

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Infection Control in HCP Workgroup: Methodology Impact

Practical Impact:
• For pathogens with full formal literature review, key questions will inform literature review and literature review will inform recommendations, but may be broader discussion
  • We purposefully picked more open-ended key questions
• For pathogens with little to no new information/data/literature, most recommendations will be based on less formal reviews, expert opinion, other relevant guidelines and harmonizing with existing recommendations
  • Aiming for practical, thoughtful guidance where little directly applicable literature

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1. Ensure that healthcare personnel either receive immunizations or have documented evidence of immunity against vaccine-preventable diseases as recommended by the CDC, CDC’s Advisory Committee on Immunization Practices (ACIP) and required by federal, state or local authorities.

2. Implement processes and sick leave policies to encourage healthcare personnel to stay home when they develop signs or symptoms of acute infectious illness (e.g., fever, cough, diarrhea, vomiting, or draining skin lesions) to prevent spreading their infections to patients and other healthcare personnel.

3. Implement a system for healthcare personnel to report signs, symptoms, and diagnosed illnesses that may represent a risk to their patients and coworkers to their supervisor or healthcare facility staff who are responsible for occupational health.

4. Adhere to federal and state standards and directives applicable to protecting healthcare workers against transmission of infectious agents including OSHA’s Bloodborne Pathogens Standard, Personal Protective Equipment Standard, Respiratory Protection standard and TB compliance directive.
Section 2: Epidemiology and Prevention of Selected Infections Transmitted Among HCP and Patients

Specific Pathogen Sections:

- Bloodborne Pathogens (HIV, HBV, HCV)
- Conjunctivitis / Adenovirus
- Cytomegalovirus
- Diphtheria
- Acute GI Infections (Norovirus, *C. difficile*, others)
- Hepatitis A
- Herpes Simplex
- Measles
- Meningococcal Disease
- Multidrug-Resistant Gram Negative Bacteria
- Mumps
- Parvovirus
- Pertussis
- Poliomyelitis
- Rabies
- Rubella
- Scabies and Pediculosis
- *Staphylococcus aureus* (MSSA/MRSA)
- *Streptococcus* (group A)
- Tuberculosis
- Vaccinia
- Varicella
- Viral Respiratory Infections (Influenza, RSV, others)
- Potential Agents of Bioterrorism (eg, Anthrax)

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Section 2: Diphtheria

• Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
• Reviewed ACIP 2011 and CDC resources
  – *Information for Close Contacts Worksheet:*
• Reached out to CDC SMEs for input
• Developed “draft” draft recommendations and narrative section
• Presented for HICPAC review and feedback, Nov 2018
• Revised and updated draft based on HICPAC feedback and SME input
Section 2: Diphtheria *Draft* Recommendations

1998 Recommendation

a. Encourage vaccination with Td every 10 years for health care personnel (Table 1) (9,19). *Category IB*

**DRAFT Update**

**Delete:** Narrative will refer to *ACIP 2011 Recommendations for Immunization of Healthcare Personnel* and to CDC recommendations for adult vaccine schedules.

- **Draft Narrative, Background:** “Prevention of transmission of *C. diphtheriae* in healthcare settings involves (a) encouraging vaccination of healthcare personnel against diphtheria in compliance with routine adult vaccine schedules; ...”
- **ACIP:** “*Tetanus and diphtheria toxoids (Td).* All adults should have documentation of having received an age-appropriate series of Td-containing vaccine and a routine booster dose every 10 years ...”
- **HICPAC Core Practices, Section 8 Occupational Health:** “1. Ensure that healthcare personnel either receive immunizations or have documented evidence of immunity against vaccine-preventable diseases as recommended by the CDC, CDC’s Advisory Committee on Immunization Practices (ACIP) and required by federal, state or local authorities.”

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Section 2: Diphtheria *Draft* Recommendations

**1998 Recommendations**

b. Obtain nasopharyngeal cultures from exposed personnel and monitor for signs and symptoms of diphtheria for 7 days after exposure (149). *Category IB*

c. Administer antimicrobial prophylaxis to personnel who have contact with respiratory droplets or cutaneous lesions of patients infected with diphtheria. Also administer a dose of Td to previously immunized exposed personnel who have not been vaccinated within the previous 5 years (Table 1) (19,149). *Category IB*

d. Repeat nasopharyngeal cultures of personnel found to have positive cultures at least 2 weeks after completion of antimicrobial therapy. Repeat antimicrobial therapy if personnel remain culture positive (149). *Category IB*

e. Exclude exposed personnel and those identified as asymptomatic carriers from duty until antimicrobial therapy is completed and results of two nasopharyngeal cultures obtained at least 24 hours apart are negative (Table 3) (149). *Category IB*
Section 2: Diphtheria Draft Recommendations

**DRAFT Update Recommendation:**

1. For healthcare personnel who have an exposure to diphtheria, regardless of vaccination status,
   a. Administer postexposure prophylaxis in accordance with CDC recommendations.
Section 2: Diphtheria Draft Recommendations

**DRAFT Update Recommendation:**

1. For healthcare personnel who have an exposure to diphtheria, regardless of vaccination status,
   
b. Exclude from work and obtain nasal and pharyngeal swabs for diphtheria culture:
   
   1. If nasal AND pharyngeal cultures are negative for *C. diphtheriae*, healthcare personnel may return to work while completing postexposure antibiotic therapy.
   
   2. If nasal OR pharyngeal cultures are positive for *C. diphtheriae*,
      
a. Complete postexposure antibiotic therapy.
      
b. Healthcare personnel may return to work when:
         
         1. postexposure antibiotic therapy is completed AND
         
         2. at least 24 hours after completion of postexposure antibiotic therapy, two nasal AND pharyngeal cultures for diphtheria obtained at least 24 hours apart are negative.
Section 2: Diphtheria Draft Recommendations

DRAFT Update Recommendation:

1. For healthcare personnel who have an exposure to diphtheria, regardless of vaccination status,

c. Implement daily monitoring for the development of signs and symptoms of diphtheria for 7 days after the last exposure.
Section 2: Diphtheria Draft Recommendations

DRAFT Update Recommendation:

2. For healthcare personnel with diphtheria infection, exclude from work until:
   a. Antibiotic and antitoxin therapy are completed AND
   b. At least 24 hours after completion of antibiotic therapy, two nasal and pharyngeal cultures for diphtheria obtained at least 24 hours apart are negative.
Section 2: Diphtheria

Narrative Outline

• Background
  – Prevention of transmission in healthcare settings
• Occupational Exposures
• Clinical Features
• Testing and Diagnosis
• Postexposure Prophylaxis
“Transmission of diphtheria occurs through deposition of respiratory, oral, or nasal secretions, discharge from skin lesions, or, rarely, fomites, from an infected source person on the mucus membranes of a susceptible host. Unprotected (ie, not wearing a facemask), close contact with an infectious source person or their secretions may be considered an exposure to diphtheria. Close contact may include performing a physical examination on; feeding or bathing a patient; bronchoscopy; intubation; or administration of bronchodilators.”

“Exposure to cutaneous diphtheria lesions may include unprotected contact with the lesions or their drainage, such as when changing lesion dressings or handling potentially infectious secretions without wearing recommended PPE (ie, gown and gloves).”
Section 2: Diphtheria

DRAFT Narrative: Postexposure Prophylaxis

“Postexposure prophylaxis for diphtheria includes receipt of diphtheria vaccine and a single dose of intramuscular benzathine penicillin G or a 7- to 10-day course of oral erythromycin. Detailed information regarding the dosage and administration of postexposure vaccine and antimicrobial therapy is available on the CDC website [link].

“Administration of postexposure prophylaxis does not always eliminate the carrier state. For HCP identified as *C. diphtheriae* carriers, positive post-treatment cultures typically prompt administration of additional courses of treatment. The CDC website provides additional information on the management of *C. diphtheriae* carriers [link].”
Section 2: Group A *Streptococcus*

- Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
- Reviewed current CDC guidelines and recommendations
- Reached out to CDC SMEs for input
- Developed “draft” draft recommendations
- Presented for HICPAC review and feedback, Nov 2018
- Revised and updated draft based on HICPAC feedback and SME input
Section 2: Group A *Streptococcus Draft* Recommendations

1998 Recommendations

a. Obtain appropriate cultures and exclude personnel from patient care or food handling if they have draining lesions that are suspected to be caused by *Streptococcus*. Work restrictions should be maintained until streptococcal infection has been ruled out or personnel have received adequate therapy for 24 hours (Table 3) (369,371,374). **Category IB**

b. Do not routinely exclude personnel with suspected or confirmed carriage of group A *Streptococcus* from patient care or food handling unless it is shown epidemiologically that they are responsible for disseminating the organism in the health care setting (Table 3) (369,373,378). **Category IB**
Section 2: Group A *Streptococcus Draft* Recommendations

**DRAFT Update Recommendation:**

1. Postexposure prophylaxis and work restrictions are not necessary for healthcare personnel who have an exposure to Group A *Streptococcus*. 

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Section 2: Group A *Streptococcus* Draft Recommendations

**DRAFT Update Recommendation:**

2. For healthcare personnel with known or suspected group A *Streptococcus* infection, obtain testing for group A *Streptococcus* and exclude from work until group A *Streptococcus* infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered.

a. For healthcare personnel with known or suspected group A *Streptococcus* draining skin lesions that cannot be adequately contained or covered (eg, on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.
Section 2: Group A *Streptococcus* Draft Recommendations

**DRAFT Update Recommendation:**

3. Work restrictions are not necessary for healthcare personnel with known or suspected group A *Streptococcus* colonization, unless they are epidemiologically linked to transmission of the organism in the healthcare setting.
**Section 2: Group A *Streptococcus* Draft Recommendations**

**DRAFT Update Recommendation:**

4. For healthcare personnel with group A *Streptococcus* colonization who are epidemiologically linked to transmission of the organism in the healthcare setting,
   a. Administer chemoprophylaxis in accordance with CDC recommendations AND
   b. Exclude from work until 24 hours after the start of effective antimicrobial therapy AND
   c. Obtain follow-up testing for group A *Streptococcus* 7 to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy.
Section 2: Group A *Streptococcus*

Narrative Outline:

• Background
  – Prevention of transmission in healthcare settings

• Occupational Transmission

• Clinical Features

• Testing and Diagnosis

• Postexposure Prophylaxis

• Outbreaks
Section 2: Group A *Streptococcus*

**Background**

“Prevention of transmission of GAS in healthcare settings involves (a) in addition to using Standard Precautions, placing patients with known or suspected GAS infection in recommended transmission-based precautions according to their clinical manifestations of GAS disease and (b) excluding potentially infectious HCP from work.”

**Occupational Transmission**

“Healthcare-associated transmission of GAS has been documented from patients to healthcare personnel (HCP) and from HCP to patients. “There are no recommended actions, such as administering postexposure prophylaxis (PEP) or work restrictions, after HCP exposure to GAS. Contact is the major mode of transmission of GAS in healthcare settings.”
Section 2: Group A *Streptococcus*

Postexposure Considerations

“Although PEP is not administered after HCP exposure to GAS, if clinical symptoms compatible with GAS infection develop, GAS infection may be the underlying etiology and testing and treatment may be indicated.”
Section 2: Group A *Streptococcus*

**Outbreaks**

“Even one case of postpartum or postsurgical GAS infection typically prompts an epidemiological investigation because of the potential for prevention of additional cases. CDC maintains recommendations for screening HCP during GAS outbreaks in healthcare settings, including which HCP to select for screening and which body sites to culture [link].

“When screening of HCP is performed, sites from which specimens are obtained and cultured include the throat, anus, vagina, and any skin lesions.

“Colonization with GAS does not necessitate treatment unless the carrier is epidemiologically linked to GAS transmission in the healthcare setting. Information regarding dosage and administration of chemoprophylaxis for GAS-colonized HCP who are epidemiologically linked to transmission is available on the CDC website [link].”
Section 2: Varicella (Varicella-Zoster Virus)

- Workgroup reviewed 1998 recommendations for gaps/obtdate recommendations
- Reviewed ACIP 2011 recommendations
- Reached out to CDC SMEs for input
- Presented “draft” draft recommendations and narrative text update to HICPAC, August 2018
- Revised and edited based on HICPAC feedback and in consultation with CDC SMEs
Section 2: Varicella (Varicella-Zoster Virus)

- Clarified recommendations and aligned with Isolation Precautions recommendations
Section 2: VZV Draft Recommendations

1998 Recommendations

a. Administer varicella vaccine to susceptible personnel, especially those that will have contact with patients at high risk for serious complications (Table 1). Category IA

b. Do not perform serologic screening of persons with negative or uncertain history of varicella before administering varicella vaccine to personnel, unless the institution considers it cost-effective. Category IB

c. Do not routinely perform postvaccination testing of personnel for antibodies to varicella. Category IB

DRAFT Update

Delete: Narrative will refer to ACIP 2011 Recommendations for Immunization of Healthcare Personnel and to HICPAC Core Practices Document.

• ACIP: “Healthcare institutions should ensure that all HCP have evidence of immunity to varicella.”

• HICPAC Core Practices, Section 8 Occupational Health: “1. Ensure that healthcare personnel either receive immunizations or have documented evidence of immunity against vaccine-preventable diseases as recommended by the CDC, CDC’s Advisory Committee on Immunization Practices (ACIP) and required by federal, state or local authorities.”
Section 2: VZV Draft Recommendations

1998 Recommendations

e. Develop guidelines for managing health care personnel who receive varicella vaccine; for example, consider precautions for personnel who acquire a rash after receipt of varicella vaccine and for other health care personnel who receive varicella vaccine and will have contact with susceptible persons at high risk for serious complications from varicella. Category IB

f. Develop written guidelines for postexposure management of vaccinated or susceptible personnel who are exposed to wild-type varicella. Category IB

DRAFT Update

Delete: Section 1 of the updated Healthcare Personnel Guideline addresses administrative issues related to immunization of healthcare personnel, including development of policies and procedures. Draft updated recommendations address development of rash after receipt of varicella vaccine.
Section 2: VZV Draft Recommendations

1998 Recommendations

I. Perform serologic screening for immunity to varicella on exposed personnel who have not had varicella or are unvaccinated against varicella. **Category IB**

m. Consider performing serologic screening for immunity to varicella on exposed, vaccinated personnel whose antibody status is not known. If the initial test result is negative, retest 5 to 6 days after exposure to determine whether an immune response occurred. **Category IB**

**DRAFT Update**

**Delete:** Recommendations for vaccination of healthcare personnel, including serologic screening, are addressed in *ACIP 2011 Recommendations for Immunization of Healthcare Personnel.*
Section 2: VZV Draft Recommendations

1998 Recommendations

d. NO RECOMMENDATION for administering postexposure varicella vaccination for the protection of exposed, susceptible personnel. 

UNRESOLVED ISSUE

g. Exclude personnel from work who have onset of varicella until all lesions have dried and crusted (Table 3). Category IB

h. Exclude from duty after exposure to varicella personnel who are not known to be immune to varicella (by history or serology), beginning on the tenth day after the first exposure until the 21st day after the last exposure (28th day if VZIG was given; Table 3). Category IB
Section 2: VZV Draft Recommendations

1998 Recommendations

i. Restrict immunocompetent personnel with localized zoster from the care of high-risk patients until lesions are crusted; allow them to care for other patients with lesions covered. **Category IB**

j. Restrict immunocompromised personnel with zoster from contact with patients until their lesions are crusted (Table 3). **Category IB**

k. Restrict susceptible personnel exposed to zoster from patient contact from the tenth day after the first exposure through the 21st day after the last exposure (28th day if VZIG was given; Table 3). **Category IB**

n. Consider excluding vaccinated personnel from work beginning on the 10th day after the first exposure through the 21st day after the last exposure if they do not have detectable antibodies to varicella, or screen daily for symptoms of varicella (Table 3). **Category IB**
Section 2: VZV Draft Recommendations

1998 Recommendations

o. Do not routinely give VZIG to exposed susceptible personnel, unless immunosuppressed, HIV infected, or pregnant. If VZIG is given, exclude personnel from duty from the 10th day after the first exposure through the 28th day after the last exposure (Tables 1 and 3). **Category IB**

DRAFT Update

Delete/Reframe: For vaccine versus VarizIG for postexposure prophylaxis, narrative provides brief description and refers to ACIP 2011 and a 2013 Update document on administration of immune globulin. Draft updated recommendation addresses extension of work restrictions for personnel who receive immune globulin as PEP.
Section 2: VZV Draft Recommendations

DRAFT Update Recommendation:

1. For healthcare personnel with evidence of immunity to varicella who have an exposure to varicella or disseminated or localized herpes zoster:
   
a. Postexposure prophylaxis is not necessary.
   
b. Work restrictions are not necessary.
Section 2: VZV Draft Recommendations

DRAFT Update Recommendation:

2. For healthcare personnel without evidence of immunity to varicella who have an exposure to varicella or disseminated or localized herpes zoster:
   a. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations.
   b. Exclude from work from the 8th day after the first exposure through the 21st day after the last exposure.

1. Work restrictions are not necessary for healthcare personnel who previously received one dose of the varicella vaccine and will receive the second dose of vaccine within 5 days after exposure.

2. If varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from work from the 8th day after the first exposure through the 28th day after the last exposure.

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Section 2: VZV Draft Recommendations

DRAFT Update Recommendation:

3. For healthcare personnel with varicella, exclude from work until all lesions have dried and crusted; or, for those who only have non-vesicular lesions that do not crust, exclude from work until no new lesions appear within a 24-hour period.

4. For healthcare personnel with disseminated herpes zoster, or for immunocompromised healthcare personnel with localized herpes zoster until disseminated disease has been ruled out, exclude from work until all lesions have dried and crusted.
Section 2: VZV Draft Recommendations

DRAFT Update

5. For healthcare personnel with localized herpes zoster, including vaccine-strain herpes zoster and immunocompromised healthcare personnel with localized herpes zoster who have had disseminated disease ruled out:

a. Cover all lesions and exclude from care of patients at increased risk for complications from varicella disease (eg, neonates, pregnant women, immunocompromised persons of any age) until all lesions are dried and crusted.

b. If lesions cannot be covered (eg, on the hands or face), exclude from work until all lesions are dried and crusted.
Section 2: VZV Draft Narrative Section

Changes since HICPAC review, August 2018:

• Added sentence in Background, line 42: “CDC recommends that susceptible HCP should not enter the room of a patient with varicella, disseminated herpes zoster, or localized herpes zoster if immune caregivers are available.” (cites Isolation Precautions)

• For readability and clarity:
  o Reorganized headings so that Occupational Exposures is second, after Background
  o Divided Clinical Features into sub-headings for Varicella and Zoster
Section 2: VZV Draft Narrative Section

Occupational Exposures

“VZV can be spread from person to person by direct contact, inhalation of aerosols from vesicular fluid of skin lesions of acute varicella or herpes zoster, and possibly through infected respiratory secretions from patients with varicella that also may be aerosolized.

Varicella and Disseminated Herpes Zoster

“Unprotected (eg, not wearing recommended personal protective equipment (PPE)) contact with patients with varicella or disseminated herpes zoster, their secretions, or air containing infectious particles may be considered an exposure to VZV. Exposures in healthcare settings may include unprotected entry into a source patient’s room and touching vesicular fluid from skin lesions without PPE. Experts differ regarding the duration of exposure to an infectious patient (eg, being in the same room) that is needed for transmission. Sources suggest time frames from 5 minutes to up to 1 hour. Brief, unprotected entry into a source patient’s room without touching the patient or surfaces is generally not considered an exposure.

Localized Herpes Zoster

“VZV can also spread from a person with active localized herpes zoster to cause varicella in a susceptible person (ie, who has never had varicella or has not received varicella vaccine) from touching vesicular fluid from skin lesions without PPE.11 The lesions are infectious until they dry and crust over.”
Section 2: VZV Draft Narrative Section

Postexposure Prophylaxis

“Exposed HCP without evidence of VZV immunity should receive postexposure vaccination as soon as possible in accordance with CDC and ACIP recommendations. Vaccination within 3 to 5 days of exposure may modify the disease if infection occurs. Vaccination 6 or more days after exposure is still indicated because it induces protection against subsequent exposures.

“For HCP without evidence of immunity who have a contraindication to varicella vaccination and are at increased risk for severe disease (eg, pregnant, immunocompromised), varicella-zoster immune globulin should be administered as soon as possible (within 10 days) after exposure to VZV. Treatment with immune globulin can prolong the incubation period to 28 days after exposure. Detailed information regarding dosage and administration of PEP is available on the CDC website [link].”
Pause

• Those were ‘draft recommendations’ being presented for a vote (discussion welcome)

• Next are ‘DRAFT draft recommendations’ being presented for discussion (no voting today)
Section 2: Cytomegalovirus

- Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
- Reviewed existing CDC guidance
- Presenting “draft” draft recommendations

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Section 2: Cytomegalovirus

1998 Recommendations

a. Do not restrict personnel from work who contract CMV-related illnesses (119). *Category IB*

b. Ensure that pregnant personnel are aware of the risks associated with CMV infection and infection control procedures to prevent transmission when working with high-risk patient groups (Table 6) (3,117). *Category IA*

c. Do not routinely use workplace reassignment as a method to reduce CMV exposures among seronegative pregnant personnel (88,92,95-97,102,105,106,119,120). *Category IA*
Section 2: Cytomegalovirus

1998 Recommendations

b. Ensure that pregnant personnel are aware of the risks associated with CMV infection and infection control procedures to prevent transmission when working with high-risk patient groups (Table 6) (3,117). Category IA

DRAFT Update

Delete: Section 1 of the updated Healthcare Personnel Guideline addresses administrative considerations, including counseling.
Section 2: Cytomegalovirus

1998 Recommendations

a. Do not restrict personnel from work who contract CMV-related illnesses (119). *Category IB*

c. Do not routinely use workplace reassignment as a method to reduce CMV exposures among seronegative pregnant personnel (88,92,95-97,102,105,106,119,120). *Category IA*

**DRAFT Draft Update Recommendations:**

1. Work restrictions are not necessary for healthcare personnel who contract CMV.

2. Routine exclusion of CMV seronegative pregnant or immunocompromised healthcare personnel from caring for patients with CMV is not necessary.

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Section 2: Parvovirus

• Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
• Reviewed existing CDC guidance
• Presenting “draft” draft recommendation
Section 2: Parvovirus

1998 Recommendations

a. Ensure that pregnant personnel are aware of the risks associated with parvovirus infection and of infection control procedures to prevent transmission when working with high-risk patient groups (Table 6) (274,275). Category IB

b. Do not routinely exclude pregnant personnel from caring for patients with B19. Category IB
Section 2: Parvovirus

1998 Recommendations

a. Ensure that pregnant personnel are aware of the risks associated with parvovirus infection and of infection control procedures to prevent transmission when working with high-risk patient groups (Table 6) (274,275). Category IB

DRAFT Update

Delete: Section 1 of the updated Healthcare Personnel Guideline addresses administrative issues, including counseling.

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Section 2: Parvovirus

1998 Recommendations

b. Do not routinely exclude pregnant personnel from caring for patients with B19. *Category IB*

*DRAFT Draft Update Recommendation:*

1. Routine exclusion of pregnant or immunocompromised healthcare personnel from caring for patients with Parvovirus B19 is not necessary.
Section 2: Conjunctivitis

- Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
- Reviewed existing CDC guidance
- Reached out to CDC SMEs for input
- Literature Review proposed
Section 2: Conjunctivitis

1998 Recommendation:

a. Restrict personnel with epidemic keratoconjunctivitis or purulent conjunctivitis caused by other microorganisms from patient care and the patient’s environment for the duration of symptoms. If symptoms persist longer than 5 to 7 days, refer personnel to an ophthalmologist for evaluation of continued infectiousness. Category IB

Current State:

• A 14-day exclusion is often used in practice. (Red Book: “Health care professionals with known or suspected adenoviral conjunctivitis should avoid direct patient contact for 14 days after onset of disease in the most recently involved eye.”)
• CDC SMEs unaware of literature to support the 14-day exclusion

• Work group proposes Literature Review to determine whether transmission occurs in healthcare settings from HCP to others beyond resolution of symptoms of epidemic keratoconjunctivitis

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Section 2: Poliomyelitis

• Workgroup reviewed 1998 recommendations for gaps/outdated recommendations
• Reviewed existing CDC resources
Section 2: Poliomyelitis

1998 Recommendations

a. Determine whether the following personnel have completed a primary vaccination series: (1) persons who may have contact with patients or the secretions of patients who may be excreting wild polioviruses and (2) laboratory personnel who handle specimens that might contain wild polioviruses or who do cultures to amplify virus (Table 1) (21). **Category IA**

b. For above personnel, including pregnant personnel or personnel with an immunodeficiency, who have no proof of having completed a primary series of polio immunization, administer the enhanced inactivated poliovirus vaccine rather than oral poliovirus vaccine for completion of the series (Table 1) (21). **Category IB**

c. When a case of wild-type poliomyelitis infection is detected or an outbreak of poliomyelitis occurs, contact the CDC through the state health department. **Category IB**

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Section 2: Poliomyelitis

DRAFT Update:

• 1998 recommendations are related to vaccination and reporting, which are addressed elsewhere and therefore will not be carried forward.

• *Workgroup proposes* narrative section without recommendations.
Next Steps

• Vote: Varicella, Diphtheria, Group A *Streptococcus* Sections

• Incorporate HICPAC feedback and develop draft sections: CMV, Parvovirus, Polio (scheduled for HICPAC vote 08/2019)

• Continue work on Conjunctivitis/ Adenovirus, Viral Respiratory Diseases, *S. aureus*

• Submit for CDC clearance and public comment: Pertussis, Meningococcal Disease, Diphtheria, Group A *Streptococcus*

• Begin next pathogen sections
Acknowledgments

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CDC/DHQ Support: Kendra Cox, Jamesa Hogges, Kristin Roberts, Srila Sen, Devon Schmucker, Erin Stone

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Discussion/Comments/Questions