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SPECIAL EDITION

HICPAC is gone - now what?

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The Healthcare Infection Control Practices Advisory Committee (HICPAC) was established in 1991 with the mandate to develop, disseminate, and oversee standardized recommendations for infection prevention and control practices in the United States (Centers for Disease Control and Prevention [CDC], 2022). The Committee provided expert guidance across multiple domains, including central line insertion and maintenance, isolation precautions, personal protective equipment (PPE) use, and numerous other practices essential to preventing healthcare-associated infections (Siegel et al., 2007; O'Grady et al., 2011).

HICPAC's close association with the Centers for Disease Control and Prevention has provided the Committee with both scientific credibility and a national platform for promoting standardized, evidence-based infection prevention practices. In addition, HICPAC recommendations have helped inform accreditation standards and regulatory expectations for infection prevention programs across healthcare settings (Department of Health and Human Services, 1994).

Who is HICPAC?

The Healthcare Infection Control Practices Advisory Committee (HICPAC) was chartered to include 14 voting members appointed by the Secretary of Health and Human Services (HHS). These members were selected for their subject-matter expertise in fields such as infectious diseases, infection prevention and control, healthcare epidemiology, nursing, public health, and other areas relevant to healthcare safety (Department of Health and Human Services [HHS], 1994; CDC, 2022). HICPAC convened up to eight times per year, typically at the Centers for Disease Control and Prevention (CDC) headquarters in Atlanta, Georgia.

Under its charter, the Committee was responsible for developing, updating, and reviewing evidence-based recommendations for infection prevention and control in healthcare settings. This included ongoing evaluation of emerging scientific literature to ensure that guidance remained current, scientifically valid, and aligned with best practices (CDC, 2022).

HICPAC's recommendations for patient care included several foundational documents, such as the isolation precautions guidelines, which address the prevention of transmission of infectious agents in healthcare settings (Siegel et al., 2007), and the guidelines for the prevention and management of central line-associated infections (O'Grady et al., 2011). Additional guidance developed or endorsed by HICPAC encompassed hand hygiene practices (Boyce & Pittet, 2002), environmental cleaning and disinfection strategies, and the reprocessing of medical devices and equipment—each serving as a critical component of comprehensive healthcare infection prevention programs.

Guidelines That Made a Measurable Difference

Among the numerous documents produced by HICPAC, several have had particularly significant impact on patient safety and infection prevention outcomes. One of the most influential was the *Guidelines for the Prevention of Intravascular Catheter-Related Infections* (O'Grady et al., 2011). This guideline was among the first comprehensive efforts to codify evidence-based standards for the insertion, maintenance, and management of central venous catheters. Implementation of these recommendations has been associated with marked reductions in central line-associated bloodstream infections (CLABSIs). Data reported to the National Healthcare Safety Network (NHSN) have shown that many healthcare facilities experienced sustained periods with zero CLABSI events following adoption of the guideline-recommended practices (CDC, 2023).

Another foundational contribution from HICPAC was the *Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings* (CDC/HICPAC, 2017). This guidance was one of the first to systematically address infection prevention requirements across the full continuum of healthcare—not only within hospitals, but also in outpatient clinics, long-term care facilities, home health services, and other non-acute care environments. By establishing a universal framework for basic infection prevention measures, the document helped extend standardized safety practices beyond traditional hospital walls and into all settings where patients receive clinical care.

Now Where Do We Go?

HICPAC was formally disbanded effective March 31, 2025, following a CDC determination—aligned with a broader federal initiative—to eliminate advisory committees deemed unnecessary, duplicative, or no longer aligned with agency priorities (Essential Hospitals, 2025). This action was part of an administrative effort to streamline federal advisory structures, but it immediately raised concern across the medical and public health communities. Many professional organizations expressed alarm that the dissolution removed a key source of expert-driven, evidence-based guidance for infection prevention and control (Infectious Diseases Society of America [IDSA], 2025).

One anticipated consequence of HICPAC's termination was the loss of a unified national framework for accrediting and regulatory agencies, including the Centers for Medicare &

Medicaid Services (CMS), which have historically relied on HICPAC guidance to inform standards for infection prevention programs (LeadingAge, 2025). Other accrediting bodies and healthcare oversight organizations have similarly voiced concern that the absence of HICPAC could create a vacuum in national standard-setting.

Without this centralized expert committee, stakeholders fear the development of a fragmented landscape in which states, local jurisdictions, or individual institutions create their own infection-control requirements. Such a mosaic of divergent guidelines could undermine national consistency, complicate compliance for healthcare facilities operating across multiple jurisdictions, and weaken the unified approach that has long underpinned effective infection prevention efforts (IDSA, 2025).

It should be noted that not all HICPAC activities were as successful as the widely adopted guidelines previously described. Several professional organizations and advocacy groups have raised concerns regarding the Committee's transparency and communication practices. Critics have argued that HICPAC has not consistently provided detailed public accounting of its deliberations, rationales, or the evidentiary basis for certain recommendations (National Nurses United, 2023; People's CDC, 2023).

Concerns have also been raised about whether the Committee's membership always included the full breadth of expertise necessary to address highly specialized or emerging issues. This critique was particularly prominent during the development of recent guidance addressing airborne transmission of respiratory pathogens, including COVID-19. Some experts objected to recommendations endorsing the use of surgical masks for certain COVID-19 scenarios, stating that these positions were not aligned with prevailing scientific consensus on aerosol transmission and respiratory protection (NPR, 2023; National Nurses United, 2023).

Finally, issues related to potential conflicts of interest have been raised. Some critics argue that certain committee members may face real or perceived conflicts due to professional roles in healthcare systems that could benefit financially from treating healthcare-associated infections (HAIs). Under the current fee-for-service reimbursement model, hospitals may receive payment for managing conditions including some HAIs, although Medicare's 2008 Hospital-Acquired Conditions (HAC) rule restricted reimbursement for many such conditions with limited exceptions. COVID-19 was not included in the prohibition and remained reimbursable (CMS, 2008; CMS, 2020). These circumstances have contributed to scrutiny regarding the impartiality of decision-making.

Accreditation organizations expect each entity they "certify" to use "nationally recognized" or "accepted" infection-control standards. This requirement ensures that accredited organizations are meeting or exceeding established standards of care and prevents facilities from developing infection-control programs that rely solely on internally created or unsupported practices.

Importantly, accrediting bodies *do not* require a single-source guideline. Instead, they expect organizations to review, adopt, and implement guidance from recognized authorities, including:

- CDC (including legacy HICPAC publications)
- World Health Organization (WHO)
- Occupational Safety and Health Administration (OSHA)
- Professional societies such as APIC, SHEA, AORN and IDSA
- Peer-reviewed, evidence-based clinical guidelines

As summarized in **Table I**, all major accrediting organizations require infection-prevention programs to be grounded in legitimate external standards rather than institution-defined protocols.

Historically, many accreditation frameworks implicitly relied on HICPAC—via CDC—as a central source of nationally recognized guidance. With the dissolution of HICPAC, accrediting bodies such as CMS, The Joint Commission, DNV, HFAP/ACHC, CIHQ, and AAAHC must now re-evaluate and clarify what qualifies as “nationally recognized” infection-control guidance. In parallel, healthcare organizations may be forced to choose among multiple authoritative sources—CDC, APIC, SHEA, WHO, and others—without a single anchoring federal advisory body.

This situation raises the possibility of fragmentation. If states, professional societies, and accrediting agencies diverge in their interpretations, healthcare organizations may encounter inconsistent or conflicting requirements across jurisdictions. This challenge is magnified for large multi-state systems such as Tenet®, HCA®, or CommonSpirit®, whose facilities may face different or even contradictory standards depending on state-level guidance or accreditor interpretation.

Is there a solution, where do we go from here?

Two major infection prevention organizations—the Association for Professionals in Infection Control and Epidemiology (APIC) and the Society for Healthcare Epidemiology of America (SHEA)—are currently engaged in discussions to provide a service similar to that previously offered by HICPAC. Both organizations include highly qualified and nationally recognized experts, and several of their members have previously served on HICPAC or contributed to CDC infection-control guidelines (APIC, 2025; SHEA, 2025).

APIC and SHEA each hold longstanding credibility within the healthcare community, including among accrediting and regulatory agencies. This credibility is reflected in accreditation frameworks that require adherence to “nationally recognized infection prevention and control guidelines” and current “evidence-based guidelines and national standards,” many of which have historically been informed or supported by these professional societies (The Joint Commission, 2025). As a result, APIC and SHEA are well positioned to help fill the guidance gap created by the dissolution of HICPAC.

As organizations move forward in this new environment, it is incumbent upon them to **monitor the guidelines promulgated by recognized professional organizations** — for example Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), Society of Gastroenterology Nurses and Associates (SGNA), and Association of periOperative Registered Nurses (AORN). Their guidance documents, based on current evidence, should form the foundation for institutional infection-prevention policies and procedures (APIC, 2025; SHEA, 2025; SGNA, 2018; AORN, 2024).

For larger health-system organizations that consist of multiple facilities, it is critical to maintain active communication with the system's regulatory or compliance divisions, to ensure consistent policy adoption and compliance across all sites. For independent (free-standing) facilities, all infection-control policies should be explicitly tied to relevant, recognized scientific guidelines from these authorities.

In addition, all hospitals and health-care facilities must **monitor the activities and requirements of their local and state health departments**, since public-health regulations and mandates can vary geographically and may affect infection-control obligations (e.g., reporting requirements, outbreak response protocols, or environmental/occupational health mandates) (NACCHO / Local Health Departments, 2024).

The dissolution of a single federal advisory committee does not eliminate the need for rigorous infection prevention standards. Instead, it **re-emphasizes the responsibility of health-care organizations to stay vigilant and proactive** in adopting, updating, and implementing evidence-based guidance from multiple credible sources.

- Relying on recognized professional organizations (APIC, SHEA, SGNA, AORN, etc.) can sustain high-quality infection-prevention programs even in the absence of a central federal guidance body.
- For multi-facility systems, strong internal regulatory governance and communication are essential to ensure consistency and compliance across sites.
- Independent facilities must remain diligent in aligning their protocols with current national guidance and be ready to respond to evolving public-health mandates at the local or state level.
- Ultimately, the fragmentation of guideline sources underscores the importance of **robust surveillance, consistent policy review, and institutional commitment to patient and staff safety**.

This multi-layered, decentralized approach can — if implemented conscientiously — preserve or even strengthen infection-prevention practices. But it also carries the risk of variability in standards unless organizations commit to constant review, alignment, and oversight.

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TABLE I

This table offers a crosswalk comparing the expectations of major accreditation bodies regarding the use of nationally recognized guideline-setting organizations as the foundation for infection prevention and control programs.

Organization	Requirement Language	Meaning / Implications	Citation
<p>The Center for Healthcare Improvement in Quality (CHIA)</p>	<p>The Organization must develop, implement, and maintain an active hospital-wide program for the control of healthcare acquired infections (HAI)...and optimization of antibiotic use through stewardship.</p>	<p>"The program must demonstrate adherence to nationally recognized infection prevention and control guidelines...as well as to best practices for improving antibiotic use...."</p>	<p>Accreditation Standards for Hospitals Participating in Medicare (Eff 1/26)</p>
<p>CMS (Centers for Medicare & Medicaid Services)</p>	<p>Hospitals must implement an infection control program "consistent with nationally recognized infection prevention and control guidelines." (42 CFR §482.42)</p> <p>Also CMS references AORN in 482.51</p>	<p>CMS does not specify one source (e.g., HICPAC), but mandates adherence to established, evidence-based national standards. Hospitals must demonstrate alignment with an accepted guideline set.</p>	<p>42 CFR §482.42, <i>Conditions of Participation: Infection Prevention and Control</i> (ECFR.gov)</p>
<p>CMS – Long-Term Care</p>	<p>Facilities must implement policies "consistent with accepted national standards" for infection prevention.</p>	<p>Reinforces the principle that infection-control programs must follow recognized expert standards, not institution-invented practices.</p>	<p>CMS QSO-24-08-NH (2024)</p>
<p>DNV (DNV GL Healthcare)</p>	<p>Requires compliance with "CDC, WHO, OSHA, CMS requirements... and other national guidelines." (DNV CIP program)</p>	<p>DNV accreditation ties infection-prevention programs to major national and international guideline authorities, emphasizing externally validated practices.</p>	<p>DNV Healthcare, <i>Certification in Infection Prevention (CIP)</i></p>
<p>DNV – NIAHO Accreditation</p>	<p>Aligns with CMS CoP and requires organizations to follow nationally recognized guidelines for infection control.</p>	<p>Facilities accredited by DNV must demonstrate practice consistency with</p>	<p>DNV NIAHO Accreditation Requirements (Rev. 25-0, 2025)</p>

Organization	Requirement Language	Meaning / Implications	Citation
DNV – NIAHO Accreditation	Aligns with CMS CoP and requires organizations to follow nationally recognized guidelines for infection control.	Facilities accredited by DNV must demonstrate practice consistency with accepted national standards.	DNV NIAHO Accreditation Requirements (Rev. 25-0, 2025)
HFAP / ACHC (Healthcare Facilities Accreditation Program, now under ACHC)	Requires adherence to "current recognized standards of infection prevention and control" and evidence-based national guidelines.	HFAP/ACHC expects facilities to base their infection-prevention programs on accepted expert standards, similar to CMS and DNV.	ACHC Accreditation Manual (latest accessible edition)
TJC (The Joint Commission) – all programs (Language may vary with program)	The policies and procedures are in accordance with the following hierarchy of references: ... c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures.	TJC expects facilities to base their infection-prevention programs on accepted expert standards, similar to CMS	TJC Comprehensive Manual on the Accreditation of Healthcare Organizations. NB: There are multiple nested programs with this requirement (applicable manuals and latest accessible edition)

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