World Health Network

SUPPORTING MATERIALS FOR THE SUPPLEMENTARY COMPLAINT DATED OCTOBER 23, 2024

The present supplementary complaint is submitted as a follow-up to the complaint filed on October 29, 2023 (hereinafter the "**Primary Complaint**") with the HHS Inspector General by the WHN about violations of law by employees of HHS regarding the conduct of the Healthcare Infection Control and Prevention Advisory Committee (hereinafter "**HICPAC**"). A further supplementary complaint was filed with the Inspector General on August 15, 2024.

This supplementary complaint is issued following the observations made during HICPAC's August 22, 2024 meeting and in light of the recently announced upcoming meeting scheduled for November 14-15, 2024. HICPAC is still conducting itself in a manner that is grossly negligent for at least the following reasons, which are each discussed in detail below. These reasons are:

- HICPAC has still failed to meet its requirement set forth in its Charter in the section designated "Membership and Designation": HICPAC is still not constituted of 14 non-Federal members. In fact, only 11 members were present and are designated. As such, HICPAC has failed to compose itself of members with a sufficient diversity of opinion. Therefore, the meeting held on August 22, 2024 was held in violation of its Charter and therefore any decisions reached during that meeting cannot be considered legally binding;
- the current HICPAC members are guilty of a conflict of interest. They are tasked with deciding matters regarding infection prevention in a healthcare setting, but these members hold positions where they financially benefit from ignoring infection. Infection and the resulting illness drives use by patrons of their hospitals. Effectively preventing infection and the resulting illness would lower revenue for these members' healthcare businesses (the hospitals);
- HICPAC has established the Isolation Precautions Guideline Workgroup (Workgroup) for managing airborne transmission that is to report to HICPAC. The basis for HICPAC establishing such a committee, where it hands down its duties to this Workgroup, is

unclear. Moreover, this Workgroup conducts its activities privately, thereby permitting HICPAC to escape its duties of conducting itself transparently. Such violation of transparency runs directly contrary to the provisions of Federal Advisory Committee Act (hereinafter "**FACA**"); and

- COVID-19 has been scientifically established to be an airborne pathogen. Its presence as a continuous threat in healthcare settings demands inclusion of HICPAC members who possess an expertise in airborne transmission.

A. HICPAC still fails to be composed of 14 members:

The HICPAC Charter requires that the committee be composed of 14 members. This violation of its Charter had already been brought to the attention of the Inspector General in WHN's Primary Complaint filed on October 29, 2023.

However, on August 22, 2024, HICPAC held a meeting without the required number of members. Only 11 members had been selected. This action by HICPAC demonstrates that it ignores its own Charter and the authority of the Inspector General to enforce that Charter. The WHN respectfully requests that the Inspector General require the CDC and its HICPAC committee to conduct themselves in a lawful manner and immediately remediate this unlawful situation.

The WHN stresses that constituting a HICPAC Workgroup is not sufficient to meet its obligations under the Charter, as its Charter clearly states "[T]he ***Committee*** shall consist of 14 non-Federal members" (Emphasis ours.)

From the time of WHN's original Complaint up until the present day, HICPAC has been and remains an illegally constituted committee. As such its actions have no legal validity or enforceability.

B. The current HICPAC members have an active conflict of interest by being asked to decide upon infection prevention in a healthcare setting

The WHN appreciates that the *Federal Advisory Committee Act* (FACA) does not categorically prohibit conflict of interest within most of its committees. In fact, the FACA even encourages in some instances conflicts of interest amongst its committee members in order to foster debate.

However, we submit that when the conflict of interest is pervasive throughout the vast majority (and here, virtually throughout the entirety of its committee membership), and when this conflict of interest is in stark contrast with the very purpose of the Committee, this conflict of interest

vitiates the Committee's ability to fulfill its function and calls into question the very purpose of its existence.

HICPAC's Charter states, "[T]he HICPAC shall provide advice and guidance […] regarding the ***practice of infection control*** and strategies for surveillance, ***prevention, and control of healthcare-associated infections***, antimicrobial resistance, and related events in settings where healthcare is provided." (Emphasis ours.) Therefore, committee members that are compensated for encouraging spread of infection (or at the very least compensated for being knowingly or willfully ignorant of the science of infection control in a healthcare setting), are in conflict of interest with the very objective of HICPAC, i.e., preventing and controlling healthcare-associated infections.

More specifically, it is well established that direct payment systems can lead to perverse incentives against the prevention of hospital-acquired infections (HAIs). In fee-for-service payment models, hospitals are reimbursed based on the number of services provided, including the treatment of complications like HAIs. This system creates a financial incentive where hospitals can generate more revenue by providing additional care to treat these infections, rather than by preventing them in the first place.

To address such perverse incentives, the Centers for Medicare & Medicaid Services (CMS) instituted countermeasures. In 2008, CMS implemented a policy that no longer reimburses hospitals for the extra costs associated with certain hospital-acquired conditions, including HAIs like catheter-associated urinary tract infections (CAUTIs) and central line-associated bloodstream infections (CLABSIs). This policy forces hospitals to absorb the additional cost of treating patients with these infections, counteracting the financial incentives of the fee-for-service model that could otherwise benefit hospitals financially from treating infections which they themselves create.

Despite these efforts, hospital management is still financially incentivized not to prioritize the prevention of airborne HAIs, such as hospital-acquired COVID-19. The financial structure of current payment models often rewards the treatment of infections rather than their prevention, which specifically undermines efforts to prevent airborne transmission, the primary mechanism for hospital-acquired COVID-19.

Many members of HICPAC are from hospital management, and as such, have direct financial interests that conflict with the prevention of hospital-acquired infections. This conflict of interest, long recognized in the context of other HAIs, must now also be addressed for COVID-19 and other airborne diseases. Failure to address this issue undermines effective infection control

practices and jeopardizes patient safety. It is essential to reassess the financial and structural incentives that shape hospital management's approach to infection prevention.

Significantly, CMS has not instituted similar disincentive programs for COVID-19 nosocomial infections. As a result, under the current CMS system, hospitals are not penalized for COVID-19 infections acquired within their facilities. The absence of financial disincentives means that, unlike other targeted HAIs, there is no direct penalty or reduction in reimbursement to hospitals when patients contract COVID-19 during their hospital stay. Instead, current financial incentives for hospital management promote rather than prevent those infections.

Further, it is important to note that multiple members of HICPAC and the Working Group have other financial incentives that create conflicts of interest. A high proportion of them receive substantial funding from the CDC, and more specifically from the National Center for Emergent and Zoonotic Infectious Diseases (NCEZID), the CDC center with which HICPAC is associated.

An important principle of FACA is that employees of the agency that is being advised (in this case, the CDC) are not allowed to be members of the committee due to the inherent nature of financial relationships that may preclude independence. While funding is not strictly forbidden, it is apparent that conflict of interest should be avoided in this context.

A financial relationship between the institution and individual members such as that which currently exists between CDC and virtually all of the members of the HICPAC committee seriously risks comprising the independence of their judgment. This is the case not merely because specific funding links may influence particular decisions, but also because the relationships created by such funding may well incentivize the committee to advance or reject decisions of certain types, such as refusing to recognize the full impact of an airborne pathogen on hospital based infection control and the practical, real-world steps that must be taken to address it.

A non-exhaustive list of the funding to members of HICPAC or the Workgroup and their institutions is provided in Appendix A, appended herewith.

Furthermore, Members of HICPAC, recognized for their expertise in areas such as bloodstream infections, sepsis, sharps injuries, hand hygiene, fomite transmission, sterilization and disinfection, antimicrobial resistance, and Ebola, are funded specifically for their work in these fields. This creates a potential conflict of interest which may interfere with a decision to shift the focus of infection prevention to airborne diseases, which is required to deal effectively with the hospital-based transmission of COVID-19.

Such a shift could threaten the funding that supports their salaries, research, staff, and associated programs, as well as their positions of authority in infection prevention and control, and that of their colleagues. This inherent tension is further complicated by the same type of conflict of interest in relation to the CDC officials responsible for nominating HICPAC members and setting the committee's agenda, including the current and former HICPAC Federal Officers and the director of NCEZID.

Additionally, the Secretary of HHS should be informed that COVID-19 infections acquired in healthcare institutions must be classified and treated as healthcare-associated infections (HAIs) within the same programs that have been in place since 2008 to prevent HAIs. These programs address, in part, the conflicts of interest within healthcare institutions arising from the fee-for-service model, which discourages the reporting of HAIs due to the financial impact of losing CMS payments for treating those infections.

It is essential that the monitoring and reporting of COVID-19 infections in healthcare settings be capable of accurately determining which infections are caused by HAIs. Currently, these programs focus on preventing infections such as catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), surgical site infections (SSI), ventilator-associated events (VAE), including ventilator-associated pneumonia (VAP), Clostridioides difficile infections (C. diff), and methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections.

For context, a recent report from NSW Australia, with a population of 8 million, found that thousands of COVID-19 infections were caused by healthcare-associated transmission in hospitals, leading to hundreds of deaths in the past year[1]. This underscores the urgent need for stronger prevention measures and transparent reporting to prevent further avoidable harm.

These conflicts of interest prevent the majority of HICPAC's members from objectively assessing and addressing the committee's stated objective in relation to an airborne pathogen of COVID-19, i.e. controlling and preventing infection in healthcare settings.

C. The unlawful constitution of a HICPAC Workgroup

HICPAC has composed a Workgroup (see Appendix **B** for current membership information) to assess the matter of airborne infection transmission in healthcare settings. However, the

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[1] Haylee Gleeson. "Thousands of patients caught COVID in NSW hospitals last year and hundreds died, new data shows", *ABC News*, October 13, 2024. https://amp.abc.net.au/article/104448862 (consulted on October 16, 2024)

dealings of this Workgroup are not open to the public, and their discussions remain confidential. The current Workgroup operates in secrecy, and it is unclear how HICPAC has to respond to recommendations made by this Workgroup. This lack of transparency is a direct violation of FACA. At 5 U.S.C. App. § 3(2), FACA states that the Act applies to "or ***any subcommittee or other subgroup*** thereof" (Emphasis ours). As such, the Workgroup, as an advisory subcommittee or subgroup of HICPAC, would also be subject to the provisions of FACA. At 5 U.S.C. App. § 10(a)(1), it is stated that this subcommittee or subgroup shall hold its meeting open to the public. The narrow exceptions to having meetings open to the public under 5 U.S.C. App. § 10(d) do not apply here in the case of the Workgroup. As such, the Workgroup's current dealings, performed in secrecy, are in violation of the provisions of FACA. By operating in secrecy, the Workgroup undermines public trust and violates the legal obligations set forth by FACA, which aim to prevent undue influence and ensure balanced decision-making. The Workgroup's conduct also raises concerns about how HICPAC will respond to recommendations made by the Workgroup, as those decisions may not be subject to the public scrutiny necessary to ensure accountability.

Moreover, if HICPAC has to constitute such a Workgroup to analyze matters that are under its purview, this emphasizes that the current composition of HICPAC is insufficient to meet its objective. Its need for a Workgroup underlines that the current HICPAC members do not possess the required expertise to decide upon airborne transmission in healthcare settings.

It is curious that even though HICPAC, in direct violation of its Charter, still has three vacancies, rather than filling those vacancies with experts who possess airborne transmission expertise and bringing the committee into legal compliance, it decided instead to establish a Workgroup with such expertise.

We submit that this act of constituting Workgroups can be construed by the public as a tactic for HICPAC to avoid having delicate and potentially contentious debates exposed to the scrutiny of the public eye.

For these reasons, the WHN submits to the Inspector General that HICPAC should instead concentrate on filling its remaining vacancies with experts versed in airborne transmission, instead of relegating the task of studying airborne transmission to a Workgroup with questionable legal status.

Further evidence regarding the advisory role of the Workgroup and its confidential operations in violation of FACA, as well as the manifest limitations placed on the influence of airborne transmission experts added this year, is available in meeting summaries obtained by National Nurses United (NNU). These summaries, not analyzed in detail in this document, can be found

under a dropdown menu labeled “HICPAC’s Response to NNU’s FACA Request for the Updated HICPAC IP Workgroup Meeting Summaries (July 2023-June 2024)” on the following webpage: https://www.nationalnursesunited.org/cdc-work-group-updates.

Special attention should be given to the summaries from January 18, 2024, and February 14, 2024 regarding the inclusion of airborne transmission experts this year. The February 14 summary notably states:

• “[Workgroup (WG)] meetings, unlike HICPAC meetings, are not open to the public, and WG materials are to be kept confidential and not shared with anyone outside the WG.”

• “Only WG members and invited consultants should participate in WG meetings.”

• “WG members who cannot adhere to the confidentiality requirements may lose their role on the WG.”

• “WGs are not consensus-forming bodies and do not vote — they present options to the HICPAC committee to consider, and the committee is the voting entity.”

The secrecy surrounding the Workgroup’s proceedings stands in direct contrast to FACA’s requirements for transparency and public involvement in advisory committee activities. The claim that “WGs […] present options to the HICPAC committee to consider” is misleading, as the Workgroup often provides nearly complete guidance that is subjected to minimal editing during HICPAC’s public meetings. This suggests that the majority of HICPAC’s advisory role has been illegally delegated to this Workgroup, which operates in secrecy without the FACA-mandated opportunities for public input during the guidance development process.

The consequences of this are clear in the 2023 public meeting records, where there is a pronounced disconnect between the Workgroup’s recommendations and public comments. Commenters have repeatedly stressed the need for airborne transmission prevention, the inclusion of airborne transmission experts in guideline development, representation of vulnerable groups—including frontline healthcare workers and patients—and, above all, the necessity of ensuring safe access to healthcare, which is currently lacking (See public meeting records at https://www.cdc.gov/hicpac/php/about/index.html).

HICPAC’s actions suggest a departure from its mandate to operate in the public interest, using an illegal mechanism to shield itself from public oversight. By positioning the Workgroup as a hybrid of subcommittee members and advisors, it seems HICPAC has sought to evade FACA’s requirements for public involvement. According to 5 U.S.C. App. § 3(2), FACA clearly states that the term “advisory committee” includes any “task force, or other similar group.” Merely labeling a

task force as a “Workgroup” does not exempt this workgroup, nor by extension HICPAC, from FACA’s public meeting requirements.

D. HICPAC still fails to include members with an expertise in airborne transmission

As submitted in the Primary Complaint, the COVID-19 pandemic and the continuous presence of COVID-19 in the United States have increased the urgency of understanding airborne transmission of infection in healthcare settings. In fact, in 2024, the CDC has confirmed the airborne nature of COVID-19 transmission[2].

However, despite still having three vacancies, HICPAC continues to fail to include members with an expertise in airborne transmission. In fact, HICPAC’s current understanding of airborne transmission is so lacking that it had to take the steps and consume federal resources to compose a Workgroup to counsel itself on airborne transmission.

Instead of composing a Workgroup, we stress that HICPAC should be required to meet its necessary membership quota and fill those vacancies with actual members who possess the requisite knowledge on airborne transmission. In fact, the public can only conclude that HICPAC’s behavior regarding airborne transmission is highly suspicious, since HICPAC seems to be taking great pains to avoid having to share with the public its deliberations regarding airborne transmission with the public.

CONCLUSION

The CDC has historically been slow to act in response to pathogen-related threats, instead waiting until the threat became so flagrant that it had little choice but to begin to react. This was the case with the HIV crisis in the 1980s, where tens of thousands had to perish prior to the CDC taking effective action to protect the public[3].

The CDC is repeating the same errors that it made with HIV, this time with COVID-19. Tens of thousands will continue to die from COVID-19 unless the CDC, and its HICPAC committee, break free from their past pattern and retain experts with qualifications that are relevant to dealing with the current threat. Here, that threat is COVID-19.

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[2] Gregory et al., *COVID-19 CDC Yellow Book 2024*, Center for Disease Control and Infection, https://wwwnc.cdc.gov/travel/yellowbook/2024/infections-diseases/covid-19 (consulted on September 22, 2024)

[3] Pearl, Robert. *Denial: The Hidden Link Connecting Mpox, COVID-19, HIV/AIDS*, Forbes, September 16, 2024, https://www.forbes.com/sites/robertpearl/2024/09/16/denial-the-hidden-link-connecting-mpox-covid-19-hivaids/ (consulted on September 22, 2024)

We respectfully urge the officials of the OIG not to cast a blind eye on what is literally a life and death situation, perhaps for one of your own dear friends or family members. Please review the present complaint and the activities of HICPAC. Require that HICPAC obey the law and comply with its Charter.

Respectfully yours,

World Health Network

Appendix A

Appendix A: HICPAC Member Conflicts of Interest

Summary Table:

Name	Affiliation	Hospital Executive / Manager	Funded by CDC	Expertise focus area
Michael Lin, MD, MPH (Co-Chair)	Rush University Medical Center	No	(1) Epicenter $6.2m 2020-4 (2) SHEPheRD	Bloodstream infections
Laura Evans, MD, MSc	University of Washington	Medical Director, Critical Care UWMC	Salary from 2 CDC and 1 NIH grants (1) Infection prevention and control (unspecified) (2) National Emerging Special Pathogens Training and Education Center (NETEC), and (3) NIH grant (unspecified). CDC Institutional funding: (4) Project Firstline	Sepsis
Erica Shenoy, MD, PhD	Mass General Brigham	Chief of Infection Control, Mass General Brigham	(1) Principal Investigator CDC program on infection prevention and patient safety (likely Project Firstline) (2) Medical Director of HHS ASPR funded RESPTC CDC Institutional funding: (3) Epicenter 5.2M 2020-3	Disinfection

Connie Steed, MSN, RN	Prisma Health	Director, Infection Prevention and Control Prisma Health, Corporate Director Prisma Health (recently retired)	(1) Project Firstline	Sharps
David Jay Weber, MD, MPHc	UNC School of Medicine and UNC Gillings School	Associate Chief Medical Officer, UNC Medical Center; Medical Director, Department of Infection Prevention, UNC Medical Center	(1) Principal Investigator of Epicenter $5.7m 2020-24 (2) HHS ASPR funded RESPTC	Infection prevention and occupational health preparedness, new and emerging diseases, vaccines, tuberculosis, environmental contamination and disinfection
Colleen Kraft, MD, MSc	Emory Medicine	Associate Chief Medical Officer of Emory Hospital from 1/2020-9/2023	(1) CDC elastomeric research project CDC Institutional funding: (2) Epicenter $5.5m 2020-24 (3) Project Firstline (4) National Partners Cooperative Agreement (5) HHS ASPR: RESPTC	Ebola treatment, elastomeric masks.

Jennie H. Kwon, DO, MSCI	Washington University in St. Louis	Section Director for Healthcare Epidemiology & Infection Prevention, the Medical Director of Infection Prevention, and Senior Epidemiologist at Washington University in St. Louis	(1) Co-investigator: Epicenters Program $6.0M 2020-4	antimicrobial resistance.
Sharon Wright, MD, MPH	Beth Israel Lahey Health	Chief Infection Prevention Officer at Beth Israel Lahey Health	CDC Institutional funding: (1) Project Firstline (2) Epicenter $5.2M 2020-3	Bacterial endocarditis, Emerging infectious diseases, Epidemiology, Hospital-Acquired Infections, Infectious disease prevention, Influenza, Methicillin-resistant Staphylococcus aureus (MRSA), Osteomyelitis, Surgical infectious diseases

Katherine (Kate) Ellingson, PhD	College of Public Health, University of Arizona	No	Former CDC trainee and employee and continues to work with CDC as a guest researcher. Funding not specified in standard public sources.	hand hygiene, multidrug resistant organisms
Lela Luper, BSN, RN	Chickasaw Nation Department of Health	No	CDC Institutional funding: CDC funds to National Indian Health Board includes Chicaksaw Nation (1) Firstline (2) National Partners Cooperative Agreement	None specified
Lisa Baum, MA	New York State Nurses Association	No	None	None specified

HICPAC Member Conflicts of Interest – CDC Funding Programs

1. Epicenter Program

The National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), directed by Daniel Jernigan, administers the Epicenter Program. The Healthcare Infection Control Practices Advisory Committee (HICPAC) is affiliated with this CDC division. The program currently funds

11 Epicenters, with **6 of the 11 HICPAC members representing 5 of these Epicenters** (two current HICPAC members represent a single Epicenter). Historically, 3 of the 5 original Epicenter-funded institutions (since the program's inception in 2006) and 5 of the 11 Epicenters (since 2015) are represented by current HICPAC members.

HICPAC Member-Affiliated Epicenters (Since 2015):

1. Emory/PEACH University Project
Project: U54 CK000601 | Cost FY2000-4: $5.5M

2. Duke University & UNC Project
Project: U54 CK000616 | Cost FY2000-4: $5.7M

3. Harvard Pilgrim Health Care Institute (affiliated with two HICPAC member institutions: Mass General Brigham & Beth Israel Deaconess)
Project: U54 CK000611 | Cost FY2000-4: $5.2M

4. Washington University & BJC Project
Project: U54 CK000609 | Cost FY2000-4: $6.0M

5. Rush University Chicago Prevention and Intervention Epicenter (CPIE)
Project: U54 CK000607 | Cost FY2000-4: $6.2M

Non-HICPAC Affiliated Epicenters:

6. Johns Hopkins University
7. University of Iowa
8. University of Maryland-Baltimore
9. University of Utah
10. University of Pennsylvania
11. J. Craig Venter Institute & Cleveland VA

Epicenter Program Links:

- CDC Epicenters Program Overview
- Additional Link 1
- Additional Link 2

2. Project Firstline

Project Firstline is an educational and training cooperative funded by the CDC. The program is led by Liz McClune, MSW, MPA, from the Division of Healthcare Quality Promotion, which is part of NCEZID, which is affiliated with HICPAC. Of the **18 organizations funded through Project Firstline, 5 are represented by HICPAC members**, including 4 medical centers and 1 healthcare and public health association.

Funded Medical Centers Represented by HICPAC Members:

1. Emory University
2. Massachusetts General Hospital
3. PRISMA Health – Midlands
4. University of Washington
5. National Indian Health Board

Other Funded Medical Centers:

6. NYC Health + Hospitals
7. University of Nebraska Medical Center / Nebraska Medicine
8. University of South Florida
9. Yale New Haven Health

Funded Professional Societies, Advocacy Organizations, and Research Institutes:

10. American Academy of Pediatrics
11. American Health Care Association
12. American Medical Association
13. Asian and Pacific Islander American Health Forum
14. Heath Research and Educational Trust (HRET)
15. National Association of County and City Health Officials
16. National Hispanic Medical Association
17. National Network of Public Health Institutes
18. RTI International

Project Firstline Links:

- CDC Project Firstline Overview
- Additional Link 1

3. Healthcare Safety Research (SHEPheRD Program)

The SHEPheRD Program supports healthcare safety research through the NCEZID Division of Healthcare Quality Promotion, headed by Michael Bell, the previous Federal Officer of HICPAC. One HICPAC member, the co-chair Michael Lin and his institution Rush University, is supported by this program.

SHEPheRD Program Links:

- CDC SHEPheRD Program Overview

4. National Partners Cooperative Agreement Funding

The CDC's National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce (NCSTLTPHIW) funded 48 organizations this year through $176 million in the first year of a five year cycle. Two of the funded organizations are represented by HICPAC members: Emory University and the National Indian Health Board.

National Partners Cooperative Agreement Links:

- CDC Cooperative Agreement Overview

5. HHS ASPR RESPTC Program

The U.S. Department of Health and Human Services' (HHS) Administration for Strategic Preparedness and Response (ASPR) supports **13 Regional Emerging Special Pathogen Treatment Centers** (RESPTC). Of these, **3 institutions are represented by HICPAC members**:

Organizations Supported by ASPR RESPTC Represented in HICPAC:

1. Massachusetts General Hospital, Boston, MA

Medical Director of RESPTC: HICPAC member Erica Shinoy

2. Emory University, Children's Healthcare of Atlanta
3. UNC-Chapel Hill & UNC Hospitals, Chapel Hill, NC

Other Organizations Supported by ASPR RESPTC:

3. UNC-Chapel Hill & UNC Hospitals, Chapel Hill, NC
4. Cedars-Sinai Medical Center
5. Denver Health & Hospital Authority in Denver, CO
6. Johns Hopkins Hospital
7. Nebraska Medical Center in Omaha, NE
8. New York City Health and Hospitals Corp/HHC Bellevue Hospital Center in New York

9. Providence Sacred Heart Medical Center & Children's Hospital in Spokane, WA
10. Spectrum Health System in Grand Rapids, MI
11. University of Minnesota Medical Center
12. University of Texas Medical Branch at Galveston in Galveston, TX
13. Washington Hospital Center, Washington, DC

ASPR RESPTC Links:

- HHS ASPR RESPTC Overview

Conflict of Interest Linked to HICPAC Members' Expertise:

Members of HICPAC, recognized for their expertise in areas such as bloodstream infections, sepsis, sharps injuries, hand hygiene, fomite transmission, sterilization and disinfection, antimicrobial resistance, and Ebola, are funded specifically for their work in these fields. This creates a potential conflict of interest in shifting the focus of infection prevention to airborne diseases. Such a shift could threaten the funding that supports their salaries, research, staff, and associated programs, as well as their positions of authority in infection prevention and control, and those of their colleagues. This inherent tension is further complicated by the role of CDC officials responsible for nominating HICPAC members and setting the committee's agenda, including the current and former HICPAC Federal Officers and the director of NCEZID.

Summary of HICPAC Members and Their Funding and other Conflicts of Interest:

1. **Michael Lin, MD, MPH (Rush University Medical Center)**

- **Funding:** Over $12.5 million in funding from the CDC and NIH over the last 5 years.
- CDC Funded Projects:
    - Prevention Epicenter
    - SHEPheRD program
- Non-CDC Funding:
    - Fomite transmission project (REALM project): OCLC, Institute of Museum and Library Services, Battelle (REALM project related to archives, libraries, and museums).

Expertise focus: Bloodstream infections, drug-resistant organisms.

- **Potential Conflict:** Extensive CDC and NIH funding, and for research projects on fomite transmission and other non-airborne transmission mechanisms creates potential conflicts of

interest particularly in formulating guidelines relevant to airborne transmission, due to influence on HICPAC recommendations.

2. Laura Evans, MD, MSc (University of Washington)
Medical Director of Critical Care at the University of Washington Medical Center.

- **Funding:**
    - CDC: Investigator on infection prevention and control, receiving funding for salary support, research expenses, and staff.
    - CDC and ASPR: National Emerging Special Pathogens Training and Education Center (NETEC), funding for salary support.
    - NIH: Funding for sepsis research.

Expertise focus: sepsis.

- **Potential Conflict:** Extensive CDC and NIH funding for infectious disease and sepsis-related projects, creates potential conflicts of interest, particularly in formulating guidelines relevant to airborne transmission, due to influence on HICPAC recommendations. Executive/ Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

3. Erica Shenoy, MD, PhD (Mass General Brigham)
Chief of Infection Control for Mass General Brigham healthcare system.

- **Funding:**
    - CDC: Principal Investigator on a CDC-funded National Infection Prevention and Control cooperative agreement.
    - NIH and ASPR RESPTC: Medical Director of Regional Emerging Special Pathogens Treatment Center.
    - Institutional Funding: Harvard Pilgrim Epicenter, $5.2M (2020–2023).

Expertise focus: sterilization and disinfection

- **Potential Conflict:** Extensive CDC funding for Infection Prevention and Control education and decision support, coupled with leadership roles in sterilization and disinfection, creates potential conflict of interest when making decisions affecting the development of infection control protocols particularly in relation to airborne transmission. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

4. Connie Steed, MSN, RN (Consultant, Former Prisma Health)
Former Corporate Director, Corporate IPC Director for Prisma Health.

- **Funding:**
    - CDC Project Firstline: Prisma Health's institutional funding for infection prevention.

Expertise focus: sharps injuries and bloodborne exposures, hand hygiene.

- **Potential Conflict:** Involvement in CDC-funded educational initiatives related to infection prevention coupled with leadership roles in sharps injuries creates potential conflicts of interest when making decisions affecting recommendations on airborne transmission prevention protocols. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

5. David Jay Weber, MD, MPH (UNC Hospitals)

Associate Chief Medical Officer UNC Hospitals; Medical Director, Department of Infection Prevention, UNC Medical Center

- **Funding:**
    - CDC: Principal Investigator for the Duke-UNC Epicenter grant ($5.7M).
    - ASPR RESPTC: Involvement in pathogen preparedness and training.

Expertise focus: infection prevention and occupational health preparedness, new and emerging diseases, vaccines, tuberculosis, environmental contamination and disinfection.

- **Potential Conflict:** Extensive CDC and ASPR funding for infection prevention and control projects, coupled with leadership roles in environmental contamination and disinfection, presents a potential conflict of interest in developing guidelines and policies related to airborne transmission. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

6. Colleen Kraft, MD, MSc (Emory University School of Medicine)

Associate Chief Medical Officer of Emory Hospital from 1/2020-9/2023

- **Funding:**
    - CDC Projects: Emory/PEACH Prevention Epicenter ($5.5M), Project Firstline, National Partners Cooperative Agreement.
    - HHS ASPR RESPTC: Funding for pathogen treatment preparedness.

Expertise focus: Ebola treatment, elastomeric masks.

- **Potential Conflict:** Extensive CDC and HHS-funding related to infection prevention and pathogen treatment, coupled with leadership roles in Ebola treatment, creates potential conflict of interest when influencing policies affecting resource allocation related to their area of funding and expertise, including in relation to airborne transmission. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

7. Jennie H. Kwon, DO, MSCI (Washington University)
Section Director for Healthcare Epidemiology & Infection Prevention, Medical Director of Infection Prevention, and Senior Epidemiologist

- **Funding:**
    - NIH, CDC, AHRQ: Multiple research grants from federal agencies, including funding for antimicrobial resistance projects.
    - CDC Epicenters Program: Co-investigator.

Expertise focus: antimicrobial resistance

- **Potential Conflict:** Extensive CDC funding for research in antimicrobial resistance, coupled with leadership roles in antimicrobial resistance, creates potential conflict of interest when shaping policy and guidance for airborne transmission. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

8. Sharon Wright, MD, MPH (Beth Israel Lahey)
Chief Infection Prevention Officer, Beth Israel Lahey

- **Funding:**
    - Harvard Pilgrim Epicenter: $5.2M (2020–2023).

Interests: Bacterial endocarditis, Emerging infectious diseases, Epidemiology, Hospital-Acquired Infections, Infectious disease prevention, Influenza, Methicillin-resistant Staphylococcus aureus (MRSA), Osteomyelitis, Surgical infectious diseases

- **Potential Conflict:** Receiving institutional funding from CDC programs focused on infection prevention and absence of expertise in airborne transmission prevention places Wright in a position where her decisions on HICPAC could influence future funding or guidelines in infection prevention, including for airborne transmission. Executive/Manager at healthcare institution that benefits financially from treatment of infections in healthcare.

9. Katherine (Kate) Ellingson, PhD (University of Arizona)

- **Funding:** Principal Investigator or co-investigator on more than 15 grants and contracts, details not specified.
- Prior CDC Employment: Former Epidemic Intelligence Service officer and Health Scientist at the CDC. Continues to work with CDC colleagues on infection prevention.
- **Potential Conflict:** Prior employment with the CDC and ongoing collaboration may influence impartiality in developing CDC infection prevention policies.

10. Lela Luper, BSN, RN (Chickasaw Nation Department of Health)

- **Funding:**

- CDC Project Firstline: National Indian Health Board funding, which includes support for the Chickasaw Nation.
- National Partners Cooperative Agreement: CDC funding through the National Indian Health Board.

Expertise focus: None specified (no research)

- **Potential Conflict:** Participation in HICPAC while receiving CDC funding through her role at the Chickasaw Nation may present a conflict in advocating for or shaping policy related to infection prevention and public health services.

11. Lisa Baum, MA (New York State Nurses Association)

- **Funding:** None specified.

Expertise focus: None specified (no research)

- **Potential Conflict:** No research funding or prior CDC employment reported, minimizing potential conflicts of interest, but not representing expertise in airborne transmission.

Summary of Conflicts:
Many of the HICPAC members have substantial financial connections to CDC programs, either directly or through their institutions, creating potential conflicts of interest. Almost all are experts in domains of infection prevention creating financial conflict of interest with the newly recognized importance of airborne transmission. Many are also Executive/Managers at healthcare institutions that benefit financially from treatment of infections in healthcare.

This document highlights potential conflicts of interest involving members of HICPAC who are affiliated with institutions that receive substantial funding from CDC programs, and organizational financial interests, which may impact impartial decision-making.

Expanded information on HICPAC members:

1. Michael Lin:

Co-Chair of HICPAC: Michael Lin, Rush University Medical Center

Bio indicates over $12.5 million in CDC and NIH funding over the last 5 years.

Projects funded by CDC to Michael Lin:

CDC Prevention Epicenter.

CDC SHEPheRD program

Expertise focus: Blood stream infections, drug-resistant organisms.

Additional Funding: PI of fomite transmission project (not airborne transmission). REALM project and Chicago PROTECT. “REopening Archives, Libraries, and Museums (REALM) funded by OCLC, the Institute of Museum and Library Services, and Battelle regarding operations of archives, libraries, and museums.”

Links:

https://www.rushu.rush.edu/faculty/michael-lin-md-mph

https://www.cdc.gov/healthcare-associated-infections/php/prevention-epicenters/rush.html

https://www.rushu.rush.edu/education-training/graduate-medical-education/fellowship-programs/combined-rumc-cch-infectious-diseases-fellowship/divisional-expertise-research/healthcare-epidemiology-infection-control-prevention

https://www.oclc.org/realm/faq.html

2. Laura Evans, MD, MSc

Laura Evans, MD, MSc, Department of Medicine, University of Washington

Medical Director of Critical Care at the University of Washington Medical Center.

Grant funding for salary support, research expenses and staff from:

CDC: Investigator on infection prevention and control, funding for salary support, research expenses and staff.

CDC and ASPR: National Emerging Special Pathogens Training and Education Center (NETEC), funding for salary support

NIH: Sepsis research, receiving funding for salary support

Expertise focus: sepsis.

https://www.abim.org/about/boards-and-committees/governance/abim-council/

https://www.cdc.gov/project-firstline/programs/index.html

https://netec.org/

3. Erica Shenoy, MD, PhD

Erica Shenoy, MD, PhD, Chief of Infection Control for Mass General Brigham healthcare system.

CDC-funded: Principal Investigator on a CDC-funded National Infection Prevention and Control and Improving Patient Safety in the United States cooperative agreement focused on innovation in IPC education and clinical decision support.

NIH ASPR RESPTC: Dr. Shenoy is Medical Director of the Regional Emerging Special Pathogens Treatment Center at MGH (RESPTC), one of thirteen federally-funded centers.

Institutional funding:

Harvard Pilgrim Epicenter 5.2M 2020-3

Expertise focus: sterilization and disinfection

Links:

https://www.massgeneral.org/doctors/19366/erica-shenoy

https://aspr.hhs.gov/newsroom/Pages/RESPTC-Prep-Award-24Oct2022.aspx

https://www.cdc.gov/project-firstline/programs/index.html

https://www.cdc.gov/healthcare-associated-infections/php/prevention-epicenters/index.html

4. Connie Steed MSN, RN

Infection Prevention Consultant

Former Corporate Director, Corporate IPC Director for Prisma Health.

CDC institutional funding: Firstline

Expertise focus: sharps injuries and bloodborne exposures, hand hygiene.

Links:

https://apic.org/connie-steed/

https://apic.org/About-APIC/Awards/Distinguished-Awards/carole-demille-award/

https://www.cdc.gov/hicpac/php/roster/index.html

5. David Jay Weber, MD MPH

David Jay Weber, MD MPH, Associate Chief Medical Officer UNC Hospitals; Medical Director, Department of Infection Prevention, UNC Medical Center

UNC Principal Investigator on the CDC supported Duke-UNC Epicenter grant. $5.7 Million 6/1/21-5/31/26

Also involved in ASPR RESPTC

Expertise and focus: infection prevention and occupational health preparedness, new and emerging diseases, vaccines, tuberculosis, environmental contamination and disinfection.

https://www.med.unc.edu/medicine/infdis/people/david-weber/

https://www.highergov.com/grant/U54CK000616/

https://medschool.duke.edu/news/duke-unc-one-five-epicenters-nationwide-receive-funding-cdc

https://sph.unc.edu/sph-news/unc-awarded-3m-for-emerging-pathogen-preparedness-and-training/

6. Colleen Kraft, MD, MSc

Colleen S. Kraft, MD., Associate Professor, Emory University School of Medicine

Associate Chief Medical Officer of Emory Hospital from 1/2020-9/2023

Funding: (1) CDC elastomeric research project

Institutional funding:

(2) Prevention Epicenter Emory/PEACH University Project: U54 CK000601 Cost FY2000-4: $5.5M

(3) Firstline

(4) National Partners Cooperative Agreement

(5) HHS ASPR: RESPTC

Expertise focus: Ebola treatment, elastomeric masks.

https://med.emory.edu/departments/medicine/profile/?u=CSKENDR

https://www.cdc.gov/healthcare-associated-infections/php/prevention-epicenters/index.html

https://news.emory.edu/stories/2019/01/kraft_SCDP_respirator_contract/index.html

7. Jennie H. Kwon, DO, MSCI

Jennie H. Kwon, DO, MSCI, Washington University, Section Director for Healthcare Epidemiology & Infection Prevention, Medical Director of Infection Prevention, and Senior Epidemiologist

Funded by the NIH, CDC, AHRQ, and multiple foundations.

CDC Epicenters program: co-investigator Kwon

Expertise focus: antimicrobial resistance

https://infectiousdiseases.wustl.edu/people/jennie-h-kwon/

https://www.cdc.gov/healthcare-associated-infections/php/prevention-epicenters/washington.html

8. Sharon Wright, MD, MPH

Sharon Wright, MD, MPH, Chief Infection Prevention Officer, Beth Israel Lahey

Institutional Funding

Harvard Pilgrim Epicenter 5.2M 2020-3

Interests: Bacterial endocarditis, Emerging infectious diseases, Epidemiology, Hospital-Acquired Infections, Infectious disease prevention, Influenza, Methicillin-resistant Staphylococcus aureus (MRSA), Osteomyelitis, Surgical infectious diseases

Links:

https://betsylehmancenterma.gov/news/q-a-dr-sharon-wright-on-ways-to-build-and-extend-the-capacity-of-infection-prevention-teams

9. Katherine (Kate) Ellingson, PhD

Katherine (Kate) Ellingson, College of Public Health, University of Arizona

Principal Investigator or co-investigator on more than 15 grants and contracts. Funding sources not provided.

Began her career as an Epidemic Intelligence Service officer and Health Scientist at the Centers for Disease Control and Prevention. As a guest researcher at CDC, she continues to work with federal colleagues on infection prevention and transfusion safety.

Expertise: hand hygiene, multidrug resistant organisms.

https://publichealth.arizona.edu/directory/katherine-ellingson

https://ellingsonlab.arizona.edu/

https://deptmedicine.arizona.edu/profile/katherine-ellingson-phd

10. Lela Luper, BSN, RN

Lela Luper, RN, BS, CICAda, OK, Infection Preventionist, Chickasaw Nation Department of Health

Funding support:

Project Firstline National Indian Health Board includes Chicksaw Nation

National Partners Cooperative Agreement Funding National Indian Health Board (Announced Oct 2, 2024)

Expertise focus: None specified

Links:

https://apic.org/lela-luper/

https://apic.org/about-apic/committees-old/education-committee/chair/

https://www.nihb.org/about_us/board.php

https://nihb.org/project-firstline/

https://www.nihb.org/

11. Lisa Baum, MA

Lead Occupational Health & Safety Representative, New York State Nurses Association

Expertise focus: None specified

https://m.usw.org/news/media-center/articles/2024/local-9544-member-takes-infection-control-expertise-to-cdc-with-new-appointment

Federal Officer:

Alexander J. Kallen, MD, MPH

Chief, Prevention and Response Branch

National Center for Emerging and Zoonotic Infectious Diseases

Author of multiple papers on hospital acquired infections none of which are on airborne transmission.

Appendix B

Appendix B: HICPAC Isolation Precautions Guideline Workgroup Members

Current and former HICPAC members:

1. **Michael Lin (Co-Chair)**, Current HICPAC member (See Appendix A)

2. **Sharon Wright (Co-Chair)**, Current HICPAC member (See Appendix A)

3. **Erica Shenoy**: Current HICPAC member (See Appendix A)

4. **Connie Steed:** Current HICPAC member (See Appendix A)

5. **Hilary Babcock:** Recent member of HICPAC

   BJC Healthcare vice president and chief quality officer

   https://infectiousdiseases.wustl.edu/people/hilary-m-babcock-md-mph/

6. **Elaine Dekker:** Recent member of HICPAC

   San Francisco General Hospital and Trauma Center IPC Program Manager,

   https://zsfgmedicine.ucsf.edu/sites/zsfgmedicine.ucsf.edu/files/inline-files/JuneNewsletterFinal.pdf

7. **Judith Guzman-Cottrill:** Recent member of HICPAC

   CDC Funding:

   1. Medical Director for the Oregon Health Authority's Project Firstline,

   2. Curriculum Director of the CDC-funded national LEAP Fellowship program

   https://www.theoma.org/Shared_Content/News/Articles/2024/March/OMA%20Member%20Spotlight%20Championing%20Infectious%20Disease.aspx

8. **Julie Trivedi:** Recent Member of HICPAC

   Chair Infection Control Committee for UT Southwestern William P. Clements Jr. University Hospital

https://utswmed.org/doctors/julie-trivedi/

9. **Deborah Yokoe:** Recent member of HICPAC

Medical Director for Hospital Epidemiology and Infection Prevention for the adult services UCSF Department of Medicine

https://medicine.ucsf.edu/people/deborah-yokoe

Members with expertise and focus on airborne transmission in occupational or environmental medicine added in 2024:

10. Lisa Brosseau, Bioaerosol Scientist & Industrial Hygienist

https://www.lisabrosseau.com/

11. Melissa McDiarmid, Division Head Occupational Health and Environmental Medicine University of Maryland School of Medicine

https://www.medschool.umaryland.edu/profiles/mcdiarmid-melissa/

12. Robert Harrison, UCSF Division of Occupational Environmental and Climate Medicine

https://oecm.ucsf.edu/people/robert-harrison

13. Jane Thomason, National Nurses United (NNU) lead industrial hygienist

https://www.nationalnursesunited.org/press/nnu-invited-to-join-cdcs-hicpac-workgroup-on-infection-prevention

14. William Bennett, UNC School of Medicine

Professor of Medicine in the Center for Environmental Medicine, Asthma and Lung Biology (CEMALB) .

CDC Institutional funding for UNC (See Appendix A)

CDC supported Duke-UNC Epicenter grant. $5.7 Million 6/1/21-5/31/26

ASPR Funding: RESPTC

https://www.med.unc.edu/cemalb/about-the-center/faculty-and-staff/faculty-2/bill-bennett/

Other Members:

15. Mark Russi, Current Liaison Representative to HICPAC

    Emeritus Professor of Medicine at the Yale Medical School

    Yale University Occupational and Environmental Medicine Clinic

    https://medicine.yale.edu/profile/mark-russi/

16. Morgan Katz, Director of Antimicrobial Stewardship at Johns Hopkins Bayview Hospital.

    ASPR funding: RESPC to affiliated Johns Hopkins Hospital

    CDC funding: Epicenter Program institutional funding to Johns Hopkins University

    https://profiles.hopkinsmedicine.org/provider/morgan-katz/2702797

17. Anurag Malani, Recent Liaison Representative to HICPAC

    Medical Director of Healthcare Epidemiology, Special Pathogens, and the Antimicrobial Stewardship Programs at Trinity Health St. Joseph Mercy Ann Arbor.

    https://sph.umich.edu/faculty-profiles/malani-anurag.html

Sources:

https://www.cdc.gov/hicpac/media/pdfs/2021-October-HICPAC-Summary-508.pdf

https://stacks.cdc.gov/view/cdc/129497/cdc_129497_DS1.pdf

https://www.cdc.gov/hicpac/media/pdfs/2018-February-HICPAC-Transcript-P.pdf

https://www.cdc.gov/hicpac/media/pdfs/August-22-2024-HICPAC-Meeting-Summary-508.pdf

https://www.cdc.gov/infection-control/hcp/healthcare-personnel-epidemiology-control/authors.html