



SHEA

The Society for Healthcare
Epidemiology of America

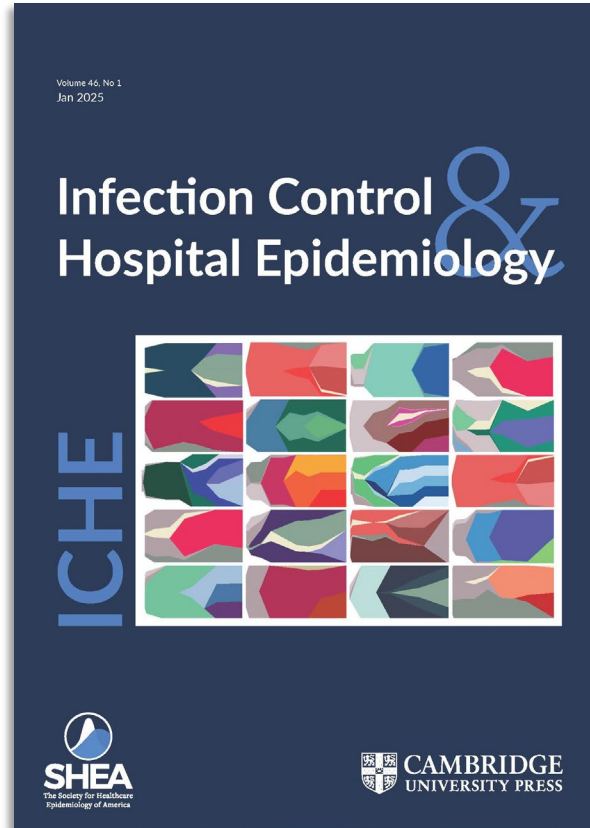
SAFE HEALTHCARE FOR ALL



Music:

www.bensound.com

ICHE Journal



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.

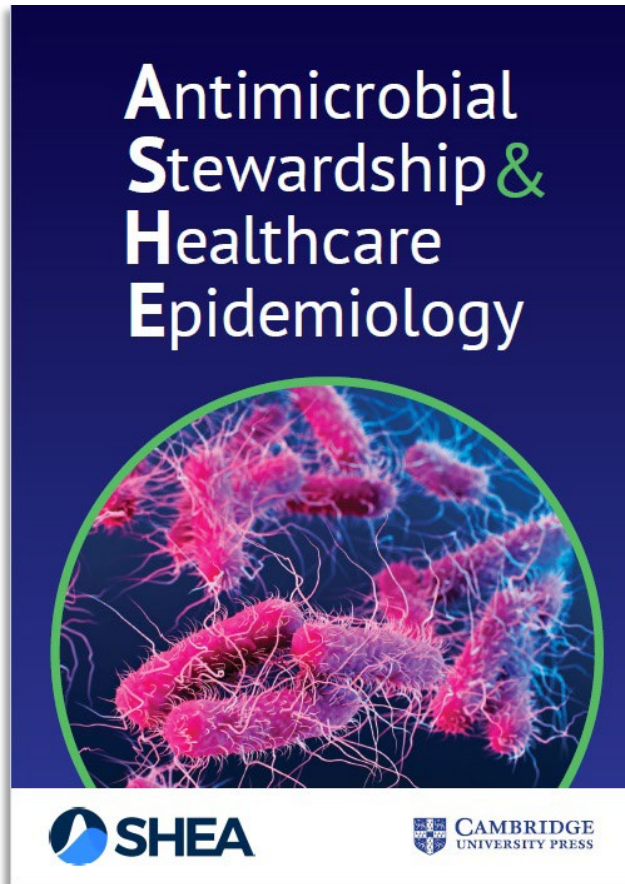
www.cambridge.org/iche



SAFE HEALTHCARE FOR ALL

Music:
www.bensound.com

ASHE JOURNAL



High quality articles across the full spectrum of antimicrobial stewardship and healthcare epidemiology.

Exceptional author experience through constructive peer review, competitive turnaround times, immediate online publication, a streamlined production process, and social media promotion.

Global, **open access journal**, bringing the widest possible impact, reach and discoverability of your research.

www.cambridge.org/ashe



SAFE HEALTHCARE FOR ALL

Music:
www.bensound.com

TUNE IN TO SHEA'S PODCASTS



AVAILABLE ON:



Online ID Fellows Course

Primer on Healthcare Epidemiology, Infection Control & Antimicrobial Stewardship



SCAN TO
LEARN MORE





NEW!

SHEA Members Open Forum

Get ready for real discussion! This is a peer-driven, discussion-based program designed for SHEA members to connect, share experiences, and talk through real-world challenges.



August 27th at 4:00 – 5:00 pm ET

Moderator: Harjot K. Singh, MD, ScM



You Can Help!

Improving Antibiotic Stewardship
and Infection Prevention in
Nursing Homes



eLearning Course





LEARNINGCE
SHEA Online Education Center

SAVE THE DATE!
Visit LearningCE
for details



UPCOMING LIVE PROGRAMS

Quality Improvement: From Principles to Practice

August 17, 2026 | 3:30 – 4:30 pm ET

Expanding Handshake Stewardship: Practical Strategies for Scaling Collaborative Antimicrobial Stewardship Rounds

September 9, 2026 | 3:30 – 4:30 pm ET

Measuring the Social & Environmental Impact of Antimicrobial Stewardship & Infection Prevention

October 6, 2026 | 4:00 – 5:00 pm ET

November 9, 2026 | 4:00 – 5:00 pm ET



Virtual Workshop

Two Day Workshop: November 5 - 6, 2026

Improving Infection Prevention & Antibiotic Use in Long-Term Care: From Guidance to Practice



Connect with SHEA



@SHEA_Epi



facebook.com/SHEApreventingHAIs



linkedin.com/company/shea



SHEA Webinar

Town Hall
2026

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



SAFE HEALTHCARE FOR ALL

Music:
www.bensound.com

August Town Hall Panelists:



Dr. Bernard Camins
Mount Sinai



Dr. Katie Passaretti
Advocate Health



Dr. Chris Nyquist
*Children's Hospital
Colorado*



Dr. Tom Talbot
Vanderbilt University

Invited Panelist:



Dr. Rachael Lee
UAB Heersink School of Medicine



Isolation Precautions

SHEA Town Hall

Katie Passaretti, MD
Chief Infection Prevention Officer
Professor, Internal Medicine/Infectious Diseases
Advocate Health

08/11/2026

Isolation in 2026: What Do We Have to Work With?

The 2007 CDC guideline

Foundational isolation document
Now 19 years old.

Updates stalled

The HICPAC draft of Part 1 was ready for Federal Register comment in Nov 2024.
Now halted and archived.

HICPAC terminated

Ended March 2025 after 34 years



“

Without such a body, the infrastructure essential for effective infection prevention within the US health care system risks fragmentation, inconsistency, and weakening.

Talbot et al., JAMA 2025

Healthcare Infection Prevention Advisory Group (HIPAG)

A joint APIC and SHEA national advisory group, launched June 1, 2026 to keep IPC expertise coordinated across the care continuum.

A national resource for expertise

In infection prevention and the spread of antimicrobial resistance in healthcare.

Review and contextualize evolving evidence

Interpret evolving evidence and identify the areas that require clarification.

Rapid response when threats emerge

Support rapid-response approaches during emerging infectious disease threats and infection-related public health challenges.

Close the expertise gap

Support alignment around evidence-based practice across acute, ambulatory and long-term care settings.

HIPAG REPRESENTATIVES

Rebecca Alvino
UC Davis Health
Tania Bubb (APIC Chair)
Memorial Sloan Kettering
Rashida Conway
Kaiser Permanente
Brooke Decker
VA Pittsburgh

Erin Epton
CA Dept. of Public Health
Jennifer Hanrahan
Marshall University
Claire Jai
Methodist / HCA Healthcare
Lela Luper
Chickasaw Nation Dept. of Health

Tara Millson
MedStar Health
Russ Olmstead
Trinity Health
Cindy Prins (Vice-Chair)
Univ. of Central Florida
Amy Spallone
MD Anderson

Mike Sebert
Children's Medical Center Dallas
Mike Stevens
West Virginia University
Gabriela Andujar Vazquez
Dartmouth Health
Sharon Wright (Chair)
Beth Israel Lahey Health

The Push and Pull of Isolation Decisions

Two imperatives in tension: preventing transmission and preventing unintended harm to patient and environment



WHY WE ISOLATE

- MDRO transmission drives real morbidity, mortality and outbreaks
- Colonized patients can serve as a reservoir for transmission to others across a unit
- For some pathogens and settings, barriers do reduce acquisition

WHY ISOLATION CARRIES ITS OWN COST

- **Patient harm** — 40% higher adjusted odds of delirium-related outcomes, 36% fewer clinician visits, and 18% less direct contact time. Higher anxiety and depression scores. Decreased patient satisfaction
- **Cost** — ~ \$31–\$47 per patient-day; donning and doffing added 31 staff minutes per isolated patient-day. Impact on throughput if multi-patient rooms
- **Avoidable burden:** Removing unnecessary isolation freed 4,087 isolation-days and avoided >\$141,000 at one hospital; targeted PPE use may cut time, cost, waste, and carbon impact by more than half.

Isolation is neither universally beneficial nor uniformly harmful. The evidence of harm has limitations, and the infection prevention benefit differs by pathogen and setting. The question is whether the expected benefit outweighs the burden.

WHAT FACILITIES ACTUALLY DO

SRN Survey 2026: Clearance Protocols to Discontinue Contact Precautions Highly Variable

THEN

2012 · APIC

73% had a policy to stop precautions for MRSA and 57% for VRE — yielding 64 distinct MRSA strategies and 48 for VRE.

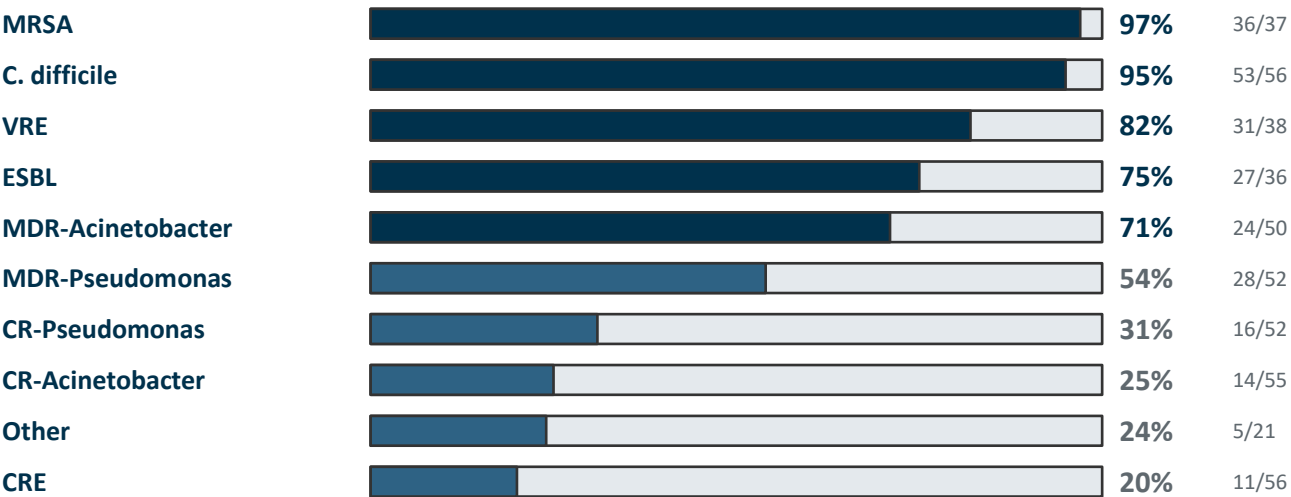
2014 · SHEA Research Network

No shared definition of “multidrug-resistant.” 20% isolated neither MDR-Pseudomonas nor MDR-Acinetobacter.

2014 · NHSN facility survey

80% of acute care hospitals isolated for MRSA, CRE or VRE and 70% for ESBL — varying by region and facility type.

NOW — 2026 SURVEY: FACILITIES WITH A PROTOCOL FOR CLEARING PRECAUTIONS



96%

of facilities (54/56) had a clearance protocol for at least one MDRO

CRE is the outlier

Only 20% have any protocol to clear precautions for CRE.

Time based criteria most common

Time was a more common criterion than cultures for every organism.

Duration varies wildly

From “end on discharge” to “more than a year” across organisms.

Same variability in approach, same limited data guiding it in 2026 as in 2012 and 2014.

Adapted from Table 2. Infect Control Hosp Epidemiol. 2026 Feb 18;47(4):386–393. doi:10.1017/ice.2025.10394. Denominators are facilities using contact precautions for that organism.
Prior surveys: APIC 2012; SHEA Research Network 2014; Weiner et al., NHSN Annual Facility Survey, 2014.

Isolation Based on Type of Interaction – EBP as an example?

NO CRITERIA, NO DATA

C. auris

Colonization persists for months to years, no decolonization strategy, no deisolation criteria — precautions continue every admission. Cases have risen every year since 2016.

6.9% of colonized patients later had a positive clinical specimen

Carbapenemase-producing organisms

No standard CDC deisolation timeframe; practice defaults to the index stay, then case-by-case. Substantial rise in NDM-CRE, 2019–2023.

20% of facilities have any protocol to clear CRE precautions

Impact of no clearance

- Barrier to therapy, dining, socialization and rehabilitation.
- Less staff contact, more depression and anxiety, deconditioning and falls.
- No endpoint to work toward, because no criteria exist to reach.

ENHANCED BARRIER PRECAUTIONS – Skilled Nursing Facilities

Gown and glove use for high-contact care activities instead of room entry, so residents keep full facility access.

Who it applies to

Residents with an MDRO, a wound, or an indwelling device. Replaces contact precautions for chronic colonization.

When PPE goes on

Bathing, dressing, transfers, hygiene, device and wound care, linen changes — not every room entry.

Regulatory expectation

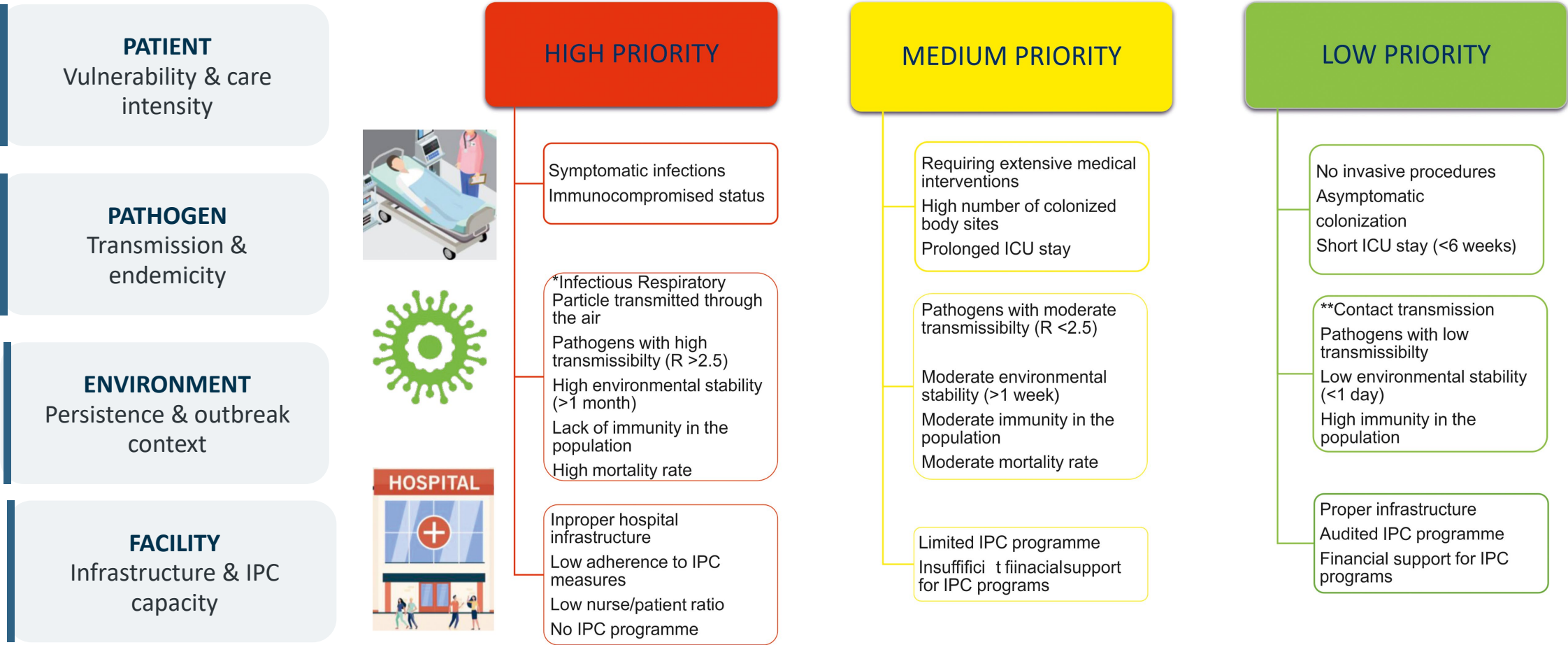
CMS QSO-24-08-NH folded EBP into existing IP regulation in 2024; surveyors assess resident identification, PPE availability and use for high touch activities.

Implementation challenges

Gown use, staff education, workflow integration, signage and staff acceptance are the recurring barriers — not the concept.

When isolation precautions have no endpoint, how can we do isolation in a way people can live with.

Individualized Patient Isolation Decisions instead of Traditional Organism Based?



CURRENT STATE **Operationally challenging to implement but important: Sites are already making these trade-offs**

Why in the World Do I Need to Wear this?

Evidence-based review of PPE

Rachael Lee, MD MSPH

Financial Disclosures

- Dr. Rachael Lee has no relevant financial disclosures.
- I utilized AI to help with some formatting of slides

Respiratory Viruses

What does this healthcare worker need to wear for influenza?



What does this healthcare worker need to wear for influenza?



What does this healthcare worker need to wear for RSV (and parainfluenza and human metapneumovirus??)



What does this healthcare worker need to wear for RSV (and parainfluenza and human metapneumovirus??)

*



*Respiratory Etiquette per standard precautions

What does this healthcare worker need to wear for rhinovirus?



What does this healthcare worker need to wear for rhinovirus?



What does this healthcare worker need to wear for Adenovirus pneumonia?



What does this healthcare worker need to wear for Adenovirus pneumonia?



What does this healthcare worker need to wear for COVID-19?



What does this healthcare worker need to wear for COVID-19?



Pathogen	Recommendations	Duration	Comments
Rhinovirus	Droplet + Standard	Duration of illness	• Droplet most important route of transmission • Outbreaks have occurred in NICUs and LTCFs • Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants)
Influenza	Droplet + Standard	n/a	For novel avian influenza: Airborne + contact + standard
Adenovirus pneumonia	Droplet + contact + Standard	Duration of illness	Outbreaks in pediatric and institution setting reported.
Human metapneumovirus	Contact + Standard	Duration of illness	• HAI reported but route of transmission not established . Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. • Wear masks according to Standard Precautions.
Respiratory syncytial virus infection	Contact + Standard	Duration of illness	• Wear mask according to Standard Precautions • In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding
Parainfluenza virus infection,	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; Droplet if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and “supershedders” highest risk for transmission via small droplet nuclei and large droplets

An old question:

REVIEW ARTICLE

MEDICAL PROGRESS

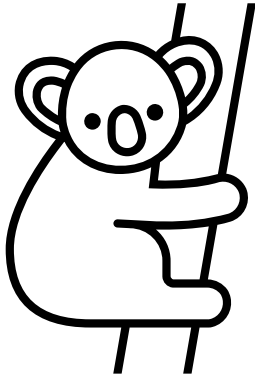
How Contagious Are Common Respiratory Tract Infections?

Table 2. Factors Shown to Be Important in the Transmission of Common Respiratory Agents.

Agent	Direct Contact	Large- or Medium-Droplet Aerosol	Tiny-Droplet Aerosol (Droplet Nuclei)
Bacteria			
<i>Neisseria meningitidis</i>	Yes	Yes	No
<i>Streptococcus pyogenes</i>	Yes	Yes	No
<i>Streptococcus pneumoniae</i>	Yes	Yes	No
<i>Mycobacterium tuberculosis</i>	No	No	Yes
Viruses			
Influenzavirus	Yes	Yes	Yes
Adenovirus	Yes	Yes*	Yes*
Respiratory syncytial virus	Yes†	Yes	No
Rhinovirus	Yes†	Yes	No

Studies from the 80s (🕒_🕒)

young adult volunteers working on a pediatric ward were exposed in 3 different manners to infants with RSV infection.

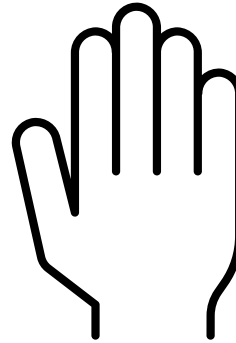


Cuddlers

Exposed to an infected infant by caring for the baby 2–4 h in the usual manner:

feeding, diaper changing, and playing with the infant.

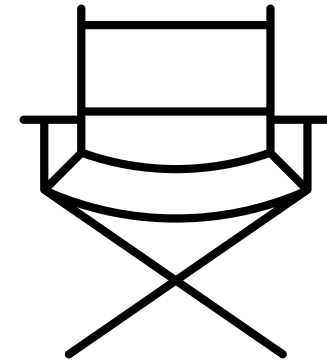
These staff wore gowns but no mask or gloves



Touchers

touched ungloved hand surfaces likely to be contaminated with the baby's secretions when the infant was out of the room.

They then gently rubbed the mucous membranes of their nose or eye.



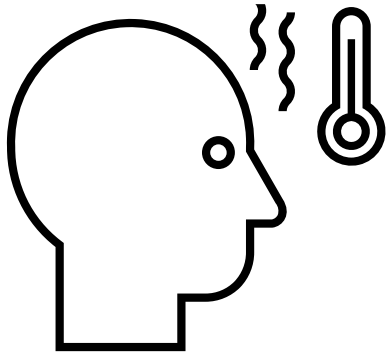
Sitters

Exposed to an infected baby by sitting at a distance of >1.8 m from the bed.

They wore gowns and gloves, but no masks, and were allowed to touch only the book they were reading.

Studies from the 80s (🕒_🕒)

young adult volunteers working on a pediatric ward were exposed in 3 different manners to infants with RSV infection.

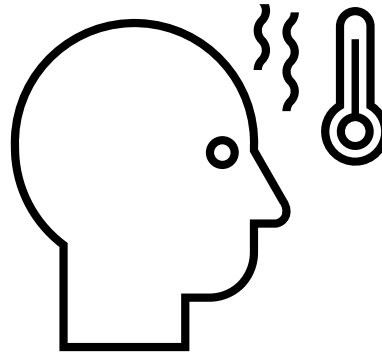


Cuddlers

Exposed to an infected infant by caring for the baby 2–4 h in the usual manner:

feeding, diaper changing, and playing with the infant.

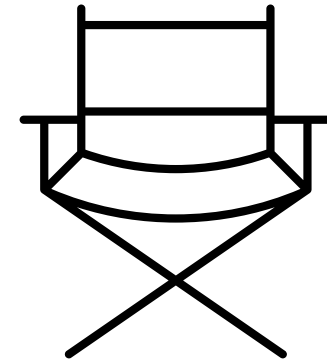
These staff wore gowns but no mask or gloves



Touchers

touched ungloved hand surfaces likely to be contaminated with the baby's secretions when the infant was out of the room.

They then gently rubbed the mucous membranes of their nose or eye.



Sitters

Exposed to an infected baby by sitting at a distance of >1.8 m from the bed.

They wore gowns and gloves, but no masks, and were allowed to touch only the book they were reading.

Viable respiratory viruses persist on surfaces

39

Virus	Hard / nonporous	Porous / skin	Study note
RSV¹	Countertop 6 h; gloves 1.5 h	Cloth/tissue 30–45 min; skin 20 min	Fresh secretions; surface-to-hand transfer recovered.
Influenza A/B²	Steel/plastic 24–48 h	Cloth/paper <8–12 h; hands ≤5 min	Estimated practical transfer window ~2–8 h.
Rhinovirus^{3,4}	Contaminated handles/tiles transmitted infection	Fingerpads: 38% at 1 h; 16% at 3 h	Self-inoculation of nose or eye was required.
SARS-CoV-2⁵	Plastic/steel 72 h; copper 4 h	Cardboard 24 h	High inoculum; viable titer declined exponentially.

1 Hall CB et al. J Infect Dis. 1980;141:98–102.

2 Bean B et al. J Infect Dis. 1982;146:47–51.

3 Ansari SA et al. J Clin Microbiol. 1991;29:2115–2119.

4 Gwaltney JM Jr, Hendley JO. Am J Epidemiol. 1982;116:828–833.

5 van Doremalen N et al. N Engl J Med. 2020;382:1564–1567.

The COVID-19 Contact Isolation Conundrum

CDC guidance still includes N95 + gown + gloves + eye protection-guidance based initially on maximum PPE due to protect HCW

Emory · 9 hospitals

SHEA Spring 2026 abstract

74% fewer COVID isolation days

With gowns + gloves



88,963 days

After removal



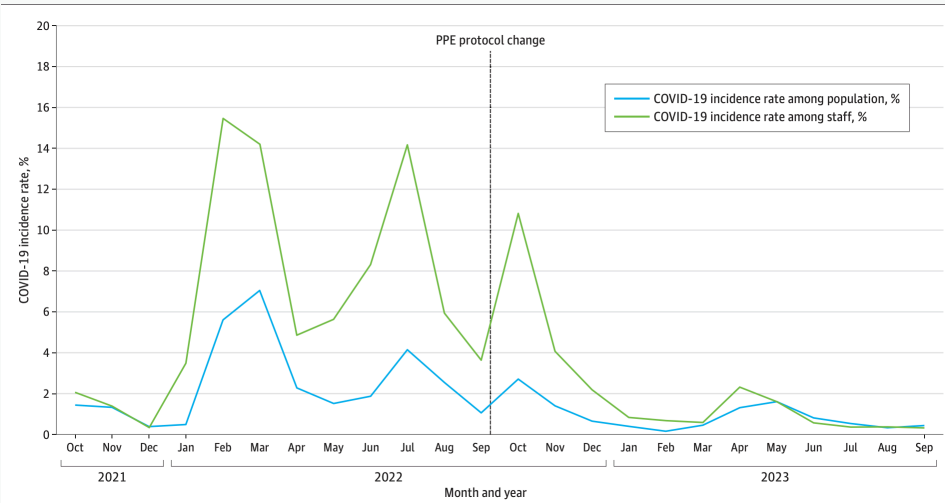
23,378 days

No increase in hospital-onset COVID
Major reduction in waste and global warming potential

Singapore · national change

September 2022

Routine COVID PPE changed to N95 alone. Staff infection did not rise; about 440,500 gowns were avoided over 12 months.



Across two studies, routine gown and glove removal cut isolation burden and waste without a detectable COVID safety signal. Keep N95 respiratory protection; use contact PPE for anticipated exposure.

Peacock A, et al. Antimicrob Steward Healthc Epidemiol. 2026;6(Suppl 1):s92. doi:10.1017/ash.2026.10573 · Sutjipto S, et al. JAMA Netw Open. 2025;8(4):e255264. doi:10.1001/jamanetworkopen.2025.5264

Contact Isolation for MDROs

MRSA/VRE De-Isolation Studies

AJIC 2020 | Interrupted time series

3 ACADEMIC MEDICAL CENTERS

4 HAI categories assessed

CLABSI · CAUTI · Mediastinal SSI · VAP

NO SIGNIFICANT INCREASE in

Rates trended downward after routine precautions stopped-likely due to bundled horizontal Infection prevention practices

ICHE 2022 | Multihospital cohort

15 ACUTE-CARE HOSPITALS

12 de-escalated | 3 controls

MRSA 0.14 → 0.15
VRE 0.05 → 0.05
per 1,000 patient-days

No statistically significant rate change.

All sites had low baseline rates and strong hand hygiene.

CID 2026 | VA policy analysis

121 VA HOSPITALS

905,164 admissions

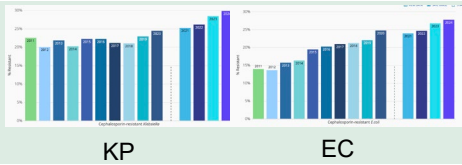
MRSA surveillance + contact-precaution policy change due to COVID-19

NO CONSISTENT INCREASE IN ADJUSTED MODELS

Baseline MRSA burden explained much of the increase seen with discontinuation of screening and isolation.

1 Haessler S et al. Am J Infect Control. 2020;48:1466–1473. | 2 Martin EM et al. Infect Control Hosp Epidemiol. 2022;43:1595–1602.
3 Khader K et al. Clin Infect Dis. 2026;83:e113–e119. Rates shown as HAIs per 1,000 patient-days.

ESBLs

TRENDS in ESBL	ESBLs continue to increase globally despite recommendations for contact precautions. Transmission from ESBL- <i>K. pneumoniae</i> has estimated to be at least 2× that from. ESBL- <i>E. coli</i> . In a 10 year study assessing acquisition of ESBL after contact, only 2 patients were identified as transmission events (shared room, colonization only)	
MOSAR-ICU, 2014	In-hospital transmission rates were reported as ~3× higher for ESBL organisms than for VRE or MRSA. Phase RCT trial of improvement in HH, universal CHG and then screening and contact isolation found that contact isolation did not improve in-hospital rates of ESBL. Much of rates of improvement were due to improving HH and CHG (reducing MRSA and VRE).	A strong ICU risk signal did not prove added benefit from routine isolation.
Does Screening and Isolating reduce rates?	In a 4-year multihospital study, implementation of a hospital-wide intervention involving screening and isolation of clinical <i>E. coli</i> and <i>Klebsiella</i> spp urine isolates for ESBL-EK did not lead to a decrease in nosocomial ESBL-EK incidence.	NO REDUCTION in incidence but continued increase in community rates.
Cluster Randomized crossover RCT, Lancet ID 2020	20 wards; 38,357 admissions. Ward-acquired ESBL-E: 6.0 vs 6.1 per 1,000 patient-days at risk (contact isolation vs standard precautions); adjusted IRR 0.99 (95% CI 0.80–1.22). [4]	NO ADDED BENEFIT in non-critical-care wards with extensive screening.

Individualize Contact Precautions: prioritize outbreaks, high-risk settings, prolonged close contact, and more transmissible species/clones; maintain strong Standard Precautions, hand hygiene compliance, and surveillance.

1 Tschudin-Sutter S et al. Clin Infect Dis. 2017;65:342–347. doi:10.1093/cid/cix258 | 2 Derde LPG et al. Lancet Infect Dis. 2014;14:31–39.
3 Han JH et al. Infect Control Hosp Epidemiol. 2013;34:1160–1166. | 4 Maechler F et al. Lancet Infect Dis. 2020;20:575–584. doi:10.1016/S1473-3099(19)30626-7

Conclusions

Strong horizontal infection prevention strategies should remain the foundation for contact isolation decisions

Hand hygiene

Standard precautions

Cleaning, equipment practices, and care bundles

WGS may help answer questions about CP uncertainty

4-year prospective implementation
2,660 MDR isolates (MRSA, VRE, CRAB, ESBL-E, CPE) and found 76