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The Society for Healthcare Epidemiology of America

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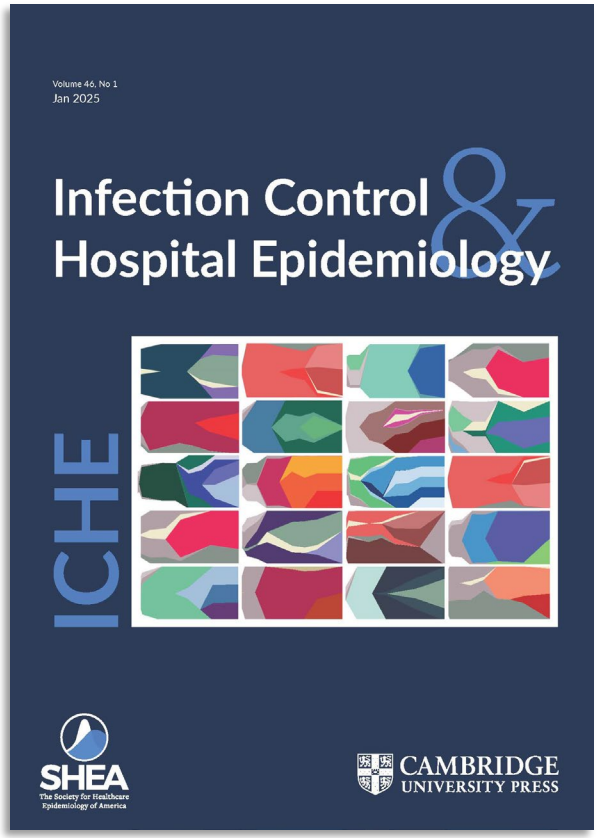

Infection Control & Hospital Epidemiology publishes scientifically authoritative, clinically applicable, peer-reviewed research on control and evaluation of the transmission of pathogens in healthcare institutions and on the use of epidemiological principles and methods to evaluate and improve the delivery of care. Major topics covered include infection control practices, surveillance, antimicrobial stewardship, cost-benefit analyses, resource use, occupational health, and regulatory issues.

www.cambridge.org/iche

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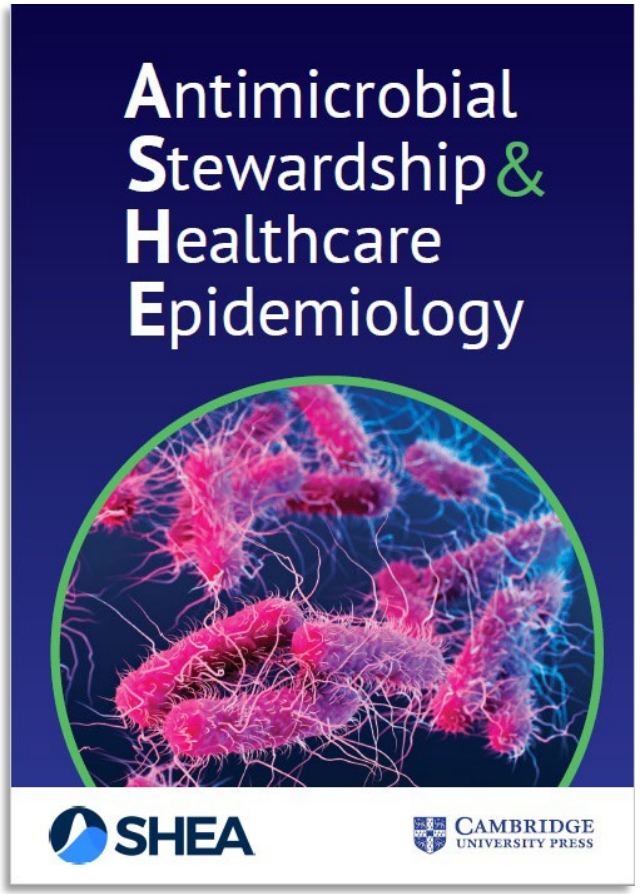

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UPCOMING PROGRAMS & ACTIVITIES

Courses/Webinars

Diagnostic Stewardship Programs: From Concept to Implementation
January 26, 2026 @ 2:00 – 3:00 pm ET

COMING SOON

LearningCE Course

You Can Help! Improving Antibiotic Stewardship and Infection Prevention in Nursing Homes

A new bite-sized education program designed for Long Term Care staff coming January 30th, 2026!

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SHEA Webinar

Town Hall 2026

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Housekeeping

- Technical difficulties? Visit: https://support.zoom.us
- Webinar recording, PowerPoint presentation, and references available on learningce.shea-online.org
- Streaming Live on SHEA's Facebook page
- Zoom Polling, Q&A & Chat

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January Town Hall Panelists:

Dr. Marci Drees
ChristianaCare

Dr. Katie Passaretti
Advocate Health

Dr. Chris Nyquist
Children's Colorado

Dr. Tom Talbot
Vanderbilt University

Invited Panelist:

Jane Siegel, MD

California Department of Public Health (2018 – 2024)

Respiratory Viruses in Healthcare: Practical Strategies and Persistent Questions

January 2026 Town Hall

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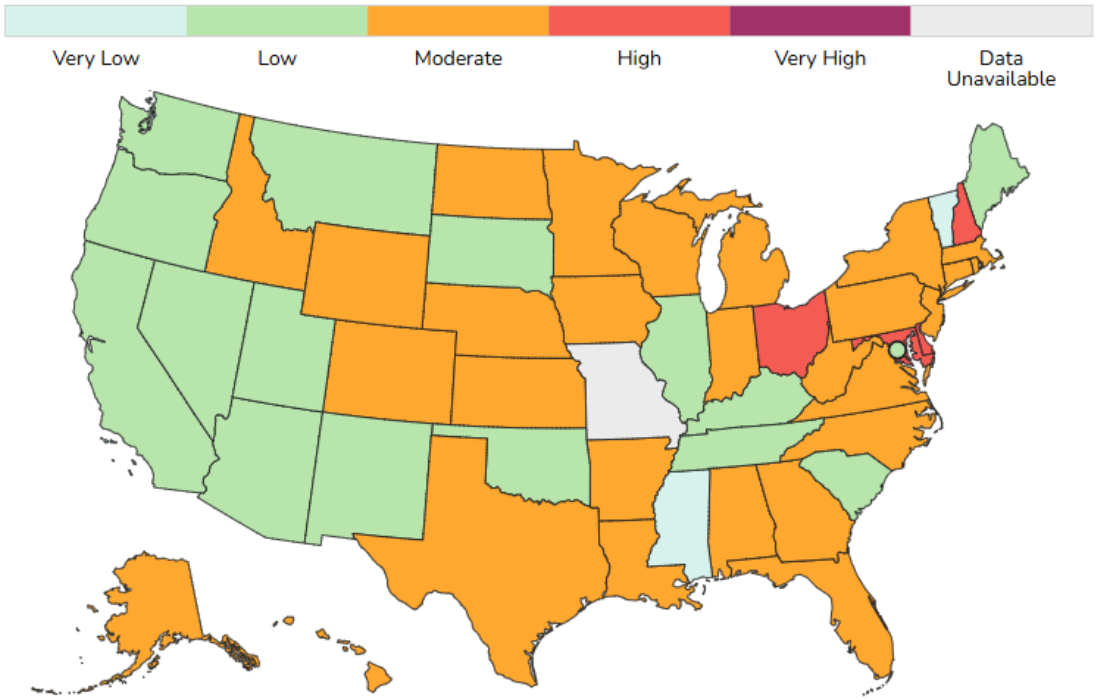
The Society for Healthcare Epidemiology of America

January 2026 Town Hall Background

- Current respiratory virus epidemiology in US
- Important papers/Issues
  - Influenza A H3N2 K variant
  - Alterations to CDC immunization recommendations and impact on healthcare-associated viral respiratory infections (HAVRI)
  - Recent papers of note of HAVRI

Respiratory Virus Activity Levels

Acute Respiratory Illness



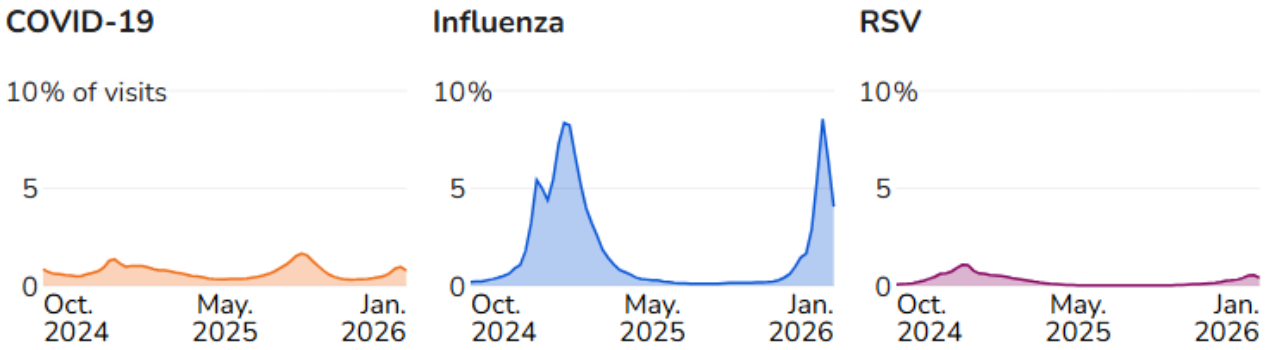
U.S. territories

AS GU MP PR VI

Emergency Department Visits for Viral Respiratory Illness

Weekly percent of total emergency department visits associated with COVID-19, influenza, and RSV. Refer to data notes for more details.

Emergency department visits in **the United States**



Data last updated on January 14, 2026 and presented through January 10, 2026. View this dataset on data.cdc.gov.

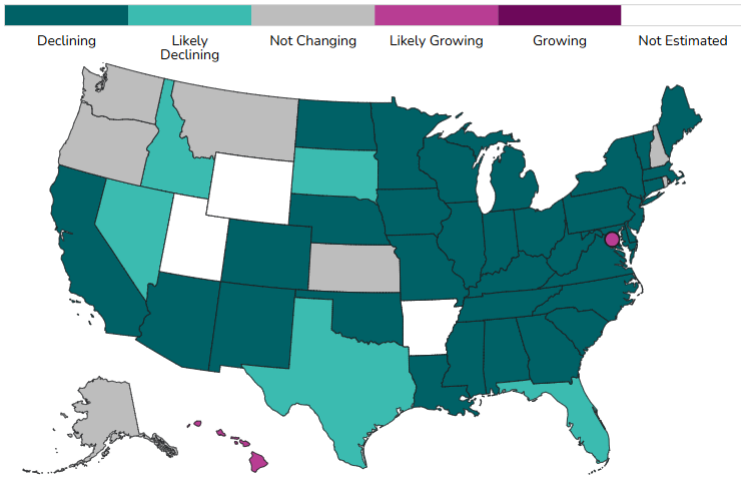
https://www.cdc.gov/respiratory-viruses/data/activity-levels.html#cdc_data_surveillance_section_7-data-notes

Epidemic Trends

CDC uses data from emergency department visits to model epidemic trends. This model helps tell whether the number of new respiratory infections is growing or declining in your state. While this model tells us the trend, it does not tell us the actual number of current infections with SARS-CoV-2 (the virus that causes COVID-19), influenza virus, or RSV. Refer to data notes for more details.

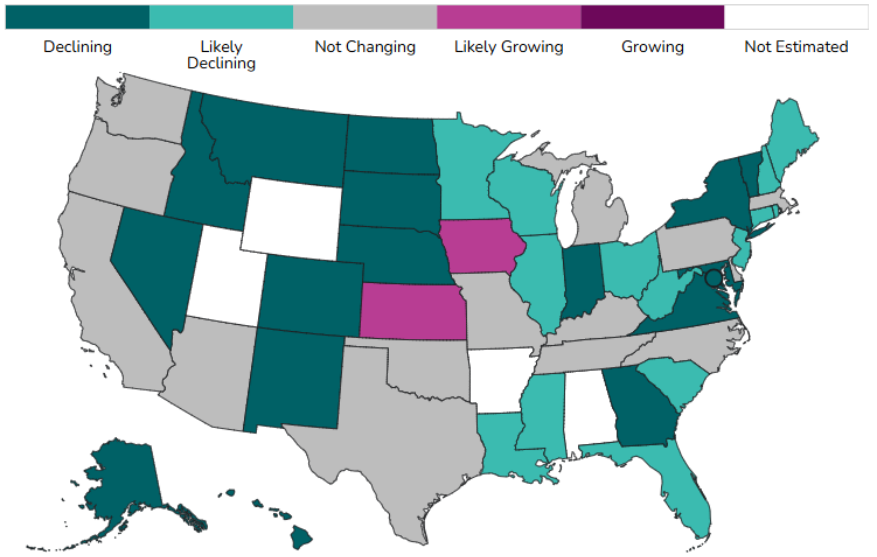
COVID-19 | Influenza | RSV

Epidemic Trend



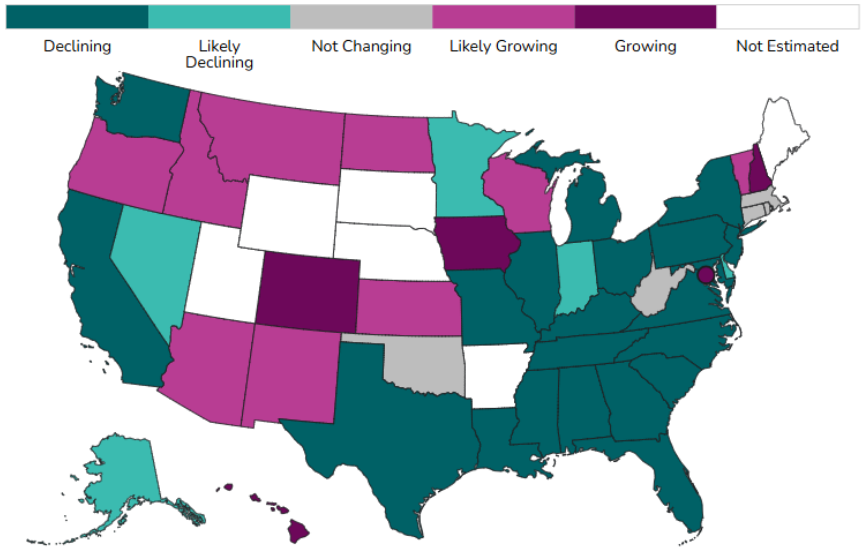
COVID-19 | **Influenza** | RSV

Epidemic Trend



COVID-19 | Influenza | **RSV**

Epidemic Trend



https://www.cdc.gov/respiratory-viruses/data/activity-levels.html#cdc_data_surveillance_section_7-data-notes

Wastewater Map

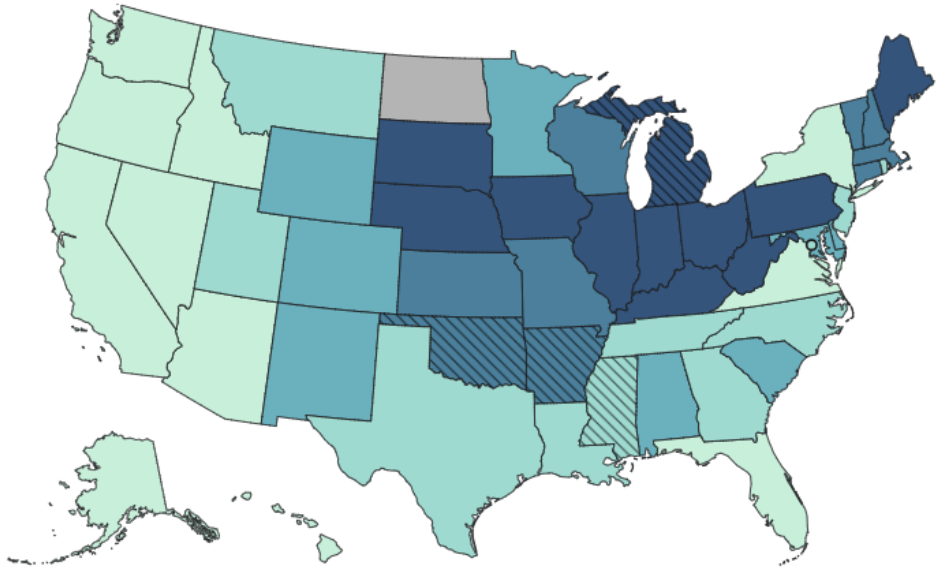
Wastewater (sewage) can be tested to detect traces of infectious diseases circulating in a community, even if people don't have symptoms. You can use these data as an early warning that levels of infections may be increasing or decreasing in your community. COVID-19 wastewater trends may differ from some health outcome findings, such as hospitalization trends, as COVID-19 is causing severe disease less frequently than earlier in the pandemic.

COVID-19 | Influenza A | RSV

Wastewater Viral Activity Level

Very Low | Low | Moderate | High | Very High | No Data

Limited Coverage*



U.S. territories

GU VI

https://www.cdc.gov/respiratory-viruses/data/activity-levels.html#cdc_data_surveillance_section_7-data-notes

TENNESSEE INFLUENZA WEEKLY REPORT

WEEK 1

January 4, 2026 - January 10, 2026

INFLUENZA ACTIVITY SNAPSHOT

SURVEILLANCE INDICATOR	TREND	CURRENT WEEK	PREVIOUS WEEK
ILLNESS Percentage of outpatient visits due to influenza-like illness (ILI)	▼	6.3%	8.8%
LABORATORY Percentage of positive specimens & predominant strain of influenza	▼	37.5% *Flu A (H3)*	47.7% *Flu A (H3)*

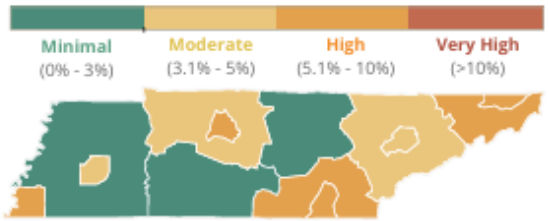
	NEWLY REPORTED *during week of January 4, 2026*	SEASON TOTAL *since September 28, 2025*
OUTBREAKS 2 or more ill persons of a shared setting	2	17
DEATHS Newly reported* and season total pediatric influenza-associated deaths in TN	0	0

*Deaths are reported publicly once the public health investigation is complete and cases have been confirmed. The week of reporting may not reflect the actual week of death.

INFLUENZA-LIKE ILLNESS (ILI)

Percent of Outpatient Visits for Influenza-Like Illness

Week 1

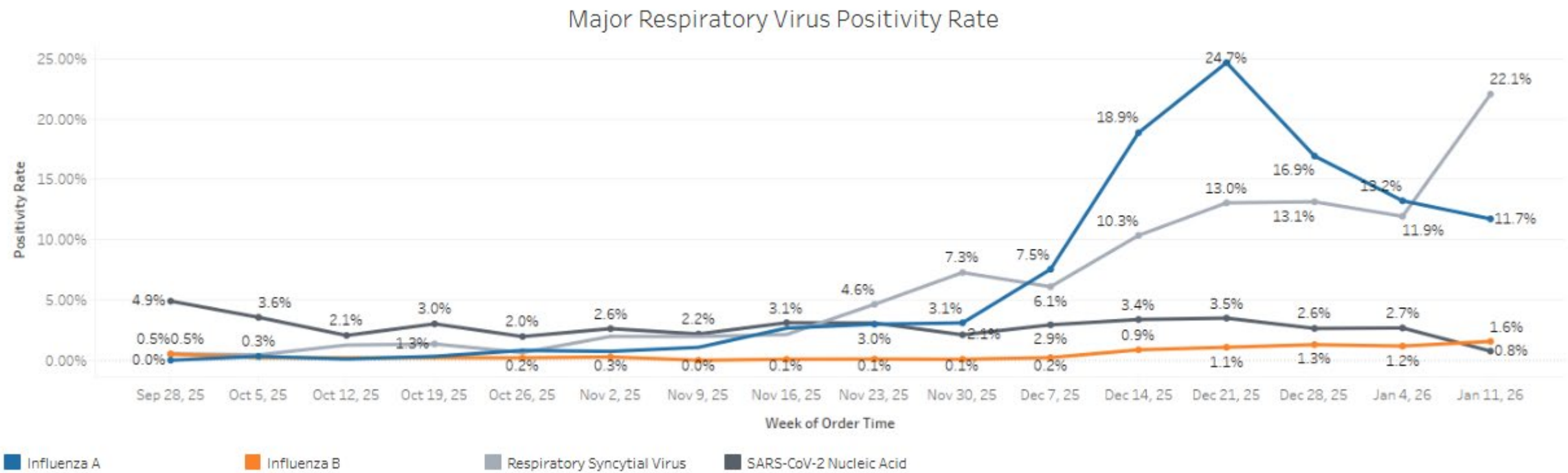


The U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) monitors outpatient visits for respiratory illness referred to as influenza-like illness (ILI). Tennessee has approximately 100 sentinel providers across the state that contribute this data weekly from a variety of healthcare setting such as primary care, pediatrics, county health departments, student health centers, and emergency departments.

ILI is defined as a fever plus cough or sore throat, not laboratory-confirmed influenza. Therefore these data may capture respiratory illness visits due to infection with any pathogen that can present with similar symptoms, including influenza, SARS-CoV-2, and RSV.

TN State Average	6.3%
Chattanooga/Hamilton County Metro	7.6%
East Region	4.6%
Jackson/Madison County Metro	5.9%
Knox County Metro	4.4%
Memphis/Shelby County Metro	7.6%
Mid Cumberland Region	5.6%
Nashville/Davidson County Metro	6.4%
Northeast Region	6.4%
Southeast Region	7.1%
South Central Region	0.5%
Sullivan County Metro	8.0%
Upper Cumberland Region	1.1%
West Region	2.2%

VANDERBILT UNIVERSITY
MEDICAL CENTER



PAHO Pan American Health Organization

PAHO issues alert on simultaneous circulation of seasonal influenza and respiratory syncytial virus in the Americas

Weekly US Influenza Surveillance Report: Key Updates for Week 1, ending January 10, 2026

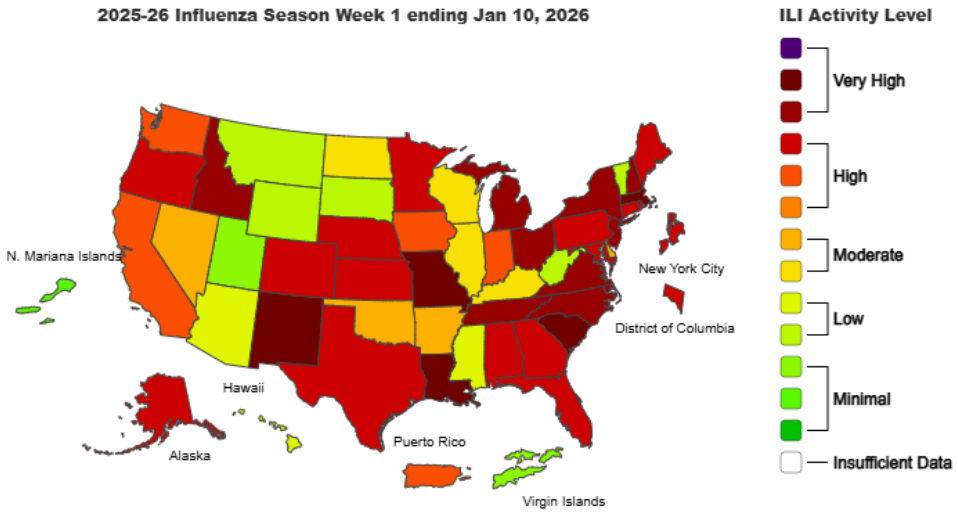
Viruses

Clinical Lab

18.6% (Trend ↓)
positive for influenza
this week.

Public Health Lab

The most frequently reported influenza viruses this week were influenza A(H3N2).



Illness

Outpatient Respiratory Illness

5.3% (Trend ↓)
of visits to a health care provider this week were for respiratory illness (above baseline).

Activity Map

8 moderate jurisdictions
36 high or very high jurisdictions

NHSN LTCF Respiratory Data

54.9 (Trend ↓)
weekly hospitalization rate per 100,000 residents

NHSN Hospital Respiratory Data

27,428 (Trend ↓)
patients admitted to hospitals with influenza this week.

FluSurv-NET

50.4
cumulative hospitalization rate per 100,000 population

NCHS Mortality

2.1% (Trend ↑)
of deaths attributed to influenza this week.

Pediatric Deaths

15 influenza-associated deaths were reported this week for a total of 32 deaths this season.

Influenza A H3N2 K variant

Virus Subtype or Lineage	Genetic Characterization				
	Total No. of Subtype/Lineage Tested	HA Clade	Number (% of subtype/lineage tested)	HA Subclade	Number (% of subtype/lineage tested)
A/H3	547				
		2a.3a.1	547 (100%)	J.2	2 (0.4%)
				J.2.2	5 (0.9%)
				J.2.3	20 (3.7%)
				J.2.4	23 (4.2%)
				K	497 (90.9%)

New 'super flu' strain concerns epidemiologists. Here are the symptoms

This 'super flu' could cause widespread serious illness, health experts say

"Superflu" or same old flu? How subclade K influenza is playing out worldwide

A fast-spreading strain of influenza A (H3N2), known as subclade K, has fuelled headlines warning of a possible "superflu". The reality is more nuanced, scientists say.

- New emerged subgroup; dominant circulating form (Europe/Japan)
- Associated with early starts to flu season
- Carries mutations c/w vaccine strain
- No evidence that can bypass immunity (vax or past infxn) or causes more severe illness
- Current vaccine appears to provide meaningful protection (adults 32-39%; kids 72-75% effective)

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
January 5, 2026

Contact: HHS Press Office

202-690-6343

Submit a Request for Comment

CDC Acts on Presidential Memorandum to Update Childhood Immunization Schedule

WASHINGTON, D.C. — JANUARY 5, 2026 — Deputy Secretary of Health and Human Services Jim O'Neill, in his role as Acting Director of the Centers for Disease Control and Prevention (CDC), today signed a decision memorandum* [PDF, 894 KB] accepting recommendations from a comprehensive scientific assessment [PDF, 1.05 MB] of U.S. childhood immunization practices, following a directive from President Trump to review international best practices from peer, developed countries.

https://www.hhs.gov/press-room/cdc-acts-presidential-memorandum-update-childhood-immunization-schedule.html

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

News Release

AAP Opposes Federal Health Officials' Unprecedented Move to Remove Universal Childhood Immunization Recommendations

ACP American College of Physicians®
Leading Internal Medicine, Improving Lives

ACP Issues Dire Warning: Adopting Vaccination Schedules Based on Those Used by Other Countries Will Put U.S. Lives at Risk

PRESS RELEASES

AMA

AMA statement on changes to childhood vaccine schedule

IDSA and over 200 health organizations urge Congress to conduct oversight of changes to vaccine schedule

National Foundation for Infectious Diseases®

Joint Letter on US Childhood Immunization Schedule

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POLICY UPDATE

Important Highlights

SHEA Joins National Call for Congressional Oversight on Abrupt Childhood Vaccine Schedule Changes

On January 5, 2026, the U.S. Department of Health and Human Services (HHS) announced significant changes to the recommended childhood immunization schedule—changes that were not based on credible scientific evidence and were made without the transparent public process that such decisions demand. Among the most concerning revisions, federal health officials are no longer recommending the influenza vaccine for children, and the new schedule appears to mirror guidance used in Denmark rather than evidence-based U.S. standards.

In response, **SHEA joined 230 medical professional societies in signing a letter** urging Congress to conduct swift and robust oversight into this decision. The letter calls for an investigation into:

- **Why the schedule was changed without scientific justification**
- **Why credible evidence was disregarded**
- **Why the Advisory Committee charged with advising the HHS Secretary on immunizations did not address these changes during its public meetings**

HHS's decision to dismantle a well-established, evidence-based childhood vaccine schedule threatens to create confusion for families and healthcare professionals and could leave more children vulnerable to serious vaccine-preventable diseases.

SHEA and its partners emphasize that any changes of this magnitude must occur through a transparent, public process where the underlying scientific data is disclosed and rigorously reviewed by experts. Anything less undermines public trust and jeopardizes the health of our communities. Log into MySHEA to read a detailed analysis of this policy change.

Trump Administration Changes to U.S. Pediatric Vaccine Recommendations, as of January 5, 2026

Disease(s)/Vaccine	Pre-2025	As of Jan 2026	Change (Y/N)
COVID-19*	Routine	SCDM	Y
Influenza**	Routine	SCDM	Y

Unvaccinated patients = Potential vectors for HAVRI

COVID-19 still causes severe disease, but up-to-date vaccines are effective, new research shows

- EuroSAVE Network (WHO/Country Collaboration)
- Enhanced surveillance for ARI in hospitals
- Examined May 2023-May 2024 ARI hospitalizations
- SARS-CoV-2 caused 10% (only 3% had COVID vax w/in past 12 mos)
- Kosovo 3 yr study: UTD vax = 72% effective preventing hosp
- 6 country study: recent (6 mos) vax prevent 60% of hospitalizations

https://www.who.int/europe/news/item/31-12-2025-covid-19-still-causes-severe-disease--but-up-to-date-vaccines-are-effective--new-research-shows

Risk mitigation of shared room ventilation and filtration on SARS-CoV-2 transmission: a multicenter test-negative study

Victoria Williams MPH[1], Kevin L. Schwartz MD, MSc[2,3,4], Kevin Brown PhD[3,4], Matthew Muller MD, PhD[5,6], Jeff Powis MD, MSc[5,7], Daniel Ricciuto MD[5,8], Alexander Kiss PhD[1], Mark Downing MD, MHSc[2], Sharon Sukhdeo MD, MSc[1,5], Thomas Dashwood MD[5,7], Jacob Romano BSc[8], Rob Kozak PhD[1], Lorraine Maze dit Mieusement RN, MN[1] and Jerome A. Leis MD, MSc[1,4,5,9]

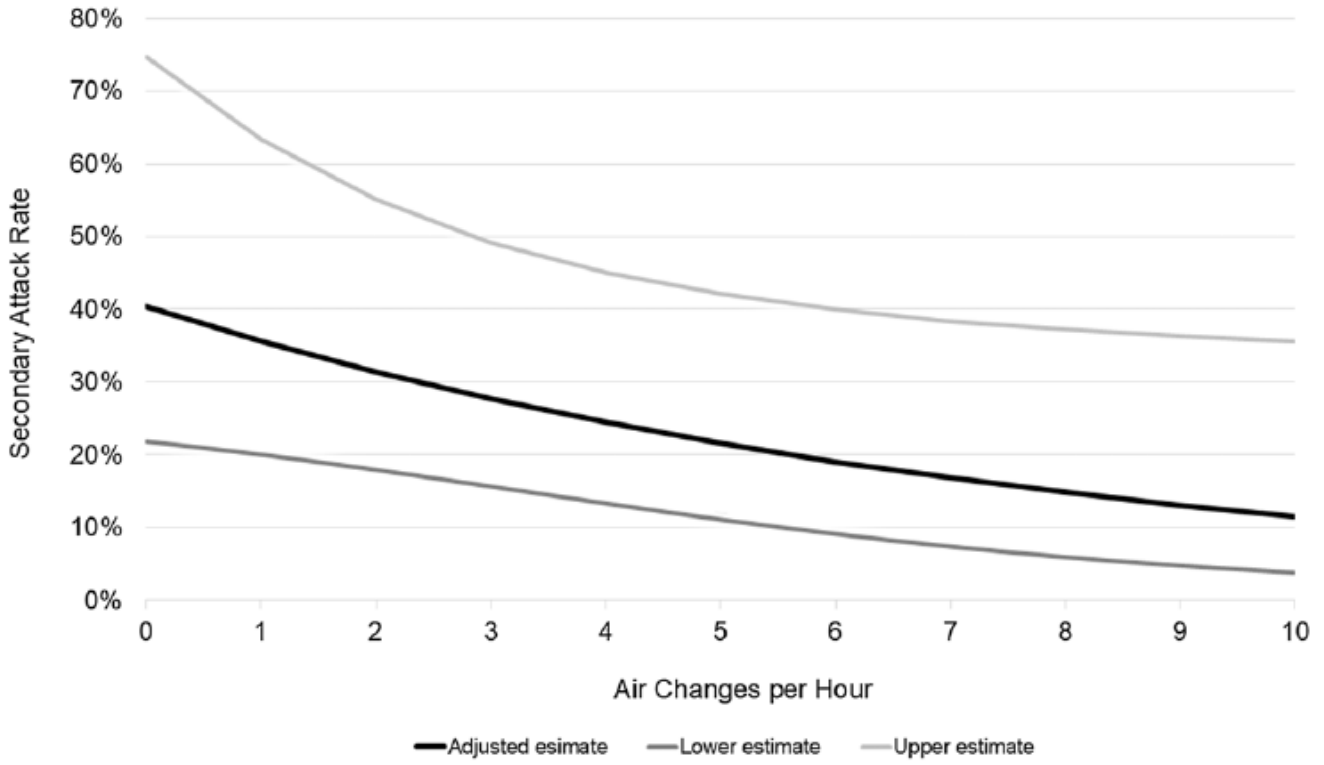


Figure 2. Estimated SARS-CoV-2 secondary attack rate along with 95% confidence intervals in shared hospital room, per number of room air changes per hour (ACH) after adjustment for other confounders.

Williams V et al ICHE 2025;46:1013-1019

Genomic epidemiology of healthcare-associated respiratory virus infections in Pittsburgh, Pennsylvania, 2018–2020

Vatsala Rangachar Srinivasa MPH[1,2,3], Marissa P. Griffith BS[1,2], Alexander J. Sundermann DrPH[1,3], Emma Mills BS[2], Nathan J. Raabe MPH[1,2,3], Kady D. Waggle MS[1,2], Kathleen A. Shutt MS[1,2], Tung Phan MD, PhD[7], Anna F. Wang-Erickson PhD[3,5,6], Graham M. Snyder MD, MS[2,4], Daria Van Tyne PhD[2], Lora Lee Pless PhD[1,2,#] and Lee H. Harrison MD[1,2,3,#]

Table 2. Summary of genetically related clusters

Cluster	No. Patients	Hospital	Epidemiologic link	Virus	Time between first and last specimen (days)
1	5	PH ($n=4$) AH-1 ($n=1$)	PH: Overlapping stay	Rhinovirus C	8
2	2	PH	Shared unit	Rhinovirus A	12
3	2	PH ($n=1$) AH-2 ($n=1$)	Unknown	Rhinovirus A	12
4	2	PH ($n=1$) AH-2 ($n=1$)	Unknown	Rhinovirus A	0
5	2	PH ($n=1$) AH-1 ($n=1$)	Unknown	Rhinovirus A	2
6	2	PH ($n=1$) AH-2 ($n=1$)	Unknown	Rhinovirus B	5
7	4	PH ($n=3$) AH-1 ($n=1$)	PH: Shared unit AH-1: Unknown	RSV B	55
8	2	PH ($n=1$) AH-2 ($n=1$)	Unknown	RSV A	33
9	3	AH-1	Shared unit	RSV B	8
10	4	PH ($n=1$) AH-1 ($n=1$) AH-2 ($n=2$)	AH-2: Shared unit PH/AH-1: Unknown	Influenza A virus	25
11	2	AH-1	Shared unit	Influenza A virus	4
12	2	PH ($n=1$) AH-1 ($n=1$)	Unknown	HMPV A2	0
13	2	AH-1	Unknown	HMPV A2	32
14	2	PH	Common provider	HMPV B1	9

PH, Pediatric hospital; AH-1, Adult hospital 1; AH-2, Adult hospital 2; RSV, respiratory syncytial virus; HMPV, human metapneumovirus

Srinivasa VR et al ICHE 2026;47:53-63

Viable viruses in airborne particles detected during cough by participants with acute respiratory viral infections

Tay GTP et al J Hosp Infect 2025;164:18-26

The role of spatial distance in SARS-CoV-2 nosocomial transmission

Illingworth CJR et al J Hosp Infect 2025;166:71-81

Impact of rapid screening of respiratory viral infections on patient management in a healthcare facility

Cambien G et al J Hosp Infect 2026;167:192-98

The burden of healthcare-associated viral infections in hospitalized children

Baxter J et al J Hosp Infect 2026;in press

Lim LL et al AJIC 2025;53:1091-99

Vaccination coverage outcomes and health care organization program implementers' experiences after introduction of a health care worker influenza vaccination mandate in Victoria, Australia, 2022-2023

Huang FS et al AJIC 2025;53:1350-53

Effectiveness of COVID-19 vaccination to prevent health care personnel absences: A single site experience

Bucher D et al AJIC 2025;53:1347-49

Trends in rhinovirus/enterovirus health care-associated infections at a large academic hospital from July 2018 to June 2024

Gagnon J et al AJIC 2026; in press

Effectiveness of using full personal protective equipment in reducing the transmission of SARS-CoV-2 in health care workers: A systematic review

HAVRI: IP Challenges

- Implementing facility masking
  - What metrics? What thresholds? Implementation issues
- Applying transmission-based precautions in non-acute settings
- Virus-specific vs virus-agnostic approaches
- Ventilation challenges

Key Points about Preventing Respiratory Virus Infections in Long Term Care Facilities

Jane D. Siegel, MD

1/19/26

How Various Groups within a Healthcare Facility Contribute to Preventing Infection

www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InfectionPrevention.aspx

Elements of a LTCF respiratory virus prevention and control plan

- **Vaccination**
- Resource Allocation
- **Source Control Masking**
- Education
- Ventilation and Filtration of Indoor Air and Isolation Areas (regular maintenance)
- Active daily monitoring for respiratory Illness during periods of increased community activity
- Management of HCP with Respiratory Symptoms or COVID-19 Exposures
- **Testing**
- Isolation, Transmission-Based Precautions, Cohorting
- During increased community activity or outbreak: screen visitors for signs and symptoms
  - Notify LHD if outbreak
- **Treatment** (influenza, COVID-19), c**hemoprophylaxis** (influenza)

www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/
www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CA_RecsPrevControl_RespVirus_SNFs.pdf (2025-2026)
Multisociety guidance for infection preventionand control in nursing homes.Infection Control & Hospital Epidemiology (2025), 46, 1069–1096. doi:10.1017/ice.2025.10252

VENTILATION IN HEALTHCARE SETTINGS

In healthcare settings, ventilation is important because it helps remove things from the air that we don't want to breathe in – like small virus particles. Good ventilation improves air quality and reduces the risk of germs spreading.

WHAT TO KNOW

Understand what an air change is and why recommended air changes per hour are important in healthcare.

- An air change means the air in a room is replaced with new air.
- Air changes are usually measured by the hour – air changes per hour (ACH).
- In healthcare facilities, nearly every type of room has a recommended number of ACHs to help reduce the risk of germs spreading among patients and staff.

Respect wait times to allow the air in rooms to clear.

- The infection prevention or clinical leaders in your area, like your nurse manager, will use the ACH to figure out how long a room should sit empty after a patient with a possible or confirmed respiratory infection has left.
- It is okay to enter a room before the air is completely cleared, including while the patient is still there, if you use the recommended personal protective equipment (PPE).

Ask before making changes to the ventilation in a room.

- Rooms are often connected in healthcare facilities.
- Making a change to the ventilation in one room – like opening a window or closing vents to adjust temperature – can change the ventilation in other places, too.
- **That's why it's important to talk to the person or team at your facility that is responsible for maintaining air filtration and ventilation if you have concerns about the ventilation in a room.**

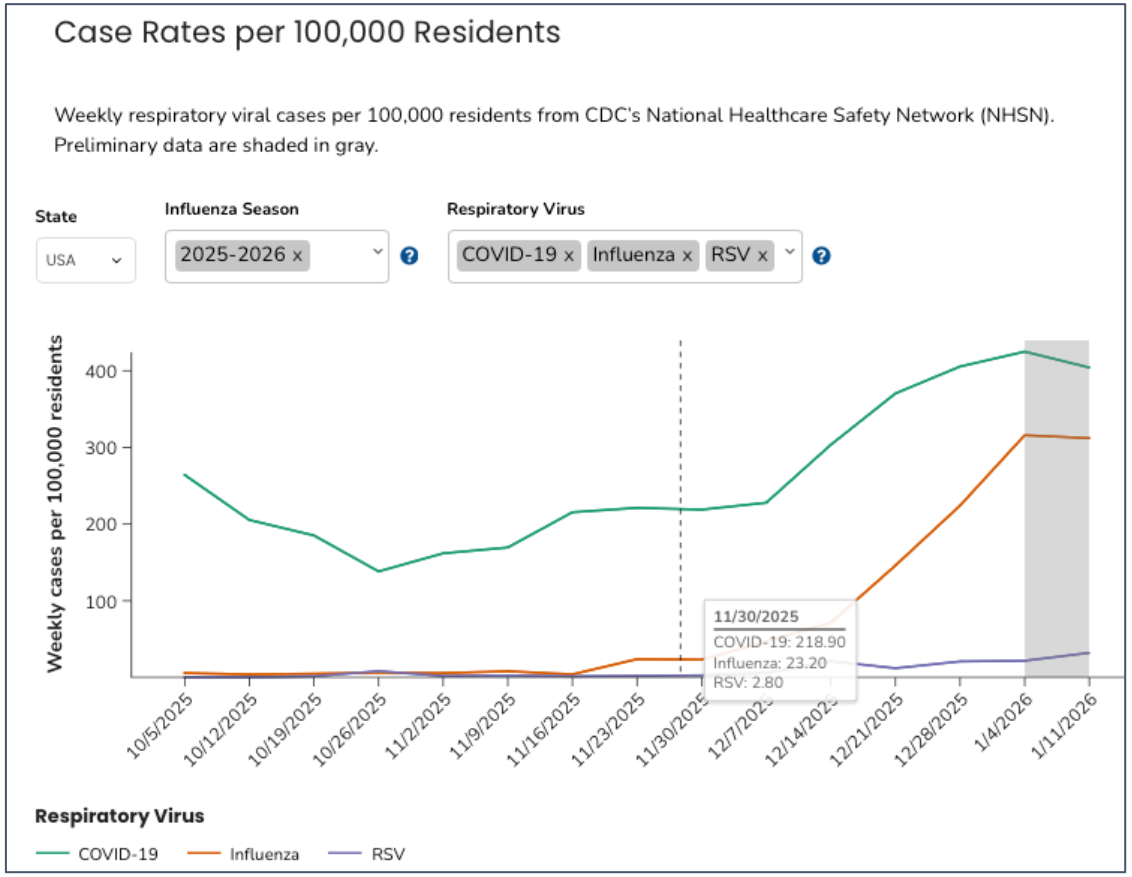
Make sure vents are not blocked.

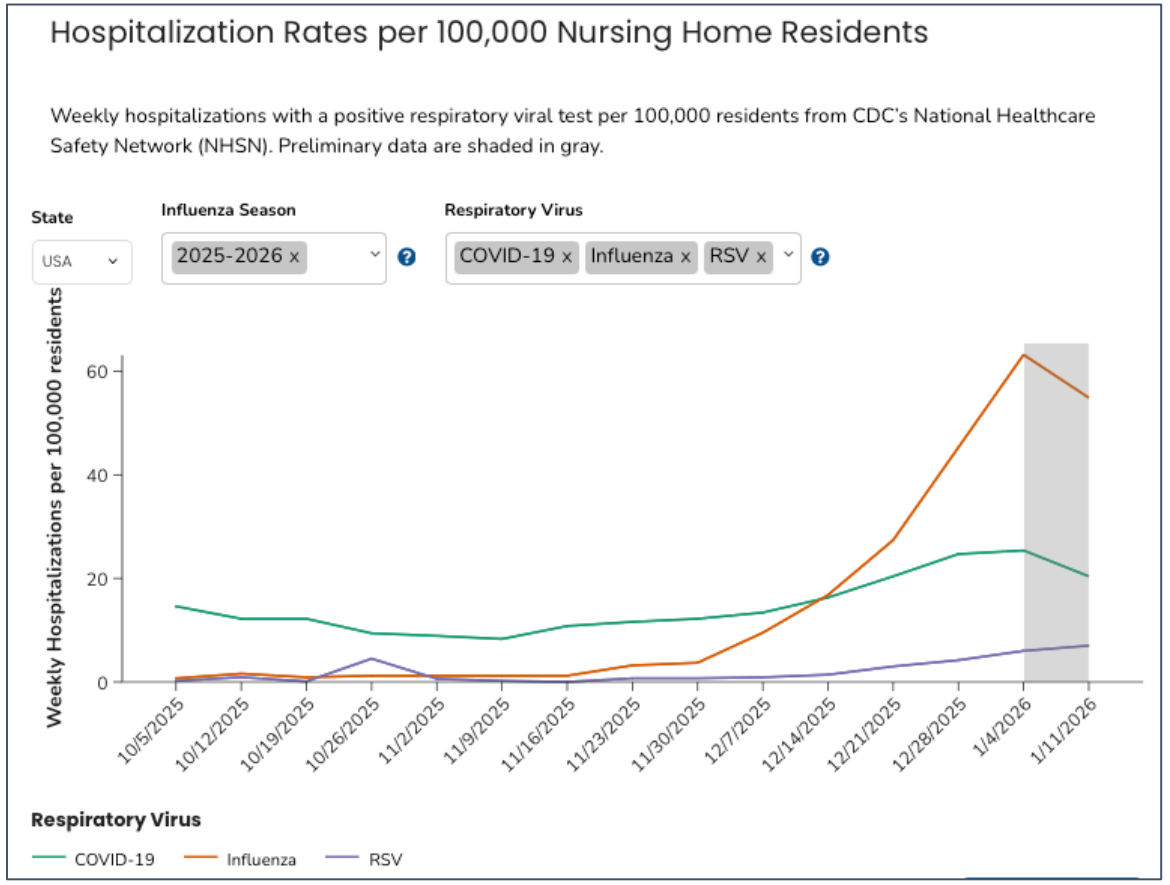
- A blocked vent could prevent the ventilation system from functioning like it is supposed to.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
CDC
PROJECT FIRSTLINE
cdc.gov/ProjectFirstline

Also:
https://doi.org/10.1016/j.jamda.2024.105195

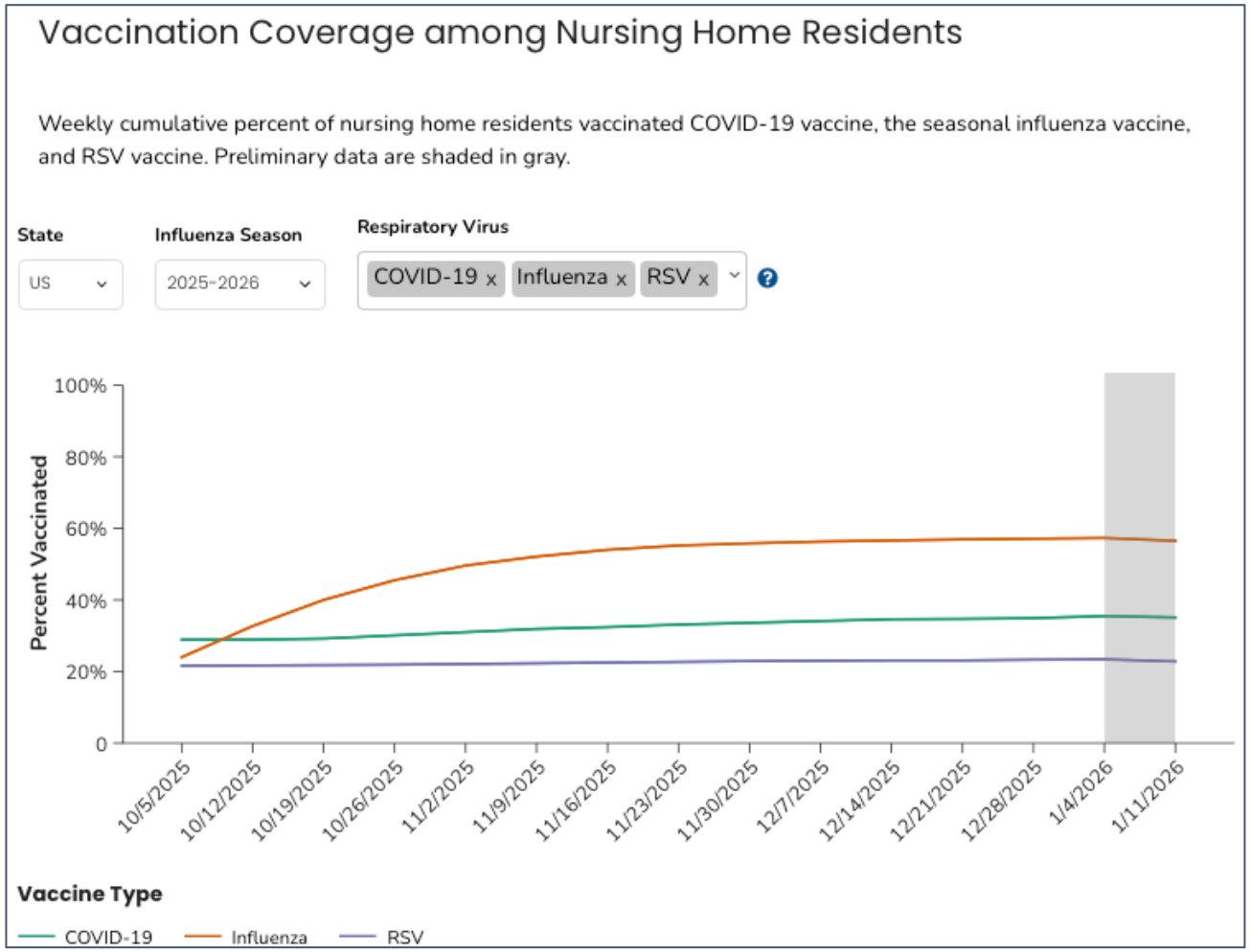
Case and Hospitalization Rates of Influenza, RSV, and COVID-19 in Nursing Home Residents 10/5/2025-1/11/2026 (15,000 nursing homes)





https://www.cdc.gov/nhsn/ltc/ltc-report-overview.html (updated 1/15/26)

Vaccination Coverage with Influenza, RSV, and COVID-19 Vaccine 10/5/25-1/11/26: Nursing Home Residents vs. U.S. Overall



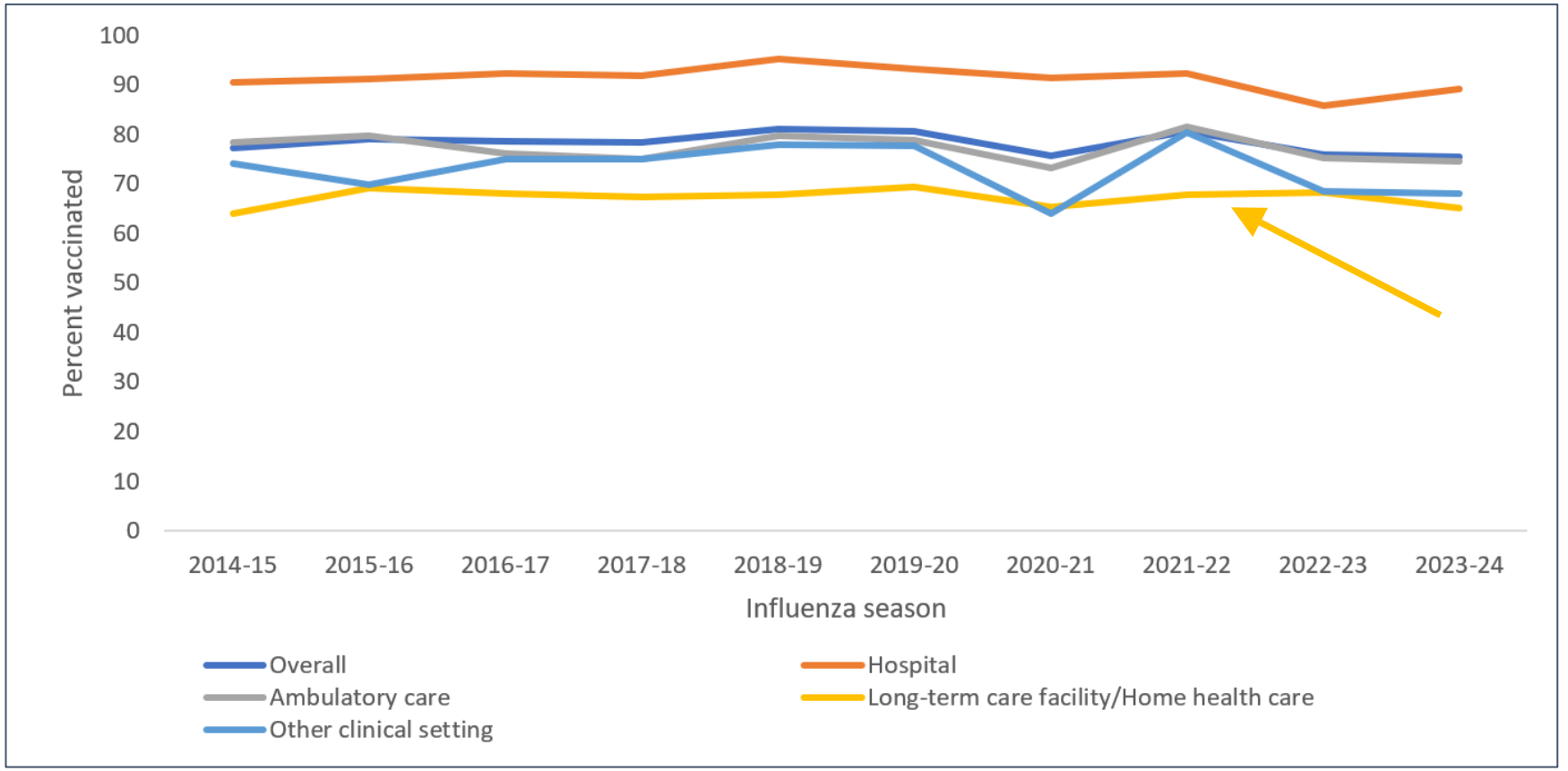
https://www.cdc.gov/nhsn/ltc/ltc-report-overview.html (updated 1/15/26)

Vaccination in U.S. overall 10/11/25-1/3/26

	≥ 18 yr.	< 18 yr.
Flu	44.1%.	42.5%
COVID-19	16.7%	6.9%
RSV	50-74 yr 32.5%	≥ 75 yr 41.4%

https://www.cdc.gov/fluvaxview/dashboard/adult-coverage.html

Percentage of health care personnel who received influenza vaccination, by work setting — Internet panel surveys, United States, 2014-2015 through 2023-2024 influenza seasons



https://www.cdc.gov/fluvaxview/coverage-by-season/health-care-personnel-coverage-2023-24.html