Note: The meeting proceeded as outlined in the agenda (https://www.cdc.gov/hicpac/pdf/HICPAC-Agenda-November2023-508.pdf). This summary has moved the order of some items for ease of review.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

Healthcare Infection Control Practices Advisory Committee

November 2-3, 2023

Atlanta, Georgia

Record of the Proceedings

Contents

Attendees

HICPAC Members
Elaine Dekker, RN
Mohamad Fakih, MD, MPH
Judy Guzman-Cottrill, DO
Colleen Kraft, MD, MSc
Jennie H. Kwon, DO, MSCI
Michael Lin, MD, MPH (Subject Matter Expert)
Erica Shenoy, MD, PhD
JoAnne Reifsnyder, PhD, MBA, MSN
David Jay Weber, MD MPH
Sharon Wright, MD, MPH

***Ex Officio* Members**
Megan Hayden, BSN, RN, Centers for Medicare & Medicaid Services (CMS)
David Henderson, MD, National Institutes of Health (NIH)
Jimi Risse, RN, Indian Health Service (IHS)
Leyi Lin, MD, Agency for Healthcare Research and Quality (AHRQ)
Melissa Miller, MD, MS, Agency for Healthcare Research and Quality (AHRQ)
LCDR Scott Steffen, PhD, CQIA, CQI, Food and Drug Administration (FDA)

Liaison Representatives
Lilian Abbo, MD, MBA, Infectious Disease Society of America (IDSA)
Hilary Babcock, MD, MPH, Society for Healthcare Epidemiology of America (SHEA)
Kristina Bryant, MD, American Society of Nephrology (ASN)
Paul Conway, American Association of Kidney Patients (AAKP)
Patti Costello, American Hospital Association (AHA)
Karen DeKay, MSN, RN, CNOR, CIC, Association of periOperative Registered Nurses (AORN)
Erin Epson, MD, Council of State and Territorial Epidemiologists (CSTE)
Chris Lombardozzi, MD, America's Essential Hospitals (AEH)
Lisa McGiffert, Patient Safety Action Network (PSAN)
Maureen McGrath, Public Health Agency of Canada (PHAC)
Karen Ravin, MD, Pediatric Infectious Diseases Society (PIDS)
Mark Russi, MD, MPH, American College of Occupational and Environmental Medicine (ACOEM)
Robert Sawyer, MD, Surgical Infection Society (SIS)
Benjamin Schwartz, MD, National Association of County and City Health Officials (NACCHO)
Sarah Smathers, MPH, CIC, FAPIC, Association for Professionals in Infection Control and Epidemiology (APIC)
Stephanie Taylor, MD, MSc, Society of Hospital Medicine (SHM)
Tiffany Wiksten, BSN, APN, DNP, The Joint Commission (TJC)

CDC Representatives
Michael Bell, MD
Sydnee Byrd, MPA
Angela Driver
Beth Golshir, MPH
Alexander J. Kallen, MD, MPH
Aaron Kofman, MD
David Kuhar, MD
Michele Neuburger, DDS, MPH
Melissa Schaeffer, MD
Erin Stone, MPH
Laura Wells, MA

Members of the Public
Seifer Almasy, Member of the Public
Naomi Bar-Yam, MSW, PhD, World Health Network
Victoria Becker, MSN, NP, Retired, Nurse Practitioner
Joaquin Beltran, Founder, Action / Care / Equity (ACE)
Eric Berg, MPH, Deputy Chief of Health, Cal/OSHA
Christine Braile, Parent of a Son with Primary Immune Deficiency
Roselie Bright, ScD, Retired Federal Epidemiologist
Lisa Brosseau, ScD, CIH, Center for Infectious Disease, Research, and Policy, University of Michigan
Megan Cunningham, MBA, Mother of Immunocompromised Child
Don Ford (Reg Mills), OBT
Lisa Foreman, MSN, Nurse Practitioner
Maria Giffen-Castro, Public Commenter
Jay Herzmark, RN, Certified Industrial Hygienist, Safe Work Washington Volunteer
Chloe Humbert, Public Commenter
Kevin Kavanagh, MD, MS, Board Chairman, Health Watch USA℠
Anne Miller, MBA, Executive Director, Project N95
Aysha Mirza, MBS, Stem Cell Biologist, COVID Compliance Expert, Public Health Advocate, SAG-AFTRA Member, World Health Network Member
Rachel Nussbaum, MPH Student, Young University
Danielle Peck, M.Ed, Patient from Michigan
Mary Jirmanus Saba, Political Economist, Member of The People's CDC
Shimi Sharief MD, MPH, Public Health Physician and Nephrologist
Darius Sivin, PhD, Editor in Chief, *New Solutions*
Zenei Triunfo-Cortez, RN, President, National Nurses United (NNU)
Kathleen Turturice, Member, World Health Network (WHN)
Stephanie Wallace, PhD, MS, Cambridge Communications & Training Institute (CCTI)
Andrew Wang, PhD, Federally Qualified Healthcare Center (FQHC), The People's CDC

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Healthcare Infection Control Practices Advisory Committee (HICPAC)

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Minutes of the Meeting

The United States (US) Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) Division of Healthcare Quality Promotion (DHQP) convened a hybrid meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC) on November 2-3, 2023.

Thursday: November 2, 2023

Call to Order / Roll Call / Announcements

Sydnee Byrd, MPA, Program Analyst
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

Alexander J. Kallen, MD, MPH
HICPAC Designated Federal Officer

Ms. Byrd called to order the first day of the November 2-3, 2023 HICPAC meeting at 9:03 AM Eastern Time (ET), welcomed everyone, and called the roll. Meeting and voting quorum were established and maintained throughout the day. HICPAC members disclosed the following conflicts of interest (COIs):

- Dr. Judy Guzman-Cottrill is a consultant for Oregon Health Authority's Healthcare-Associated Infections (HAI) Program.
- Dr. Colleen Kraft is a scientific advisor for Seres Therapeutics and a consultant for Rebiotix Inc.
- Dr. Michael Lin receives research support in the form of contributed products from OpGen, LLC and Sage Products, which is now a part of Stryker Corporation. He previously received an investigator-initiated grant from CareFusion Foundation, which is now part of BD.

Ms. Byrd indicated that public comment was scheduled following the presentations and before any votes. She explained public comments would be limited to 3 minutes each, and that commenters should state their names and organization for the record before speaking. She reminded everyone that the public comment period is not a question and answer (Q&A) session.

Dr. Kallen welcomed everyone to the November 2023 meeting of the HICPAC and made a few announcements. He recognized the following members who would be retiring at the end of the year and welcomed a new incoming member:

Outgoing Members

- Dr. Judy Guzman-Cottrill has been a member of HICPAC from 2019–2023 and has been instrumental in the National Healthcare Safety Network (NHSN) Workgroup (WG), including leading some incredible work on pediatric definitions and her work on the Isolation Precautions WG.
- While Dr. Mohamad Fakih, Ms. Elaine Dekker, and Dr. JoAnne Reifsnyder were recognized during the last meeting, Dr. Kallen offered a special note of thanks to them for extending their terms through the end of 2023.

Incoming Liaison Member

- Dr. Erin Epson (CSTE) is Medical Director and Chief of the Healthcare-Associated Infection (HAI) Program at the California Department of Public Health (CDPH). She is Board Certified in Internal Medicine and Infectious Disease and completed Medical Epidemiology training as an Epidemic Intelligence Service (EIS) Officer at CDC. In her role at the CDPH HAI Program for the past 9 years, Dr. Epson is responsible for overseeing statewide and regional HAI and antimicrobial resistance (AR) prevention and response activities. At the national level, Dr. Epson serves as the CSTE Representative and Governance Committee Co-Chair of the **C**ouncil for **O**utbreak **R**esponse: **H**ealthcare-Associated Infections **A**ntimicrobial-Resistance Pathogens (CORHA). In this capacity, she has led the development and updating of *COVID-19 Healthcare Outbreak Investigation and Reporting Thresholds* in addition to multiple other CORHA products.

Division of Healthcare Quality Promotion (DHQP) Update

Michael Bell, MD
HICPAC Designated Federal Officer

Dr. Bell provided 2 brief DHQP updates. First, he expressed gratitude to the many long-term care partners and technical leads who have made it possible over the past several years and are currently working to ensure that long-term care facilities (LTCF) and providers and staff are well-protected. The current work has been related to ensuring that, with the respiratory season upon us, long-term care populations are able to gain access to and receive vaccines should they desire to be immunized. That work has been very important to make sure that there is not a gap. Second, the NHSN is one of CDC's premier data systems for healthcare-related issues. The NHSN grew from CDC's partnership with and support from CMS. Over 5,000 acute care hospitals use NHSN. That increased to an even larger number due to the COVID-19 pandemic because of a need to have visibility into long-term care spaces to understand whether residents in LTCF were being harmed disproportionately and so forth. CDC was tasked with extending NHSN to the roughly 16,000 nursing homes throughout the country, which was undertaken rapidly. With the end of the Public Health Emergency (PHE), some of CDC's data priorities have shifted. A process is underway to identify what needs to be retained and understand how to progressively reduce the burden of data collection and submission on all of the participating facilities, being extremely sensitive to the fact that staffing in LTCF is limited. Especially in long-term care, there often are no dedicated individuals to collect and submit data compared to acute care facilities. An effort is being made to identify automatable, machine-collectable data elements. This is a combination of reassessing metrics where possible and working closely with

the health informatics world and electronic health record (EHR) companies to streamline and automate where possible. Behind the scenes are the staff who are working to ensure that any changes made are still valid, measure what they are intended to measure, and continue to drive progress and reduce bad outcomes.

Isolation Precautions Guideline Workgroup

Part 1: Initial Discussion

Michael Lin, MD, MPH and Sharon Wright, MD, MPH
Co-Chairs, Isolation Precautions Guideline WG

Dr. Lin reminded everyone that the findings and conclusions being shared during this session were draft, had not been formally disseminated by the CDC, and should not be construed to represent any agency determination or policy. He reviewed the agenda for this session, which included an overview of Part 1 of the draft Isolation Precautions Guideline framework, with discussion of the following sections:

- ❑ **Section A:** Overview of Transmission of Infectious Agents
- ❑ **Section B:** Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings
- ❑ **Section C:** Precautions to Prevent Transmission of Infectious Agents

He explained that on behalf of the Isolation Precautions Guideline WG, he and Dr. Wright would present the first draft of an update to Part 1 of the 2007 Isolation Precautions Guidelines to HICPAC for consideration. Portions of this 2-day HICPAC meeting would be dedicated to detailed discussion and review of the guidelines, and if ready, HICPAC members would vote at the conclusion of the meeting regarding whether the draft guideline is ready for CDC review followed by a 60-day public comment period via the *Federal Register*. Comments received during the 60-day public review period would inform draft guideline revision by HICPAC and CDC, which would occur before any future HICPAC consideration of the draft guideline for a final meeting discussion and vote projected for 2024.

Dr. Lin began with 3 key points from the 2024 Guideline. (1) Updates were made to the conceptual framework for pathogen transmission, including the recognition of a continuum of pathogen transmission by air, rather than an outdated dichotomy of “droplet” versus “airborne” transmission. (2) New categories are proposed for Transmission-Based Precautions, including a new category for transmission through the air called Special Air Precautions, which is expected to increase the use of National Institute for Occupational Safety and Health (NIOSH)-approved® fit-tested N95 (or higher-level respirators) during responses to pandemic or emerging respiratory viruses. (3) The 2024 Guideline does not provide any pathogen-specific guidance. Pathogen-specific guidance will be addressed in a future Part 2.

The WG’s goal is the creation of an update to the 2007 Isolation Precautions Guideline. The draft guideline is intended to replace corresponding content in the 2007 Guideline. Elements of the 2007 Guideline that are not directly affected by this update, including the 2007 guideline’s Appendix A, will remain active until updated. Specifically, the update is meant to be clearer with more concise language and formatting. The recommendations largely address infection prevention strategies that frontline healthcare personnel (HCP) may implement at the point of care. The guideline is intended to be applicable to all healthcare settings.

As a reminder, Parts I–IV of the 2007 Guideline were combined into a single Part 1 in the 2024 Guideline. Part 1 is pathogen-agnostic. Appendix A of the 2007 Guideline eventually will be replaced by Part 2 of the 2024 Guideline, which will be pathogen-specific and represents future HICPAC work. This table depicts the general outline of the 2024 Guideline:

Section	Titles
Section A	Overview of Transmission of Pathogens in Healthcare Settings
Section B	Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings
	Hand Hygiene
	Personal Protective Equipment (PPE) for Healthcare Personnel: General Considerations; Gloves; Gowns; Masks; Respirators; Eye/Face Protection*
	Environmental Controls: Environmental Cleaning and Disinfection; Specialized Air Handling
Section C	Precautions to Prevent Transmission of Infectious Agents
	Standard Precautions*
	Transmission-based Precautions*
	Syndromic and Empiric Applications of Transmission-based Precautions*
	Use of Transmission-Based Precautions to Prevent Transmission by Touch*
	Use of Transmission-Based Precautions to Prevent Transmission through the Air*
	Source Control; Patient Placement; Transport of Patients*

Note: Headers with imbedded recommendations are highlighted in red and asterisk*

Drs. Lin and Wright began the review of key aspects of Section A, Recommendation Formulation and Categorization (from Part 1 Draft Guideline Appendix), Section B, and Section C.

Section A: Overview of Transmission of Infectious Agents

Factors Affecting Transmissibility

- Transmission occurs when an at-risk person acquires a pathogen from an infectious person. Transmission is determined by pathogen, environmental, and person factors at the time of event. While pathogen factors are often biologically intrinsic (e.g., the ability of a pathogen to remain viable during transit), environmental and person-specific factors may vary by location and over time. Environmental variables include air (e.g., temperature, humidity, ventilation) and surface (e.g., material, porosity) conditions. Factors that vary among infectious persons include pathogen load and shedding rate. Factors that vary among at-risk persons include host defense mechanisms that are non-immune-based (e.g., intact skin) and immune-based (e.g., pathogen-specific immunity from prior infection or vaccination).

Significance of Transmission

- Transmission can result in colonization or infection. Based on the health impact that a pathogen is expected to have on an individual or the community, some pathogens are recognized as requiring intensive efforts to prevent transmission, while others may not rise to that level. Less intensive effort might be indicated when outcomes are not usually severe, the population has a high degree of immunity, and effective therapeutics and vaccines are available. The boundaries describing those categories require risk assessment and can vary by setting and population at risk.

Transmission Pathways

- In the healthcare setting, pathogen transmission pathways can be grouped into two broad categories: pathogens that spread via the air, and pathogens that spread via touch.

- Pathogens generally spread via a major pathway, though multiple pathways might contribute to spread. Pathogen transmission epidemiology is informed by observing patterns of infection spread.

Transmission Via Air

- Pathogens can transmit via air over short distances through direct splash or spray of the pathogen onto a part of the body (e.g., spray from a sneeze landing on a person's eyes or mouth) or variably across ranges of distance and time via suspended infectious particles. Pathogens suspended in the air cause infection via inhalation and deposition along the respiratory tract, anywhere from the nasal or oral passages to the lungs.

- Historically, the infection prevention community has categorized transmission of respiratory pathogens as "droplet" or "airborne."
  - While these epidemiologic terms reflect observed patterns of short versus long distance transmission respectively, the terms do not explicitly describe a continuum of respiratory pathogen transmission through the air.

- Pathogens that spread via the air preferentially transmit over short distances, due to greater concentrations of infectious particles in the air near an infectious person.

- However, each pathogen has a signature pattern of observed transmission that extends variably across short-to-long distances and over time, reflecting unique characteristics such as pathogen viability while suspended in the air and the required dose for causing an infection in a susceptible person.

- Pathogens that remain infectious for a long time while suspended in the air (e.g., *M. tuberculosis*, measles virus, and varicella virus) are capable of causing infections over long distances, such as across a large part of a building or healthcare facility.

Transmission Via Touch

- Transmission via touch occurs through physical contact with the pathogen.

- Transmission in healthcare settings can occur via intact skin, non-intact skin (including percutaneous routes such as needlestick injury), or mucous membranes of the face and gastrointestinal tract.

- Transmission by touch can involve intermediary reservoirs such as people, surfaces, or equipment that facilitate spread.

Approach to Transmission-Based Precaution Recommendations

- Recommendations for Transmission-Based Precautions are based on evaluation of clinical epidemiologic studies in healthcare settings.

- Evidence reviews in this guideline focus on clinical studies with infection outcomes because such studies compare prevention strategies in the context of feasibility, user adherence, and implementation within a hierarchy of controls (e.g., engineering, administrative, and personal protective equipment controls) available in the healthcare setting to reduce risk of infection.

- The methodology and evidence reviews informing recommendations in this guideline are available in this guideline's Appendix. Recommendations in this guideline largely address infection prevention strategies available to frontline HCP at the point of care.

Recommendation Formulation and Categorization (From Appendix of the Draft Guideline)

Recommendation Formulation

- The authors conducted a thorough review of the recommendations contained in the 2007 Guideline. This review identified recommendations from the 2007 Guideline that remained relevant in 2023; these recommendations were carried forward as **Standard Practice** and are noted as such in the 2024 update. The authors additionally identified gaps in the 2007 Guideline that required the development of new recommendations.

Recommendation Categorization

- New recommendations also were categorized as **Standard Practice** if they met any of the following criteria:
  - Are consistent with recommendations in current CDC guidelines or guidance (e.g., the Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings)
  - Are consistent with current federal regulations
  - Are consistent with manufacturer instructions for use (e.g., recommendations to follow instructions for proper use or reprocessing)

- New recommendations not categorized as Standard Practice were categorized as **Expert Opinion**, with supporting peer-reviewed literature where available.

Section B: Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings

Overview

- Section B describes the fundamental elements of infection prevention available to frontline HCP in healthcare settings, with a focus on personal protective equipment (PPE). Other important elements, such as hand hygiene and environmental controls, are highlighted, with details referred to other existing guidelines.

- The use of PPE falls within a hierarchy of controls designed to reduce risk of illness or injury for both infectious and non-infectious exposures in the workplace.

- The hierarchy of controls, in preferred order of action based on general effectiveness, has five components:

  - **Elimination** (remove or prevent entry of the pathogen into a facility, e.g., using virtual instead of in-person visits to manage some potentially infectious patients)
  - **Substitution** (although generally not applied to infectious pathogens, refers to substituting a more hazardous agent with a less hazardous form, e.g., substituting toxigenic *C. difficile* with non-toxigenic *C. difficile*)
  - **Engineering Controls** (isolate, capture, and reduce levels of pathogen in the environment, e.g., improving ventilation)
  - **Administrative Controls** (work policies and procedures that prevent pathogen exposure and disease, e.g., vaccination of HCP)

- **Personal Protective Equipment** (PPE used to prevent pathogen exposure and spread)

- PPE is last in the hierarchy because it relies on the user to determine appropriate use (e.g., time, situation) and to use PPE correctly, depends on availability at the point of care, and depends on PPE to function properly. Other components may be more reliable in reducing risk when applied and maintained at the facility level (e.g., ventilation).

Hand Hygiene

- Hand hygiene is a foundational component of infection prevention and control. Routine use of alcohol-based hand sanitizer — and handwashing with soap and water when hands are visibly soiled or when otherwise indicated — prevents transmission of potential pathogens to patients, personnel, and environmental surfaces from hands that are soiled or transiently colonized. Detailed recommendations for hand hygiene are addressed in the CDC Guideline for Hand Hygiene in Health-Care Settings.

Personal Protective Equipment (PPE) for Healthcare Personnel (HCP)

General Considerations Recommendations

1. HCP must be trained and demonstrate competency in the selection, putting on, use, removal, and disposal of PPE. (*Standard Practice*)
2. Employers in healthcare settings are required to provide readily available PPE to HCP, ideally at or near likely points of use. (*Standard Practice*)
3. Sizing and models should be chosen to accommodate the needs of the local workforce. (*Standard Practice*)

Glove Recommendations

Indications

1. Non-sterile gloves are indicated in any of the following situations: (1) any anticipated contact with body fluids or infectious material, (2) touching mucous membranes or non-intact skin, (3) handling soiled items such as used wound dressings, and (4) as indicated by Transmission-Based Precautions. Activities that do not meet these criteria do not require gloves. (*Standard Practice*)

Use

2. HCP should perform hand hygiene prior to reaching into a box of non-sterile exam gloves and putting on gloves, to reduce the risk of contaminating both the remaining gloves in the box and the gloves being put on. (*Expert Opinion*)
3. During care of a single patient, gloves should be changed after a task or procedure if contact occurs with potentially infectious material (e.g., if moving from a dirty task to a clean task). (*Standard Practice*)
4. Remove gloves if torn or soiled, and before caring for another patient. (*Standard Practice*)
5. Hand hygiene should be performed immediately after removing gloves, because pathogens on used gloves can contaminate hands during glove removal. (*Standard Practice*)
6. HCP should not practice extended glove use in place of hand hygiene. (*Standard Practice*)

Selection

7. Non-sterile gloves should be available in a range of sizes so that all users will be able to select a glove that fits comfortably without excess material that could impair function. (*Standard Practice*)

Gown Recommendations

Indications

1. Non-sterile gowns are indicated in any of the following situations: (1) when an activity is anticipated to contaminate HCP clothing through direct touch or splash, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. Gowns should be worn to cover the individual's clothing with all fasteners secured. (*Standard Practice*)

Mask Recommendations

Indications

1. Masks are indicated in any of the following situations: (1) when an activity is anticipated to create splashes or spray to the face, (2) as source control, and (3) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. Masks should not be reused as they can serve as a reservoir of infectious material if they become soiled during use. (*Standard Practice*)
3. Masks should be changed when soiled, damaged, or harder to breathe through. (*Standard Practice*)
4. Extended use is not practiced with masks except when used for source control, and then disposed of when removed or after use when caring for a patient on Transmission-Based Precautions. (*Standard Practice*)

Selection

5. A fluid resistant mask should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

Mask Narrative

- Masks are devices worn over the nose and mouth that perform three primary functions: (1) block direct splashes to the mucous membranes of the nose and mouth, (2) contain exhaled respiratory secretions (source control), and (3) provide filtration of inhaled air.

- Masks include surgical masks, face masks (sometimes referred to as procedure masks), and enhanced barrier face coverings.

- Among mask types, efficacy can vary depending on fit. Well-fitting masks refer to masks that fit closely against the face with minimal gaps, especially along the edges of the mask. A loose-fitting mask may block splashes from reaching the nose or mouth, but may not fully contain the secretions of the wearer or efficiently filter inhaled air. Well-fitting masks may include: any mask approved for use in healthcare that fits well without adjustment; masks with adjustments or modifications, such as knotted ear loops or mask fitters; and enhanced barrier face coverings.

Respirator Recommendations

Indications
1. Respirators are used as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use
2. A seal check should be performed each time an HCP puts on a fit-tested respirator to ensure that the respirator is properly seated on the face. (*Standard Practice*)
3. Single use disposable respirators should not be reused as they can serve as reservoir of infectious material if they become soiled during use. (*Standard Practice*)
4. Reusable respirators must be cleaned, disinfected, and dried between uses according to the manufacturer's instructions for use. (*Standard Practice*)
5. Optimally, extended use is not practiced with single use respirators except when used for source control and then disposed of when removed or after use when caring for a patient on Transmission-Based Precautions. (*Standard Practice*)
6. Respirators should be changed when soiled, damaged, or harder to breathe through. (*Standard Practice*)

Selection
7. A fluid resistant respirator should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

Respirator Narrative

- Respirators are devices worn over the nose and mouth that provide filtration of inhaled air. Respirators work by passing air delivered to the wearer through a filter with defined filtration efficacy. Respirators may perform two addition functions similar to masks: (1) block direct splashes to the mucous membranes of the nose and mouth (if fluid-resistant), and (2) contain exhaled respiratory secretions (source control), if the respirator is the type that filters exhaled air. In most situations, respirators can be worn in place of a mask, whenever a mask is indicated (See **Masks Recommendations: Indications**).

- It is important to limit the amount of inhaled air that comes from leaks around the respirator, because leaked air is not filtered. Filtration efficacy for fit-tested respirators is expected to be greater than that for masks. Factors that influence the decision to use a respirator instead of a mask include pathogen-associated morbidity and mortality from infection, the level of aerosols of infectious particles anticipated to be present, lack of effective treatment or vaccine, transmissibility of the pathogen, and situations in which the major mode of transmission has yet to be determined.

- A respirator's effectiveness is reduced if it is not worn correctly for the entire duration of exposure. Respirators that are uncomfortable or those that are expected to be used for long periods of time may provide challenges with HCP tolerability and compliance.

Eye/Face Protection Recommendation

Indications
1. Eye/face protection is indicated in either of the following situations: (1) when an activity is anticipated to create splashes or spray of potentially infectious material to the face, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. If reusable devices are used for eye and face protection, protocols must be in place for cleaning, disinfection, and drying between uses, per manufacturers' instructions for use. (*Standard Practice*)

Selection

3. The selection of eye and face protective equipment should consider the nature of the activity for which it will be used. (*Standard Practice*)

Environmental Controls: Environmental Cleaning and Disinfection—Narrative

- Environmental surfaces serve as reservoirs for some pathogens that transmit by touch. Routine and targeted cleaning of environmental surfaces, as indicated by the level of patient or HCP contact and degree of soiling, reduces the burden of environmental pathogens. EPA-registered disinfectants that have microbiocidal activity against likely pathogens on surfaces are used according to manufacturers' instructions. Refer to "CDC Guidelines for Environmental Infection Control in Health-Care Facilities" and "CDC Guideline for Disinfection and Sterilization in Healthcare Facilities" for details.

Specialized Air Handling—Narrative

- Airborne infection isolation rooms for containment of air in a designated space (AIIRs) are engineered to prevent flow of air from the room to other parts of the facility (e.g., into the hallway) through use of both negative pressure and 100% outside exhaust (or HEPA-filtered exhaust).

- In addition, these rooms often have a higher number of air changes per hour compared to standard patient rooms, which may provide a higher level of protection to others entering the room. Additional features of AIIRs are described in the CDC Guidelines for Environmental Infection Control in Healthcare Facilities.

- Other environmental controls can be useful components of the layered approach to preventing transmission of infection through air. Although full discussion would be out of scope for the current document, it is important to recognize the importance of interventions such as general ventilation with sufficient delivery rates of clean air to dilute pathogens in air, local exhaust ventilation to capture pathogens at their source, and removal of infective pathogens from air such as by filtration through portable HEPA filters or by inactivation via ultraviolet germicidal irradiation. An advantage of these interventions is that they do not require individual compliance to be effective.

Section C: Precautions to Prevent Transmission of Infectious Agents

Overview

- There are two tiers of precautions to prevent transmission of infectious agents: Standard Precautions and Transmission-Based Precautions. Standard Precautions apply to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious pathogen. **Implementation of Standard Precautions is the primary strategy to prevent transmission of pathogens in healthcare settings.**

- Transmission-Based Precautions apply to the care of patients with known or suspected infectious pathogens, which require additional control measures to effectively prevent transmission. Since a patient's infectious status often is not known at the time of initial encounter with healthcare personnel (HCP), Transmission-Based Precautions are used empirically, according to the clinical syndrome and the likely etiologic agents at the time, and then modified as needed when the pathogen is identified or a transmissible infectious etiology is ruled out.

Standard Precautions

Recommendation

1. Standard Precautions apply to the care of all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered, and at all times. (*Standard Practice*)

Narrative

- Standard Precautions are a group of infection prevention and control practices that are based on the principle that all blood, body fluids, secretions, excretions (except sweat in most circumstances), nonintact skin, and mucous membranes may contain transmissible infectious agents.

- Components of Standard Precautions are defined in the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and include:

  - Hand hygiene
  - Environmental cleaning and disinfection
  - Injection and medication safety
  - Risk assessment with use of appropriate personal protective equipment (e.g., gloves, gowns, masks) based on activities being performed
  - Minimizing Potential Exposures (e.g., having patients and visitors wear a mask when respiratory symptoms are present)
  - Reprocessing of reusable medical equipment between each patient or when soiled

- Performing a risk assessment is central to Standard Precautions; this includes assessment by HCP of their risk of exposure to potentially infectious materials for each activity being performed. Based on that assessment, HCP implement practices and use PPE to prevent possible exposure.

- Performing a risk assessment can be challenging, and HCP might not anticipate all potential opportunities for exposure. To reduce this risk, facilities might choose to systematically apply elements of Standard Precautions to situations recognized as likely to present a risk of pathogen transmission. For example, because it can be difficult to anticipate if a patient with a respiratory infection will cough or sneeze during an encounter, facilities may choose to implement universal use of eye protection by HCP (in addition to the already indicated mask or respirator) for the care of patients with respiratory virus infections.

Transmission-Based Precautions

Recommendation

1. HCP should be trained on how and when to apply Transmission-Based Precautions, including how to put on, correctly use, and remove PPE. (*Standard Practice*)

Narrative

- Transmission-Based Precautions are used when transmission is not completely interrupted using Standard Precautions alone. For pathogens that have multiple routes of transmission (e.g., disseminated herpes zoster virus infection), more than one Transmission-Based Precautions category will be used. Whether applied singly or in combination, Transmission-Based Precautions are used in addition to Standard Precautions. See Appendix A (2007) for recommended precautions for specific pathogens and infections.

- When Transmission-Based Precautions are indicated, acceptance by patients and adherence by HCP may be improved by addressing potential adverse effects on patients (e.g., anxiety, depression and other mood disturbances, perceptions of stigma, and reduced contact with clinical staff).

Syndromic and Empiric Applications of Transmission-Based Precautions
Recommendation

- Use appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs consistent with a transmissible infection, to reduce transmission risk. (*Standard Practice*)

Use of Transmission-Based Precautions to Prevent Transmission by Touch
Recommendations

1. **Contact Precautions** (applies to all healthcare facilities)
    a. Patients are cared for in a dedicated space, preferably a single patient room. See Patient Placement and Patient Transport sections below for more details. (*Standard Practice*)
    b. A gown and gloves are used for all interactions that may involve contact with the patient or the patient's environment. Gown and gloves should be put on upon entry into a patient's designated space (generally defined the patient's bedspace or room) and properly removed and disposed before exiting the designated space. (*Standard Practice*)
    c. Patient-care equipment (e.g., blood pressure cuffs, stethoscopes) is ideally dedicated to the patient and the patient's designated space. Disposable equipment may be used to minimize cross-transmission. If shared patient-care items are used, they should be cleaned and disinfected prior to use with other patients in accordance with the manufacturer's instructions for use. (*Standard Practice*)
    d. In general, clean, unopened patient care supplies should not be stored in the room but should be available near the room to allow easy access while ensuring that large amounts of supplies do not become contaminated. Any disposable supplies that are brought into the room should not be returned to the general supply; they may be sent home with the patient upon discharge if needed (e.g., for dressing changes) or discarded. For clinical areas where supplies are stored routinely within rooms (e.g., outpatient clinic rooms), supplies should be stored in covered or closed clean storage areas. (*Standard Practice*)
    e. Frequent cleaning and disinfection of room surfaces (e.g., at least daily or prior to use by another patient in ambulatory settings) is used to reduce environmental reservoirs of infectious material, focusing on frequently touched surfaces and areas in the immediate vicinity of the patient. See Environmental Infection Control Guidelines for additional details. (*Standard Practice*)

2. **Enhanced Barrier Precautions** (applies to Skilled Nursing Facilities):

a. Enhanced Barrier Precautions are indicated, when Contact Precautions do not otherwise apply, for nursing home residents with multidrug-resistant organism (MDRO) infection or colonization. (*Expert Opinion*)
b. Enhanced Barrier Precautions may be considered for residents at high risk for MDRO colonization, regardless of known MDRO status (e.g., residents with wounds and/or indwelling medical devices). (*Expert Opinion*)
c. Use a gown and gloves for high-contact resident care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (e.g., central venous catheter, urinary catheter, feeding tube, tracheostomy/ventilator management), and wound care. In general, gown and gloves would not be required for resident care activities other than those listed above, unless indicated per Standard Precautions. (*Expert Opinion*)
d. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until the indication for Enhanced Barrier Precaution is resolved (e.g., resolution of wound or discontinuation of the indwelling medical device). (*Expert Opinion*)

Narrative

- Enhanced Barrier Precautions are intended for the prevention of MDRO transmission in skilled nursing facilities. They refer to the use of gown and gloves during high contact resident care activities that risk potential transfer of MDROs to HCP hands and clothing. Preventing this transfer can then help prevent MDRO transmission when HCP perform high contact care activities on other residents. They also take into account the special circumstances of care in a skilled nursing facility (e.g., home-like environment) and barriers to implementing Contact Precautions for residents infected or colonized with an MDRO.
    - For example, MDRO colonization may persist for long periods (e.g., months to years); restriction of a resident to their room on the basis of their MDRO status, as recommended for residents on Contact Precautions, would result in prolonged isolation of the resident to the detriment of their overall health and wellbeing.
- The target MDROs for Enhanced Barrier Precautions may be prioritized by public health and through local risk assessment.
- Enhanced Barrier Precautions may be considered for other congregate settings in healthcare facilities other than skilled nursing facilities (e.g., congregate behavioral health).

Narrative Table 1: Transmission-Based Precautions to Prevent Transmission by Touch (Except Skilled Nursing Facilities)

Category	PPE	Situation	Dedicated Medical Equipment	Single occupancy
Contact Precautions	Gown/glove for all activities	Any entry into designated patient space	Yes	Preferred; if not available, then cohort

Narrative Table 2: Transmission-Based Precautions to Prevent Transmission by Touch for Skilled Nursing Facilities

Category	PPE	Situation	Dedicated Medical Equipment	Single occupancy
Contact Precautions	Gown/glove for all activities	Any entry into designated patient space	Yes	Preferred; if not available, then cohort
Enhanced Barrier Precautions	Gown/glove during high contact resident care activities	When Contact Precautions do not otherwise apply: Indicated for residents with infection or colonization with an MDRO Consider for residents at high risk for MDRO colonization, regardless of known MDRO status (e.g., residents with wounds or indwelling medical devices)	Not required. Clean and disinfect equipment between residents (per Standard Precautions)	Not required

Use of Transmission-Based Precautions to Prevent Transmission through the Air

Recommendations

1. **Routine Air Precautions**
   a. A mask is worn by HCP on room entry, and eye protection is used based on Standard Precautions. (*Standard Practice*)
   b. Private rooms are preferred; if not available, then cohort. (*Standard Practice*)
   c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Standard Practice*)
   d. Source control masking should be used by the patient when they leave their room (e.g., for transport to a procedure). (*Standard Practice*)

2. **Special Air Precautions**
   a. A NIOSH-approved® fit-tested N95 (or higher-level) respirator and eye protection are worn by HCP on room entry. (*Expert Opinion*)
   b. A private room is indicated. (*Expert Opinion*)
   c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Expert Opinion*)
   d. Source control masking is indicated for the patient when they leave their room (e.g., for transport to a procedure). (*Expert Opinion*)

3. **Extended Air Precautions**
   a. A NIOSH-approved® fit-tested N95 (or higher-level) respirator is worn by HCP on room entry, and eye protection is used based on Standard Precautions. (*Standard Practice*)
   b. A private room is indicated. (*Standard Practice*)
   c. An AIIR is required. (*Standard Practice*)
   d. Source control masking is indicated for the patient when they leave their room. (*Standard Practice*)
   e. Travel outside the room should be limited (e.g., for necessary procedures and treatments). (*Standard Practice*)

Narrative

- The previous categories of Droplet Precautions and Airborne Precautions have now been divided into three categories to better reflect the continuum of transmission for reasons

described in Section A. Pathogen-specific recommendations may be found in Appendix A (2007), which will be updated with interim suggestions for how facilities may map existing categories to new categories of Transmissions-Based Precautions, until recommendations for all pathogens have been updated.

- Routine Air Precautions are focused on reducing transmission of common, often endemic, respiratory pathogens that spread predominantly over short distances based on observed patterns of transmission, and for which individuals and their communities are likely to have some degree of immunity.

- Special Air Precautions are applied to patients with a respiratory pathogen, typically new or emerging, that is not observed or anticipated to spread efficiently over long distances (such as through ventilation systems), for which infection generally leads to more than mild illness, and where immunity (or vaccine) and effective treatment are not available.

- Extended Air Precautions are used when providing care to patients with pathogens that are observed to spread efficiently across long distances and over extended times, such that room air needs to be contained (e.g., prevented from moving into the hallway where individuals are not appropriately protected).While not required for Routine Air Precautions, HCP may choose voluntarily to wear a NIOSH-approved® N95 (or higher-level) respirator, per existing federal regulations.

- For Routine and Extended Air Precautions, eye protection may be added as required PPE based on infection control risk assessment performed by the facility for specific pathogens (e.g., implementing eye protection for care of all patients with respiratory viral infections during periods of high incidence in the community or facility).

- For Special Air Precautions, although an AIIR is not routinely recommended, an AIIR may be suggested for certain pathogens listed in Appendix A (2007), and for pathogens with uncertain transmission characteristics.

Air Narrative, Table 3: Transmission-Based Precautions to Prevent Transmission through the Air

Category	Mask or Respiratory Protection	Eye Protection	AIIR[a]
Routine Air Precautions	Mask	Per Standard Precautions	Not routinely recommended
Special Air Precautions	NIOSH-approved® N95 (or higher-level) respirator	Yes	Not routinely recommended
Extended Air Precautions	NIOSH-approved® N95 (or higher-level) respirator	Per Standard Precautions	Yes

AIIR[a] = Airborne Infection Isolation Room for Containment of Air in a Designated Space

Special Situations
Narrative

- Some procedures performed on patients may be more likely to generate higher concentrations of aerosols of respiratory particles than others. There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of these procedures (sometimes called “aerosol-generating procedures”) for healthcare settings. Certain procedures that involve manipulation of the patient’s airway and close proximity between the patient and the HCP may increase risk of pathogen transmission by air. Facilities may perform an infection control risk assessment to implement Special Air or Extended Air precautions for patients with certain target pathogens, or for all patients regardless of symptoms or confirmed infection, during certain higher risk procedures.

Source Control
Recommendations

1. During periods of higher levels of community respiratory virus transmission, facilities should consider implementing one of the tiers of source control:
    a. Having HCP mask when interacting with patients (e.g., on entry to the patient’s room or bedspace). (*Expert Opinion*)
    b. Having all individuals (e.g., patients, visitors, and HCP) mask upon entry to the facility or a clinical area. (*Standard Practice*)

2. Source control measures can be implemented facility-wide or targeted toward higher risk areas (e.g., emergency departments, urgent care, bone marrow transplant units, or units experiencing an outbreak) based on a facility risk assessment. (*Standard Practice*)

Patient Placement
Recommendations

1. Single patient rooms are the preferred option for patients requiring Transmission-Based Precautions, whether to prevent transmission by touch or through the air. (*Standard Practice*)

2. In long-term and other residential settings, room placement decisions should balance risks to the infectious individual and to other patients. (*Standard Practice*). Residents in Enhanced Barrier Precautions do not require placement in a single person room. (*Expert Opinion*)

3. In ambulatory settings, patients requiring Transmission-Based Precautions should be placed in an exam room or cubicle as soon as possible rather than waiting in common areas. (*Standard Practice*)

4. If single patient rooms are not available, patients housed (cohorted) in the same room should have the same pathogen infection or colonization status to the greatest extent possible. (*Standard Practice*)

5. Any time room sharing occurs, practices need to be in place to limit potential for cross-contamination, including ready access to hand hygiene supplies, changing PPE between roommates, and dedicating patient care items or cleaning and disinfecting shared equipment after each use. (*Standard Practice*)

Transport of Patients
Recommendations

Patient Considerations

1. Patients under Transmission-Based Precautions (with the exception of Enhanced Barrier Precautions alone) should leave their room only when medically necessary for their evaluation or care. (*Standard Practice*)

2. If the patient is being isolated for a pathogen transmitted through the air, they should use source control, (i.e., wear a mask), any time they are outside of their room, unless a mask is medically contraindicated or the individual is not capable of wearing a mask safely. (*Standard Practice*)

3. If the patient is cared for using Contact Precautions for a pathogen transmitted by touch, appropriate barriers (e.g., clean patient gown, wrapping sheet, or impervious dressing) should be used to cover affected areas of the patient's body during transport when infectious skin lesions or drainage are present. (*Standard Practice*)

4. Before transport, direct communication with the HCP receiving the patient is required to ensure notification regarding the nature of the infection, the type of Transmission-Based Precautions required, and when the patient will arrive. (*Standard Practice*)
    a. Communication at time of transport applies to within-facility transfers and between-facility transfers. (*Standard Practice*)

Transporter Considerations

1. HCP transporting patients should follow Standard Precautions for pathogens to avoid spreading infectious material during transport. (*Standard Practice*)
    a. This includes performing hand hygiene before beginning transport, ensuring that wheelchairs and gurneys used for transport have been cleaned and disinfected prior to use, putting on all appropriate PPE prior to contact with the patient when assisting with patient movement at the destination location, and removing and discarding soiled PPE. (*Standard Practice*)

2. PPE might be recommended during transport in certain circumstances:
    a. When transporting a patient with a pathogen that presents a high risk for morbidity and mortality for HCP (e.g., Ebola virus), all pathogen-recommended PPE should be used. (*Expert Opinion*)
    b. When transporting a patient with a pathogen transmitted through the air, the transporter should carry a mask or respirator with them based on the recommended Transmission-Based Precaution category. If the patient is unable to wear a mask for source control or if the patient will require medical care during transport (e.g., suctioning), the transporter should put on a mask or respirator prior to assisting the patient. (*Expert Opinion*)
    c. When transporting a patient with a pathogen transmitted by touch, gloves might be used if there is a need to touch the patient during transport (e.g., a clean pair of non-sterile gloves can be carried, put on prior to assisting the patient and discarded immediately afterward and followed with hand hygiene). (*Expert Opinion*)

3. If a patient on Special Air Precautions is unable to wear source control, or if a patient is on Extended Air Precautions for a highly contagious infection (e.g., varicella or measles), the transport route and process should include a selection of the time and route of travel within

a facility to minimize exposure of others during transport (*Expert Opinion*), and use of appropriate PPE by staff during transport and at the destination location. (*Standard Practice*)

Use of Personal Protective Equipment by Visitors
Narrative

- The use of PPE (e.g., gowns, gloves, or masks) by visitors in healthcare settings may be considered, particularly in settings where they are providing hands-on care and having very close patient contact (e.g., feeding, dressing). In these situations, visitors may have contact with other patients or the environment and could contribute to transmission if PPE is not used. Specific recommendations may vary by facility or by unit and are determined by the level of interaction and the suspected or proven infection for which Transmission-Based Precautions might be recommended.

Visitors as Sources of Infection
Narrative

- Visitors, including patient family members, have been identified as the source of several types of healthcare-associated infections (e.g., pertussis, M. tuberculosis, and respiratory viruses). Visitor symptom screening can reduce risk of healthcare-associated infections and may be especially important for high-risk patient care areas, such as oncology and neonatal intensive care units.

- Visitor symptom screening may be passive (e.g., using signs that alert visitors with symptoms of infection not to enter clinical areas) or active (e.g., asking each visitor to report current symptoms and recent exposures to persons with infection or relevant travel, with subsequent review by facility staff to determine whether the visitor can proceed with visitation).

Discontinuation of Transmission-Based Precautions
Narrative

- In general, Transmission-Based Precautions are intended to remain in effect for limited periods of time (i.e., while the risk for transmission of the infectious agent persists or for the duration of the illness). For most infectious diseases, this duration reflects known patterns of persistence and shedding of infectious agents associated with the natural history of the infectious process and its treatment. Colonization with MDROs can persist for months to years.

- In acute care hospitals, Contact Precautions are often left in place throughout the entire admission or may have a set duration based on repeat testing or symptom resolution.

- In nursing homes, Enhanced Barrier Precautions are used to better accommodate the communal and residential environment of the setting and are left in place for the duration of the resident's stay or until their risk factors have resolved (e.g., indwelling medical device is removed or wound is healed).

- Refer to Appendix A (2007) for pathogen/disease specific recommendations.

Discussion Points

At various points during the initial presentation, HICPAC (voting) members, HICPAC ex officio members, and HICPAC liaisons raised questions, made observations, and provided

suggestions pertaining to Section A, Recommendation Formulation and Categorization (from Appendix), Section B, and Section C. The discussion points are summarized as follows:

Section A: Overview of Transmission of Infectious Agents

- Perhaps it would make sense to include a general introduction section that describes topics that are deferred to other existing guidelines.

- This section uses the term "point of care" versus "point of use." Perhaps "point of use" should be used throughout because some of the interventions are not done at the "point of care" by the individuals who are delivering care.

- Later in the guideline, there will be recommendations that are described as "standard" or "expert opinion." Perhaps it would be helpful in this introduction section to describe what is meant by each of these terms.

- Under "Air" there is mention of "inoculating dose." That probably should be mentioned higher up under factors that affect transmissibility to be more general because that is true for all pathogens, particularly for fecal, oral, and gastrointestinal pathogens. For lower inoculum pathogens such as norovirus, there is concern about person-to-person transmission such as in a playroom or the higher ones such as salmonella, food, and waterborne that have less person-to-person transmission.

- The beginning mentions healthcare settings. Perhaps it would be beneficial to define exactly which healthcare setting to which this will apply (e.g., all healthcare settings, acute care, home care, et cetera). Dr. Wright clarified that the intent was to apply to all healthcare settings.

Recommendation Formulation and Categorization (from Appendix)

- This provides clarity on Standard Practice and should be helpful for those working on the front line.

- Highlighting this in the introduction would drive the reader to the Appendix to better understand this point.

Section B: Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings

Overview

- It is not clear whether the example given for engineering controls means improving ventilation specifically or the use of specialized pressurization, or if it was more conceptual:

    - Dr. Wright indicated that she did not think the WG meant anything specific in this particular section for environmental controls. This was more about efforts that would be made at the facility level rather than for frontline HCP.

    - The WG discussed how precise the environmental information should be. The thought was to link the reader to the CDC Environmental Infection Control Guidelines that is more detailed with regard to ventilation, air handling, UV, and other options.

- It would be preferable to use the term “point of use” rather than “point of care.”

- This section seems to suggest that selection of PPE is at the individual-level, given the bullet that states, “PPE is last in the hierarchy because it relies on the user to determine appropriate use . . .” However, the tie back to facility protocol is not made clear. The way this is worded, it relies on the user to make an individual and subjective decision as opposed to something that is based on a facility’s protocol. There is tremendous confusion and hesitancy for families in terms of entering facilities. Patients feel that they are their own best advocates in situations where a facility is not making clear what the individual HCP needs to do around a vulnerable patient, such as a transplant patient. Any type of messaging has to include HCP and members of the public who may be contemplating entering a facility for an elective procedure and their family:

    - Dr. Wright clarified that as they moved through the recommendations, there would be more about protocols and some specifics about user and facility responsibilities.

Hand Hygiene

- Perhaps “or an antiseptic” could be added in parentheses to the line pertaining to “alcohol-based hand sanitizer” and “handwashing with soap and water.” Some practitioners use chlorhexidine with water rather than bland soap.

- However, some facilities do not use chlorhexidine. Perhaps there is a different way of stating this that covers the options available so that no one feels the need to change to something else.

PPE for HCP: General Considerations: Recommendations

- The terms “donning” and “doffing” are used more readily in describing PPE. For the reader, it might be appropriate to use those terms here instead of “putting on” and “removal.”

    - Dr. Wright indicated that it was a conscious decision of the WG to use “putting on” and “removal” and specifically avoid the use of “donning” and “doffing” to be more easily interpretable by all levels of staff.

- Dr. Bell noted: Regarding sizing and models, there is selection for local workforces. However, many instances have been reported about the incorrect models and sizes being received during the crisis. Perhaps there is a place to flag the importance of being prepared to share that information with local jurisdictions or others in the event of a crisis. This information could go beyond just healthcare epidemiologist/infection preventionist awareness and be more easily shared with external organizations that might be delivering supplies and others who might be engaging initially with additional surge supplies, et cetera. This is not concrete enough to rise to the level of a recommendation, but something could be included in the narrative:

    - A WG member indicated that the WG discussed surge and recalled that a paragraph was included about surge planning. Additional information and examples could be added.

- It might be useful to share that ensuring that adequate PPE supplies are available can be achieved by engaging local supply chains and that it is not only during surges. It is important

to make sure that appropriate PPE is always available for HCP. This could go in the overview for Section B or the narrative.

PPE for HCP: Glove Recommendations

- Perhaps it would be stronger in the *Indications* component to state clearly that "gloves should not be worn for activities that do not meet these criteria" instead of "activities that do not meet these criteria do not require gloves." The evidence supports that the use of gloves when not indicated results in failures of hand hygiene and risks to patients.

- Regarding the *Indications* component, mention of "anticipated contact with body fluids" has been accompanied by "with the exception of sweat" in the past. It was not clear whether this was a deliberate omission. It would dramatically increase the use of gloves for routine healthcare since almost everyone presents with some sweat on them. The question regards whether sweat should be part of Standard Precautions:

  - Dr. Kofman pointed out that for Ebola and some of the viral hemorrhagic fevers (VHF), sweat is included as a potential transmissible body fluid.

  - Dr. Wright added that the WG would discuss this further.

PPE for HCP: Gown Recommendations

- This is another area that describes topics that are not covered by the guideline (e.g., the NIOSH recommendations). If there is a section at the front stating that certain topics, for example choice of the gowns, are not covered and to refer to other guidelines, this might be a place to state that there are many other guidelines that are informed and related to this guideline:

  - Dr. Wright noted that for the sake of time, only the recommendations were being presented. In the narrative, there is a reference to NIOSH and a link directly to the NIOSH guideline.

- Removal of the gown is a fragile component of the process, but there is nothing specific in this section:
  - Dr. Wright confirmed that while there is a reference to donning and doffing sequence, there is nothing specific in this section. The WG will revisit this.

- Regarding use, there is a statement about covering the individual's clothing. Perhaps something should be included about the arms in case someone is wearing a short-sleeved shirt:
  - Dr. Wright indicated that the WG could review prior wording, and they would have an opportunity in the upcoming Part 2 to address PPE with respect to specific pathogens.

  - Dr. Bell added that the rationale for protection of clothing is so that the gown (unlike clothes) does not have to be taken off and washed if something gets on it. There has been a routine reliance on washing things off, such as washing the wrists off if there is a splash versus taking a hermetically sealed approach.

  - It was pointed out that gowns are designed in a certain style based on the way they are expected to be used. If this is too prescriptive, people may begin to think that

they have options. However, there really are not any options. Facilities set the protocols for what type of PPE is acceptable.

- One suggestion would be to state, “Gowns should be worn to cover the individual’s clothing and any exposed skin with all fasteners secured.”

- Dr. Bell agreed that the pragmatic approach makes sense but flagged that with all PPE that is used for contact by touch, there always are gaps. Gloves are not taped to the gown, sealant is not put on at the neck, and there are gaps in facial protection. There is a tendency to overextend, especially when people are frightened. He cautioned about making that insinuation. Thinking back to 2014 and Ebola, people literally put duct tape on their necks and caused themselves injury because they were worried. While he did not want to recreate that unnecessary worry, at the same time he does not want to create a new problem such as short-sleeved gowns.

- One way to address this would be an emphasis on the importance of the doffing technique. No PPE is perfect and that is a point at which the risk of self-contamination and cross-contamination. Any language related to that and the training of HCP addresses that important point broadly across all forms of PPE.

PPE for HCP: Mask Recommendations and Narrative

- In terms of extended use for source control, it is not clear whether this is truly considered to be a Standard Practice for HCP prior to the pandemic. It is understandable when used as a source control for patients or visitors. It also is not clear whether extended use is truly permitted as a Transmission-Based Precaution:

    - Dr. Wright responded that the wording was confusing, and the intent was that the mask would be disposed of after use when used for a patient on Transmission-Based Precautions. The WG will revise the wording.

    - Dr. Lin added that Mask Recommendation #4 mapped to “Strategies for Conserving the Supply of Medical Masks” NIOSH/CDC. That is contained in the “Conventional Strategies” part of that document.

    - There needs to be clarification about Standard Practice or Expert Opinion. As defined, Standard Practice is based on prior guidance. It is important to be able to reference back to prior guidance.

    - There is a precedent for extended use. During influenza season, some facilities have required unvaccinated HCP to use source control with a mask and they were allowed to engage in extended use of those masks. The stipulation is to change the mask if it becomes soiled, damp, or used when caring for a patient who was on droplet precautions or other Transmission-Based Precautions.

    - There often has been confusion about extended use and reuse. If there is an opportunity to flag this as not being reuse, that could be helpful to readers. Dr. Wright pointed out that #2 specified that masks should not be reused.

- Historically, HCP have been told not to modify their PPE. However, people have been set up for an almost impossible situation because it says the mask must be tight-fitting, yet it is not tight-fitting out of the box.

- Perhaps a caveat could be added to not change the structure or integrity of the PPE and add “in accordance with the manufacturer's recommendations” so that people are not inadvertently changing the actual structure or function of the PPE.

- Dr. Lin read lines 123-129 of the draft document:

  → “Reuse” refers to the use of the same PPE item for multiple encounters with different patients, with removal of the PPE item between encounters. PPE can consist of products that are labeled for single use or as reusable. Single use PPE is not intended to be reused. Reusable items are reprocessed between uses according to manufacturer’s instructions for use.

  → “‘Extended use” refers to use of the same PPE item for encounters with different patients, without removing the PPE item between patient encounters. Extended use is not considered standard practice and should be avoided unless otherwise specified in recommendations (e.g., extended use of masks for source control).

- In terms of the Mask Narrative section and enhanced barrier face coverings, generally the focus in health care is Levels 1, 2, and 3 of face masks. Much of well-fitting versus loose-fitting depends upon the facial structure and the design of the mask. Generally, no modifications are to be made to PPE. It is supposed to be worn as described in the instructions. For instance, mask fitters can be purchased but are not part of the NIOSH guidelines. Mask fitters could render the mask less effective, given that masks were not created with a mask fitter in mind:

  - This is not a recommendation. It is part of the narrative and is something that the WG felt belonged there. Dr. Wright recalled that the WG’s intent was that the use of PPE in order to make it have a better fit to the face was something that everyone practiced during the pandemic, but there is no guidance for that. There is a type of mask that is being developed that is not yet approved for use. The WG was trying to make a place for it as that guidance comes forward. While they can be purchased now, they are not approved for medical use yet (Note: this refers to barrier face coverings that adhere to ASTM F3502).

  - Dr. Bell added that there is still an FDA hurdle to have a medical device approval. The fact that these masks are made of better filtration material, fit better in general, and are less burdensome than formal respiratory protection might be an opportunity in the future to replace medical masks, such as surgical masks, with something that is better made. This is an attempt to acknowledge that they exist and have people start thinking about them.

  - Perhaps it would be helpful to note “once approved for use in facilities” to make it clear that the new mask (i.e., barrier face coverings that adhere to ASTM F3502) is not yet FDA-approved.

  - This also might be a good opportunity in the guideline itself to give examples and then make sure that facilities designate specific modifications that are permissible. It is unlikely that manufacturers will be persuaded to provide modifications, so this should be placed on the facility. Suggested wording, “Only facility-approved modifications may be made to masks. Modifications should not reduce the effectiveness of the mask.”

- In the mask and respiratory sections, it would be worth including something about how facial hair impacts efficiency of masks and respirators and can render them much less efficient. Masks and respirators are designed to be worn on cleanly shaved individuals and hair does interfere with protection from aerosols.

- Some studies have shown that simple modifications, such as using a figure 8 for the ear loops or a clip behind the head make the user more comfortable and results in 50% improvement of the effectiveness of the mask.

PPE for HCP: Respirator Recommendations and Narrative

- There is concern about the first bullet of the narrative stating that “In most situations, respirators can be worn in place of a mask . . .” The first recommendation is to utilize N95 respirators as indicated by Transmission-Based Precautions. It is not clear why a respirator would be worn in place of a mask when a mask is what is indicated per either Standard or Transmission-Based Precautions (e.g., it is not a substitute):

  - Dr. Wright clarified that the narrative is not necessarily only in support of the recommendations. There are some things in the narrative that are not strong enough to meet the level of a recommendation, but the WG felt that they should be included and that the narrative also should include descriptions of other uses for these types of PPE.

  - There was still concern that these detract from the initial recommendation that these are worn per Transmission-Based Precautions because then the narrative says that a respirator can be worn as a substitute for a mask. However, a mask has very specific indications that were just specified.

  - Dr. Lin clarified that the distinction for the narrative was that it focused more on function than indication. When the WG was writing 1 and 2 in the first paragraph of the narrative about blocking splashes and respiratory secretions, the follow-on sentence was to recapitulate some of the aspects of function of the mask and not necessarily indications.

  - Perhaps revising the last sentence of the first paragraph in the narrative to state, “as with masks, respirators function . . .” so that it does not sound like a substitute.

- The occupational Respiratory Protection Program (RPP) program should be pulled out because it is not related to Transmission-Based Precautions and seems out of place:

  - Dr. Wright indicated that the last paragraph references the RPP that complies with standards established by the Occupational Safety and Health Administration (OSHA). This is shown in the Draft Guideline lines (pages 251–255), but was not included on the slide that was shown. While she understood the point, the issue was

that it is an OSHA regulation that respirators need to be available even if they are not being used for PPE. The purpose of this section was to make sure people are aware of the RPP program.

  - The WG had a lot of discussion about this. Based on practical experience and thinking about the person who is going to be using this document and teaching to it, it references where someone can go for help and offers additional information and a link to a toolkit. It also speaks to personal choice use of an N95 and how it does not require fit testing. It is important to show the linked documents.

  - Perhaps the links could be kept to OSHA, but the statement could read, "when worn per Transmission-Based Precautions" because this whole section is about the use of N95s per Transmission-Based Precautions.

  - Dr. Lin noted that the purpose of that sentence was to contextualize that respirators are part of an RPP. There was not an intent to go further than to ensure that people are aware that it is part of that program. This can be worded better to make sure that it is focused on just the intent.

- In terms of the sentence in the last bullet in the narrative regarding respirators that are uncomfortable, there is a lot of evidence to support that they in fact do provide challenges with HCP tolerability and compliance. It is important to highlight that this does pose challenges and if it is difficult to comply, respirators cannot actually be effective.

- Recommendation 1 is that respirators are used as indicated by Transmission-Based Precautions, while Recommendation 5 calls out use as source control. This implies that they can be used for source control, which raised a question about whether that was the intent. Perhaps it would be worthwhile to include that in Recommendation 1 to mimic what is done with the mask recommendation, which calls out Transmission-Based Precautions and source control.

PPE for HCP: Eye/Face Protection Recommendations

- Perhaps it would be clearer to use "eye and face" rather than "eye/face." Some people may interpret the slash as "and" or as "or."

- More clarity is needed about what is meant by "face." Does it mean protecting the whole face with a face shield? This could be confusing to people:

  - Dr. Wright noted that this is included in the narrative but was not included in the slide deck for the sake of time.

  - Dr. Bell added that it really is mucous membranes they are trying to keep from being exposed. Perhaps it would be helpful to be more specific as opposed to using the word "face." They were not trying to send the message that the entire face is at risk, it really is the mucosa of the eyes, nose, and mouth. Perhaps it would be helpful to include that in the narrative.

  - Perhaps this could be addressed in more detail in the pathogen-specific section, because there are times when the full face is recommended to be covered (e.g., Ebola), while an option is given for other pathogens.

- "Eye protection" actually has a definition. Sometimes HCP think that their personal glasses are eye protection and that they do not need the requirements. Perhaps PPE that is created for this purpose could be identified in the recommendation, which would address that issue:

    - Dr. Wright pointed out that there is a statement in the last section of the narrative about eyeglasses not providing protection.

- Often there is eye protection for which the manufacturer's instructions for use are impossible to implement or do not include allowance for use of low-level disinfectants that are used in healthcare facilities. This is a difficult situation because it is not clear what should be done to clean eye protection in between uses:

    - The guideline talks about cleaning reusable devices between uses. Perhaps it would be of value to call out extended use and perhaps mirror the language used in some of the other recommendations. Extended use is okay, but once a HCP enters a Transmission-Based Precautions room, it must be cleaned.

- There is mention in the narrative of using face protection as a barrier to prevent the wearer from inadvertently touching their eyes. People touch their eyes all the time, yet people are not required to wear eye protection all day long.

- A question was posed about where the narrative would be, if it would be a visible part of what people would look at in connection with these guidelines. In reality, people on the frontline may not jump by to the narrative to find more details:

    - Dr. Wright indicated that the idea was to have this guideline be similar to the HCP Occupational Health Guideline in which the recommendations are listed first and followed immediately by the narrative. This would be visible to all staff. Infection prevention teams at all healthcare facilities review these documents and then build the narrative and recommendations into their education for staff.

    - A HICPAC Liaison added that in their groups and facilities, the narrative is a key part of the way that they use the recommendations and the entire document. Both the recommendations and the narrative form the basis for how their internal policies and recommendations are developed. They are visible to everyone all in one document when posted on the website.

Environmental Controls: Environmental Cleaning and Disinfection: Narrative

- Perhaps "routine and targeted cleaning" would be better to read "routine and targeted cleaning and disinfection." Cleaning is the physical removal of dirt and microbes, while disinfection is much more effective in eliminating microbes.

- Consider adding a link to the EPA table that refers to the specific disinfectants for various organisms. This includes a very long list of all the approved agents and the contact times, which is very useful.

Specialized Air Handling: Narrative

- Perhaps a reference to "protected environment" would make sense in terms of protection of patients against fungal pathogens. Given that this is a form of specialized air handling, it

seems out of place to reference airborne infection isolation room (i.e., AIIR) without at least referencing other recommendations related to their use.

- If ultraviolet germicidal irradiation (UVGI) is going to be mentioned, perhaps reference should be made to current knowledge and recommendations related to this, which is in very specific situations. There is interest in this topic; it is sometimes applied in situations where it is not recommended, and the recommendations are currently very narrow for these types of interventions.

- It would be beneficial for CDC to be stronger in the discussion of the use of ventilation. While inclusion of ventilation is appreciated, it seems somewhat soft and needs more language to substantiate that this is imperative for facilities to do some major work on general ventilation:

    - Dr. Wright pointed out that the majority of this guideline is focused on what frontline staff are able to do to prevent transmission. The other documents for which links are provided describe more about the requirements for facilities and recommendations. The WG felt that getting into more detail here was out of scope for this document.

Section C: Precautions to Prevent Transmission of Infectious Agents

Overview
- No additional comments.

Standard Precautions
Recommendation
- No additional comments.

Narrative
- In the third paragraph, the section on risk assessment is central. The last line mentions “to prevent such exposures.” Perhaps this also should include “and self-contamination.” A major reason those PPE elements would be worn would be not only to prevent the potential for exposure, but also the self-contamination that could lead to risk to patients:

    - Dr. Bell noted that while risk assessment is easy to say, it is tough to implement. He wondered whether there was any additional heft, context, or detail anyone could suggest to stress the importance of risk assessment.

    - Perhaps application of existing screening tools could be emphasized in terms of Standard Precautions. For instance, Ascension has a Global Infectious Disease Screening Tool that is utilized every time a patient presents that helps to identify what type of Standard Precautions should be used by HCP.

    - Dr. Lin clarified that this might be blending in a level of syndromic application of Transmission-Based Precautions where based on symptoms or epidemiology, Transmission-Based Precautions are applied. While it is related to this discussion, the goal here is to try to give examples of specific actions or activities that HCP are doing that may need a higher level of PPE. In the interest of time, examples in the draft document were not included on the slide. The rest of the paragraph in the draft

document states, “For example, when planning to irrigate a wound and perform a dressing change, HCP would anticipate the potential for splashes and sprays during irrigation and the potential for contact with the wound or contaminated dressing materials. To prevent such exposures, they would put on gloves, a gown, eye protection and a mask prior to performing the activity.” This may be difficult in some cases for HCP to recognize and is a challenge from an education perspective.

  - One suggestion for potentially elevating this is in the narrative or in a recommendation would be to emphasize that part of training should focus on conducting a risk assessment. A lot of this has to do with the pressures surrounding HCP that impede them from making a risk assessment or taking the time once a risk assessment is done, which may happen in the middle of a task when the HCP suddenly realizes that there is a draining wound and that they need to pause and put on the appropriate PPE. In terms of real practice, emphasizing the “time out” or “taking a pause” before walking in the door is one way to elevate this.

  - People might perceive the guideline as trying to be all-inclusive if too much is included. Perhaps a website could be developed to guide Infection Preventionists (IPs) on how to teach to these precautions based on their facility. Critical thinking needs to be put into place, but that can be challenging.

  - Risk assessment starts upstream with education and demonstration of competency. It is the organization’s (healthcare facility’s) responsibility to identify areas where risks occur and educate and train staff to ensure that they are competent to choose PPE in the situations in which they need to use it, as well as the types of PPE. Competency-based training is often learned during nursing or medical school but may be outdated or not up to the expectations of one’s organization. Consideration must be given to the baseline education HCP will need to demonstrate that they are competent to choose PPE in the situations in which it is required and choose the type of PPE that will protect them.

  - To meet the goal of trying to highlight the importance of risk assessment, perhaps comments could be added to the narrative that focus on training and expectations and institutional needs to provide that so that staff are adequately prepared to make risk assessments in the moment.

  - There are electronic triggers that can steer HCP or frontline workers toward what needs to be done. Perhaps something could be added to the narrative about this.

- Regarding the fourth paragraph stating “in addition to the already indicated mask or respirator” it might be helpful to add “depending on the pathogen” because these are chosen based on the risk assessment.

- Also in the fourth paragraph, rather than “facilities may choose to implement *universal* use of eye protection by HCP” perhaps the word “routine” in place of “universal” would better convey the idea that one would routinely wear eye protection in such circumstances.

Transmission-Based Precautions
Recommendation

- Perhaps this same statement made in Transmission-Based precautions recommendation #1 is needed in Standard Precautions.

- Relevant to highly communicable pathogens, perhaps the phrase “dispose of” should be added to the end of the recommendation to read, “HCP should be trained on how and when to apply Transmission-Based Precautions, including how to put on, correctly use, remove, and dispose of PPE.”

Narrative

- In the last sentence of the second paragraph regarding adverse events (AEs), this is an expanding literature and it is not absolutely clear that patients who are placed on Transmission-Based Precautions experience all of these. While the word “potential” is included, some of these potential impacts are perhaps not as present as they were thought to be in the past.

Syndromic and Empiric Applications of Transmission-Based Precautions
Recommendation

- It is important to consider that certain people who are colonized may be asymptomatic but can still transmit a pathogen:

    - Dr. Wright noted that this would fall into pathogen-specific material in the updated Appendix A(2007).

    - While some risks are pathogen-specific, there are times when Transmission-Based Precautions are used besides when patients develop signs and symptoms, either when they have been diagnosed or are at risk of developing illness from having been exposed.

    - One approach might be to split this as syndromic and empiric and just empiric, which may be based on an asymptomatic individual with an appropriate exposure. While this could be addressed in the Appendix A(2007) approach, in the setting of and exposure, asymptomatic but colonization, or expected potential colonization, some of these may be implemented.

    - Dr. Lin noted that the main thrust of this section was to direct HCP to think about signs and symptoms. It is not clear whether the asymptomatic patient belongs here or in another section. This is an uncommon but important gap that does come up sometimes.

    - Perhaps “suspected or known to have a transmissible infection, based on either signs and symptoms or on other reasons (e.g., epidemiologic)” could be added.

Use of Transmission-Based Precautions to Prevent Transmission by Touch
Recommendations

- No additional comments.

Contact Precautions

- Perhaps more specificity is needed about cohorting.

- The use of the phrase “patients are cared for in a designated space” in 1.a is appreciated as it relates to dialysis facilities, because it acknowledges that there are places that do not necessarily have rooms. The phrase “preferably a single patient room” sometimes causes a problem because it may lead some facilities to assume that they cannot care for certain patients if they do not have a single patient room. Perhaps the phrase “preferably a single patient room, if available” would address this.

- The second sentence in 1.b uses the term “upon entry into a patient’s designated space,” but “designated space” might be defined differently by different facilities. However, the interactions are really about the contact with the patient and environment. As written, “upon entry” sets people up to just crossing the threshold requiring the use of gowns and gloves, which is not necessary. In addition, crossing the threshold does not necessarily mean the HCP would have contact with the patient or the environment:

    - Dr. Lin noted that previously this was worded as “entry into a patient’s room.” The rewording into “designated space” allows for healthcare facilities to designate something different than the room. Of course, there are other situations in which a room does not apply such as post-operative units. The way this is intended is to allow for some designation if healthcare facilities to choose to say that there is a space within the room that is not considered “designated space.”

    - Perhaps it would be better to state “when contact with the patient or environment is anticipated.” Otherwise, it seems to read that the gown and gloves should be put on when entering a location.

    - The table in the narrative also has “any entry into designated patient space.” Some read “room or designated space” initially as space in places where there are bays, such as a post-anesthesia care unit (PACU) or emergency department (ED) space. It does not read as if a space could be designated within a room. There seems to be some opportunity to clarify the intent of the language in the recommendation or narrative.

- In 1.d regarding patient care supplies, the last sentence that states “supplies should be stored in covered or closed clean storage areas,” it would be helpful to add “and hand hygiene performed before accessing them.” A problem that is seen routinely is that clean supplies are accessed with contaminated hands or gloves. Therefore, they are no longer clean and present a risk to patients.

- There is nothing in this section about restriction of residents to rooms, although this is included in Enhanced Barrier Precautions states in 2.d that “Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions . . .” It is not clear whether the concept is that Contact Precautions patients are restricted to their rooms. This needs to be clarified in Contact Precautions:

    - Dr. Lin indicated that perhaps the issue of patients leaving rooms could be addressed for Contact Precautions to make sure it is covered, but noted that this guideline is not intended to change current practice. There is discussion about patient transport in hospital and general settings. In the Transport of Patients recommendations, item 1 under Patient Considerations states, that “Patients under

Transmission-Based Precautions (with the exception of Enhanced Barrier Precautions alone) should leave their room only when medically necessary for their evaluation or care (*Standard Practice*)." This potentially could address the issue of Contact Precautions.

Enhanced Barrier Precautions

- 2b states that Enhanced Barrier Precautions "may be considered for residents at high risk for MDRO colonization, regardless of known MDRO status," but it seems that this should read, "with no known MDRO status."

- For Enhanced Barrier Precautions in nursing homes, when residents are out of their rooms in common areas where they are congregating with others (e.g., lunch, dinner, activities), some have much more activity than others. Exposure varies depending upon the mobility of residents and their activities. There is no discussion about how much activity residents can engage in outside of their rooms and the risk of contamination of those surroundings. Perhaps this should be considered as part of an assessment before moving to Enhanced Barrier Precautions:

  - Dr. Lin pointed out that this depends on the context of the particular MDRO in a Skilled Nursing Facility (SNF) and the phase in which infection control is being applied to control that MDRO. The guidance is clear that Contact Precautions would apply in an outbreak or epidemic setting when trying to control a targeted MDRO. Built into the Enhanced Barrier Precautions is the understanding that a facility may not be at the same level of epidemic control, but are in more of a maintenance phase. This tries to balance autonomy with residents and their common activities with the need for infection control. The types of activities available to residents are not called out, with an intent to be silent about that.

- An inquiry was posed about whether the WG discussed containment strategies to try to prevent the spread of MDRO among catheterized patients or patients who are incontinent or coverage of wounds per Enhanced Barrier Precautions.

  - In terms of Item b and "residents with wounds and/or indwelling medical devices," Dr. Lin indicated that the WG and HICPAC (in June and August) discussed this indication. As shown with the evidence review, there was not enough information or evidence from the HICPAC WG perspective or from HICPAC to recommend the indication of residents with wounds and/or indwelling medical devices as a strong recommendation. The wording was to broaden the indication to use the word "consider" instead of something more directive like "should." The table in the narrative was broadened to state, "Consider for residents at high risk for MDRO colonization, regardless of known MDRO status (e.g., residents with wounds or indwelling medical devices)" because there might be other factors epidemiologically for example that might trigger this.

Narrative

- The third bullet uses the term "healthcare facilities" but previously, the term "healthcare settings" has been used.

- Single occupancy is listed in the table as "Preferred; if not available, then cohort." Perhaps more specificity could be added to cohorting. For instance, there could be co-circulating

RSV, influenza, and COVID during respiratory season. Putting 2 people in the same room would not be prudent because 1 might have COVID and the other might have RSV and dual infections would be possible. Similarly with diarrheal disease, 1 could have Norovirus and another could have something else. If both patients had RSV, this might be acceptable. However, there could be sub-species and variants:

  - Dr. Lin agreed that this was a good point and noted that the section on patient placement that discusses cohorting would be the place to address this.

Use of Transmission-Based Precautions to Prevent Transmission through the Air
Recommendations

- Under Special Air Precautions, 2.b states "private room indicated." There are many instances in which there are not enough private rooms, yet there would be cohorting. It is not clear why cohorting is not mentioned, given that cohorting would be practical and would make sense if patients have the same organism.

- For Extended Air Precautions, 3.c states that an AIIR is required. This puts facilities in a bind that may not have an AIIR readily available, so some flexibility is needed here. It would make sense to say "required when available" and then "make every effort to identify and AIIR."

- Extended Air Precautions 3.e describes limiting travel outside the room, which is understandable. However, this is applied broadly in the Transport section to anyone on Transmission-Based Precautions. It is not clear why this is highlighted specifically there.

- For source control masking in 1d, 2d, and 3d, perhaps there would be value in clarifying what type of mask is indicated for patients who leave their room. While this is assumed to mean a surgical mask, it might be helpful to clarify this for the frontline and to avoid confusion:

  - Dr. Lin noted that there is a section in Patient Transport that discusses what patients wear.

Narrative

- The third bullet in the narrative uses the term "more than mild illness," but if this is intended to convey that it causes "severe illness" it should be stated as such.

- In terms of the phrase in the third bullet in the narrative that states "and where immunity (or vaccine) and effective treatment are not available," there may be a period during which there are excellent vaccines or immunity. Perhaps this should be reworded to state "or effective treatments are not available."

- The reference in the fifth bullet to the voluntary use of an N95 does not seem to belong here. If other federal regulations are going to be referenced, this should not appear here because this is about what is necessary and recommended for these precautions:

  - From a patient perspective, "voluntary" is consistent or inconsistent with the call for following federal regulations. This places the burden on the patient to correct the HCP in instances where they are hospitalized and under these different situations, so there was sentiment that the word "voluntary" should be removed.

- Dr. Wright noted that this particular bullet is pointing to the OSHA RPP, which states that any HCP can choose to wear an N95 in places where an N95 is not required without fit testing.

- This seems out of place here in that this is a section in which the guideline is telling people what should be done. Therefore, it is confusing to have this piece included here. Certainly, the OSHA regulations are very important, but are not relevant here in terms of explaining what is required for Transmission-Based Precautions. People who use these guidelines go to the narrative immediately. After just saying what is required, this introduces another concept that is confusing.

- Perhaps this could be pulled out of Transmission-Based Precautions and a separate paragraph or two could be created about the voluntary use of an N95.

- Many HCP have reported that if the voluntary use of PPE is limited, there are instances in which some facilities will not allow them to use certain PPE.

- When people are voluntarily using N95s when only isolation masks are recommended, it is not for source control as much as it is for their own protection and when they do not feel that an isolation mask is sufficient.

- The guideline should be stating what HICPAC thinks is required. Including "per OSHA requirements" makes it sound like there is an OSHA requirement to wear a higher level of protection, but that HICPAC is recommending something less. However, OSHA just requires that people are allowed to wear a higher level of protection than what is recommended. It may be better to remove this. There is an OSHA requirement that this must be allowed, so hospitals have to allow for this and have the capacity and supplies for people to make this choice as part of the OSHA requirement.

- If language about voluntary use and a link to the OSHA requirement is going to be included, more context is needed to clarify that it is just a link to an existing guidance and why the link is referenced.

- In terms of Table 3, it is not clear why eye protection is listed as "yes" for Special Air Precautions but as "Per Standard Precautions" for Routine and Extended Air Precautions:

  - Dr. Wright indicated that the WG felt that because Special Air Precautions are often applied to pathogens that are either emerging or for which transmission has not been fully elucidated, it would be better to include eye protection in the precautions as being required. The use of eye protection in Routine Air Precautions pertain to when one is at risk for a splash or a spray.

  - The wording about eye protection is not only on Table 3, but also is in the recommendation.

  - There could be a situation in which there is an emerging infection for which the transmission route is not yet clear. Once the route of transmission is identified, it is

not clear whether people should be held to continue to use eye protection once it has been determined that a transition should be made to Standard Precautions.

Special Situations
Narrative
- No additional comments.

Source Control
Recommendations
- It is not clear why 1.b is identified as Standard Practice or where the evidence is for that:
    - Dr. Lin clarified that this particular recommendation is in the Core Practices, which is why 1.a was considered Expert Opinion and 1.b was considered Standard Practice.
    - If this is intended for all healthcare settings, it would be helpful to clarify “all individuals, including patients” which would presumably include residents in a facility or clinical area and whether it would apply to the residents who are in their rooms, which are generally considered their homes. If residents are added, clarify whether it is in their own room or out in the shared areas.
    - This also could apply to persons in an inpatient setting in their room with a roommate in terms of whether they are expected to be masked the whole time. Perhaps a clause could be added that states, “in direct interactions with HCP, visitors, et cetera.”
- In 2, it is not clear what is meant by “higher risk areas” since this is about source control. It seems like 2 risks are being described here, but the intent is not clear:
    - This is about preventing asymptomatically-infected people from transmitting. The specific locations that are called out are places where vulnerable patients might frequent (e.g., EDs, urgent care, bone marrow transplant units, or units experiencing an outbreak). Units experiencing an outbreak would pertain to person-to-person transmission as well. The intent was people who are susceptible or people who are vulnerable.
    - For units experiencing an outbreak, this is about recognizing the potential increased risk of asymptomatic staff in that space because they may have been infected or exposed during that outbreak, so it is still a source control-focused recommendation and not necessarily a protection recommendation.

Narrative
- Masks and respirators are listed interchangeably as source control. Given that source control is being applied here across various populations, perhaps it would be better to say “source control” versus "mask” or “respirator.” It is known that effectiveness will be driven by compliance and feasibility. Therefore, the use of these words interchangeably is not correct. It is not clear how to interpret this:
    - Dr. Wright said she did not think the WG was commenting on selecting one or the other. This is just saying regardless of whether one is using a mask or a respirator,

each can reduce the amount of secretions that get into the environment. The intent was to be consistent with the prior wording, although that probably needs to be discussed further.

- Regarding asymptomatic transmission, the word “proportion” is used. It is a “portion” and perhaps is not as high as has been thought previously, so it could be a “small portion” may be infectious during an asymptomatic period. The evidence is evolving, at least related to COVID:

  - Dr. Wright clarified that this is meant to be pathogen-agnostic and is not meant to have a specific proportion, because it probably would depend on the pathogen itself.

Patient Placement
Recommendations

- In the table, for Enhanced Barrier Precautions, single occupancy is not required. Perhaps it would make sense to mention also that cohorting might still be a consideration, especially for residents with known MDRO infection or colonization:

  - Dr. Lin thought this might be addressed in patient placement more globally. This is a challenge in nursing home settings where, depending upon the pathogen of interest, even if focused on a particular class of pathogens, there may be differences in what is known about the genetics and epidemiology of what a particular resident is carrying.

- While not every setting can be called out, perhaps it would be beneficial to call out dialysis facilities specifically because of the lack of single patient rooms in many facilities.

- Perhaps types of pathogens need to be more nuanced either in the recommendation and/or the narrative. For instance, there are multiple types of influenza and they co-circulate. This is so nuanced, it is not likely to fit well in a single sentence and may need to go into the background or narrative in some way:

  - Dr. Lin suggested that perhaps Recommendation 4 could state “same pathogen variant or resistance mechanism” instead of “same pathogen infection” in order to quality “pathogen” in order to get at that nuance.

  - Dr. Wright added that since this will involve a variety of settings, not every setting is going to be able to determine down to the specific type of pathogen, so they should not be overly prescriptive.

  - Each setting is going to have its own unique situations that will lead to a risk assessment. For instance, in a small SNF without a lot of rooms but a lot of variety of colonization, cohorting may be based on cohorting a colonized patient with a patient who has no devices and is not at high risk themselves. Perhaps to address this, something could be added about risk assessment and how to consider risk.

- Maybe Recommendation 4 should be about “pathogen susceptibility and, if known, the mechanisms of resistance.”

- For Recommendation 5, patients sharing a room also may be sharing a restroom, dining halls, and other places, which should be factored in. There needs to be an emphasis on not only the placement of hand hygiene, but also cleanliness and disinfection.

- Recommendation 5 states “practices *need* to be in place” but ought to be changed to “practices *should* be in place” to be consistent with the wording in Recommendations 1-4.

- All items listed in Recommendation 5 are Standard Precautions and should be implemented anyway.

Transport of Patients
Recommendations

Patient Considerations
- For Recommendation 2, the statement “unless a mask is medically contraindicated or the individual is not capable of wearing a mask safely” is very appropriate and perhaps should be in Source Control because it is about source control regardless of transport or other scenarios.

- Recommendation 4.a could be collapsed into 4 so that it is all one statement, which is what seems to be intended.

Transporter Considerations
- Remove “for pathogens” from Recommendation 1.

- For Recommendation 2, if a patient has source control and is merely being transported, it is not clear why anyone transporting them also needs to wear a mask or respiratory protection. For instance, if someone with tuberculosis is being transported, they are wearing a mask. Right now, the person transporting them who is not engaged in direct care would not use an N95 respirator, but this makes it sounds like they should have that with them.

- For Recommendation 2.b, individuals engaging in direct care absolutely should be wearing PPE appropriate for care for that patient. However, then there is no one with clean non-gloved hands to touch all of the things in the hospital to escort them. Perhaps a statement could be included stating something to the effect of, “If PPE is worn during transport, there must be a member of the healthcare team with clean, non-gloved, not wearing PPE to push all of the buttons and guide the patient through transport.” The transporter would not be the one delivering care.

    - Dr. Lin indicated that the intent here, especially in situations where patient care has to be delivered, the rationale for having the transporter carry a mask/respirator is for situations such as suctioning or potentially other situations where there is a closed space and there is a medical emergency. The transporter would not necessarily wear the mask/respiratory all the way through transport.

    - Sometimes the nurse is the transporter or may have to perform patient care with the transporter standing next to the patient, or the transporter and others may get stuck on an elevator with a patient for several floors. If source control cannot be maintained, the transporter still may need that coverage.

- For Recommendation 4, it may be beneficial to clarify certain situations such as Emergency Medical Staff (EMS) who are in the process of resuscitation and also transporting who have been yelled at for wearing PPE inappropriately when actually engaging with the patient. Consider adding a sentence stating, “This does not apply to someone who is engaging in a clinical process.” Perhaps this could go in the narrative.

Use of PPE by Visitors

Narrative

- Often visitors are not aware of the nuances with pathogens and are conscious about the presence of COVID still. The reluctance to mention N95 masks is confusing. CDC’s website says that someone who was recently exposed should wear an N95 mask anytime going outside or visiting a public place, which would include visiting someone at the hospital. There is a contradiction here. While this is not pathogen-specific, with this and the last discussion, it is alarming that a healthcare worker may not be carrying an N95 mask for circumstances that may arise unexpectedly. All of these things can be confusing to laypersons, may be confusing to healthcare workers, and does not seem to make a lot of sense not to just recommend an N95 mask:

    - Dr. Lin clarified that the intent of this section was to describe a situation in which there is a sick patient in a healthcare setting and trying to protect the well visitor coming to see them from potentially acquiring something from the sick patient. This is where having the pathogen-specific guidance makes more sense. The point is well-taken about someone who is sick and visiting, which is under the isolation guidance in terms of preventing a sick person from further transmitting their pathogen.

    - Dr. Wright added that an N95 is just one of the options in terms of the guidance for people who go out into the community. This is not COVID-specific by any means. The WG can revisit the language because the last thing they want is for the language to be confusing to readers whether they are HCP or members of the public.

- It is great that so much flexibility is provided, acknowledging that there are many different settings. Practically, in a pediatric hospital, parents are living in the room. It does not make as much sense for them to wear PPE if they are going to sleep in the bed with the patient, which is not advocated but happens. Since contact with other patients and the environment and the potential for transmission are called out, perhaps consideration could be given to talking about the importance of hand hygiene when entering and leaving the room and including a statement that if a visitor is caring for/staying in the room with a patient who is on TBP, they are restricted from spending time in communal areas within the hospital or suggesting some other approaches. It is not pediatric-specific, so it might be good to call out hand hygiene and other measures.

- The language states that “In these situations, visitors may have contact with other patients or the environment . . .” but visitors are not generally thought of as going from bed-to-bed to other patients. Generally, that has been a rationale in Contact Precautions for having visitors wear gowns and gloves. The intent here is that in very specific situations, the visitor is actually providing care and would wear the gown and gloves to limit their contamination. Even so, they are not going to be interacting with other patients.

- Dr. Lin said he thought this was meant to be somewhat broader in that visitors also are in common areas where patients are transiting potentially. It is a small risk, but the WG can review the language. Perhaps “patients” could be removed. Ultimately, the goal is to prevent patient-to-patient spread via visitors as potential vectors. Transmission by touch might not be as much of a risk, but transmission by air potentially could be an issue that does not necessarily require contact in patient rooms.

- There are instances in which people do go room-to-room, such as people doing balloons around Christmas, basketball teams visiting, et cetera. While they may be screened, this is not an infrequent occurrence, particularly in long-stay units like burn, bone marrow, trauma, et cetera. It is important to make a statement about PPE and hand washing.

- Use of PPE by Visitors and Visitors as Sources of Infection seem to be overlapping.

Visitors as Sources of Infection
Narrative

- It would make sense under this category to reiterate or highlight the importance of hand hygiene education to the visitor before they enter the room to protect the patient and when they leave the room in case their hands were contaminated.

- A comment should be made in this category as well about the visitor entering only the room of a patient on TBP and not entering shared spaces such as playrooms, kitchens, family rooms, et cetera.

- In the first bullet, consider saying “symptom and exposure” for screening:

    - Another question that arises frequently and possibly should be part of screening is the vaccination status of visitors. This is particularly important for units in which recent receipt of live vaccines in asymptomatic visitors could pose risk, especially to the most vulnerable patients:

    - Dr. Lin pointed out that this could be tough to ask visitors at the time of entry. It seems like the best time to manage that is at the time of vaccines being given in terms of letting recipients know that because they received a live vaccine, they need to be careful about X, Y, and Z. It is not clear how to hardwire that in since it is about safety in the healthcare setting and potentially elsewhere.

    - Practically speaking, particular units impose restrictions. How those are actually implemented is not addressed in this section.

    - Dr. Bell suggested that perhaps one way to do this would be to include a precise call out for specific vaccines. Recent vaccination ideally would cover a lot of people, could be confusing, and may even send a mixed message about risk related to vaccines, which is not the intent.

    - That is done practically. An example would be live-attenuated influenza vaccine (LAIV) in the prior 7 days. The addition of “visitor symptom and exposure screening” might capture the other research. For immunocompromised patients typically

includes exposure to measles without evidence of immunity in some prior period. Perhaps this could point to ACIP, which would keep it up to date.

  - It is important to recognize that these are primarily in the narrative and the "consider" category and should not give facilities the impression that every visitor should be stopped on the way in to be asked about each specific vaccine that may apply only in certain settings. It would make sense to include all of these as considerations for designing visitor programs.

  - Consider changing the second line from "Visitor symptom screening can reduce risk …" to "Visitor screening can reduce risk of HAI and may be especially important …" A line could be added after that with potential suggestions, such as "This potentially could include screening of symptoms, recent exposures, or recent receipt of live virus vaccines.

  - Guidance of how this could be done and not placing it on a single individual could help to avoid the creation of a hostile situation between the visitor, the family member, the nursing staff, and the facility. This is important to do, but so is how it is said could be difficult to define in a document like this.

- In the second bullet, consider revising the last sentence in the parentheses to state, "with subsequent review by facility staff and consultation with infection prevention to determine whether the visitor can proceed with visitation and development of an evaluation of the sick family member before returning" because they represent a hazard to the patient, staff, and community. This would be for certain diseases like TB, pertussis, and other respiratory viruses:

  - Most of the time, evaluations can be protocolized so that IPs do not have to be called every time.

- Perhaps a bullet needs to be added about educating visitors. For example, parents who have other children at home and have a respiratory infection should not be visiting a newborn in the NICU.

- It is important to recognize how important visitors are to patients and their healing. This should not be perceived as imposing barriers to what is essential access of visitors to patients.

- Another important aspect of this is that patients may be in the hospital for several days before anyone knows what pathogen is causing their illness. The fact is that there is a slow response to testing patients in that there is not a system that provides rapid testing. Visitors are coming in and out who are being exposed, and the patient is exposing HCP and others without knowing what pathogen they have. This happens every day in every hospital and there are plenty of anecdotal stories about it. Quicker diagnoses of pathogens that are causing illness must be discussed among professionals:

  - Dr. Lin acknowledged the importance of this comment and pointed out that there is a section on syndromic application of TBP that is applicable to many situations in which patients are presenting with symptoms, but even the best tests available have some delay. Therefore, emphasis on the use of empiric TBP based on syndromes

such as respiratory viral illnesses could mitigate some of the risk. Better testing in general would help to apply the appropriate precautions.

- While better testing is needed, parents visit the NICU daily. This could become very challenging because testing cannot be done daily. This was seen with COVID. Someone could be asymptomatic one day and symptomatic the next. Language that gives more leverage to facilities may allow them to implement more effectively.

Discontinuation of Transmission-Based Precautions
Narrative

- Regarding the first bullet:
  - Perhaps the last line stating “Colonization with MDROs can persist for months to years” could be revised to state “Colonization with some MDROs can persist for months to years” so that it does not imply that for every single MDRO, someone is going to be in isolation for months to years.

- For the second bullet:
  - For “In acute care hospitals, Contact Precautions are often left in place throughout the entire admission” it is not clear whether this is all facilities. Someone under Contact Precautions in nursing homes should similarly be reassessed to determine whether they still need Contact Precautions.
  - Consider changing “set duration based on repeat testing or symptom resolution” to “set duration based on repeat testing time, symptom resolution, or some combination” because often a series of parameters will be used when determining the duration of isolation required. Perhaps a point could be included about the importance of reassessing the continued need for each of the TBP to decrease the burden on HCP and the patient to emphasize this point.

- In terms of an inquiry about whether the reference in the fourth bullet to Appendix A (2007) is where the pathogen-specific recommendations are and that it means they are not being updated:
  - Dr. Lin clarified that the intent is for Part 2 of the 2024 guideline to include pathogen- and disease-specific recommendations. That is future work by HICPAC. Until that is completed, Appendix A (2007) is the current source for the pathogen- and disease-specific recommendations. The timeline for this is projected to be the next 1 to 2 years.
  - Dr. Wright added that as was done in the HCP Guideline, pieces will come through and be updated as soon as possible after completing the review and approval process. The plan is to have language at the top of Appendix A (2007) that refers back to the hopefully growing Part 2 and eventually Appendix A (2007) will be archived.

Part 2: Review of Recommendations After Incorporation of Comments

During the second day of the meeting, Dr. Lin explained that the context for this discussion was to go through the recommendations, with a goal to discuss the recommendations with the HICPAC membership in the larger meeting for the eventual planned vote at the end of this session. The edits and changes shown were presented during this session to reflect the discussion that occurred the previous day and the changes the WG made to be responsive to the membership recommendations.

As a reminder about recommendation formulation, the authors conducted a thorough review of the recommendations contained in the 2007 Guideline. This review identified recommendations from the 2007 guideline that remained relevant in 2023. These recommendations were carried forward as Standard Practice and are noted as such in the 2024 Guideline. For the update, the authors additionally identified gaps in the 2007 Guideline that required development of new recommendations.

New recommendations also were categorized as Standard Practice if they met any of the following criteria:

- Consistent with recommendations and the current CDC guidelines or guidance (e.g., the Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings).
- Are consistent with current federal regulations.
- Are consistent with manufacturer instructions for use (e.g., recommendations to follow instructions for proper use or reprocessing).
- New recommendations not categorized as Standard Practice were categorized as Expert Opinion, with supporting peer-reviewed literature where available.

The proposed recommendations with the incorporation of the comments made the previous day were reviewed as follows, with revisions highlighted in yellow or strikethroughs and additional HICPAC discussion points shown after each section:

Section B: Personal Protective Equipment (PPE) for Healthcare Personnel (HCP)

PPE for HCP
General Considerations Recommendations

1. Healthcare personnel (HCP) must be trained and demonstrate competency in the selecting, putting on, using, removing, and disposing of PPE in a manner to prevent exposures and self-contamination. (*Standard Practice*)
2. Employers in healthcare settings are required to provide readily available PPE to HCP, ideally at or near likely points of use. (*Standard Practice*)
3. Sizing and models should be chosen to accommodate the needs of the local workforce. (*Standard Practice*)

Additional HICPAC Discussion Points
- First use of acronyms should be defined once, with use of the acronym thereafter.

PPE for HCP
Glove Recommendations

Indications

1. Use non-sterile gloves ~~are indicated~~ in any of the following situations: (1) any anticipated contact with ~~body fluids~~ blood or other potentially infectious material, (2) touching mucous membranes or non-intact skin, (3) handling soiled items such as used wound dressings, and (4) as indicated by Transmission-Based Precautions. Activities that do not meet these criteria do not require gloves. (*Standard Practice*)

Use

2. HCP should perform hand hygiene prior to reaching into a box of non-sterile exam gloves and putting on gloves, to reduce the risk of contaminating both the remaining gloves in the box and the gloves being put on. (*Expert Opinion*)
3. During care of a single patient, gloves should be changed after a task or procedure if contact occurs with potentially infectious material (e.g., if moving from a dirty task to a clean task). (*Standard Practice*)
4. Remove gloves if torn or soiled, and before caring for another patient. (*Standard Practice*)
5. Hand hygiene should be performed immediately after removing gloves, because pathogens on used gloves can contaminate hands during glove removal. (*Standard Practice*)
6. HCP should not practice extended glove use in place of hand hygiene. (*Standard Practice*)

Selection

7. Non-sterile gloves should be available in a range of sizes so that all users will be able to select a glove that fits comfortably without excess material that could impair function. (*Standard Practice*)

Additional HICPAC Discussion Points

- Under *Indications*, perhaps it would make more sense to say, “in the following situations” and remove “any” because it is just these situations.
- For *Use*, the word “exam” should be removed from bullet 2. HCP may be reaching into a box of gloves to clean something in the environment that is contaminated versus for exam use.

PPE for HCP
Gown Recommendations

Indications

1. Use non-sterile gowns ~~are indicated~~ in ~~any of~~ the following situations: (1) when an activity is anticipated to contaminate HCP clothing through direct touch or splash, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. Gowns should be worn to protect skin and prevent soiling of ~~cover the individual’s~~ clothing, with all fasteners secured. (*Standard Practice*)
3. Remove gowns if damaged or soiled, and before caring for another patient. (*Standard Practice)*

Additional HICPAC Discussion Points

- Perhaps bullet 2 under *Use* should be “protect skin and prevent contamination of clothing” as it is not always just soilage, but also may be contamination with bacteria. In addition, “contaminant” was used in the *Indications*, so it would be more aligned.
- While the same suggestion was made about bullet 3 under Use, it was noted that this is a different situation in that if soiled, a gown would need to be changed before a procedure in a patient’s room.

- Bullet 2 under *Use* will state “to protect skin and prevent soiling of clothing.” Perhaps “skin” needs to be added to bullet 1 under *Indications* as well:
  - This is taught as contamination to clothing and not so much as a barrier precaution otherwise. With intact skin, this generally would not be considered an exposure.
  - The OSHA Bloodborne Pathogens Standard mentions protection of skin under PPE.
  - This is somewhat challenging because there is discussion about gloves for skin protection, but the gown is clothing protection. The previous day there was discussion about short-sleeved gowns, but it seems that the concept is really more focused on clothing. If the recommendation says, “gowns anytime contamination of skin is anticipated,” people might be putting on a gown when all they need is gloves. Perhaps it should stay the way it is, or “skin” should be removed from bullet 2 rather than adding “skin” to bullet 1 to be more consistent.
  - Perhaps bullet 1 could read, “Gowns should be worn correctly with all fasteners secured.”

PPE for HCP
Mask Recommendations

Indications
1. Use masks ~~are indicated~~ in ~~any of~~ the following situations: (1) when an activity is anticipated to create splashes or spray to the face, (2) as source control, and (3) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use
2. Masks should not be reused as they can serve as a reservoir of infectious material if they become soiled during use. (*Standard Practice*)
3. Masks should be changed if they become soiled, damaged, or harder to breathe through. (*Standard Practice*)
4. Extended use ~~is~~ should not be practiced with masks except when used for source control. When practicing extended use for source control, masks should be disposed of:
   a) anytime they are removed *(Standard Practice)*, and
   b) if they are used during the care of a patient for whom a mask is indicated as part of Transmission-Based Precautions. (*Standard Practice*)

Selection
5. A fluid-resistant mask should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

Additional HICPAC Discussion Points
- There is a (*Standard Practice*) missing in bullet 4 before the yellow highlighted “When practicing.”
- In bullet 2, perhaps “soiled” should be replaced with “contaminated” to be consistent with other recommendations:
  - As a statement of why they should not be reused, this seems correct. The mask should be removed if it becomes soiled and discarded. However, they should not be reused because they may become contaminated during use. This is a statement about not reusing masks. It would be a reservoir because it became contaminated, or because it is grossly soiled.
  - In some cases, an explanation is provided for the “why” and sometimes not. In this case, the “why” for not reusing is contamination.

PPE for HCP
Respirator Recommendations

Indications
1. Used respirators as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use
2. A seal check should be performed each time an HCP puts on a fit-tested respirator to ensure that the respirator is properly seated on the face. (*Standard Practice*)
3. Single use disposable respirators should not be reused as they can serve as a reservoir of infectious material if they become soiled during use. (*Standard Practice*)
4. Reusable respirators should ~~must~~ be cleaned, disinfected, and dried between uses according to the manufacturer's instructions for use. (*Standard Practice*)
5. ~~Optimally, extended use is not practiced with single use respirators except when used for source control and then disposed of when removed or after use when caring for a patient on Transmission-Based Precautions. (Standard Practice)~~ Respirators should be changed ~~when~~ if they become soiled, damaged, or harder to breathe through. (*Standard Practice*)

Selection
6. A fluid-resistant respirator should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

Additional HICPAC Discussion Points
- No additional comments.

PPE for HCP
Eye and Face Protection Recommendations

Indications
1. Protect the eyes and face ~~protection is indicated~~ in ~~either of~~ the following situations: (1) when an activity is anticipated to create splashes or spray of potentially infectious material to the eyes or face, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use
2. If reusable devices are used for eye and face protection, protocols must be in place for cleaning, disinfection, and drying between uses, per manufacturers' instructions for use. (*Standard Practice*)

Selection
3. The selection of eye and face protective equipment should consider the nature of the activity for which it will be used. (*Standard Practice*)

Additional HICPAC Discussion Points
- This may be implied by bullet 3, but it is not clear whether the intent is to choose whether one needs eye protection or eye and face protection based on the situation. A lot of the eye protection is really eye protection, and then there are full-face masks that provide a different kind of protection. The recommendations should not imply inadvertently that full face shields are needed for eye protection:

- There is more in the narrative about the factors that should be considered in selection among the available devices, but more could be added about the indications.

Section C: Standard & Transmission-Based Precautions

Standard Precautions
Recommendation

1. Standard Precautions apply to the care of all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered, and at all times. (*Standard Practice*)
2. HCP should be trained on how and when to apply Standard Precautions, including how to put on, correctly use, remove, and dispose of PPE. (*Standard Practice*)

Additional HICPAC Discussion Points
- Regarding bullet 1, consider changing "all patients" to "every patient" because this would more strongly suggest that there should be a risk assessment for every single patient interaction. This may need to be changed in the Core Practices as well:
  - Dr. Lin confirmed that Core Practices does say "all patients."
  - There was HICPAC support for this edit as long as it is consistent throughout so that there is no confusion.
- The way this is written, with the inclusion of bullet 2, does address a comment from the previous day regarding placing more emphasis on what is expected in terms of training of HCP to understand and be able to implement Standard Precautions.

Transmission-Based Precautions
Recommendation

1. HCP should be trained on how and when to apply Transmission-Based Precautions, including how to put on, correctly use, remove, and dispose of PPE. (*Standard Practice*)

Additional HICPAC Discussion Points
- Perhaps this could indicate that HCP should be trained on how to choose the correct PPE. For instance, "HCP should be trained on how and when to apply Transmission-Based Precautions, including how to choose, put on, correctly use, remove, and dispose of PPE" unless that is a recommendation elsewhere:
  - HCP probably would not choose for a TBP but is captured in Standard Precautions.
  - HICPAC agreed to leave this statement "as is."

Syndromic and Empiric Applications of Transmission-Based Precautions
Recommendation

1. Use appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs consistent with a transmissible infection, to reduce transmission risk. (*Standard Practice*)

Additional HICPAC Discussion Points
- Dr. Lin reminded everyone that the previous day, there was a question about whether "empiric" was the right word, given that the main thrust of this recommendation as written is

for patients who are symptomatic. While typically that is not thought of as syndromic, in a larger sense, there are empiric applications of TBPs for some patients who are not symptomatic. An example would be somebody with an epidemiologic exposure, such as a patient with a ventilator coming from a SNF that had a known high incidence or prevalence of a target MDRO.

- The emphasis is on someone without a diagnosed infection who has symptoms and the expectation of HCP to recognize those symptoms and implement TBPs in the absence of a diagnosis. The "and" is not needed because this is an empiric application of TBPs based on a syndrome. Highlighting that and not getting into asymptomatic TBPs is a good idea because here, the emphasis truly is on how important it is to recognize the symptoms up front. The proposal would be for the title to be "Empiric Syndromic …" or "Empiric" could be removed and the title could be "Syndromic Applications of Transmission-Based Precautions."
  - The way empirical application of isolation often is taught is based on the syndrome with which the patient presents. This is being applied empirically, not syndromically.
  - "Empiric" could be removed because the actual recommendation is to apply this when a patient develops signs and symptoms. Having "Empiric" in the title might be confusing to people.
  - Perhaps something about epidemiologic risk factors and empiric application could be added in the narrative so that the idea is not lost, but it does not reach the level of a recommendation. While HICPAC would be voting to approve the recommendations, the WG could consider the title later as long as the recommendation does not change.
  - Perhaps the recommendation should state, "Use Transmission-Based Precautions at the time that a transmissible infection is suspected." Then "signs and symptoms" would not be required, and the patient would be suspected to have a transmissible infection based on anything (e.g., symptoms, exposure history, epidemiological risk factors, et cetera) and that could be spelled out in the narrative. It is concerning to tying empiric application directly to signs and symptoms when sometimes it may be based on a history or some other factor.
  - The 2007 Guideline described it as "Syndromic and Empiric Applications of Transmission-Based Precautions" and instead of saying "signs and symptoms" it describes implementing Transmission-Based Precautions on clinical presentation and likely pathogen. Clinical presentation includes history in addition to signs and symptoms.
  - The intent is to emphasize the teaching of signs and symptoms as a trigger for TBP.
  - There was some sentiment that leaving the recommendation "as is" and describing it further in the narrative misses the boat because this is about situations when there are not signs and symptoms, but patients still would be empirically placed on TPB because of a history. There are 2 situations in which this recommendation is applicable: 1) when there are signs and symptoms; and 2) when a patient is empirically placed on TBP simply because of exposure history, travel from an endemic area, and numerous other possibilities.
  - Dr. Lin pointed out that there was a proposal to comment on the second point in the narrative, so the WG will make sure that it is at least clear in the narrative.

Section C: Transmission-Based Precautions (TBP) to Prevent Transmission via Touch
Recommendations

1. **Contact Precautions** (applies to all healthcare settings ~~facilities~~)

a. ~~Patients are~~ Care for patients in a dedicated space, preferably a single patient room if available. See Patient Placement and Patient Transport sections below for more details. (*Standard Practice*)
b. Use a gown and gloves ~~are used~~ for all interactions that may involve contact with the patient or the patient's environment. Gown and gloves should be ~~put on upon entry into a patient's designated space (generally defined the patient's bedspace or room)~~ properly removed and disposed of before exiting the patient's room (or designated space). (*Standard Practice*)
c. Ideally, patient-care equipment (e.g., blood pressure cuffs, stethoscopes) should be ~~is ideally~~ dedicated to the patient and the patient's designated space. Disposable equipment may be used to minimize cross-transmission. If shared patient-care items are used, they should be cleaned and disinfected prior to use with other patients in accordance with the manufacturer's instructions for use. (*Standard Practice*)
d. In general, clean, unopened patient care supplies should not be stored in the room but should be available near the room to allow easy access while ensuring that large amounts of supplies do not become contaminated. (*Standard Practice*)
    a. Any disposable supplies that are brought into the room should not be returned to the general supply; they may be sent home with the patient upon discharge if needed (e.g., for dressing changes) or discarded. (*Standard Practice*)
    b. For clinical areas where supplies are stored routinely within rooms (e.g., outpatient clinic rooms), supplies should be stored in covered or closed clean storage areas. (*Standard Practice*)
e. Frequently clean~~ing~~ and disinfect~~ing~~ room surfaces (e.g., at least daily or prior to use by another patient in ambulatory settings) ~~is used~~ to reduce environmental reservoirs of infectious material, focusing on frequently touched surfaces and areas in the immediate vicinity of the patient. See Environmental Infection Control Guidelines for additional details. (*Standard Practice*)

Additional HICPAC Discussion Points

- Some facilities have changed "before" to "upon" exiting a space because some rooms are so tight for space, the trash can is placed just outside of the room at the doorway. Saying "before" existing could create problems in small spaces.
- The intent regards whatever contamination is on gowns and gloves and should be removed when HCP are leaving. Sometimes that happens right outside of the door, but they should not be going through corridors with that PPE, so "upon" would offer flexibility depending on the facility's size, set up, et cetera.
- It was noted that because there was much more nuance to the donning of PPE based on everyone's comments from the previous day, the WG will include this in the narrative with more detail. It is not being removed completely. It just will not be in the recommendation itself.

2. **Enhanced Barrier Precautions** (applies to Skilled Nursing Facilities):
    a. Use Enhanced Barrier Precautions ~~are indicated~~ when Contact Precautions do not otherwise apply, for ~~nursing home~~ residents infected or colonized with multidrug-resistant organisms (MDRO). (*Expert Opinion*)
    b. Enhanced Barrier Precautions may be considered for residents at high risk for MDRO colonization (e.g., residents with wounds and/or indwelling medical devices), ~~regardless of known~~ even if not known to be infected or colonized with an MDRO. (*Expert Opinion*)
    c. Use a gown and gloves for high-contact resident care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (e.g., central venous catheter, urinary

catheter, feeding tube, tracheostomy/ventilator management), and wound care. In general, gown and gloves would not be required for resident care activities other than those listed above, unless indicated per Standard Precautions. (*Expert Opinion*)

d. Residents should ~~are~~ not be restricted to their rooms or limited from participation in group activities. (*Expert Opinion*)
e. Enhanced Barrier Precautions ~~do not impose the same activity and room placement restrictions as Contact Precautions; they are intended to be in~~ should remain in place for the duration of a resident's stay in the facility or until the indication for Enhanced Barrier Precaution is resolved (e.g., resolution of wound or discontinuation of the indwelling medical device). (*Expert Opinion*)

Additional HICPAC Discussion Points

- For clarity for SNF, perhaps this should say "patients and residents" since SNFs provided both post-acute short-term and long-term care:
  - Dr. Lin noted that this was an open question about wording in terms of harmonizing with CDC's website, given that it states "patients" and not "residents."
  - The long-term care guidance refers to persons as "residents" but there are "patients" in SNF as well, so this would make it incongruent.
  - The CMS guidance uses the terms "resident" and "Nursing Facility" in terms of payment mechanisms.
  - The proposal would be to replace "residents" with "patients and residents" in EBP and to use the term "Nursing Homes" versus "Skilled Nursing Facilities." That also would be consistent with CDC language on EBP on its website.

Section C: TBP Transmission via the Air Recommendations

1. Routine Air Precautions

a. ~~A mask is worn by~~ HCP should use a mask on room entry, and use eye protection ~~is used~~ based on Standard Precautions. (*Standard Practice*)
b. ~~Private rooms are preferred~~ Place patient in a private room; if not available, then cohort. (*Standard Practice*)
c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Standard Practice*)
d. Source control ~~masking~~ should be used by the patient when they leave their room (e.g., for transport to a procedure). (*Standard Practice*)

2. Special Air Precautions

a. HCP should use a NIOSH-approved® fit-tested N95 (or higher-level) respirator and eye protection ~~are worn by HCP~~ on room entry. (*Expert Opinion*)
b. Place patient in a private room ~~is indicated~~; if not available, then cohort. (*Expert Opinion*)
c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Expert Opinion*)
d. Source control ~~masking~~ should be used by the patient when they leave their room (e.g., for transport to a procedure). (*Expert Opinion*)

3. Extended Air Precautions

a. HCP should use a NIOSH-approved® fit-tested N95 (or higher-level) respirator ~~is worn by HCP~~ on room entry, and eye protection is used based on Standard Precautions. *(Standard Practice)*
b. Place patient in a private patient room ~~is indicated~~. (*Standard Practice*)

c. An AIIR is required. If an AIIR is not available, the patient should wear source control and be isolated in a standard private patient room with the door closed. The patient should be transferred to an AIIR as soon as possible. (*Standard Practice*)
d. Source control ~~masking~~ should be used for the patient when they leave their room (e.g., for transport to a procedure). (*Standard Practice*)
~~e. Travel outside the room should be limited (e.g., for necessary procedures and treatments). (*Standard Practice*)~~

Additional HICPAC Discussion Points

- To be consistent, harmonize to include "See Patient Placement."
- In terms of source control, make sure that (e.g., for transport to a procedure) is consistent.
- All of the Air recommendations mention that if a private room is not available, cohorting should be used and Patient Placement is referred to. However, Contact Precautions by Touch bullet 1.a just say, "if available." These should be harmonized:
  - It would not be possible to cohort in a dialysis facility. Other strategies probably would have to be implemented.
  - To address the concerns raised, the WG plans to add information with the nuances of cohorting and all of the ways that could be defined.
  - In terms of air, private rooms are preferred.

Section C: Source Control and Patient Placement Recommendations

Approaches to Source Control in Healthcare Settings
Recommendations

1. During periods of higher levels of community respiratory virus transmission, facilities should consider implementing one of the following approaches ~~tiers of~~ to source control:
   a. ~~Having~~ HCP ~~mask~~ use source control when interacting with patients (e.g., on entry to the patient's room or bedspace). (*Expert Opinion*)
   b. ~~Having~~ All individuals (e.g., patients, visitors, and HCP) ~~mask~~ use source control, ~~if tolerated~~, upon entry to the facility or a clinical area. (*Standard Practice*)
      a. In most circumstances, it is not necessary for patients to use source control when in their room; it could be considered when care is being provided. *(Expert Opinion)*

2. At any level of community respiratory virus transmission, consider implementing source control measures ~~can be implemented facility-wide or~~ targeted toward higher risk areas (e.g., emergency departments, urgent care) or units (e.g., bone marrow transplant units, ~~or units experiencing an outbreak~~ based on a facility risk assessment. (*Standard Practice*)

Additional HICPAC Discussion Points

- Perhaps 1.b should be changed from "patients" to "patients and residents" to make this clearly applicable to nursing homes:
  - This is going to be a struggle throughout the entire document because many components talk about patients that could apply to the nursing home setting. The WG has taken the stance that "patients" in general could apply to residents, but it is setting-dependent. This might have to be changed throughout the document in many cases, so the WG proposed to leave it this way.

- One approach would be in the beginning to state something to the effect of "Throughout the document, we refer to "patients." This implies to individuals who may be residents in facilities.
- The WG also can make sure that it is better defined in the narrative.

Patient Placement
Recommendations

1. Use single patient rooms ~~are the preferred option~~ for patients requiring Transmission-Based Precautions, whether to prevent transmission by touch or through the air. (*Standard Practice*)

2. In long-term and other residential settings, room placement decisions should balance risks to the infectious individual and to other patients. (*Standard Practice*) Residents in Enhanced Barrier Precautions do not require placement in a single person room. (*Expert Opinion*)

3. In ambulatory settings, patients requiring Transmission-Based Precautions should be placed in an exam room or designated space ~~or cubicle~~ as soon as possible rather than waiting in common areas. (*Standard Practice*)

4. If single patient rooms are not available, patients housed (cohorted) in the same room should have the same pathogen ~~infection or colonization status~~ to the greatest extent possible. (*Standard Practice*)

5. Any time room sharing occurs, practices should ~~need to~~ be in place to limit potential for cross-contamination, including ready access to hand hygiene supplies, changing PPE between roommates, and dedicating patient care items or cleaning and disinfecting shared equipment after each use. (*Standard Practice*)

Additional HICPAC Discussion Points

- The specific TBP section says to put patients in a private room, but that they could be cohorted if a private room is not available and it is mentioned in bullet 4 for these recommendations, but perhaps that needs to be added to bullet 1 as well:
  - Given that cohorting has come up many times, the WG will make modifications and will clarify in the narrative.
  - Perhaps bullet 4 could be moved below bullet 1 because they go together. The others could be rearranged and renumbered.
  - Dr. Lin pointed out that the intent of the WG was that bullets 1, 2, 3 identify different healthcare settings and bullet 4 is globally applied to 1, 2, and 3.
  - Perhaps bullet 4 needs to state "a single patient room or dedicated space."
- In bullet 3, emergency departments and emergency care clinics should be included in addition to ambulatory settings rather than seating people in waiting rooms to be placed into a private room unless these fall under "ambulatory care."
  - Generally, EDs and urgent care are classified under "ambulatory care."

Section C: Patient Transport Recommendations

Transport of Patients
Recommendations

Patient Considerations

1. Patients under Transmission-Based Precautions (with the exception of Enhanced Barrier Precautions alone) should leave their room only when medically necessary for their evaluation or care. (*Standard Practice*)

2. If the patient is being isolated for a pathogen transmitted through the air, they should use source control, (i.e., wear a mask), any time they are outside of their room, unless a mask is medically contraindicated or the individual is not capable of wearing a mask safely. (*Standard Practice*)

3. If the patient is cared for using Contact Precautions for a pathogen transmitted by touch, appropriate barriers (e.g., clean patient gown, wrapping sheet, or impervious dressing) should be used to cover affected areas of the patient's body during transport when infectious skin lesions or drainage are present. (*Standard Practice*)

4. Before intra-facility or between-facility transport, direct communication with the ~~HCP~~ receiving department or facility ~~the patient~~ is required to ensure notification regarding the nature of the infection, the type of Transmission-Based Precautions required, and when the patient will arrive. (*Standard Practice*)
    a. ~~Communication at time of transport applies to within-facility transfers and between-facility transfers. (Standard Practice)~~

Transporter Considerations

1. HCP transporting patients should follow Standard Precautions to avoid spreading infectious material during transport. *(Standard Practice)*
    a. This includes performing hand hygiene before beginning transport, ensuring that wheelchairs and gurneys used for transport have been cleaned and disinfected prior to use, putting on all appropriate PPE prior to contact with the patient when assisting with patient movement at the destination location, and removing and discarding soiled PPE. (*Standard Practice*)

2. PPE is not routinely worn by HCP transporting patients, except in the following situations when all recommended PPE should be worn:
    a. When transporting a patient with a pathogen that presents a high risk for morbidity and mortality for HCP (e.g., Ebola virus), ~~all pathogen recommended PPE should be used~~. (*Expert opinion*)
    b. When providing care to the patient during transport. (*Expert Opinion*)
        a. An ungloved individual should be present to assist with opening doors and operating elevators. (*Expert Opinion*)

3. HCP transporting patients should carry and use PPE under the following circumstances:
    a. When transporting a patient with a pathogen transmitted through the air, the transporter should have a mask or respirator available to them based on the recommended Transmission-Based Precaution category. If the patient is unable to use source control or if the patient will require medical care during transport (e.g., suctioning), the transporter should put on a mask or respirator prior to assisting the patient. (*Expert opinion*)
    b. When transporting a patient with a pathogen transmitted by touch, the transporter should carry gloves with them. ~~might be used~~ If the patient requires hands on assistance during transport, the transporter should put on gloves prior to touching the patient, and when finished, discard the gloves and perform hand hygiene. (*Expert Opinion*)

4. If a patient on Special Air Precautions is unable to wear source control, or if a patient is on Extended Air Precautions for a highly contagious infection (e.g., varicella or measles), the transport route and process should include a selection of the time and route of travel within a facility to minimize exposure of others during transport (*Expert Opinion*), and use of appropriate PPE by staff during transport and at the destination location. (*Standard Practice*)

Additional HICPAC Discussion Points

- For Transporter Considerations bullet 2, the first line is agreeable. However, the language needs to be crisper about situations in which all recommended PPE should be worn. Ebola should be put second because the more common scenario is a transporter having direct interaction with a patient on Transmission-Based Precautions during transport in which case, a member of the team needs to be not in any PPE with clean non-glove hands to interact with the environment. They are the ones doing the escorting, pushing the buttons, getting the team through the hallways. Maybe it should not say "providing care" because a transporter might not be providing care but they are having interactions. If they are having direct interactions, they would be in PPE. Suggested language for 2 "When transporting a patient with a pathogen" and then "When PPE is worn by the transport team, there must be a member of the team who is not wearing gown, gloves, and who has clean non-gloved hands to interact with the environment."
    - Keep it simple and make 2.c "An ungloved individual should be present to assist with opening doors and operating elevators." Then it does not matter what isolation a patient is in, there will be someone with clean ungloved hands.
    - It might not be clear to the reader what "interact" means.
    - Perhaps saying "direct contact" would be enough.
    - For transmission by air, there might not be touch contact but there might be proximity contact. "Direct contact" could be viewed a number of ways. Generally, that means something that is active and different from transporting. There is bagging a patient, et cetera.
    - A transporter who is not a clinician but who is having direct contact with the patient or who is somehow assisting the team and helping with the patient should have PPE.
    - "Direct contact" interaction could just be talking, such as the transporter saying, "Hello, I hope you're feeling well" as an interaction with the patient.
    - Suggested language, "PPE is not routinely worn by HCP transporting patients except in the following situations when all recommended PPE should be worn: a) when having direct contact with a patient on Transmission-Based Precautions during transport (*Expert Opinion*); sub-bullet a) when PPE is worn by the transport team, there must be a team member who is not wearing a gown or gloves to interact with the environment; b) when transporting a patient with a pathogen that presents a high risk for morbidity and mortality for HCP (e.g., Ebola) (*Expert Opinion*).
    - If someone is wearing PPE, it is because of a pathogen of concern, but someone who is not wearing PPE is needed just the same.
    - "Have a clean team member" applies to either a high-consequence or regular Transmission-Based Precautions.
    - Make that 2.c.

- For bullet 3, when talking about a pathogen transmitted by touch, it is in a patient who is on Transmission-Based Precautions because there are many pathogens transmitted by touch for which one would not glove to have direct contact with a patient:

- Perhaps revise 3 to say, “HCP transporting patients on Transmission-Based Precautions should carry and use PPE under the following circumstances” because it applies to both 3.a and 3.b.
- It is not clear that the word “carry” is needed. Some using PPE will mean that PPE is available to transporters where they are going. It seems fairly impractical that people would be carrying the PPE around with them every time they transport someone on Transmission-Based Precautions.
- This was an intent by the WG to remind HCP that they should bring PPE with them in case it is not available, such as in an elevator.
- Dr. Bell’s recollection was that they were trying to avoid people in full PPE or even relatively close to full PPE, wandering through facilities and then possibly touching things with soiled gloves. It is mostly gloves. It could be conditional. It already has been said that they should not be wearing PPE as they move through the facility if they are not touching the patient. Perhaps “should use PPE and carry it with them if necessary” would address this.
- “Should have gloves available to them” might be better.
- Some facilities give their transporters fanny packs at the beginning of their shift that can be cleaned and disinfected with gloves and hand sanitizer, so they can do what they need to as they move throughout the facility and always have it available.
- The proposed change for 3.a and 3.b was instead of “carry a mask or respirator” the language should read, “A transporter should have a mask or respirator available to them . . .” Similarly, “A transporter should have gloves available to them.”
- To be clear, the new version would say, “HCP transporting patients on Transmission-Based Precautions should have PPE available to them and use PPE in the following circumstances: a) When transporting a patient with a pathogen transmitted through the air, the transporter should have a mask or respirator available to them based on the recommended Transmission-Based Precaution category. If the patient is unable to use source control or if the patient will require medical care during transport (e.g., suctioning), the transporter should put on a mask or respirator prior to assisting the patient. (*Expert opinion*); b) When transporting a patient with a pathogen transmitted by touch, the transporter should have gloves available to them. If the patient requires hands on assistance during transport, the transporter should put on gloves prior to touching the patient, and when finished, discard the gloves and perform hand hygiene. (*Expert opinion*)”

- No additional comments were provided for bullet 4.

Part 3: Vote

Vote

The votes were taken following the Public Comment sessions but have been included with their respective session for ease of reading.

Vote #1 Section B: Personal Protective Equipment (PPE) for Healthcare Personnel for (HCP) Recommendations

PPE for HCP
General Considerations Recommendations

1. Healthcare personnel (HCP) must be trained and demonstrate competency in the selecting, putting on, using, removing, and disposing of PPE in a manner to prevent exposures and self-contamination. (*Standard Practice*)
2. Employers in healthcare settings are required to provide readily available PPE to HCP, ideally at or near likely points of use. (*Standard Practice*)
3. Sizing and models should be chosen to accommodate the needs of the local workforce. (*Standard Practice*)

PPE for HCP
Glove Recommendations

Indications
1. Use non-sterile gloves in the following situations: (1) any anticipated contact with blood or other potentially infectious material, (2) touching mucous membranes or non-intact skin, (3) handling soiled items such as used wound dressings, and (4) as indicated by Transmission-Based Precautions. Activities that do not meet these criteria do not require gloves. (*Standard Practice*)

Use
2. HCP should perform hand hygiene prior to reaching into a box of non-sterile gloves and putting on gloves, to reduce the risk of contaminating both the remaining gloves in the box and the gloves being put on. (*Expert Opinion*)
3. During care of a single patient, gloves should be changed after a task or procedure if contact occurs with potentially infectious material (e.g., if moving from a dirty task to a clean task). (*Standard Practice*)
4. Remove gloves if torn or soiled, and before caring for another patient. (*Standard Practice*)
5. Hand hygiene should be performed immediately after removing gloves, because pathogens on used gloves can contaminate hands during glove removal. (*Standard Practice*)
6. HCP should not practice extended glove use in place of hand hygiene. (*Standard Practice*)

Selection
7. Non-sterile gloves should be available in a range of sizes so that all users will be able to select a glove that fits comfortably without excess material that could impair function. (*Standard Practice*)

PPE for HCP
Gown Recommendations

Indications
1. Use non-sterile gowns in the following situations: (1) when an activity is anticipated to contaminate HCP clothing through direct touch or splash, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use
2. Gowns should be worn correctly, with all fasteners secured. (*Standard Practice*)
3. Remove gowns if damaged or soiled, and before caring for another patient. (*Standard Practice)*

PPE for HCP
Mask Recommendations

Indications

1. Use masks in the following situations: (1) when an activity is anticipated to create splashes or spray to the face, (2) as source control, and (3) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. Masks should not be reused as they can serve as a reservoir of infectious material if they become contaminated during use. (*Standard Practice*)
3. Masks should be changed if they become soiled, damaged, or harder to breathe through. (*Standard Practice*)
4. Extended use should not be practiced with masks except when used for source control. (*Standard Practice*) When practicing extended use for source control, masks should be disposed of:
    a) anytime they are removed *(Standard Practice)*, and
    b) if they are used during the care of a patient for whom a mask is indicated as part of Transmission-Based Precautions. (*Standard Practice*)

Selection

5. A fluid-resistant mask should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

PPE for HCP
Respirator Recommendations

Indications

1. Use respirators as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. A seal check should be performed each time an HCP puts on a fit-tested respirator to ensure that the respirator is properly seated on the face. (*Standard Practice*)
3. Single use disposable respirators should not be reused as they can serve as reservoir of infectious material if they become soiled during use. (*Standard Practice*)
4. Reusable respirators should be cleaned, disinfected, and dried between uses according to the manufacturer's instructions for use. (*Standard Practice*)
5. Respirators should be changed if they become soiled, damaged, or harder to breathe through. (*Standard Practice*)

Selection

6. A fluid-resistant respirator should be used in situations when splashes and sprays are anticipated. (*Standard Practice*)

PPE for HCP
Eye and Face Protection Recommendations

Indications

1. Protect the eyes and face in the following situations: (1) when an activity is anticipated to create splashes or spray of potentially infectious material to the eyes or face, and (2) as indicated by Transmission-Based Precautions. (*Standard Practice*)

Use

2. If reusable devices are used for eye and face protection, protocols must be in place for cleaning, disinfection, and drying between uses, per manufacturers' instructions for use. (*Standard Practice*)

Selection

3. The selection of eye and face protective equipment should consider the nature of the activity for which it will be used. (*Standard Practice*)

HICPAC voted unanimously to approve the language as proposed above for Section B PPE for HCP. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #2 Section C: Standard & Transmission-Based Precautions

Standard Precautions
Recommendation

1. Standard Precautions apply to the care of every patient, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered, and at all times. (*Standard Practice*)
2. HCP should be trained on how and when to apply Standard Precautions, including how to put on, correctly use, remove, and dispose of PPE. (*Standard Practice*)

Transmission-Based Precautions
Recommendation

1. HCP should be trained on how and when to apply Transmission-Based Precautions, including how to put on, correctly use, remove, and dispose of PPE. (*Standard Practice*)

Syndromic and Empiric Applications of Transmission-Based Precautions
Recommendation

1. Use appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs consistent with a transmissible infection, to reduce transmission risk. (*Standard Practice*)

HICPAC voted unanimously to approve the language as proposed above for Section C Recommendations for Standard Precautions, Transmission-Based Precautions, and Syndromic and Empiric Applications of Transmission-Based Precautions. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #3: Section C - Transmission-Based Precautions (TBP) to Prevent Transmission via Touch Recommendations

1. **Contact Precautions** (applies to all healthcare settings)
    a. Care for patients in a dedicated space, preferably a single patient room if available; if not available, then cohort. See Patient Placement section for more details. (*Standard Practice*)
    b. Use a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Gown and gloves should be properly removed and disposed upon exiting the patient's room (or designated space). (*Standard Practice*)
    c. Ideally, patient-care equipment (e.g., blood pressure cuffs, stethoscopes) should be dedicated to the patient and the patient's designated space. Disposable equipment may be used to minimize cross-transmission. If shared patient-care items are used, they should be cleaned and disinfected prior to use with other patients in accordance with the manufacturer's instructions for use. (*Standard Practice*)
    d. In general, clean, unopened patient care supplies should not be stored in the room but should be available near the room to allow easy access while ensuring that large amounts of supplies do not become contaminated. (*Standard Practice*)
        i. Any disposable supplies that are brought into the room should not be returned to the general supply; they may be sent home with the patient upon discharge if needed (e.g., for dressing changes) or discarded. (*Standard Practice*)
        ii. For clinical areas where supplies are stored routinely within rooms (e.g., outpatient clinic rooms), supplies should be stored in covered or closed clean storage areas. (*Standard Practice*)
    e. Frequently clean and disinfect room surfaces (e.g., at least daily or prior to use by another patient in ambulatory settings) to reduce environmental reservoirs of infectious material, focusing on frequently touched surfaces and areas in the immediate vicinity of the patient. See Environmental Infection Control Guidelines for additional details. (*Standard Practice*)

2. **Enhanced Barrier Precautions** (applies to Nursing Homes):
    a. Use Enhanced Barrier Precautions, when Contact Precautions do not otherwise apply, for patients and residents infected or colonized with multidrug-resistant organisms (MDRO). (*Expert Opinion*)
    b. Enhanced Barrier Precautions may be considered for patients and residents at high risk for MDRO colonization (e.g., patients and residents with wounds and/or indwelling medical devices), even if not known to be infected or colonized with an MDRO. (*Expert Opinion*)
    c. Use a gown and gloves for high-contact patient and resident care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (e.g., central venous catheter, urinary catheter, feeding tube, tracheostomy/ventilator management), and wound care. In general, gown and gloves would not be required for patient and resident care activities other than those listed above, unless indicated per Standard Precautions. (*Expert Opinion*)
    d. Patients and residents should not be restricted to their rooms or limited from participation in group activities. (*Expert Opinion*)
    e. Enhanced Barrier Precautions should remain in place for the duration of a patient or resident's stay in the facility or until the indication for Enhanced Barrier Precaution is resolved (e.g., resolution of wound or discontinuation of the indwelling medical device). (*Expert Opinion*)

HICPAC voted unanimously to approve the language as proposed above for Section C Recommendations for TBP to Prevent Transmission via Touch. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #4: Section C - TBP Transmission via the Air Recommendations

1. **Routine Air Precautions**
   a. HCP should use a mask on room entry and use eye protection based on Standard Precautions. (*Standard Practice*)
   b. Place patient in a single patient room; if not available, then cohort. See Patient Placement section for more details. (*Standard Practice*)
   c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Standard Practice*)
   d. Source control should be used by the patient when they leave their room (e.g., for transport to a procedure). (*Standard Practice*)

2. **Special Air Precautions**
   a. HCP should use a NIOSH-approved® fit-tested N95 (or higher-level) respirator and eye protection on room entry. (*Expert Opinion*)
   b. Place patient in a single patient room; if not available, then cohort. See Patient Placement section for more details (*Expert Opinion*)
   c. Rooms should be appropriately ventilated, but an AIIR is not routinely needed. (*Expert Opinion*)
   d. Source control should be used by the patient when they leave their room (e.g., for transport to a procedure). (*Expert Opinion*)

3. **Extended Air Precautions**
   a. HCP should use a NIOSH-approved® fit-tested N95 (or higher-level) respirator on room entry, and eye protection is used based on Standard Precautions. *(Standard Practice)*
   b. Place patient in a single patient room. (*Standard Practice*)
   c. An AIIR is required. If an AIIR is not available, the patient should wear source control and be isolated in a standard single patient room with the door closed. The patient should be transferred to an AIIR as soon as possible. (*Standard Practice*)
   d. Source control should be used for the patient when they leave their room (e.g., for transport to a procedure). (*Standard Practice*)

HICPAC voted unanimously to approve the language as proposed above for Section C Recommendations for TBP to Prevent Transmission via Air. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #5: Section C - Source Control and Patient Placement Recommendations

Approaches to Source Control in Healthcare Settings

Recommendations

1. During periods of higher levels of community respiratory virus transmission, facilities should consider implementing one of the following approaches to source control:
    a. HCP use source control when interacting with patients (e.g., on entry to the patient's room or bedspace). (*Expert Opinion*)
    b. All individuals (e.g., patients, visitors, and HCP) use source control upon entry to the facility or a clinical area. (*Standard Practice*)
        a. In most circumstances, it is not necessary for patients to use source control when in their room; it could be considered when care is being provided. *(Expert Opinion)*

2. At any level of community respiratory virus transmission, consider implementing source control measures targeted toward higher risk areas (e.g., emergency departments, urgent care) or units (e.g., bone marrow transplant units) based on a facility risk assessment. (*Standard Practice*)

Patient Placement
Recommendations

1. Use single patient rooms for patients requiring Transmission-Based Precautions, whether to prevent transmission by touch or through the air. (*Standard Practice*)

2. In long-term and other residential settings, room placement decisions should balance risks to the infectious individual and to other patients. (*Standard Practice*) Residents in Enhanced Barrier Precautions do not require placement in a single person room. (*Expert Opinion*)

3. In ambulatory settings, patients requiring Transmission-Based Precautions should be placed in an exam room or designated space as soon as possible rather than waiting in common areas. (*Standard Practice*)

4. If single patient rooms are not available, patients housed (cohorted) in the same room should have the same pathogen to the greatest extent possible. (*Standard Practice*)

5. Any time room sharing occurs, practices should be in place to limit potential for cross-contamination, including ready access to hand hygiene supplies, changing PPE between roommates, and dedicating patient care items or cleaning and disinfecting shared equipment after each use. (*Standard Practice*)

HICPAC voted unanimously to approve the language as proposed above for Section C Recommendations for Source Control and Patient Placement. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #6: Section C - Patient Transport Recommendations

Transport of Patients
Recommendations

Patient Considerations

1. Patients under Transmission-Based Precautions (with the exception of Enhanced Barrier Precautions alone) should leave their room only when medically necessary for their evaluation or care. (*Standard Practice*)

2. If the patient is being isolated for a pathogen transmitted through the air, they should use source control, any time they are outside of their room, unless source control is medically contraindicated or the individual is not capable of using source control safely. (*Standard Practice*)

3. If the patient is cared for using Contact Precautions for a pathogen transmitted by touch, appropriate barriers (e.g., clean patient gown, wrapping sheet, or impervious dressing) should be used to cover affected areas of the patient's body during transport when infectious skin lesions or drainage are present. (*Standard Practice*)

4. Before intra-facility or between-facility transport, direct communication with the receiving department or facility is required to ensure notification regarding the nature of the infection, the type of Transmission-Based Precautions required, and when the patient will arrive. (*Standard Practice*)

Transporter Considerations

1. HCP transporting patients should follow Standard Precautions to avoid spreading infectious material during transport. *(Standard Practice)*
    a. This includes performing hand hygiene before beginning transport, ensuring that wheelchairs and gurneys used for transport have been cleaned and disinfected prior to use, putting on all appropriate PPE prior to contact with the patient when assisting with patient movement at the destination location, and removing and discarding soiled PPE. (*Standard Practice*)

2. PPE is not routinely worn by HCP transporting patients, except in the following situations when all recommended PPE should be worn:
    a. When having direct contact with a patient on Transmission-Based Precautions during transport. *(Expert Opinion)*
    b. When transporting a patient with a pathogen that presents a high risk for morbidity and mortality for HCP (e.g., Ebola virus). (*Expert opinion*)
    c. When PPE is worn by a transport team, there must be a team member not wearing gowns or gloves to interact with the environment. *(Expert Opinion)*

3. HCP transporting patients on Transmission-Based Precautions should have PPE available to them and use PPE in the following circumstances:
    a. When transporting a patient with a pathogen transmitted through the air, the transporter should have a mask or respirator available to them based on the recommended Transmission-Based Precaution category. If the patient is unable to use source control or if the patient will require medical care during transport (e.g., suctioning), the transporter should put on a mask or respirator prior to assisting the patient. (*Expert opinion*)
    b. When transporting a patient with a pathogen transmitted by touch, the transporter should have gloves available to them. If the patient requires hands on assistance during transport, the transporter should put on gloves prior to touching the patient, and when finished, discard the gloves and perform hand hygiene. (*Expert opinion*)

4. If a patient on Special Air Precautions is unable to wear source control, or if a patient is on Extended Air Precautions for a highly contagious infection (e.g., varicella or measles), the transport route and process should include a selection of the time and route of travel within a facility to minimize exposure of others during transport (*Expert Opinion*), and use of appropriate PPE by staff during transport and at the destination location. (*Standard Practice*)

HICPAC voted unanimously to approve the language as proposed above for Section C Recommendations for Patient Transport. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Proposed Update of Patient Placement and PPE Recommendations for Andes and Nipah Viruses (Appendix A)

Aaron Kofman, MD
Medical Epidemiologist
Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

Dr. Kofman presented the proposed updates to the PPE recommendations for Andes and Nipah viruses in terms of Appendix A of the 2007 Isolation Precautions Guideline. Regarding the rationale, a number of recent examples of risk for non-Ebola viral hemorrhagic fever (VHF) pathogen importation to the US have arisen. Earlier in 2023, there were 2 Marburg outbreaks in Equatorial Guinea and Tanzania. Over the years, Lassa and Crimean Congo Hemorrhagic Fever often have been possible diagnoses for ill returning travelers from endemic regions. In 2023, there have been 2 US patients with Nipah on the differential diagnosis. In 2018 in the US, there was a single imported Andes virus case, which is a person-to-person transmissible hantavirus.

During the June 2023 HICPAC meeting, proposed updates to PPE and patient placement recommendations for Lassa, Crimean Congo Hemorrhagic Fever (CCHF), Marburg, and South American Hemorrhagic Fever (SAHF) viruses were approved (e.g., same as PPE and patient placement recommendations for Ebola). However, HICPAC requested additional clarification with regard to the Andes and Nipah recommendations. Given this request, a small ad hoc WG was formed to clarify the issues and bring the proposed recommendations back to the full HICPAC. While these updates were presented during the August 2023 HICPAC meeting, HICPAC was unable to vote on the recommendations because quorum was not achieved for that meeting. Given that there was not a voting quorum, the vote on the clarified recommendations was tabled until this HICPAC meeting.

As a reminder, Andes Virus is a person-to-person transmitted hantavirus spread by rodents that is endemic to South America, particularly Argentina and Chile. The clinical illness is an influenza-like initial presentation with fever, chills, headaches, cough, and shortness of breath. It can progress rapidly to respiratory failure, coagulopathy, and multi-organ dysfunction. The mortality rate is roughly 30% and there is no available vaccine or treatment. The modes of person-to-person transmission are thought to occur during close and prolonged proximity to case-patients by droplet or aerosolized inhalation or contact. The virus has been detected in a

number of body fluids, including blood, serum, peripheral blood mononuclear cells (PBMCs), urine, respiratory samples, and breastmilk. There have been documented episodes of occupationally-acquired transmission in healthcare, typically occurring in the setting of no, minimal, or incomplete PPE. The WG's recommendations are for patient placement in an airborne infection isolation room (AIIR) and for PPE to include gown, gloves, eye protection, and an N95 respirator or higher.

Nipah Virus is transmitted with a reservoir in bats in Southeast Asia, particularly Bangladesh, Malaysia, and India. Clinical illness includes a prodromal phase with fever, headache, myalgia, dizziness, respiratory symptoms, and vomiting. It can progress to neurological symptoms within 1 week involving coma, hyporeflexia, and seizures. Survivors also may have relapse or late-onset encephalitis. The mortality rate is between 40% to 75%. As with Andes Virus, there is no vaccine or treatment. Modes of person-to-person transmission are primarily through contact with body fluids, especially respiratory secretions and in the setting of prolonged exposure to case-patients, particularly patients with respiratory symptoms and who are of older age. During a 2018 outbreak in India, there was a case-patient sitting in a hallway awaiting imaging for several hours. During that time, various HCP passed in and out of that hallway. Some of them got Nipah and died, but had no actual contact with the patient that they passed by in the hall or with other known case-patients. Detection in body fluids has been from respiratory samples and urine. In addition to the example from 2018, there have been documented episodes of occupationally-acquired transmission in healthcare in endemic settings. Again, these typically have been in the setting of either no or minimal PPE. The WG's recommendations for Nipah Virus patient placement would be an AIIR and for PPE as follows:

- ❑ If suspect Nipah case and ***clinically stable***: gown, gloves, eye protection, N95 respirator or higher
- ❑ If suspect Nipah case and ***clinically unstable*** (e.g., hemodynamic instability, vomiting) OR confirmed Nipah case ***regardless of clinical stability***: use PPE according to clinically unstable VHF guidance.

Discussion Points

- No additional questions or comments.

Vote

The votes were taken following the Public Comment sessions but have been included with their respective session for ease of reading.

Andes Virus Patient Placement and PPE

- **Patient Placement:** AIIR
- **PPE:** gown, gloves, eye protection, N95 respirator or higher

Nipah Virus Patient Placement and PPE

- **Patient Placement:** AIIR
- **PPE:**
  - *If suspect Nipah case and clinically stable: gown, gloves, eye protection, N95 respirator or higher*
  - *If suspect Nipah case and clinically unstable (e.g., hemodynamic instability, vomiting)* OR *confirmed Nipah case regardless of clinical stability:* use PPE according to clinically unstable VHF guidance

HICPAC voted unanimously to approve the language as proposed above for Andes and Nipah viruses. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Healthcare Personnel Guideline Workgroup

Colleen Kraft, MD, MS
Chair, HCP Workgroup

Dr. Kraft provided an update on the *Guideline for Infection Control in Healthcare Personnel, 1998.* She noted that the findings and conclusions being presented during this session were draft, had not been formally disseminated by CDC, and should not be construed to represent any agency determination or policy. As a reminder, the original guideline was published in 1998. The HCP WG's charge was to focus on pathogen-specific issues for Infection Control in HCP. Where information is out of date, the WG will make updates using evidence-based methods where evidence is available.

Regarding the status report, **Section 1: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services** was published in October 2019.[1] The WG is now working its way through the pathogen sections to try to get them reviewed, approved, and posted. In terms of **Section 2: Epidemiology and Control of Selected Infections Transmitted Among HCP and Patients,** Diphtheria, Group A *Streptococcus*, Meningococcal Disease, and Pertussis were published in November 2021 and Rabies was published in November 2022.[2]

Regarding the current status report, the Measles, Mumps, Rubella, Varicella, and Pregnant HCP sections completed the 60-day public comment period, so a final vote was to be held during this meeting. The Cytomegalovirus (CMV) and Parvovirus B19 sections completed initial CDC clearance and soon would be posted to the *Federal Register* for a 60-day public comment period. A source control definition that will be added to the terminology appendix of this guideline has completed clearance and will be included in the CMV and Parvovirus B19 package for public comment. The Conjunctivitis section soon will enter initial clearance. *S. aureus* is a large topic for which an extensive literature review is underway. The WG has begun section scope determination for the Gastroenteritis and Viral Respiratory Infections sections. "On Deck" are Scabies/ Pediculosis, Hepatitis A, Bloodborne Pathogens (Hepatitis B, Hepatitis C, HIV), Herpes, and Tuberculosis (TB).

The Pregnant Healthcare Personnel section completed CDC clearance. This section also completed the 60-day public comment period on Regulations.gov, during which 1 comment was received from the Association for Professionals in Infection Control and Epidemiology (APIC) that already was reviewed during the August HICPAC meeting. As a reminder, that comment was as follows:

[1] https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/infrastructure.html
[2] https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/selected-infections/index.html

“The Association for Professionals in Infection Control and Epidemiology (APIC) wishes to thank the Centers for Disease Control and Prevention (CDC) for the opportunity to provide input to the CDC Draft Guidance: Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients: Pregnant Healthcare Personnel. APIC is a nonprofit, multidisciplinary organization representing 15,000 infection preventionists whose mission is to advance the science and practice of infection prevention and control. We thank the CDC and Healthcare Infection Control Practices Advisory Committee (HICPAC) for your work on this document and you have our full support for the document as written. We look forward to continuing to work with CDC to prevent HAIs in healthcare facilities.”

No changes have been proposed or made since HICPAC last voted on this draft guideline. If approved during the voting session, the section will be submitted for final CDC clearance and subsequent posting to the CDC Infection Control guideline website. The proposed recommendation is as follows:

Pregnant Healthcare Personnel
DRAFT Recommendation

1. Do not routinely exclude healthcare personnel only on the basis of their pregnancy or intent to be pregnant from the care of patients with infections that have potential to harm the fetus (e.g., CMV, HIV, viral hepatitis, herpes simplex, parvovirus, rubella, varicella).

HICPAC voted during the November 2022 public meeting to approve Measles, Mumps, Rubella, and Varicella for submission to CDC clearance. Initial CDC clearance was completed in April 2023. The 60-day public comment period was completed on Regulations.gov. A total of 5 comments were received, 4 of which were not relevant to this guideline. Clarifying edits have been proposed or made since the Committee last voted on this draft guideline, which Dr. Kraft reviewed during this session. If approved during the final voting period in this session, the sections will be submitted for final CDC clearance and subsequent posting to the CDC Infection Control guideline website. Relevant public comments were as follows:

From DuPage County Health Department (Illinois):

- Comment on measles, mumps, rubella: Suggest adding the following statement at the end of this paragraph in the narrative: "To prevent disease and transmission in health-care settings, health-care institutions should ensure that all persons who work in health-care facilities have documentation of adequate vaccination against measles, rubella, and mumps or other acceptable evidence of immunity to these diseases (Table 3)." Suggest hyperlinking "Table 3" to: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3”
    - **This link to these recommendations is already provided in the section, so no edits were made to the narrative.**

- Comment on varicella: Suggest adding the following statements at the end of this paragraph in the narrative: "Health-care institutions should ensure that all HCP have evidence of immunity to varicella. This information should be documented and readily available at the work location.“
    - **This information is already provided in the section and in Part I of this guideline, so no edits were made to the narrative.**

As a reminder, the 1998 Varicella Recommendations were as follows:

1998 Varicella Recommendations

- Administer varicella vaccine to susceptible personnel, especially those that will have contact with patients at high risk for serious complications. Category IA
- Do not perform serologic screening of persons with negative or uncertain history of varicella before administering varicella vaccine to personnel, unless the institution considers it cost-effective. Category IB
- Do not routinely perform postvaccination testing of personnel for antibodies to varicella. Category IB
- NO RECOMMENDATION for administering postexposure varicella vaccination for the protection of exposed, susceptible personnel. UNRESOLVED ISSUE
- Develop guidelines for managing health care personnel who receive varicella vaccine; for example, consider precautions for personnel who acquire a rash after receipt of varicella vaccine and for other health care personnel who receive varicella vaccine and will have contact with susceptible persons at high risk for serious complications from varicella. Category IB
- Develop written guidelines for postexposure management of vaccinated or susceptible personnel who are exposed to wild-type varicella. Category IB
- Exclude personnel from work who have onset of varicella until all lesions have dried and crusted. Category IB
- Exclude from duty after exposure to varicella personnel who are not known to be immune to varicella (by history or serology), beginning on the tenth day after the first exposure until the 21st day after the last exposure (28th day if VZIG was given). Category IB
- Restrict immunocompetent personnel with localized zoster from the care of high-risk patients until lesions are crusted; allow them to care for other patients with lesions covered. Category IB
- Restrict immunocompromised personnel with zoster from contact with patients until their lesions are crusted. Category IB
- Restrict susceptible personnel exposed to zoster from patient contact from the tenth day after the first exposure through the 21st day after the last exposure (28th day if VZIG was given). Category IB
- Perform serologic screening for immunity to varicella on exposed personnel who have not had varicella or are unvaccinated against varicella. Category IB
- Consider performing serologic screening for immunity to varicella on exposed, vaccinated personnel whose antibody status is not known. If the initial test result is negative, retest 5 to 6 days after exposure to determine whether an immune response occurred. Category IB
- Consider excluding vaccinated personnel from work beginning on the 10th day after the first exposure through the 21st day after the last exposure if they do not have detectable antibodies to varicella, or screen daily for symptoms of varicella. Category IB
- Do not routinely give VZIG to exposed susceptible personnel, unless immunosuppressed, HIV infected, or pregnant. If VZIG is given, exclude personnel from duty from the 10th day after the first exposure through the 28th day after the last exposure. Category IB

Another thing that was updated between the *Guideline for Infection Control in Healthcare Personnel, 1998* and now was the 2011 Immunization of Healthcare Personnel: Advisory Committee on Immunization Practices (ACIP) Recommendations, which are shown in the following tables for varicella and herpes-zoster:

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Varicella		
Active	Exclude from duty	Until all lesions dry and crust. If only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period
Postexposure (HCP without evidence of varicella immunity)	Exclude from duty unless receipt of the second dose within 3-5 days after exposure	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Herpes zoster		
Localized in immunocompetent person	Cover lesions; restrict from care of high-risk patients¶	Until all lesions dry and crust
Disseminated or localized in immunocompromised person until disseminated infection is ruled out	Exclude from duty	Until all lesions dry and crust
Postexposure (HCP without evidence of varicella immunity)		
Disseminated zoster or localized zoster with uncontained/uncovered lesions	Exclude from duty unless receipt of the second dose of varicella vaccine within 3–5 days after exposure	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period
Localized zoster with contained/covered lesions	For HCP with at least 1dose of varicella vaccine, no work restrictions. For HCP with no doses of varicella vaccine, restrict from patient contact	8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period

As a reminder, the Varicella-Zoster Virus DRAFT Recommendations that initially were approved in November 2022 were as follows:

1. For healthcare personnel ***with*** evidence of immunity to varicella who have an exposure to varicella or disseminated or localized herpes zoster:
    a. Postexposure prophylaxis is not necessary.
    b. Work restrictions are not necessary.
    c. Implement daily monitoring for signs and symptoms of varicella infection from the 8th day after the first exposure through the 21st day after the last exposure.

2. For healthcare personnel ***without*** evidence of immunity to varicella who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster:
    a. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/varicella.html).
    b. Exclude from work from the 8th day after the first exposure through the 21st day after the last exposure.
        1. Work restrictions are not necessary for healthcare personnel who previously received one dose of the varicella vaccine and received the second dose of vaccine within 5 days after exposure.
        2. If varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from work from the 8th day after the first exposure through the 28th day after the last exposure.

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

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

5. For immunocompetent healthcare personnel who have localized herpes zoster, including vaccine-strain herpes zoster, and for immunocompromised healthcare personnel who have localized herpes zoster and have had disseminated disease ruled out:
    a. Cover all lesions and exclude from direct care of patients at increased risk for complications from varicella disease until all lesions are dried and crusted.
    b. If lesions cannot be covered (e.g., on the hands or face), exclude from work until all lesions have dried and crusted

For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

The Varicella-Zoster Virus DRAFT Recommendations that completed clearance and public comment are as follows, with changes from the November 2022 version highlighted in yellow:

1. For asymptomatic healthcare personnel ***with*** evidence of immunity to varicella (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm#box) who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster (shingles):
    - Postexposure prophylaxis is not necessary.
    - Work restrictions are not necessary.
    - Implement daily monitoring for signs and symptoms of varicella infection from the 8th day after the first exposure through the 21st day after the last exposure.

2. For asymptomatic healthcare personnel ***without*** evidence of immunity to varicella who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster:
    - Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6228a4.htm; https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm).
    - Exclude from work from the 8th day after the first exposure through the 21st day after the last exposure.
        – Work restrictions are not necessary for healthcare personnel who previously received one dose of the varicella vaccine and received the second dose of vaccine within 5 days after exposure.
        – If varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from work from the 8th day after the first exposure through the 28th day after the last exposure.

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

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

5. For immunocompetent healthcare personnel who have localized herpes zoster, including vaccine-strain herpes zoster, and for immunocompromised healthcare personnel who have localized herpes zoster and have had disseminated disease ruled out:
    - Cover all lesions and exclude from direct care of patients at increased risk for complications from varicella disease until all lesions are dried and crusted.
    - If lesions cannot be covered (e.g., on the hands or face), exclude from work until all lesions have dried and crusted

For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

As a reminder, the 1998 Measles Recommendations were as follows:

1998 Measles Recommendations

- Ensure that all personnel have documented immunity to measles.
    - Administer measles vaccine to persons born in 1957 or later, unless they have evidence of measles immunity. Category IA
    - Administer measles vaccine to personnel born before 1957 if they do not have evidence of measles immunity and are at risk for occupational exposure to measles. Category IA
    - Do not routinely perform serologic screening for measles before administering measles vaccine to personnel, unless the health care employer considers screening cost-effective or the potential vaccinee requests it. Category IA
    - Administer postexposure measles vaccine to measles-susceptible personnel who have contact with persons with measles within 72 hours after the exposure. Category IA

- Exclude exposed personnel who do not have documented immunity to measles from duty from the fifth day after the first exposure until the 21st day after the last exposure to measles, regardless of whether they receive postexposure vaccine. Category IB

- Exclude personnel who acquire measles from duty for 7 days after rash develops or for the duration of their acute illness, whichever is longer. Category IB

Between the *Guideline for Infection Control in Healthcare Personnel,1998* and now, the 2011 Immunization of Healthcare Personnel: Advisory Committee on Immunization Practices (ACIP) Recommendations were published, which are shown in the following table for measles:

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Measles		
Active	Exclude from duty	4 days after rash appears
Postexposure (HCP without presumptive evidence of measles immunity)	Exclude from duty	5 days after first exposure through 21 days after last exposure and/or 4 days after the rash appears

As a reminder, the Measles DRAFT Recommendations initially approved in November 2022 were as follows:

1. For healthcare personnel ***with*** presumptive evidence of immunity to measles who have an exposure to measles:
    a. Postexposure prophylaxis is not necessary.
    b. Work restrictions are not necessary.
    c. Implement daily monitoring for signs and symptoms of measles infection for 21 days after their last exposure.

2. For healthcare personnel ***without*** presumptive evidence of immunity to measles who have an exposure to measles:
    a. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).
    b. Exclude from work from the 5th day after their first exposure until the 21st day after their last exposure, regardless of receipt of postexposure prophylaxis.
    c. HCP who received the first dose of MMR vaccine prior to exposure may remain at work, but should receive their second dose (at least 28 days after their first dose), and be monitored for signs and symptoms of measles infection for 21 days after their last exposure.

3. For healthcare personnel with known or suspected measles, exclude from work for 4 days after the rash appears.

4. For immunosuppressed healthcare personnel with known or suspected measles, exclude from work for the duration of their illness.

5. During a measles outbreak, administer measles vaccine to healthcare personnel in accordance with CDC and ACIP recommendations.

The Measles DRAFT Recommendations after completing clearance and public comment are as follows, with changes highlighted in yellow:

1. For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to measles (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to measles:
    - Postexposure prophylaxis is not necessary.
    - Work restrictions are not necessary.
    - Implement daily monitoring for signs and symptoms of measles infection for 21 days after their last exposure.

2. For asymptomatic healthcare personnel ***without*** presumptive evidence of immunity to measles who have an exposure to measles:
    - Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).
    - Exclude from work from the 5th day after their first exposure until the 21st day after their last exposure, regardless of receipt of postexposure prophylaxis.

- HCP who received the first dose of MMR vaccine prior to exposure may remain at work, but should receive their second dose (at least 28 days after their first dose), and be monitored for signs and symptoms of measles infection for 21 days after their last exposure.

3. For healthcare personnel with known or suspected measles, exclude from work for 4 days after the rash appears.

4. For immunosuppressed healthcare personnel with known or suspected measles, exclude from work for the duration of their illness.

5. During a measles outbreak, administer measles vaccine to healthcare personnel in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).

As a reminder, the 1998 Mumps Recommendations were as follows:

1998 Mumps Recommendations

- Administer mumps vaccine to all personnel without documented evidence of mumps immunity, unless otherwise contraindicated. Category IA

- Before vaccinating personnel with mumps vaccine, do not routinely perform serologic screening for mumps, unless the health care employer considers screening cost-effective or it is requested by the potential vaccinee. Category IB

- Exclude susceptible personnel who are exposed to mumps from duty from the 12th day after the first exposure through the 26th day after the last exposure or, if symptoms develop, until 9 days after the onset of parotitis. Category IB

Between the *Guideline for Infection Control in Healthcare Personnel,1998* and now, the 2011 Immunization of Healthcare Personnel: Advisory Committee on Immunization Practices (ACIP) Recommendations were published, which are shown in the following table for mumps:

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Mumps		
Active	Exclude from duty	5 days after onset of parotitis
Postexposure (HCP without presumptive evidence of mumps immunity)	Exclude from duty	12 days after first exposure through 25 days after last exposure or 5 days after onset of parotitis

As a reminder, the Mumps DRAFT Recommendations initially approved in November 2022 were as follows:

1. For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to mumps who have an exposure to mumps,
    a. Work restrictions are not necessary.
    b. Implement daily monitoring for signs and symptoms of mumps for 25 days after their last exposure.

2. For healthcare personnel ***without*** presumptive evidence of immunity to mumps who have an exposure to mumps, exclude from work from the 10th day after their first exposure through the 25th day after their last exposure.
    a. Healthcare personnel who received the first dose of MMR vaccine prior to exposure may remain at work, but should receive their second dose (at least 28 days after their first dose), and be monitored for signs and symptoms of mumps infection for 25 days after their last exposure.

3. For healthcare personnel with known or suspected mumps, exclude from work for 5 days after the onset of parotitis.

4. For healthcare personnel with known or suspected mumps, but without parotitis, exclude from work for 5 days after onset of their first symptom.

5. During a mumps outbreak, administer mumps vaccine to healthcare personnel in accordance with CDC and ACIP recommendations.

Mumps DRAFT Recommendations after completion of clearance and public comment are as follows, with changes highlighted in yellow:

1. For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to mumps (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to mumps,
    - Work restrictions are not necessary.
    - Implement daily monitoring for signs and symptoms of mumps for 25 days after their last exposure

2. For asymptomatic healthcare personnel ***without*** presumptive evidence of immunity to mumps who have an exposure to mumps, exclude from work from the 10th day after their first exposure through the 25th day after their last exposure.
    a. Healthcare personnel who received the first dose of MMR vaccine prior to exposure may remain at work, but should receive their second dose (at least 28 days after their first dose), and be monitored for signs and symptoms of mumps infection for 25 days after their last exposure.

3. For healthcare personnel with known or suspected mumps, exclude from work for 5 days after the onset of parotitis.

4. For healthcare personnel with known or suspected mumps, but without parotitis, exclude from work for 5 days after onset of their first symptom.

5. During a mumps outbreak, administer mumps vaccine to healthcare personnel in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).

As a reminder, the 1998 Rubella recommendations were as follows:

1998 Rubella Recommendations
- Vaccinate all personnel without documented immunity to rubella with rubella vaccine. Category IA

- Consult local and state health departments regarding regulations for rubella immunity in health care personnel. Category IA
- Do not perform serologic screening for rubella before vaccinating personnel with rubella vaccine, unless the health care employer considers it cost-effective or the potential vaccinee requests it. Category IB
- Do not administer rubella vaccine to susceptible personnel who are pregnant or might become pregnant within 3 months of vaccination. Category IA
- Administer rubella vaccine in the postpartum period to female personnel not known to be immune. Category IA
- Exclude susceptible personnel who are exposed to rubella from duty from the seventh day after the first exposure through the 21st day after the last exposure. Category IB
- Exclude personnel who acquire rubella from duty until 7 days after the beginning of the rash. Category IB

Between the *Guideline for Infection Control in Healthcare Personnel,1998* and now, the 2011 Immunization of Healthcare Personnel: Advisory Committee on Immunization Practices (ACIP) Recommendations were published, which are shown in the following table for rubella:

TABLE 5. Advisory Committee on Immunization Practices work restrictions for health-care personnel* (HCP) exposed to or infected with certain vaccine-preventable diseases and conditions

Disease/Condition	Work restriction	Duration
Rubella		
Active	Exclude from duty	7 days after the rash appears
Postexposure (personnel without evidence of rubella immunity)	Exclude from duty	7 days after first exposure through 23 days after last exposure and/or 7 days after rash appears

As a reminder, the Rubella DRAFT Recommendations initially approved in November 2022 were as follows:

1. For asymptomatic healthcare personnel with presumptive evidence of immunity to rubella who have an exposure to rubella,
    a. Work restrictions are not necessary.
    b. Implement daily monitoring for signs and symptoms of rubella infection for 23 days after their last exposure.
2. For healthcare personnel without presumptive evidence of immunity to rubella who have an exposure to rubella, exclude from work from the 7th day after their first exposure through the 23rd day after their last exposure.
3. For healthcare personnel with known or suspected rubella, exclude from work for 7 days after the rash appears.

    For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

The Rubella DRAFT Recommendations after completion of clearance and public comment, with changes highlighted in yellow:

1. For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to rubella (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to rubella,

- Work restrictions are not necessary.
- Implement daily monitoring for signs and symptoms of rubella infection for 23 days after their last exposure.

2. For asymptomatic healthcare personnel **without** presumptive evidence of immunity to rubella who have an exposure to rubella, exclude from work from the 7th day after their first exposure through the 23rd day after their last exposure.
3. For healthcare personnel with known or suspected rubella, exclude from work for 7 days after the rash appears.

   For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

Discussion Points

- "Immunocompromised" HCP are described throughout varicella and measles, but later the term "immunosuppressed" is used. It is not clear whether there is a reference to define what that means or whether the same term should be used throughout:

  - Dr. Kraft indicated that "immunocompromised" and "immunosuppressed" should be standardized throughout.

  - Dr. Kuhar added that it should be acceptable to make that change for the vote. He confirmed that the guideline includes a standard definition for "immunocompromised."

- Regarding covering lesions in varicella, there is a statement about when lesions cannot be covered, such as on the face. An inquiry was posed as to whether a mask may be used for lesions that are restricted to areas that can be covered with a mask:

  - Dr. Kraft confirmed that a mask is acceptable for lesions that could be covered with a mask.

Vote

The votes were taken following the Public Comment session but have been included with their respective session for ease of reading.

Vote #1: Pregnant Healthcare Personnel DRAFT Recommendation

1. Do not routinely exclude healthcare personnel only on the basis of their pregnancy or intent to be pregnant from the care of patients with infections that have potential to harm the fetus (e.g., CMV, HIV, viral hepatitis, herpes simplex, parvovirus, rubella, varicella)

HICPAC voted unanimously to approve the language as proposed above for pregnant healthcare personnel. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #2: Varicella-Zoster Virus DRAFT Recommendations

1. For asymptomatic healthcare personnel with evidence of immunity to varicella (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm#box) who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster (shingles):
   - Postexposure prophylaxis is not necessary.
   - Work restrictions are not necessary.
   - Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.
2. For asymptomatic healthcare personnel without evidence of immunity to varicella who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster (shingles):
   - Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6228a4.htm; https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm).
   - Exclude from work from the 8th day after the first exposure through the 21st day after the last exposure.
     - Work restrictions are not necessary for healthcare personnel who previously received one dose of the varicella vaccine and received the second dose of vaccine within 5 days after exposure.
     - If varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from work from the 8th day after the first exposure through the 28th day after the last exposure.
3. For healthcare personnel with varicella (chickenpox), exclude from work until all lesions have dried and crusted; or, for those who only have non-vesicular lesions that do not crust, exclude from work until no new lesions appear within a 24-hour period.
4. For healthcare personnel with disseminated herpes zoster (shingles) or for immunocompromised healthcare personnel with localized herpes zoster until disseminated disease has been ruled out, exclude from work until all lesions have dried and crusted.
5. For immunocompetent healthcare personnel who have localized herpes zoster (shingles), including vaccine-strain herpes zoster, and for immunocompromised healthcare personnel who have localized herpes zoster and have had disseminated disease ruled out:
   - Cover all lesions and, when feasible, exclude from direct care of patients at high risk for severe varicella (e.g., in protective environments) until all lesions are dried and crusted.
   - If lesions cannot be covered (e.g., on the hands or face), exclude from work until all lesions have dried and crusted.

For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

HICPAC voted unanimously to approve the language as proposed above for varicella-zoster virus. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #3: Measles DRAFT Recommendations

1. For asymptomatic healthcare personnel with presumptive evidence of immunity to measles (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to measles:
   - Postexposure prophylaxis is not necessary.

- Work restrictions are not necessary.
- Implement daily monitoring for signs and symptoms of measles infection for 21 days after their last exposure.

2. For asymptomatic healthcare personnel without presumptive evidence of immunity to measles who have an exposure to measles:
   - Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).
   - Exclude from work from the 5th day after their first exposure until the 21st day after their last exposure, regardless of receipt of postexposure prophylaxis.
   - Healthcare personnel who received the first dose of MMR vaccine prior to exposure may remain at work but should receive their second dose (at least 28 days after their first dose) and be monitored for signs and symptoms of measles infection for 21 days after their last exposure.
3. For healthcare personnel with known or suspected measles, exclude from work for 4 days after the rash appears.
4. For immunocompromised healthcare personnel with known or suspected measles, exclude from work for the duration of their illness.
5. During a measles outbreak, administer measles vaccine to healthcare personnel in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).

HICPAC voted unanimously to approve the language as proposed above for measles. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #4: Mumps DRAFT Recommendations

1. For asymptomatic healthcare personnel with presumptive evidence of immunity to mumps (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to mumps:
   - Work restrictions are not necessary.
   - Implement daily monitoring for signs and symptoms of mumps for 25 days after their last exposure.
2. For asymptomatic healthcare personnel without presumptive evidence of immunity to mumps who have an exposure to mumps, exclude from work from the 10th day after their first exposure through the 25th day after their last exposure.
   - Healthcare personnel who received the first dose of MMR vaccine prior to exposure may remain at work but should receive their second dose (at least 28 days after their first dose) and be monitored for signs and symptoms of mumps infection for 25 days after their last exposure.
3. For healthcare personnel with known or suspected mumps, exclude from work for 5 days after the onset of parotitis.
4. For healthcare personnel with known or suspected mumps, but without parotitis, exclude from work for 5 days after onset of their first symptom.
5. During a mumps outbreak, administer mumps vaccine to healthcare personnel in accordance with CDC and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).

HICPAC voted unanimously to approve the language as proposed above for mumps. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Vote #5: Rubella DRAFT Recommendations

1. For asymptomatic healthcare personnel with presumptive evidence of immunity to rubella (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6204a1.htm#Tab3) who have an exposure to rubella:
   - Work restrictions are not necessary.
   - Implement daily monitoring for signs and symptoms of rubella infection for 23 days after their last exposure.
2. For asymptomatic healthcare personnel without presumptive evidence of immunity to rubella who have an exposure to rubella, exclude from work from the 7th day after their first exposure through the 23rd day after their last exposure.
3. For healthcare personnel with known or suspected rubella, exclude from work for 7 days after the rash appears.

For recommendations about healthcare personnel who are pregnant or intending to become pregnant, please see the **Pregnant HCP** section.

HICPAC voted unanimously to approve the language as proposed above for rubella. Disposition of the vote was as follows:

- **9 Approved: Dekker, Fakih, Guzman-Cottrill, Kraft, Kwon, Reifsnyder, Shenoy, Weber, Wright**
- **0 Opposed**
- **0 Abstained**

Public Comment

Overview

Sharon Wright, MD, MPH
Acting HICPAC Chair

Dr. Wright welcomed and thanked the public comment speakers for addressing the committee during the first day of the November 2023 HICPAC meeting. She explained that all of the speakers submitted a request in advance of the meeting and that the final list of public commenters was determined via lottery. Given the limited public comment period, speakers were requested to limit their remarks to 3 minutes. A timer was displayed on the screen so that speakers could monitor their time. As a gentle reminder, Dr. Wright emphasized that the committee appreciates diverse viewpoints that are respectful in nature and focused on the issues being discussed during the 2-day meeting. She called upon Sydnee Byrd and Angela Driver to facilitate the session.

Mary Jirmanus Saba
Political Economist
Member, The People's CDC

Good afternoon. My name is Mary Jirmanus Saba. I'm a Political Economist and a member of The People's CDC. HICPAC received 600 pages of written comment on proposed changes to the Infection Control Guidance before today's meeting. The drafts you will vote on do not reflect any of that feedback and thus you must postpone tomorrow's vote. Much of the public comment describes jarring and unsafe experiences of healthcare workers and patients and actual harm to patients who sought healing and healthcare appointments but instead contracted COVID—patients whose healthcare providers denied reasonable accommodations requests and refused to mask. The People's CDC, a volunteer-run CDC watchdog and public health advocacy group, has received dozens of such complaints. Some said their healthcare employers even refused to allow them to wear N95 masks to protect themselves. Many complaints came from patients and workers at Massachusetts General Hospital, Dr. Shenoy's employer—people stating that their federally guaranteed right to safe medical care is being violated. The situation stands to get drastically worse if you continue with these weakened recommendations. The American Hospital Association reported hospitals are experiencing crushing financial challenges. In a brief, Sourav Bose and Serena Dasani from Penn's Leonard Davis Institute of Health Economics demonstrated that hospitals lost a lot of money due to postponed elective procedures for COVID-positive patients, while hospitals were still required to test patients upon admission. The April 5th *Boston Globe* reported Massachusetts Hospital administrators lobbied the DPH to get rid of masks, so before the CDC changed guidance on masking in healthcare last year, did hospital administrators email Rochelle Walensky just like the CEO of Delta and say, "Hospitals are losing money. Please loosen the rules on preventing COVID and other aerosol transmitted viruses in healthcare?" In making these new recommendations, are HICPAC and CDC prioritizing hospital profits over our safety? Whatever is happening, the consequences of continuing down this path are dire. They empower anti-public health forces. Just this past week, the US Senate passed a resolution to ban mask mandates on public transportation. Several Democrats even supported it. If it becomes law and we get another novel deadly virus transmitted by aerosol, states cannot mandate masks. Are they going to ban healthcare masking next? You can still do the right thing. Delay the vote, incorporate our comments, and base your recommendations on peer-reviewed evidence rather than vague and undefined expert opinion, which conveniently overlaps with healthcare management priorities. Recognize aerosol transmission and recommend N95 respirators or better for healthcare workers accordingly. Recommend upgraded standard ventilation and core control isolation protocols. Make universal masing the new standard of care year-round. Include occupational safety, healthcare unions, and patient safety groups as voting members of HICPAC. You can still do the right thing and do no harm. You can and must control and prevent disease. It's literally the CDC's mandate. Thank you.

Dr. Wright reminded everyone that the committee very much appreciates diverse viewpoints that are respectful in nature and are not personally directed at individuals or that make individuals feel at risk for their public service.

Roselie Bright, ScD
Retired Federal Epidemiologist

Good afternoon. I'm Dr. Rosalie A. Bright, a retired federal Epidemiologist with a Doctor of Science Degree in Epidemiology. I submitted a comment for the August meeting that I still stand

by. At the time, I did not have access to the materials from the June meeting. For today, I did not have access to today's meeting materials before the meeting.

1) The interpretation of policy related to using respirators versus surgical masks has been problematic:
    a. COVID-19 has high transmissibility, serious and often permanent consequences, and no cure. The worst side effects of respirators versus surgical masks are minor. These 2 factors qualify respirator use as a standard precaution by your definition.
    b. The whole idea of precaution is to take preventive action all the time, not just when one perceives present danger, and in the case of equipoise, to make policies based on erring on the side of protecting patients.

2) The Standard Precautions need to be upgraded to include universal airborne transmission precautions, including universal (that is, patients, healthcare workers, and visitors) at least respirator quality masks, air ventilation, and air cleaners, such as filters and upper room UVC. Engineering is essential for infection control. Simultaneous use of all practices is necessary.

3) Everyone must be presumed COVID-19 infectious because:
    a. It is highly transmissible, including when people are asymptomatic or pre-symptomatic.
    b. Even if one tests COVID-19 negative at the beginning of the workday, one can start emitting infectious levels of the virus by the end of the workday.
    c. Rapid tests have been negative—even when the tested person is currently infectious.
    d. Thus, everyone who seems healthy as well as anyone who has symptoms must be presumed to be infectious. This is why the HICPAC vote to recommend precautions only in the case of suspected or confirmed infection in the patient is inadequate.

4) Workers, patients, and visitors should always be supported to upgrade from mask precautions to respirators.

5) I object to allowing healthcare workers to forego precautions because of the mental health impact concerns. Your main concern should be infections.

6) The response to the current lack of COVID-19 disease surveillance should be to assume it is always present rather than to assume it has disappeared. HICPAC should recommend frequent and comprehensive monitoring for COVID-19 infection among workers, patients, and visitors so that providers can learn lessons to stop spread.

7) Healthcare workers who test positive should stay isolated at home on paid sick leave. Routine staffing levels need to be designed to accommodate realistic levels of staff sickness to reflect the realities of the pandemic. Presenteeism needs to be discouraged.

8) You haven't incorporated evidence-based comments in your draft guidance. Please reexamine your resistance to the overwhelming majority of public comments such as mine. Thank you.

Maria Giffen-Castro
Commenter

Thank you. I wish that you could see my face. I am one of the many people who is avoiding getting necessary medical care because of the risk of catching COVID. In fact, I've been avoiding going to the doctor for an ongoing issue I've been having for months now because I don't feel I can afford to risk catching COVID. How is this good for our healthcare system if patients like me are avoiding getting needed medical care? Even if you put aside the burden on the healthcare system, how is this good financially? Why should I have to risk catching a preventable disease if I have to go to the doctor or hospital? Why should my husband, who is still in his 40s, has diabetes, and kidney disease, have to risk his health to go to the doctor for these very serious issues? HICPAC and the CDC are supposed to be serving the public. HICPAC and the CDC need to start serving the public. Instead of looking to weaken protections, you need to start shouting loudly and frequently about the dangers of long-COVID, encouraging our country to clean indoor air, and encouraging the use of high-quality masks. It is my understanding that studies were "cherry-picked" that said masks don't work. I would think it's easy to come by those studies now, given that people aren't really masking at all out there. How would that not skew the results? Also, if you look, there are numerous studies saying masks do work, including at least 2 meta-analyses I found. How are we ever supposed to resolve a problem if we're not dealing with it head on and honestly. How do we expect transmission of COVID to decrease or even possibly become a non-issue one day if people are not getting the information and tools they need to stop the spread? I can't tell you how many people I've talked to who think they are not at risk for developing long-COVID. I also cannot tell you how many healthcare systems I've contacted about wearing masks only to hear they're only following the CDC's guidance. HICPAC and the CDC have a responsibility to make sure the public is educated about dangers of long-COVID, the post-cardiac risk that can happen after acute COVID infection, and that people know the proper way to protect themselves. As we have seen, vaccination is not stopping the spread. Please start taking this seriously. Please start dealing with this problem honestly and head-on. Also, one last comment, the federal government is encouraging everyone to get vaccinated, but there are literally no places I can find that are requiring masking for vaccination appointments. How on Earth is this promoting public health? Thank you.

Zenei Triunfo-Cortez, RN
President, National Nurses United

My name is Zenei Triunfo-Cortez. I'm a Registered Nurse and President for National Nurses United, the largest labor union and professional association for Registered Nurses in the US. I urge you to delay your vote on the updated guidance. While we appreciate the changes that you have made to make the work of HICPAC more publicly accessible, including posting meeting recordings and presentations and making the August meeting minutes available more quickly than past meetings, the reality is that you have not given the public an opportunity to review the draft updates that you plan to vote on today. The CDC did not publicly post the draft before the meeting and that means you are still missing essential perspectives. HICPAC members and liaisons are dominated by healthcare executives, industry representatives, and infection prevention program managers. But, HICPAC is missing the perspective of frontline nurses, other health care workers, and our unions. As nurses, we carry out many essential pieces of infection prevention. We have insights and expertise that are essential to crafting protective guidance. HICPAC is missing the perspectives of patients, including those who are immunocompromised and at higher risk of severe impacts of infections. HICPAC is also missing the perspectives of experts outside of infection prevention, such as industrial hygienists, experts in respiratory protection and ventilation, and other public health experts. During the COVID pandemic, nurses saw too many patients and colleagues become infected, get sick, and even die because of inadequate infection prevention. Too many continue to experience the impacts of

long-COVID and now extensive research has documented what nurses have advocated for since the beginning of the COVID pandemic. We need a multiple measures approach that combines ventilation; PPE, including respiratory protection anytime we are exposed to an aerosol transmissible disease like COVID; screening and isolation; exposure notification; and other measures. I urge you to delay the vote until you have incorporated input from nurses, other healthcare workers, patients, and other public health experts. CDC should host public meetings to engage input from all stakeholders like they did in 1992 when developing infection prevention guidance for multiple drug-resistance tuberculosis in healthcare settings. Thank you for the opportunity to comment.

Eric Berg, MPH
Deputy Chief of Health
Cal/OSHA

My name is Eric Berg. I'm the Deputy Chief of Health for Cal/OSHA, the California OSHA program. On February 3, 2020, about one month after the first reports of an outbreak, Cal/OSHA issued written guidance for COVID-19. Cal/OSHA stated that under existing law, workers must be protected from novel viruses such as COVID-19, unknown pathogens, and other listed viruses and pathogens through use of airborne infection isolation, NIOSH-approved respirators, source control, specific training, and several other protective measures necessary for airborne infectious diseases. These protections were and continue to be mandatory for California workers exposed to COVID-19, other novel pathogens, unknown pathogens, and many more listed airborne infectious pathogens in healthcare, correctional facilities, and certain other types of facilities, these worker protections are the law in California due to the Aerosol Transmissible Disease Standard Title 8 Section 5199 in the California Code of Regulations, which was established in 2009. In California, the Aerosol Transmissible Disease Standard is the law and prevails over CDC or any other less protective recommendations. However, CDC and other recommendations are often used as de facto law and regulation by healthcare facilities. This creates both confusion and perceived authority by healthcare facilities to use less protective measures. Going back to COVID, CDC unfortunately did not recognize COVID-19 as airborne in 2020 and issued guidance that was less protective than the law in California. The contradiction created confusion that resulted in some workplaces not complying with the ATD or Aerosol Transmissible Disease Standard and then suffering from COVID-19 outbreaks. Similarly, updates to the 2000 Guideline for Isolation Precautions that are less protective than the law in California will also create confusion and result in workers not being adequately protected. Back in 2020, disposable and single-use respirator shortages occurred. Cal/OSHA urged employers to use elastomeric respirators specifically designed to be reusable, which were not in shortage. Unfortunately, other entities put into practice the reuse of disposable and single-use respirators that were never designed or made to be reused that often resulted in inadequate protection for workers and new hazards for workers. Moving forward, we know that extensive studies from NIOSH and many others that only respirators can protect against fine and ultrafine particles that can carry certain airborne infectious pathogens.

Don Ford (Reg Mills)
OBT

This is Don Ford from OBT. Thank you to the committee for taking up the role of adding SARS-CoV-2 guidance. We all understand that the science moves faster than these committees, but the committee has made some simple oversights in addition to not keeping up with the science. I'm reminded of an internet meme that uses order of operations by challenging people to answer a math question using parenthesis, but it's a trick. In both science and math, we remove

redundant aspects, but they are understood as being there regardless. In this case, the use of order operations dictates everything touching parentheses to be equated first. We remove the second set of parentheses of this question for speed because it is understood. The same is true in how we speak of respiratory viruses. When we refer to the nature of infectious pathogens, it refers to the vector by which they transmit, not the organs they are affecting. We have sexually transmitted disease, water transmitted, and so on, including respiratory transmitted disease, which means it's spread from breathing it in. While we have removed the word for speed, the purpose is to establish risk based on transmission type. Then we even group them based on that. I believe we call it “Appendix A.” Because of this simple oversight, all methods of air and transmission are not being properly considered. We just had a 60-minute presentation that demonstrated the co-spreads of micro aerosol, which is smallest known form of airborne transmission. We need to establish our quality of care around this well-understood concept. Since this was overlooked, here's other more complicated aspects that have also been overlooked. The respirator study being cited demonstrates that respirators are effective at the workplace, but wearing them at work doesn't prevent transmission at home, so the study would be more likely to confirm the effectiveness of respirator use in healthcare settings if the data were interpreted by a neutral party. SARS 2 is recently confirmed to fuse brain cells via syncytial formation and other than Novavax, our current run of vaccines do not offer any protection for the upper respiratory tract, leaving the brains of not only patients but the professionals that are expected to provide care vulnerable to long-term damage. For many, respirators are the only brain protection we have. SARS 2 is a syncytial airborne virus that should be classified on risk levels with other similar viruses that have equal micro aerosol protections. Its defining trait for severity is its ability to create syncytia in our lungs, but it's doing it in our brains too. Recently, a study showed the more fit a variant the more likely to hospitalize you. That might seem obvious at first, but simple extrapolations can be made because of the common nature of SARS 2. SARS 2 can create new variants via co-infection. That's two infections of two different variants and it's very common. If you don't apply the proper micro aerosol protections, then we risk co-infections in hospitals where we gather the most virulent and fit variants. We have to slow the mutations of SARS 2 or else corporate manufacturers will not see the financial outcomes they want to produce the treatments that we will all need. An infection-based immunity is not effective as it takes two infections to shift your memory response, so you'll need never have protection to the new variant from your previous infection, and even most variants exist to gain immune evasion, so that allows them to infect people again and continue this process. These decisions will immediately impact vulnerable populations and it's only a matter of time till immunocompetent folks like yourself are caught in this net. This is not a theory. Recombinant variants already triggered waves while rendering our treatments ineffective faster than we can manufacture them. This is our COVID reality. This will leave everyone at constant high risk for severe outcomes. We need a proper classification of SARS 2 as an airborne syncytial virus that requires micro aerosol protections. You do not build long-term immunity allowing for co-infections. Thank you.

Chloe Humbert
Commenter

My name is Chloe Humbert. Why is it that I have to continuously ask about safety precautions when I need healthcare? I’m continuously hit with the canned answer from healthcare providers saying that, oh, they follow recommendations and guidelines, and then basically say they don’t have to prevent infection or protect me, but “Hey, you can mask if you want to.” I wrote to the CEO of Geisinger requesting ADA accommodation and in his response, he seemed more concerned with “patient experience” than he was about infection control. The response from the patient liaison also just repeated that they follow federal law and guidelines and that people who

are actively sick have to mask. The message I'm getting is that they're not going to do anything to stop transmission unless forced. The whole point of healthcare is to stop disease. I don't want to get COVID from going to the doctors, so is it about the money and the healthcare corporations wanting to just half-ass it on the cheap? Because I can't help but notice that the HICPAC committee has fancy people from highfalutin corporate executive positions, and no patient advocates. It's been suggested this isn't legal and might even render the committee's recommendations null and void. I can't believe in 2023 we're being forced into infection because the CDC has decided to adopt Brownstone Institute dark money connected people putting out PR publications that they call a "meta-study"—a study that's been widely debunked and lambasted. And this seems in order to not protect workers or patients. Rightwing anti-mask COVID contrarian think tanks shouldn't be dictating my healthcare and the working conditions of healthcare workers. The American people voted out the MAGA Scott Atlas Great Barrington Declaration herd immunity garbage. I expected better from the Biden Administration. This whole process needs revamping because the so-called experts involved are bizarrely disconnected from reality and I am not alone in these frustrations. Today, I went to an impromptu online demonstration announced just last night about COVID transmission in healthcare. This event attracted a couple hundred people at noon on Thursday, and several people who spoke at this event repeated the same experiences and concerns that I'm running up against and that you've heard in previous comments to this committee—healthcare providers putting them in danger and giving them COVID. It's unacceptable. We are not alone. Read the room. People want masks in healthcare settings. Thank you.

Naomi Bar-Yam
World Health Network

My name is Naomi Bar-Yam. I'm with the World Health Network. The world is a very different place than it was in 2007, the last time these guidelines were updated. Today, we know much more about air transmission and scientific information is more accessible to researchers, policymakers, and the public. In 2007, the last pandemic had been in the rearview mirror for almost 4 decades. Today, we are still in a pandemic and more will come. You must weigh multiple seemingly mutually exclusive factors. It's a heavy responsibility and while CDC is not a regulatory body, your guidelines have immense influence around the US and across the world. A few examples of the delicate balancing act you face: 1) As you have pointed out, it's important for your guidelines to be flexible [and] applicable in many settings and situations. At the same time, it is crucial that they be clear and unambiguous regarding patient and provider safety; 2) You consider budgets, many important measures, and programs compete for institutional resources. Perceived institutional budgetary pressures cannot prevent you from making safety guidelines reflecting well-documented science; and 3) CDC is under enormous fiscal, economic, political, and social pressure for the pandemic and pandemics to be over. They are not. Practitioners, institutions, and citizens rely on CDC for timely, science-based information to set their policies. You face a complex task. Fortunately, HICPAC members have enough experience to know that you do not have all the information and knowledge needed to make the best guidelines you can. Shirley Chisholm once said, "If they don't give you a seat at the table, bring a folding chair." Hundreds of people have brought folding chairs to this table—people who understand parts of the proverbial elephant, the whole of which HICPAC's 9 members cannot possibly see fully. What other voices do you need to fulfill your responsibility to the medical community and the American people? Infectious disease and epidemiology are well-represented on HICPAC. Sound guidelines require expertise in other areas: occupational health, aerosol transmission, and practitioners and patients who are the most directly affected. From the question of whether a reliably well-fitting surgical mask exists to individual versus facility risk assessments to where and when to use higher levels of airborne precautions—other

experts bring invaluable knowledge. They are sitting in folding chairs all around you eager to contribute to the guidelines that will protect healthcare workers, patients, and our communities. We are all on the same side. Please, invite them in. Engage their knowledge, wisdom, and expertise now. Effective guidelines require multidisciplinary understanding of the science and its implication. Thank you.

Joaquin Beltran
Founder, Action / Care / Equity (ACE)

Thank you. I'm Joaquin Beltran, Founder of actioncareequity.org. Today, I am addressing the injustice in our country of preventable hospital-acquired infections by calling on HICPAC to: 1) require respirator masks in healthcare settings; 2) improve ventilation and air filtration; and 3) bring back reporting of hospital-acquired infections. Lives should not be harmed in health settings. Lives should be saved. By definition, every patient in a healthcare setting is vulnerable and mask requirements should be the standard of care. Anything less is an exercise in negligence since the CDC has finally admitted that SARS 2 is airborne. I have a personal friend, Dr. Robby, whose mother died from a hospital-required infection of SARS 2—a tragic death that could have been prevented with mask requirements. My own grandma, who has had vascular issues after having COVID, when taking her to see a vascular specialist, the specialist told me, “I don't like wearing masks” and cited the CDC’s guidelines as reasons for not wearing one—even as the specialist admitted to knowing COVID was a vascular disease. Many of the vulnerable have little to no protection, like the immunocompromised who do not even have monoclonals available anymore and whose suppressed immune response diminishes the effectiveness of vaccines. Children also remain vulnerable as a recent study showed a 3% increase in the infant mortality rate last year, which means that all those kids never reached their first birthday. Multiple studies have shown an increased risk of type 1 diabetes for all children. While vaccines have saved lives, data presented at the CDC over the last couple of years shows that the first generation of vaccines wane quickly and a recent study showed Paxlovid does not reduce the risk of long-COVID. Pharmaceuticals alone are not enough. Masks worked so well that in 2020, one flu strain may have been eradicated, causing the CDC to remove that very strain from vaccines. HICPAC must recognize that SARS 2 is airborne and that respirators and indoor air quality upgrades are necessary to prevent and reduce transmission of all airborne viruses, including flu, RSV, and TB. Let's be clear, we have lost and continue to lose, a tragic number of healthcare workers due to death and long-COVID from hospital-acquired infections of SARS 2. Requiring respiratory masks, improving ventilation and filtration, and reporting hospital-acquired infections will help patients and our hospital workers stay safer and help address critical staffing shortages, which are reducing the overall standard of care and leading to a healthcare collapse. I’ll close with the following questions: You are the CDC. If you or a loved one ends up in the hospital and gets COVID while seeking care, how will you look back on this moment? What is preventing you from protecting patients and healthcare workers in healthcare settings? What is preventing you from requiring masking, ventilation, and filtration to save lives? What is preventing you from doing your job of controlling and preventing disease? In the spirit of Dr. King’s legacy, “Injustice anywhere is a threat to justice everywhere.” I join my brothers and sisters of every faith and nationality in calling for a cease fire in Gaza and an end to the genocide of the Palestinian people. Thank you.

Megan Cunningham
Mother of Immunocompromised Child

Good afternoon. My name is Megan Cunningham. I'm a member of the public and the mother of an immune compromised child. I want to take a moment to especially thank those in attendance

today who are showing community care by wearing masks. It's much appreciated. We stand today at an inflection point for the US medical system. Global experts in climate crises, virology, and epidemiology have repeatedly warned that SARS-CoV-2 will not be the last pandemic and projections are that the next zoonotic virus is only a handful of years in the future at most. The infection control policies that this committee ultimately puts into place are what will scaffold the US medical system's responses to the next pandemic virus. It's not an *if*, it's a *when*. The CDC's disease control and prevention mandate demands that it be aggressive and forward-looking. It is critical to remember that proactive prevention of pathogen transmission is always far easier, cheaper, and quicker than the development, distribution, or administration of any vaccine or treatment. This meeting is understandably future-focused, and I just want to give some insight into what is also going on in the present for members of the public. My family and our FFP3 N95 respirators is all seen for the last 2 years by maskless medical care providers, some of whom refuse to mask despite written ADA requests. My family foregoes all but the most urgent medical care because begging our care providers to avoid infecting us is traumatizing, inhumane, cruel, and exacerbates the already existing power imbalance between patient and medical care provider. Making respirators a standard blanket requirement for all medical settings for patients, staff, visitors, and all indoor areas of medical facilities would go a long way toward preventing nosocomial and community transmission of not only COVID, but future pandemic pathogens. Having this proposed variety of Byzantine rules and flowcharts is only going to confuse and delay action, ultimately leading to paralysis. Making the rules simple, direct, and universal will prevent a lot of unnecessary and costly debate, impasse, and ultimate inaction. Please do not weaken infection control measures. On the contrary, they should be strengthened at baseline. While talk of hand hygiene is obviously foundational for public health, it simply isn't enough in this era of transmissible and ever-evolving aerosolized viruses and asymptomatic infection. While this committee is understandably focused on patient care, I also need to highlight the cascading effects of downplaying and minimizing infectious disease, not only in this era of ongoing SARS-CoV-2, but also in the future. Whether this committee realizes it or not, the decisions you make here will impact the trajectory not only of the medical establishment, but our society as a whole. If public health and medical officials are not taking care to avoid infection, why should other employers? Why should schools? Why should the legal system? Why should charity organizations? Why should any lay member of the community? The lessening of infection control protocols ensures wider community transmission, consequently straining and breaking our already fragile healthcare systems. Please, do no harm. Thank you.

Jay Herzmark, RN
Certified Industrial Hygienist
Safe Work Washington Volunteer

This is Jay Herzmark. I'm a Registered Nurse and a Certified Industrial Hygienist. I have a Master's Degree in Occupational Health Nursing. I am retired. I ran a consulting company called Safe Work Washington. Our goal was to protect workers from occupational hazards. I continue to do that type of work, but now as a volunteer. I have worked for many years with infection control practitioners associated with hospitals in the Seattle area who were consistently very smart and knowledgeable. One thing I did notice about some of them was a frequent inability/ unwillingness to consider knowledge from outside their own profession. There is a huge quantity of knowledge about exposures to asbestos, lead, silica, and other particulate health hazards. The use of certified respirators and ventilation for exposure control is very well-studied for all these hazards. Unfortunately, many infection control practitioners hear those words and can only picture factories and construction sites, but the laws of physics are the same in healthcare. Viruses and bacteria are both particulates. They float through the air, too. They penetrate leaks,

can be flushed out with dilutional ventilation, and can be sucked out with local exhaust ventilation. As an Industrial Hygienist, I attempted to provide information to infection control practitioners about respiratory protection and ventilation as it related to tuberculosis, SARS, swine flu, and COVID. It was as if I was talking to a television. I could hear them, but they didn't hear me. But let me try again. The laws of physics apply in healthcare viruses and bacteria are particulate. They float through the air. They penetrate leaks in surgical masks. They can be flushed out of a room with dilution ventilation. They can be sucked out of a space with local exhaust ventilation. You don't have to believe me. Talk to other industrial hygienists, aerosol scientists, or ventilation engineers. They all work on air contaminant controls, but you must talk to them. While they work on stuff that is different from handwashing, antivirals, and case surveillance, what they do can control infection too. Don't just listen to your own echoes. Don't let your science be inbred. Converse with folks who know solid science beyond traditional hospital infection control. Your job here is to protect both patients and healthcare workers. No one said your job was to protect your employer's bottom line. That is not your job here. Protecting people is your job here. You are here to consider science, all the science, and make recommendations to protect these people based only on science. Your employers may have many opportunities to have their say. They will try to weaken the projections.

Shimi Sharief, MD, MPH
Public Health Physician and Nephrologist

My name is Shimi Sharief. I'm a Public Health Physician and Nephologist. I have no conflicts to disclose today. I'm speaking today in partnership with National Nurses United regarding the need for infection prevention of SARS-CoV-2 and other infectious agents with known aerosol transmission in healthcare settings to keep patients and healthcare providers safe from infection. As someone who left clinical practice in California in early 2020 due to the unavailability and inconsistency of PPE recommendations. I was able to return for a year in 2021 to 2022 here in practice in Oregon due to the added safety of cohorting and respirator availability at that time. There's continuing sound scientific evidence for the airborne nature of SARS-CoV-2 infection and the transmission of this agent, even in asymptomatic individuals, last reported up to 10% to 25% of the time. None of the presentations today acknowledged the very real escalating threat of post-COVID conditions colloquially known as "long-COVID" arising in individuals, especially healthcare personnel, from repeated SARS-CoV-2 infections. There are already workers claims in several states and increasing evidence of the dangers of repeat infections to healthcare providers from less protective PPE, including surgical masks, which have been shown to be as little as 8% protective against infection due to their loose fit. To lump SARS-CoV-2 into a disease state that is considered as causing "mild disease" only without acknowledging the post-acute state of illness is not only inaccurate, but also dangerous to the future health of our workforce. SARS-CoV-2 is extremely transmissible and still circulating in high numbers in many populations for whom effective therapeutics and vaccines do not exist and for whom current therapeutics will likely become even more inaccessible given the recent commercialization of the one effective antiviral that exists in current state. Vaccines also do not produce durable immunity against infection even in immunocompetent people. The draft evidence review simultaneously points out issues with studies comparing surgical masks and respirators yet produces guidelines recommending a loose surgical mask as standard precautions again respiratory pathogens. Even without fit testing, a filtering face piece respirator with ear loops is much more effective at containing and protecting against pathogens that spread by air. With the COVID-19 pandemic, many effective non-NIOSH approved filtering face piece respirators, even manufactured in the United States, are available in clinical staffing units. I would know since my last clinic stocked multiple N95s for provider and staff use at no cost. Until 2022, they were even the recommended choice of PPE for all patient encounters

regardless of patient symptomatology in addition to N95 respirators. This keeps providers and their patients safer from these pathogens. Surgical masks are best reserved for instances where they truly are effective, which is to prevent spray of bodily fluids such as saliva. I urge the committee to delay the vote until the public has had a chance to review and thoughtfully comment, as the draft materials were not available until this morning. We are still in a pandemic and our healthcare crisis is going to be another pandemic if we don't act now. Thanks so much.

Lisa Foreman
Nurse Practitioner

My name is Lisa Foreman. I'm a Nurse Practitioner with over 20 years of clinical experience. I'm here to address the need to require masking in all healthcare settings. All of you at CDC, the HICPAC committee, and those giving public comments all know that COVID and other respiratory illnesses are airborne. We have seen the long worshiped “Droplet Theory” completely disproven and now, even business magazines and mainstream media confirm that respiratory pathogens can spread like smoke for hours and travel much further than 6 feet. We know that breathing and speaking are [breaking up] procedures. Over half of healthcare workers now go to work with symptomatic COVID infections and over half of COVID-19 infections are asymptomatic. This underscores the urgent need for source control via N95 or elastomeric respirators. RCTs are appropriate for interventions such as pharmaceuticals, but they are the wrong metric and totally unnecessary here. Respirators take advantage of the principles of physics which were established decades ago [breaking up] are not appropriate personal protective equipment for prevention of airborne pathogen transmission engineers, aerosol scientists, and organizations like NIOSH should be allowed to inform us on our personal protective needs. Many people have put off dental work, surgeries, and procedures for years now due to the inability to mask. I've heard many stories from those who went for these procedures only to leave infected. My biggest fear these days is that I will one day be unable to avoid a doctor or dentist. Patients depend on us to protect them, and we are morally obligated to do so. It is wholly unethical to ask them to assume a 10% mortality risk from a healthcare-acquired COVID infection. They depend on us to protect them, and we are morally obligated to do so. We should not be giving patients one disease while treating them for another. We can't ignore this because it's uncomfortable, or expensive, or a reminder that we're still in a pandemic. We all know what needs to be done here. Please, give us overarching guidelines for standard precautions that address mode-congruent prevention of all airborne respiratory pathogen transmission. Let's be the adults in the room and do it. Thank you.

Danielle Peck
Patient from Michigan

My name is Danielle Peck. I'm a patient from Michigan. I appreciate you taking my comment today. Despite my efforts to mask and protect myself, I contracted COVID-19 at a doctor's office while seeking postpartum care. I often wonder how many other pregnant patients and their unborn babies, who are at significantly higher risk of severe outcomes from COVID, were also infected that day. Of course, the number of patients who should have been infected that day is zero. If standard care would have included the use of respirators by staff and patients, along with adequate ventilation, these infections would have been entirely preventable. We're in the middle of a pandemic that is still killing and disabling far too many Americans. HICPAC should be strengthening infection control measures to save lives and livelihoods of the patients that come to be healed at healthcare facilities. Instead, the changes of the proposed guidelines are shameful in that they will only weaken infection controls, causing more death and disability. I urge the HICPAC to: 1) Seek input on proposed changes during the development of the draft

guidelines using the *Federal Register* public notice process and Town Hall meetings with virtual options. The public, including patients and healthcare workers—the people who keep your hospitals running—demand a voice in this process. A few minutes of public comment at the end of a meeting is not adequate; 2) Make the process for updating the guidelines fully open and transparent; 3) Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input by multi-disciplinary scientific researchers and key stakeholders; and 4) Create clear and concise control guidelines that recognize aerosol transmission of SARS-CoV-2. This includes requiring respirators for routine air precautions for workers, patients, and visitors and implementing minimum indoor air quality standards that have been set by ASHRAE 241. Earlier in the meeting, it was suggested that the draft language around ventilation is too soft and someone else answered that ventilation is out of the scope of the documents. I agree with the concern raised and ask you where is IAQ in scope if not in this document? IAQ should absolutely be an important part of these guidelines. Lastly, I just want to draw public attention to the fact that the minutes of the August HICPAC meeting included 602 pages of public comments calling for increased infection control and transparency. Though you are only allowing a few of us to speak, thousands of us are here. We are watching, we are listening, and we are fighting for health, for care, and for our lives, and we are fighting for your lives too HICPAC. We object to the guidelines as they stand. Postpone tomorrow's vote. Prioritize safety and public health. Put the lives of patients and healthcare workers first. Thank you.

Christine Braile
Parent of a Son with Primary Immune Deficiency

Thank you. My name is Christine Braile. I am here for my son. My son is 16 and like approximately 500,000 people in the United States, has a primary immune deficiency. He also has long-COVID, which he caught 2 years ago after being infected by his home infusion nurse who refused to wear a mask properly. COVID has wrecked his life, causing him to suffer liver damage, chronic severe abdominal pain, chronic severe head pain, impaired circulation in his toes, thyroid disease, and iron deficiency. He's had 8 iron infusions on top of his IVIG and a plethora of scans, procedures, blood tests, and doctor visits, all while constantly exhausted and in pain and all while fighting to keep from reinfection, despite the best efforts of unmasked healthcare providers. Even back when there was sometimes good masking compliance, the vast majority of staff only wore loose surgical masks, defeating the purpose of protecting those who cannot mask. Because COVID is airborne, definitively and without question, loose surgical masks are not sufficient to keep anyone safe. N95s are greater, as source control reduces viral load by 95% or more if worn. Once mask mandates in healthcare were lifted, we got to see the disease-transmitting smiles of the doctors and nurses who were supposed to keep my son safe. Loosening the patient protections for respiratory diseases, especially COVID, will only hurt patients and further decimate staffing levels. Respirators, ventilation, air filtration, and UV are all needed to safeguard at-risk patients like my son. I know no one likes masks. I've seen up close the resentment and resistance of most hospital staff toward wearing masks, but COVID doesn't care and none of those people have ever lifted a finger to care for my son when he's crying in pain, unable to eat normally, see his friends, or live a typical teenager's life—none of them. HIPCAC has a duty of care to already vulnerable patients to ensure that they do not get sicker in the hospital. My son actually needs an elective surgery and we have had to postpone it as hospitals are not safe for him. How can I send him unmasked into an OR? How can I ensure he will not get COVID again from an unmasked nurse or family member in the open bay post-anesthesia care unit? I wish you could look him in the eye and tell him that his safety doesn't matter, that his life doesn't matter. Mistakes were made throughout healthcare when COVID started by not acknowledging that it is airborne. It's time to face that and correct that continuing

error by requiring well-fitting respirators, ventilation, and air filtration. My son will finally feel like his life matters and that he is worth protecting. Thank you.

Andrew Wang, DrPH, MPH
The People's CDC

Hi everyone. Thank you so much for having me today. My name is Andrew Wang. I have a Doctorate in Public Health focused on health services research. I have a Master of Public Health focused on health policy. I'm grateful for Dr. Lin and Dr. Wright for leading the HICPAC group. I know it's a lot of work. I'm very appreciative of the dedication by all the voting and non-voting members, as well as all the liaison representatives advocating for our patients and healthcare workers. I'm truly aware that you all take this work very seriously and that is why you're here today. You've dedicated your careers in healthcare and medicine, and I just want to say thank you. I know it's a large challenge that you face in making these decisions today and tomorrow regarding how to prevent healthcare-acquired COVID infections. I want to first express that I have no financial conflicts of interest. I do want to disclose that I am part of The People's CDC and so with that, my comments today reflect upon both the presentations that you have shared with us today, as well as comments that I had before the presentations. COVID-19 infections injure, harm, and cause mortality among millions of Americans. Based on both case counts and estimates, millions of Americans also are suffering from long-COVID. It is important that everyone in healthcare settings are protected from these infections. SARS-CoV-2 is spread, as you know, via inhalation of aerosol particles, with a higher risk in indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care to prevent these healthcare-acquired conditions. Layers of protection, as we discussed today and heard from many others as well, include high-quality respirators such as N95s, ventilation, air filtration, and these all have been demonstrated to protect individuals from a COVID-19 infection. The HICPAC Work Group has proposed a less cautious approach based on the results that you've shared today. You've already shared 2 major areas that are of great concern. One, you mentioned optional masking, especially when there are settings when community transmission may be at high-risk or even at low-risk, and we must be aware that the CDC is not able to log the amount of true COVID rates of transmission at this time because you only are able to collect PCR-level data for COVID-19 infections. Second, you've also discussed the situation with the pandemic being endemic. Unfortunately, whether you believe that the pandemic is endemic or not, this disease is still spreading and it's very harmful for all individuals. So with that, we must be more thoughtful, especially for the audiences that are listening in today, and we must be aware and be thoughtful and compassionate to the public. So with that, I ask you to reconsider the vote and if you cannot reconsider, please consider voting to protect patients. Thank you very much.

Ex-*Officio* / Liaison Reports

Ex-*Officio* Reports

Agency for Healthcare Research and Quality

Leyi Lin, MD, FACP
Medical Officer
Division of Healthcare-Associated Infections
Center for Quality Improvement and Patient Safety
Agency for Healthcare Research and Quality

Dr. Lin provided an update on the work of the Agency for Healthcare Research and Quality (AHRQ) that is pertinent to this meeting. The AHRQ Safety Program for MRSA prevention is an ongoing 18-month project across 3 cohorts designed to implement evidence-based infection prevention strategies in conjunction with cultural and behavior improvement measures based on the Comprehensive Unit-based Safety Program (CUSP), which is a collaboration between AHRQ and Johns Hopkins Medicine's Armstrong Institute for Patient Safety and Quality, and NORC at the University of Chicago. The first non-ICU cohort focused on patient decolonization, decontaminating the environment, prevention of person-based transmission, and reducing procedure-related infections finished in September. Data collection activities are being completed and a toolkit based on the cohort is being developed that is anticipated to be completed by Fall 2024. The high-risk surgical services cohort focused on decolonization, pre-operative skin antisepsis, antimicrobial prophylaxis, and perioperative methods to reduce infection. In the long-term cohort, skin protection, high-touch surface cleaning, reducing MDRO transmission, and using antibiotics appropriately are being emphasized. These 2 cohorts are ongoing and educational toolkits will be developed in these settings as well. The AHRQ Safety Program for Telemedicine Improving Antibiotic use began in June. This this project led by NORC with partners at Johns Hopkins will use the CUSP framework to implement tools to improve antibiotic use and assess the feasibility of the intervention in primary care practices that use telemedicine. Preparations are underway to commence recruitment this winter. The project aims to recruit 300 to 500 telemedicine practices for participation in the 18-month cohort. The AHRQ Safety Program for Improving Surgical Care and Recovery was a collaborative program to enhance recovery of surgical patients that was funded and lunched by AHRQ and was conducted by Johns Hopkins in partnership with the American College of Surgeons (ACS) and the University of California San Francisco (UCSF). This program aims to use an adaptation of CUSP to improve patient outcomes by increasing the implementation of evidence-based enhanced recovery after surgery practices in hospitals. The project was implemented in 342 hospitals nationwide. Hospitals using the tools were able to improve various surgical practices and patient outcomes. Overall, the length of time surgery patients stayed in hospitals was significantly reduced. The toolkit was released last Spring and additional Spanish language patient education materials are currently being completed and posted to the AHRQ website. The Project Protecting Nursing Homes from Infections and Hospitalization (PROTECT) Trial, an AHRQ study led by Susan Huang, recently published the results in the *New England Journal of Medicine* (*NEJM*). The investigators found that chlorhexidine bathing plus nasal decolonization significantly reduced hospital transfers among nursing home residents. Data obtained over 28,000 residents during an 18-month treatment period showed the number needed to treat was 9.7 to prevent 1 infection-related hospitalization and 8.9 to prevent 1 hospitalization for any reason.

Food and Drug Administration

LCDR Scott Steffen, PhD
Senior Program Management Officer
Center for Devices and Radiological Health
US Food and Drug Administration

LCDR Steffen reported that on July 24, 2023, the FDA recognized a new standard that the International Standards Organization (ISO) published for the use of vaporized hydrogen peroxide to sterilize medical devices. This is the first new standard of an alternative sterilization modality for medical devices in many years as part of FDA's actions to address the nation's reliance on ethylene oxide (EO). When the FDA recognizes standards, it means that FDA finds them acceptable, and that the manufacturer can make a Declaration of Conformity to the

standards to meet the pre-market submission of other equipment thereby reducing regulatory burden. On September 1, 2023, the FDA granted de novo marketing application on the ZENEX® LightStrike™. This is the first marketing application for a whole room microbiological reduction device using UV. Based on earlier conversations of the Isolation Guidance, LCDR Steffen reiterated from his June 2023 report to HICPAC that the FDA recently updated its PPE website in March 2023 that describes N95 respirators, surgical masks, facemasks, and barrier face coverings; compares surgical masks to surgical respirators; discusses general N95 precautions; and discusses the use of N95s in various settings.

National Institutes of Health

David Henderson, MD
Senior Consultant to the CEO at the Clinical Care
Associate Director for Hospital Epidemiology and Quality Improvement
National Institutes of Health

Dr. Henderson reported that the NIH has continued to relax its mitigation efforts for COVID-19. Masking on the Bethesda campus is now optional. In the hospital, both staff and patients remain masked when feasible. Testing for COVID-19 continues for inpatient admissions. Because of increased activity in the community, admissions also are being tested for RSV and influenza A and B. Ongoing monthly surveillance continues of patients during ongoing hospitalization for carbapenemase-producing organisms (CPOs). Because there has been an increase in extended-spectrum beta-lactamase (ESBL)-producing gram negatives, there also is screening for those. NIH Infection Preventionists presented 3 abstracts this year at IDWeek discussing some of the surveillance activities for COVID, RSV, CPOs, and *Candida auris* (*C. auris*). Dr. Henderson said he was especially pleased to announce that NIH's former Hospital Epidemiologist, Dr. Tara Palmore, had seen the error of her ways and is coming back to the NIH. She will work with Dr. Clifford Lane in the National Institute of Allergy and Infectious Diseases (NIAID) as the Assistant Director for Clinical Research.

Liaison Reports

American Association of Kidney Patients

Paul Conway
Chair, Policy and Global Affairs
American Association of Kidney Patients

Mr. Conway reported that the American Association of Kidney Patients (AAKP) has moved forward with its collaborations with CDC on new kidney disease surveillance. Recently, AAKP also presented with the American Society of Nephology and the full stakeholder community of the kidney professional societies and patient groups before the Kidney Interagency Coordinating Committee (KICC). One of the issues about which they made a very strong joint voice was the concern about the upcoming decision by the United States Preventive Services Task Force (USPSTF) that may not include screening for kidney disease. There is substantial correspondence on that, which AAKP has joined, stating its concerns as that would be inconsistent with national policy under the past 3 Presidential Administrations. In terms of ongoing work on AAKP's project on government determinants of health, on October 19, 2023, AAKP met with over 130 Congressional offices to raise concerns about infection control issues. In particular, one issue that they raised was catheter-related bloodstream infections and new technologies that are coming into place on that which can reduce those. It is a shared concern

with CMS, CDC, and many other agencies, including Congress and GAO. AAKP is very concerned that new products will be misidentified and put into the dialysis bundle payment system even though they are not dialysis services, so they raised that concern to Congress. They do not want to end up with a patchwork system of proactive infection control and think that new technologies can help many different types of patients, including kidney patients. AAKP also shares the ongoing concerns that have been raised by folks in the HICPAC public comment periods. One piece of advice AAKP would provide to CDC, if they start to reconsider some of their processes for HICPAC, the World Health Organization this year put out a model for substantive engagement of people with lived experiences—not that CDC has to turn to the WHO. There are also federal agencies that do this quite well, such as the Department of Defense (DoD), the Veterans Health Administration (VHA), and the FDA's Center for Devices and Radiological Health (CDRH) which do substantial work in the field of patient engagement and expert engagement in the pre-regulatory and regulatory space. AAKP encouraged CDC to take a look at those, as well as CMS's technical evaluation panels for substantive and robust engagement outside of the committee before the committee drafts materials and brings them to informal votes and sends them forward for recommendations by the CDC. AAKP thinks its broad-based, it works, it makes sense in 2023, and CDC must spread out the process and include more voices.

American College of Occupational and Environmental Medicine

Mark Russi, MD, MPH
American College of Occupational and Environmental Medicine

Dr. Russi provided an update for the American College of Occupational and Environmental Medicine (ACOEM). He reported that in 2 weeks there would be a 3-day virtual summit. A range of topics will be covered, though the emphasis will be on workplace implications of artificial intelligence (AI) and global warming. A program by ACOEM to issue regular communications to members summarizing recently published literature of relevance has been well-received. Since the last HICPAC meeting, a new guidance document regarding safety implications of increasing cannabis use has been issued. ACOEM's spring annual meeting is scheduled for mid-May. A number of presentations regarding the healthcare workplace will be included, as well as a daylong pre-conference course regarding healthcare workers.

American Society of Nephrology & Nephrologists Transforming Dialysis Safety

Kristina Bryant, MD
Professor of Pediatrics
Division of Pediatric Infectious Diseases
University of Louisville School of Medicine

Dr. Bryant reported that the American Society of Nephrology (ASN) organization has been very busy. She highlighted a few items that may be of interest to the infection prevention and healthcare epidemiology community. There is a COVID-19 After Action virtual meeting planned for November 13, 2023. This meeting was organized in collaboration with the CDC and will include members of the nephology community, government officials, and national stakeholders to discuss the impact of the COVID-19 pandemic on people living with chronic kidney disease (CKD). A diverse group of stakeholders will review successes of response to the pandemic, some remaining challenges, and preparation for future events. The ASN has had ongoing engagement with state health departments to improve the care of patients with kidney disease, In October, there was a well-attended webinar with the Florida Department of Health addressing

management of sepsis and antimicrobial stewardship in dialysis patients. There are a number of activities aimed at improving immunization. The last few months have seen the launch of the ASN Adult Immunization Project (AIP) Learning and Action Network (LAN), which is a monthly engagement opportunity via an "all-teach, all-learn environment" to drive improvements to processes and delivery of vaccinations to kidney patients. ASN has also launched Home Dialysis University (HDU), with 2 cohorts of infectious disease fellows. This is an intensive training course that is followed by 11 months of virtual longitudinal case-based training. It has a strong focus on infection prevention in home dialysis. In terms of guidelines and guidance documents, *Guidance for the Care of Patients Infected or Colonized with Sepsis and Outpatient Dialysis Facilities* soon will be released by ASN. ASN is also collaborating with CDC colleagues on the development of *Core Interventions for the Prevention of Infections in Peritoneal Dialysis*. These will be similar to what ASN has for hemodialysis. ASN has several projects promoting vaccine confidence in adults and children, for which the web links will be included in the written report. ASN is engaged in ongoing collaboration with CDC colleagues to develop materials to promote the awareness, recognition, and management of sepsis in dialysis patients.

Association of periOperative Registered Nurses

Karen DeKay, MSN, RN, CNOR, CIC
Perioperative Practice Specialist
Association of periOperative Registered Nurses

Ms. DeKay reported that Association of periOperative Registered Nurses (AORN) registration for in-person and virtual attendance is now open for the AORN annual conference March 9-12, 2024 in Nashville, Tennessee. Pre-sales have begun for the 2024 Guideline Book, which includes 6 updates of guidelines, one of which is HIV. They have begun work on updating 5 more guidelines for 2025, one of which is sterile technique, and adding a new guideline on ERAS, not the Taylor Swift kind, but enhanced recovery after surgery. She also announced that California was the 15th state to enact laws requiring surgical smoke evacuation for planned surgical procedures.

Pediatric Infectious Disease Society

Karen Ravin, MD
Pediatric Infectious Diseases Society

Dr. Ravin reported that it has been a busy time for PIDS since the last HICPAC meeting. In October 2023, PIDS welcomed a new President, Dr. Bill Steinbach, who took over for Dr. Buddy Creech who completed his 2-year term. During the recent IDWeek and at the PIDS Foundation dinner, Dr. Kris Bryant was honored with a much-deserved special award for her service as outgoing PIDS Foundation Chair and for her numerous contributions to PIDS over the past decade. In September, PIDS representatives joined colleagues from IDSA, the Cystic Fibrosis Foundation, and other industry partners on Capitol Hill to advocate for the Pioneering Antimicrobial Subscriptions to End Upsurging Resistance (PASTEUR) Act, which is a bill that seeks to create a new model for development of antimicrobial and antifungal drugs, with a goal to combat drug-resistance and improve appropriate use of antibiotics. Also on that theme, PIDS is collaborating with Sharing Antimicrobial Reports for Pediatric Stewardship (SHARPS) to continue to hold monthly webinars on antimicrobial stewardship topics. Some recent topics included *Discharge Antimicrobial Stewardship for Common Pediatric Infections* and *Improving Short-Course Treatment of Pediatric Infections*. PIDS will be partnering with the World Health Organization (WHO) to provide a pediatric webinar during World AMR Awareness Week

(WAAW) coming up later in November entitled “All Over the Map: Global AMR Surveillance and Pediatric Considerations.” PIDS will be partnering with the Society for Healthcare Epidemiology of America (SHEA) to sponsor a new educational initiative in infection prevention and control and hospital epidemiology, which will include case-based presentations with interactive discussions and is aimed at furthering education for fellows and junior faculty.

Society for Healthcare Epidemiology of America

Hilary Babcock, MD, MPH
Medical Director of Occupational Health (Infectious Diseases)
Barnes-Jewish and St. Louis Children’s Hospitals
Professor of Medicine, Infectious Disease Division

Dr. Babcock reported that SHEA recently completed its election of new SHEA 2024 Board of Trustees and said she was happy to announce that Dr. Lisa Maragakis would be the new Vice President and would become the President of SHEA over the next few years. SHEA recently completed publication of all of the updated sections of its *Compendium of Strategies to Prevent HAIs*. The sections published in the last few months include *Strategies to Prevent MRSA Transmission* and *Infection and Strategies to Prevent Infections in Catheter-Associated Urinary Tract Infections (URIs) and Surgical Site Infections (SSIs)*. These are all available through open access online at *Infection Control & Hospital Epidemiology*. Links will be included in the written report. SHEA is hosting a Strategic Communication for Healthcare Professionals Workshop in January 2024 that is designed to provide training in media communication and better science communication. SHEA also is accepting applications for the SHEA Spring Conference Scholarship Program and its International Ambassador Program. More information will be available in the written report. The SHEA Spring Conference is scheduled for April 16-19, 2024 in Houston, Texas. The theme of the conference this year is “The Future is Now: Implementing Change through People, Policy and Technology.”

Surgical Infection Society

Robert Sawyer, MD
Professor of Surgery and Medical Engineering Chair
Department of Surgery
Western Michigan University
Homer Stryker MD School of Medicine

Dr. Sawyer reported that in addition to SSIs, the Surgical Infection Society (SIS) has partnered extensively with its colleagues in the Surgical Infection Society of Europe (SIS-E) and the World Society of Emergency Surgery (WSES) to convene a series of webinars specifically devoted to improving antimicrobial use by surgeons to prevent the breeding of antimicrobial resistance. While they are surgeons, they are very interested in the nonsurgical and medical aspects of surgical infections.

The Joint Commission

Tiffany Wiksten, BSN, APN, DNP
Associate Director, Standards Interpretation Group
The Joint Commission

Dr. Wiksten announced that the CMS approved the New and Revised Infection Prevention and Control Requirements for Hospital and Critical Access Hospital Accreditation Program. It is anticipated that the publication of the New and Revised Infection Prevention and Control Standards will occur in January 2024 and will go into effect in July 2024. Currently in development are the New and Revised Infection Prevention and Control Requirements for Post-Acute and Long-Term Care Nursing Centers, Assisted Living Care, Home Health Services, Hospice, Home Infusion, Free Standing Ambulatory Infusion Centers, Long-Term Care, and Specialty Pharmacies. Anticipated public comment periods run from January through March 2024 and an anticipated final standards release effective date of January 1, 2025. Currently being researched are New and Revised Infection Prevention and Control Requirements for Ambulatory Surgery Centers, Medical Dental Centers, Urgent Immediate Care Centers, Office-Based Surgery, Behavioral Health Care, and Laboratory. Anticipated standards release and effective date will be July 1, 2025. Additionally, The Joint Commission (TJC) has identified the US CDC NHSN system as a data source to identify patient safety and quality performance by TJC accredited hospitals who already participate in NHSN as required by the US CMS programs. Acute care hospitals and critical access hospitals will be required to join TJC within the NHSN application. There will be no patient identifiers shared with TJC and hospital data will remain confidential and will not be shared with other TJC accredited hospitals. Beginning July 1, 2024, hospitals must allow TJC to access de-identified data on the following 5 CDC NHSN HAI measures from the NHSN application, all of which are currently in the CMS Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition (HAC) Reduction Program: Catheter-Associated Urinary Tract Infection Outcome Measure, Facility-Wide Inpatient Hospital Onset *C. Difficile* Infection Outcome Measure, Central Line-Associated Bloodstream Infection Outcome Measure, Colon and Abdominal Hysterectomy Surgical Site Infection Outcome Measure, and Facility-Wide Inpatient Hospital Onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure. Information about joining TJC;s NHSN group will be distributed to organizations in late 2023 and early 2024. Data collection continues through voluntary interviews with hospital outpatient ASP leaders for TJC research department study supported by the Pew Charitable Trusts entitled *Antimicrobial Stewardship in Hospital Outpatient Clinics: A Qualitative Study of Alignment with Existing Guidance*.

Adjournment

With no additional business raised or comments/questions posed, HICPAC stood in recess from 4:48 PM ET on November 2, 2023 until 9:05 AM ET November 3, 2023.

Friday: November 3, 2023

Call to Order / Roll Call / Announcements

Sydnee Byrd, MPA, Program Analyst
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

Ms. Byrd called to order the second day of the November 2-3, 2023 HICPAC meeting at 9:04 AM Eastern Time (ET), welcomed everyone, and called the roll. Meeting and voting quorum were established and maintained throughout the day. HICPAC members disclosed no new COIs. Ms. Byrd indicated that once again, public comment was scheduled following the presentations and before any votes. She explained public comments would be limited to 3 minutes each, and that commenters should state their names and organization for the record before speaking. She reminded everyone that the public comment period is not a Q&A session.

Public Comment

Overview

Sharon Wright, MD, MPH
Acting HICPAC Chair

Dr. Wright welcomed and thanked the public comment speakers for addressing the committee during the second day of the November 2023 HICPAC meeting. She explained that all of the speakers submitted a request in advance of the meeting and that the final list of public commenters was determined via lottery. Given the limited public comment period, speakers were requested to limit their remarks to 3 minutes. A timer was displayed on the screen so that speakers could monitor their time. As a gentle reminder, Dr. Wright emphasized that the committee appreciates diverse viewpoints that are respectful in nature, focused on the issues being discussed during the 2-day meeting, and not directed personally at individuals or that make individuals feel at risk for their public service. She called upon Sydnee Byrd and Angela Driver to facilitate the session.

Seifer Almasy
Member of the Public

My name is Seifer Almasy. I am a member of the public. I am avoiding healthcare settings as much as possible because current infection control practices do not include effective precautions against the airborne transmission of pathogens. I don't want to go into a space that will expose me to COVID-19, an airborne virus that causes immense long-term damage to anyone infected with it. The CDC says that nearly 1 in 5 American adults who have had COVID-19 still have long COVID. That is a horrific statistic, compounded by the failure to use precautions that would protect people from COVID-19. I am deeply afraid of being in a situation where avoiding healthcare is not an option. I was recently in such a situation when I decided I could not put off getting the Novavax and flu vaccines. After 34 phone calls and over 4 hours of either waiting on hold or pleading with whoever answered my call, I finally found a provider who wore an N95 respirator while giving me the vaccines. So far, I feel like I am unscathed, but that is because of privilege and luck. Those factors should not determine whether a patient gets to

safely access healthcare. The current power dynamics in healthcare drastically disadvantage patients. I know people who got sick with COVID-19 because they had to access healthcare settings that do not require precautions like universal masking with respirators. Patients as well as healthcare workers fear for their safety because viruses can hang in the air like smoke for hours. Many studies and experts confirm this fact. HICPAC must recommend clear, robust, and authoritative precautions against the airborne transmission of pathogens. Anything less is malpractice and will do harm. Education is needed to implement the precautions, so HICPAC must work to accomplish the following: 1) develop training plans that can reach diverse populations in many different healthcare settings; 2) cultivate safety leadership at the management levels of the healthcare industry; 3) work with unions, professional societies, communication specialists, healthcare workers, occupational safety experts, and patients to inform precautions and training; and 4) launch extensive occupational safety campaigns and public service announcements. All education must teach the following understanding that: A) airborne transmission of pathogens is real; B) airborne transmission occurs year-round; it's not merely seasonal; C) respirators, especially elastomeric respirators, protect everyone and must be warn in all healthcare settings; and D) operational ventilation and reliable air cleaning systems help protect us all, too. To close my comment, I urge the HICPAC members to recognize your power to close information gaps and save lives with clear, robust, and authoritative precautions against the airborne transmissions of pathogens. If you cannot do that today, then delay your vote until you can prepare precautions that will protect everyone. Do better. I yield my time.

Aysha Mirza
Stem Cell Biologist
COVID Compliance Expert
Public Health Advocate
SAG-AFTRA Member
World Health Network Member

I'm Aysha Mirza. I have a Masters in Biomedical Sciences. As a Stem Cell Biologist, I'm a frontline healthcare worker, SAG-AFTRA member, and with the World Health Network. I have been consulting and researching as a COVID Compliance Expert since the beginning of the ongoing pandemic on the frontlines. I was witness to the devastation and trauma in 2020 at the worst-hit hospital in the US, Elmhurst Hospital. I ran a New York City Health and Hospitals outdoor testing center and watched asymptomatic cases drive increased transmission. As a model and SAG-AFTRA member, it is outrageous that our TV and film industry takes better precautions than healthcare facilities to prevent airborne transmission of disease. We had PCR testing before gathering, masking at all times when not filming, and massive air filters with adequate ventilation for our locations. It is abysmal that our healthcare systems do not use these multi-layered preventions. As a public health advocate, I call for the utilization of respirators as opposed to surgical masks for healthcare; implementation and prioritization of clean air, including ventilation and filtration in healthcare; the reinstitution of accurate COVID-19 testing and appropriate isolation procedures; and mitigations. The role of healthcare is to provide healing. Safe care should always primarily be in the minds and goals of practitioners and institutions alike. Many people are concerned about their safety. There is a need for the CDC guidance to incorporate basic principles including, but not limited to, the need to follow local or state laws or ordinances that supersede CDC guidance, the need to follow state and federal OSHA workplace regulations, the legal requirements of the Americans with Disability Act Patient Rights, informed consent and patient rights in general, practitioner obligations to do no harm, healthcare institution obligations under do no harm and the Precautionary Principle so that healthcare institutions must provide patients with conditions enabling safe care. Where

choices are left to the practitioner or institution, these decisions must be made according to these principles, The World Health Network advises that a new set of guidelines for the CDC guidance must be developed by a fairly balanced HICPAC committee following a transparent process, which acknowledges the overwhelming body of scientific evidence and expert opinion that aerosols are a significant mode of transmission for the infectious agent COVID-19. HICPAC's draft guidelines are destroying CDC's name in prevention. Not everyone is able to advocate for themselves. Much of the public is unaware of the many ways their healthcare team should be protecting them. It is our job as healthcare providers to know better. The importance of prevention of infection in healthcare for each patient should not be abandoned. Evidence-driven practitioner and institution policies are imperative for patient health and safety. Delay the vote. Thank you.

Rachel Nussbaum
MPH Student
Young University

Hi. My name is Rachel Nussbaum. I'm pursuing my MPH at Young University. Despite vaccination and a booster, one infection with SARS-CoV-2 left me with postural orthostatic tachycardia syndrome as well as chest pain that remains over a year later. I'm 30 years old and every time I go to a doctor, I fear picking up a reinfection that can make my autonomic nervous system further deteriorate. The EPA has confirmed that SARS-CoV-2 is airborne and travels like smoke across indoor areas and is spread via inhalations and exhalations, as are tuberculosis, influenza, and measles. We know the N95 respirators are made for airborne diseases while surgical masks are best for droplet born illnesses. We know that per the CDC, wearing an N95 mask makes people 82% less likely to contract COVID compared to 66% reduction from surgical masks. We know that anywhere from 40% to 60% of infections are asymptomatic, yet it still damages our endothelial linings and creates micro-clots, which is causing the spike, and cardiac events and strokes. Among young people, it causes long-lasting inflammation and increases the risk of diabetes. It can cause our neurons to fuse, leading to memory and cognition problems. We know COVID gives between 10% and 20% of people long-lasting organ damage and chronic conditions and vaccination only reduces the risk of long-COVID by 30%. We also know that the CDC has referred to passive surveillance of COVID. PCR tests are inaccessible for many. Many people don't test when they have symptoms and many don't report their positive rapid tests, so community levels are often inaccurately estimated. Wastewater levels are currently above where they were in 2020 and 2021. Failure to appropriately protect people comes with enormous human and economic costs. In a recent study of 23,500 vaccinated healthcare providers with mild acute COVID in Quebec, 10% were experiencing ongoing long-COVID symptoms, 71% of those affected said that their state of health now interferes with their ability to work, and 16% said that they are now often unable to work. We must fight this constantly evolving iteration of SARS with every tool: N95 respirators, HEPA filters, UV sunlight, and recurrent vaccinations to compensate for waning immunity and viral evolution. Universal masking with N95s needs to become standard practice just like handwashing between patients. Anything less is a failure to do no harm and contributing to death and mass disablement of the currently well and those already with compromised health. HICPAC needs to do what's right. Pull our hospitals out of the 19th Century. Provide clean air and restore the public's trust that seeking care won't sicken them. Think of a cancer patient fighting for their life with chemotherapy; an immunocompromised child braving biological infusions; a 70-year-old grandmother who falls, breaks her hip, and while recovering in the hospital, contracts COVID and dies of the complications. All of them have been victims of hospital-acquired infections, which could be prevented if the committee agrees that healthcare

workers should do no harm and requires them to wear N95 respirators or elastomeric respirators to prevent the spread of airborne disease.

Kathleen Turturice
Member, World Health Network

Hi. My name is Kathleen Turturice. I'm a member of the World Health Network. I can't do whatever I like. I have to obey the law and so does this committee. That's what this country is all about. No one, no person, and no government agency is above the law. On October 29th, the World Health Network filed a former complaint with the HHS Office of Inspector General against HICPAC because this committee stands in violation of the Federal Advisory Committee Act, HIPCAC's own Charter, and its membership balance plan. If anyone wants to read that complaint, go to whn.global and type "HICPAC" in the search bar that's whn.global and type "HICPAC" in the search bar. HICPAC is not a legally constituted advisory committee. Its Charter mandates 14 non-federal members, not 15 not 13, but specifically and only 14. The committee's roster on the CDC website lists only 9 and has not listed 14 since 2017. This committee, therefore, has no legal standing. In addition, both FACA and the committee's own membership balance plan required that its membership be fairly balanced in its points of view. Whether or not aerosols are the primary mode of transmission for COVID-19, it cannot be denied that aerosols are a significant mode of transmission. Yet, there is not one voting member on the committee who is an expert in aerosol science, ventilation engineering, industrial hygiene, UV and HEPA filtration, respiratory protection, or occupational health and safety. In a second way, therefore, this committee is not legally constituted because its membership fails to be fairly balanced as is required by law. The draft guidelines it is considering thus have no place in the CDC's process of updating its guidance. HICPAC has also failed to provide records to the public in violation of FACA and its Charter and has obscured its process of making updates. These violations of the law have not happened by chance. HICPAC could have known and should have known about these violations but chose instead to ignore them. It has been what the law calls "willfully blind" which means that in the eyes of the law, the committee has committed these violations intentionally. This committee has no legal standing. Read it for yourself. Go to whn.global and type "HICPAC" in the search bar. Then tell the Inspector General what you think. Call 202-619-3148. Thank you.

Kevin Kavanagh, MD, MS
Board Chairman
Health Watch USA℠

I'm Kevin Kavanaugh, Board Chairman of Health Watch USA℠**.** This week's CDC decision regarding new infection control guidelines will be nothing short of lifechanging for those who work or frequent a healthcare facility. Granted, the guidelines need to be published in the *Federal Register*, but if the CDC does not change course after the deluge of common-sense criticisms, it's doubtful that the CDC will after publication. The current CDC draft guidance appears to be conflicting and in some places in error. The CDC is giving approval for the use of surgical masks to prevent the spread of airborne pathogens, such as seasonal influenza and coronaviruses. Surgical masks are not designed to stop airborne pathogens. The CDC is not routinely recommending the use of negative pressure rooms for MERS, SARS-COV-1, or SARS-CoV-2. In Enhanced Barrier Precautions, the CDC is allowing those with *Candida auris* to wander around a facility and at the same time, the CDC is warning of dangerous outbreaks of *Candida auris*. There is also a lack of provisions for air quality standards, such as ASHRAE Standard 241 for control of infectious aerosols and a lack of provisions for screening of these pathogens. The backpedaling of standards has often been justified by the imposed burden

preventive strategies would place on facilities. However, the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, considers an intervention cost-effective if the cost is less than $9.6 million per life saved. The office does not measure burden in relationship to CEO salaries or investor profits, nor should the CDC. The proposed standards will place the safety of immunocompromised individuals in healthcare settings at grave risk. This concern was further underscored by the findings of the recent INFORM and EPOCH research initiatives. The EPOCH study concluded that immunocompromised populations appear to be at substantial risk for severe COVID-19 outcomes and that effective prophylactic options are still needed for these high-risk populations. For the immunocompromised, the status quo is unacceptable and weakening current recommendations will result in a direct threat to their safety and well-being. We would encourage the CDC to be mindful of the provisions of the ADA and the impact these recommendations will have on vulnerable individuals and healthcare workers, along with patients who are experiencing reduced access to health care because of unsafe healthcare environments. Thank you.

Anne Miller
Executive Director
Project N95

Good morning. Thank you for the opportunity to speak today. I am Ann Miller, Executive Director of the national nonprofit Project N95. I have no conflicts. I speak today on behalf of the millions we have served over the last three and a half plus years, clinicians like yourselves, healthcare workers, and other frontline workers, as well as the general public. I am also here for the hundreds of others who have signed our petition urging HICPAC to do more, to do more, to protect healthcare workers and patients seeking care. Every day at the project, we hear from healthcare workers whose employers actually do not provide protection, from patients whose healthcare provider won't take precautions when asked, and from immunocompromised and medically vulnerable people or their caregivers who just want to live their lives safely. I know that we all share a desire to protect healthcare workers and patients. I am here to urge the following: First, I know you're doing hard work. Operate with more transparency to increase the trust in your recommendations. Second, I urge you and CDC to include more stakeholders. I know you have heard this before. Add voting members with aerosol and industrial hygiene and scientific expertise, as well as healthcare worker representatives. Listen to Paul Conway. He's already in the room. I know you've heard it before, and I get it. Involving more stakeholders is a messy process. It's going to be slower, but the outcome will be better. Everyone benefits when policy changes are made transparently and collaboratively. Third, you need to vastly simplify precautions for air transmission. Flexibility is really nice to have, but flexibility drives complexity. Keep it simple. These guidelines are for all care settings. Ones with it have far fewer staffing and less expertise, not just for acute care hospitals. Codify the use. This is controversial codify the use of any N95 respirators or the equivalent into the definition of standard precautions. By specifying an N95 for use in all healthcare settings, we can stop worrying about mask leakage and the issues of freestyle mask modification that might compromise performance. Believe it or not, there are comfortable N95s with clear inserts, N95s with adjustable head straps, and even N95s that don't have straps. Lastly, I urge you to delay any vote until you have broader stakeholder involvement. Believe me, I get it. It’s not easy to advocate for something that's unpopular. I've been doing it for almost 4 years. But this should not be about popularity, about politics, about personal preference, or profit margins. It’s about patient and worker safety. The adoption of seatbelts was contentious as was cessation of smoking, but we still did the right thing. Enhance healthcare worker safety and patient precautions by advancing guidelines that specify the use of N95s or equivalent as standard precautions. SARS is airborne. We don't

know who is infectious and our air is shared. Life is short. Please don't make it shorter. Thank you for your time.

Darius Sivin
Editor in Chief
New Solutions

Hi. My name is Darius Sivin. For identification purposes only, I am the Editor in Chief of *New Solutions*, a journal of occupational and environmental health policy. My statement reflects solely my own opinion. My comments concern the Isolation Precautions Guidance. The full text of the guidance should be made publicly available with ample time for review before there is a vote. Public meetings should be held allowing workers, patients, and relevant experts to comment on the full text after reviewing it. The presentation on the guidance had some encouraging elements, but I also have significant concerns. While HICPAC is to be commended for moving beyond droplet and airborne categories for respiratory pathogens, it still needs to do more to incorporate the understandings of modern aerosol science as applied to pathogens. Experts in aerosol science, including industrial hygienists, should be included in developing the guidance. The presentation included the statement that pathogens spread through the air preferentially transmit over short distances due to greater concentrations. This statement was made without regard to ventilation. Published analyses of COVID-19 transmission events showed that in some cases, more distant people were infected if they were in a direct airstream, while closer people were not infected if they were not. In addition, the presentation acknowledged the hierarchy of controls and the importance of general and local exhaust ventilation, as well as portable HEPA filters, yet the only ventilation required by the guidance is the use of AIIRs for extended air precautions. This means the guidance relies largely on the bottom of the hierarchy of controls and illustrates the importance of including ventilation experts in development of the guidance. The presentation stated that pathogen-specific factors should be used to determine the necessity for respiratory protection use. In the case of new or emerging pathogens, these factors are largely unknown. The Precautionary Principle would indicate that in the presence of unknown factors, a high level of respiratory protection, such as N95 or better, should be used. For similar reasons, it is surprising that the presentation calls for only special not extended air precautions for new or emerging pathogens “that are not observed or anticipated to spread efficiently over long distances.” Extended air precautions have no ventilation requirements. Given the massive loss of life that recently occurred due to the failure to anticipate or observe that SARS-CoV-2 spread efficiently over long distances, the lesson should be to treat newer emerging pathogens with greater caution. Finally, the recommendations include a requirement for readily available PPE. “Readily available” seems like a weasel word that allows employers to get out of providing necessary protections.

Lisa Brosseau, ScD, CIH
Industrial Hygienist
Center for Infectious Disease, Research, and Policy
University of Michigan

My name is Lisa Brosseau. I'm an Industrial Hygienist with expertise in respiratory protection and aerosol exposures. Much of my academic career has been spent drawing attention to aerosol transmissible infectious diseases in healthcare settings. I am appalled by the changes HICPAC is proposing to the 2007 Guideline for Isolation Precautions. Transmission by air is simply a recasting of the airborne droplet paradigm and fails to explicitly state that inhalation can occur both near and far from an infectious person. The scientific literature from well before the pandemic demonstrates there are many aerosol-transmissible infectious diseases in healthcare

settings, including human influenza A, adenoviruses, RSV, rhinoviruses, pertussis, among others in addition to TB, MERS, SARS, measles, chickenpox, and of course COVID-19. HICPAC fails to recognize this. The WG's evidence reviews of respirators versus surgical masks and adverse impacts of PPE are flawed and biased. In work in an online workshop held on October 13, 2023, we addressed the science demonstrating aerosol transmission of COVID-19 and other diseases, recent developments and ventilation guidelines for infectious aerosols, and well-known scientific evidence demonstrating the superiority of respirators as source control and personal protection. Stakeholders representing healthcare personnel and patients discussed their personal experiences with COVID-19. Drawing on participant input, the workshop report includes numerous recommendations, many of which have been stated multiple times in letters to CDC and HICPAC and during public comments at this and previous HICPAC meetings. It is egregious that HICPAC and CDC have refused all requests from multiple parties over the past few months to diversify membership, listen to and include more perspectives, expand scientific review beyond clinical RCTs, and open your minds to ideas the challenge the status quo. I strongly urge HICPAC to postpone the vote today and reconsider your process and recommendations. I implore you to listen to the patients, workers, and communities whose health and lives you put at risk by ignoring their requests to be more inclusive, consider all of the science, and recognize the importance of aerosol transmission. A letter to Dr. Cohen from the Society for Healthcare Epidemiology of America mischaracterized requests from stakeholders left out of the decision-making. No one is suggesting that infectious disease physicians or hospital epidemiologists should not be involved. Of course, they should. But patients and healthcare professionals and their advocates, occupational health and safety professionals, engineers, aerosol scientists, and many other stakeholders also need to be consulted and involved.

Victoria Becker, NP
Retired, Nurse Practitioner

My name is Victoria Becker. I am a retired Nurse Practitioner. I worked in nursing for 35 years in private hospitals, nonprofit healthcare systems, county health systems, and the Veterans Administration. During that time, I came to understand that physicians and others in charge of infection control did not seriously consider infectious disease risk to myself and other healthcare workers. For example, as a county Home Health Nurse, I was assigned to do direct observe treatment of a tuberculosis patient who I was initially told did not have active disease. When I questioned it, it turned out he was still considered to have active disease. When I asked to be provided with a respirator, they gave me one which hadn't been fit tested. When I asked to be fit tested, the model they provided me failed the fit test and they told me to go ahead and use it anyway. When I questioned this, other nurses who had not been fit tested were then assigned to do it. Throughout my career, infectious control professionals have ignored the facts of how diseases are transmitted through aerosols and have ignored basic information about how to protect workers and patients from infectious aerosols. One of the problems with the current HICPAC process is there is no representation of workers or other experts, such as industrial hygienists, aerosol scientists, and ventilation engineers. In particular, I do not think there is any scientific justification for recognizing that pathogens are spread by aerosols as reflected by the classification "air" and recommending that healthcare workers use only masks, which are incapable of preventing inhalation of aerosols. A combination of arrogant infection control doctors and the construct of nurses as martyrs who sacrifice our well-being to take care of others results in a lack of protection for us, which has really been proven out with the current COVID crisis. Healthcare workers and the patients we care for have been unnecessarily put at risk of our lives and health because employers supported by weak public health guidance have chosen not to spend money on respirators, effective isolation, and ventilation. Now I'm a patient

who is over 75 and therefore at risk for more serious effects of COVID who has to access health care in an environment where no precautions are taken. Neither healthcare workers nor patients are masked. There is no routine COVID testing. Healthcare workers are told to report to work even if they have tested positive. You appear to be working towards enshrining this lack of protection in your revised guidelines. Shame on you, whether you are from the public or private sector, for allowing financial concern to place workers and patients at risk.

Summary, Work Plan, & Adjournment

Sharon Wright, MD, MPH
Co-Chairs, HICPAC

In closing, Dr. Wright thanked everyone for their hard work and briefly summarized the meeting. HICPAC heard an update and voted unanimously to approve the VHF Guideline and Precautions for Andes and Nipah viruses. As a reminder, HICPAC voted during the November 2022 public meeting to approve Measles, Mumps, Rubella, and Varicella for submission to CDC clearance, which was completed in April 2023. The 60-day public comment period for these sections was completed on Regulations.gov. On the first day of the November 2023 meeting, HICPAC heard an update and voted unanimously to approve the HCP Guideline for the Pregnant Healthcare Personnel, Varicella-Zoster Virus, Measles, Mumps, and Rubella sections. Over the 2-day November 2023 meeting, HICPAC heard an update and engaged in extensive discussion on the Isolation Precautions Guideline draft and voted unanimously to approve several components within Sections B and C to move forward. In terms of next steps, the draft guideline and recommendations will be submitted to the CDC for review and clearance. Once cleared, the draft will be posted to the *Federal Register* for a 60-day public comment period. Comments received through the *Federal Register* process will be taken into consideration for incorporation into the draft and for further discussion by HICPAC. The final draft will be presented for a vote in full during a future HICPAC meeting, including the narrative sections.

With no additional business raised or comments/questions posed, HICPAC stood adjourned at 11:45 AM ET on November 3, 2023.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the November 2-3, 2023 meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC), CDC are accurate and complete.

_____ _____

Date Chair, HICPAC

Attachment #1: Acronyms Used in this Document

Acronym	Expansion
AAKP	American Association of Kidney Patients
ACIP	Advisory Committee on Immunization Practices
ACOEM	American College of Occupational and Environmental Medicine
ACS	American College of Surgeons
AE	Adverse Event
AEH	America's Essential Hospitals
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AIIR	Airborne Infection Isolation Room
AIP	Adult Immunization Project
ANA	American Nurses Association
AORN	Association of periOperative Registered Nurses
APIC	Association of Professionals of Infection Control and Epidemiology
AR	Antimicrobial Resistance
ASN	American Society of Nephrology
C. auris	*Candida Auris*
CCHF	Crimean Congo Hemorrhagic Fever
CCTI	Cambridge Communications & Training Institute
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CDRH	Center for Devices and Radiological Health
CKD	Chronic Kidney Disease
CLABSI	Central Line-associated Bloodstream Infection
CMS	Centers for Medicare and Medicaid Services
CMV	Cytomegalovirus
COI	Conflicts of Interest
CORHA	Council for Outbreak Response: Healthcare-Associated Infections Antimicrobial-Resistance Pathogens
COVID	Coronavirus Disease
CPOs	Carbapenemase-Producing Organisms
CSTE	Council of State and Territorial Epidemiologists
CUSP	Comprehensive Unit-based Safety Program
DFO	Designated Federal Official
DHQP	Division of Healthcare Quality Promotion
DoD	Department of Defense
EHR	Electronic Health Record
EIS	Epidemic Intelligence Service
EO	Ethylene Oxide
EPA	Environmental Protection Agency
ESBL	Extended-Spectrum Beta-Lactamase
ET	Eastern Time
EVD	Ebola Virus Disease
FDA	(United States) Food and Drug Administration
FQHC	Federally Qualified Healthcare Center
HAC	Hospital-Acquired Condition
HAI	Healthcare-Associated Infection

Acronym	Expansion
HCP	Healthcare Personnel
HCW	Healthcare Workers
HDU	Home Dialysis University
HHS	(United States Department of) Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
HIV	Human Immunodeficiency Virus
IDSA	Infectious Disease Society of America
IHS	Indian Health Service
IP	Infection Preventionist
ISO	International Standards Organization
IVIG	Intravenous Immunoglobulin
KICC	Kidney Interagency Coordinating Committee
LAIV	Live-Attenuated Influenza Vaccine
LAN	Learning and Action Network
LTCF	Long-Term Care Facility(ies)
MDRO	Multidrug-Resistant Organisms
MERS	Middle East Respiratory Syndrome
MRSA	Methicillin-Resistant *Staphylococcus Aureus*
NACCHO	National Association of County and City Health Officials
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NEJM	New England Journal of Medicine
NHSN	National Healthcare Safety Network
NIAID	National Institute of Allergy and Infectious Diseases
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
PASTEUR	Pioneering Antimicrobial Subscriptions to End Upsurging Resistance Act
PBMC	Peripheral Blood Mononuclear Cell
PHAC	Public Health Agency of Canada
PHE	Public Health Emergency
PIDS	Pediatric Infectious Disease Society
POTS	Postural Orthostatic Tachycardia Syndrome
PPE	Personal Protective Equipment
PROTECT	Project Protecting Nursing Homes from Infections and Hospitalization Trial
PSAN	Patient Safety Action Network
RCT	Randomized Control Trial
RN	Registered Nurse
RSV	Respiratory Syncytial Virus
SAHF	South American Hemorrhagic Fevers
SARS	Severe Acute Respiratory Syndrome
SHARPS	Sharing Antimicrobial Reports for Pediatric Stewardship
SHEA	Society for Healthcare Epidemiology of America
SHM	Society of Hospital Medicine
SIS	Surgical Site Infection Society
SMEs	Subject Matter Experts
SNF	Skilled Nursing Facility
SSI	Surgical Site Infection
TB	Tuberculosis

Acronym	Expansion
TJC	The Joint Commission
UCSF	University of California San Francisco
URI	Urinary Tract Infection
US	United States
USPSTF	United States Preventive Services Task Force
VBP	Value-Based Purchasing
VHA	Veterans Health Administration
VHF	Viral Hemorrhagic Fevers
WAAW	World AMR Awareness Week
WG	Workgroup
WHN	World Health Network
WHO	World Health Organization
WSES	World Society of Emergency Surgery

Attachment #2: Public Comment Submitted in Writing

Two written public comments were not included because they violated HICPAC Policy on including disparaging comments about committee members.

Please do everything in your power to require all hospitals to maintain the highest levels of infection prevention including requiring N95's for all health care workers, patients and visitors at all times 24/7 in every season. Thank you!

Very truly yours,

Catherine White, Stinson Beach, CA

Dear HICPAC/CDC,

In late April this year I saw my doctor for a yearly Wellness visit. In addition to specific orders related to ongoing health complaints, he ordered the usual tests for blood work and preventative screenings—all of which entail visits to a number of other health care facilities.

Two weeks later President Biden declared the pandemic emergency over which led almost all hospitals and health care providers to drop 1) masking mandates and 2) COVID-19 screening tests. As someone even the CDC designates as high risk for COVID-19 that leaves me in the precarious position of having to weigh which is the greater risk: catching COVID-19 at a blood lab (for example) because lab workers (and patients!) are not masking OR rolling the dice and hope that the potential problems that might show up in a blood test (for example) will hold off for a while.

Since the May 11 change I have spent hours calling around for new doctors still willing to mask, as well as researching ADA accommodation requirements. I have not yet gotten any of my diagnostic and preventative testing done. I am vaccinated but also understand that the COVID vaccination status has no bearing on the transmission of this particular aerosol-transmitted virus. According to the Journal of American Medical Association (JAMA) model 60% of most COVID transmission is asymptomatic.

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707

Thus at present, the best personal mitigations relevant to infectious disease that prevent aerosol transmission are N95 masks. Surgical masks have been proven over and over to fail at this job due to their obvious leakage issue--one has only to witness the state of our hospitals and health care systems and the health of their workers right now to understand the extent of this failure.

I am now concerned that the CDC will profoundly weaken its Infection Control guidance by ignoring AEROSOL TRANSMISSION which could place health workers and patients at risk of short- and long-term harm and even death from infectious diseases. Hopefully this will be addressed through the courts in the near future as I plan to PCR test should I need important medical appointments to prove that I was, in fact, COVID-free before my appointment and, if infected via nosocomial transmission, I fully intend to hold the health care facility responsible for negligence.

Universal masking is a simple measure to reduce the risk of infectious disease transmission. HICPAC should codify universal masking in health care facilities across the board and require

the use of required N95 respirators, not the loose-fitting, leaky surgical masks which have been proven at this point—3+ years into this pandemic—to be a failure in controlling viral transmission.

If, with your "permission", healthcare workers continue to refuse to wear N95s and/or downgrade to surgical masks many more workers and patients will develop COVID-19--as we are seeing in real time. If you're lucky it may not happen to a close family member, it may not happen to a close friend or colleague, but by sheer mathematical favorability it will definitely happen to someone you know. Please protect your family and your community and mine and vote AGAINST watering down infection control protections, particularly for aerosol transmission and multidrug-resistant organisms.

HICPAC needs to drag itself into the 21st century and drop the 'droplet theory'. We need MORE mitigations in health care, not less—not only for this virus but for the viral and bacterial pandemics coming down the pike. We need N95s and CO2 monitors and HEPA filters and quality ventilation systems as the STANDARD in our hospitals and health care facilities and doctors' offices. It's essential and crucial that HICPAC get aerosol experts, ventilation experts, and engineers involved.

Thank you for your attention to this critical matter.

~Martina Ortega

Dear Members of HICPAC,

As the granddaughter of a woman who was harmed by practitioners in a medical facility who did not practice appropriate infection control, I am writing to urge you to take the following steps regarding your revision of the 2007 guidance for infection control.

1. HICPAC and CDC need to fully recognize **aerosol transmission** (inhalation of small infectious particles) as a modality of disease spread to ensure health care worker and patient protection.

2. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders,including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. **I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.**

3. **I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance.** So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

4. HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their

infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to **avoid** providing necessary protection for health care personnel and patients, based on cost considerations. **I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.** A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

5. The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch"), but **fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens.** There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, both entities **fail to recognize the critical role of inhalation** and continue to recommend use of surgical/medical masks, **which do not provide respiratory protection against inhalation of infectious aerosols**. **It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.** The Work Group's proposals ultimately weaken protections for all health care personnel and all patients even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

6. The evidence review on N95 respirator and surgical mask effectiveness was **flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health**. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. **The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.**

7. CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for **infectious aerosols**. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. **There are no recommendations on ventilation.** The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

In order for the CDC to function properly and effectively to preserve public health and prevent any worsening of the ongoing Covid-19 pandemic, HICPAC needs to take the steps outlined above. Firm guidance on ventilation and indoor air quality, the use of N95 respirators, and the scientific realities of airborne transmission of pathogens is needed to restore the trust of the American public in the CDC and to restore the CDC's reputation as a legitimate scientific/medical entity among global public health agencies.

Thank you for your time to hear my concerns.

Respectfully yours,

Prof. Alexandra Burack, Patient Advocate, Cave Creek, Arizona

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To whom it may concern,

There is abundant research about how to clean the air. They're also economic studies as to the benefit of cleaning the air.

Please take every measure possible to offer clean air and medical settings.
Thank you very much,
Rebecca Lee.

Please get us out of the dark ages when it comes to respiratory illness transmission.

Remember the achievements of the last century regarding infectious diseases? It started with Sanitation. Vaccination. Handwashing.

Sanitation and handwashing are well-suited to the prevention of fecal oral diseases. These used to devastate entire populations, and still do, where adequate sanitation is not available.

For aerosol transmitting respiratory illnesses, indoor air quality is the equivalent of sanitation, and effective N95 respirator use is the equivalent of consistent handwashing.

We now have an additional, dangerous respiratory illness in addition to the ones still circulating. Do your due diligence and get us out of the dark ages.

Thank you.
Marina Lent, local public health official Massachusetts

Name: Lila Acrot
affiliation: none

Comment: Patients' lives are worth more than healthcare profit margins. There should be no risk assessment when it comes to healthcare. It must be preventative. Additionally, this current process is closed off and does not include infection control experts or aresol scientists who understand that ventilation, isolation and source control, and respirator protection such as N95s reduce the spread of all airborne illnesses.

Respirators and clean air tech must be required in all medical settings in order to reduce transmission of airborne illnesses. This will keep patients and staff healthier.

CDC/HICPAC has failed to include any discussion of or recommendations for the utilization of more

protective respirators such as Elastomeric Half-Mask Respirators (EHMRs) and Powered Air Purifying

Respirators (PAPRs), despite evidence and experience demonstrating the effectiveness of these devices

in protecting healthcare personnel from infectious aerosols. You must also acknowledge and enforce the fact that respirators are better than surgical masks. There is also no discussion

of selecting respirators with higher associated protection factors when health care personnel are at

higher risk, such as when performing procedures known to generate higher aerosols in higher

concentrations.

Dear Committee Members,

I am writing to respectfully request that respirators be the standard in healthcare regardless of vaccination status.

We know that SARS-CoV-2 is airborne and has been found to remain in the air for up to 12 hours.

We know that respirators offer superior protection to other masks.

We know that long covid risk increases as the number of infections increase.

We know that long covid can lead to disability and death.

We know that we are all vulnerable to long covid. Please keep respirators as standard in healthcare.

Additionally, ventilation, filtration and Far UV technology should be employed to support an environment where one can breathe the air without breathing in a virus capable of disabling or killing you or those you come into contact with.

We need increased transparency around what is being done to safeguard the health of everyone who works in or enters healthcare institutions.

Keeping the standard of respirator masks is a small thing we can do, that would help prevent illness and death.

Thank you for your time and for your consideration.

Lisa Pellegrino

I am writing to ask you to please consider carefully the infection control guidelines in health care facilities.

Covid19 is airborne, that has been established. Please recognize aerosol transmission. Respirators should be required for staff and patients regardless of vaccine status.

Respirators are more effective than surgical masks in preventing infection. We also need to clean their air by upgrading ventilation systems. there are many experts who have formulated guidance on this.

I need surgery. I (and others like me) are terrified of hospital-acquired COVID when we go for medical care. This should not be happening. Please do the right thing.

Margaret May

Port Angeles, WA

It is my understanding that the current draft of the Isolation Precautions Guidelines being discussed (1) fail to recognize the importance and implications of recent research regarding aerosol spread of respiratory diseases; (2) appear to treat the effectiveness of surgical masks and respirators as the same with regards to aerosol transmission of respiratory diseases; (3) do not recommend respirators be used regardless of vaccination status of patient or healthcare worker; (4) do not recommend the use of air purifier/cleaners or increased ventilation to reduce the spread of respiratory disease in a healthcare setting; and (5) generally have failed to include experts in engineering, HVAC, infectious disease epidemiology, and others who have extremely relevant and useful expertise in relation to these guidelines.

Since the COVID-19 pandemic, much research has been done showing the prevalence of aerosol spread of respiratory disease (most obviously COVID-19 itself, but also including the higher prevalence than thought of aerosol spread of things such as influenza). The implications of such aerosol transmission include the need for increased ventilation, increased air cleaning/purification measures, and the use of respirators. High quality research has shown that respirators are significantly more effective at preventing aerosol transmission of such diseases and should be recommended for health care workers in all settings to protect both healthcare workers and patients. This should be basic protocol similar to how handwashing and wearing gloves has become basic protocol for avoiding the spread of disease in healthcare settings. Failure to include the expertise of experts in relevant fields has resulted in these deficiencies in the draft guidelines. Failure to update the draft guidelines to significantly address these issues will cause significant harm to healthcare workers, patients, and the public, and create a much higher than necessary disease burden on society going forward.

Dear CDC HIPAC,

I am Janine Ryan, Independent Clean Air Advocate.

Regarding this meeting:
https://www.cdc.gov/hicpac/pdf/HICPAC-Agenda-November2023-508.pdf

It is well established that the *minimum* standards set forth by CDC are often the *maximum* standards that establishments enact for the safety of their employees and customers.

The COVID-19 pandemic has shown us the importance of universal precautions and the use of respirators in medical settings. The risk of nosocomial infections is always present, and it is important to take steps to mitigate this risk.

Strengthening the universal protection standards and implementing masking/respirator use globally in all medical and healthcare settings would be a major step forward in protecting the health of healthcare workers and patients.

As you know, universal precautions are a set of infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient. These practices include hand hygiene, use of personal protective equipment (PPE), and respiratory hygiene/cough etiquette.

Respirators are a type of PPE that should be used to protect healthcare workers and patients from airborne transmission of infectious diseases. They work by filtering out small particles, such as viruses and bacteria, from the air that is inhaled.

There is a growing body of evidence that supports the use of respirators for the prevention of nosocomial infections. For example, a study published in the journal "Infection Control and Hospital Epidemiology" found that the use of N95 respirators by healthcare workers was associated with a significant reduction in the risk of influenza infection.

The World Health Organization (WHO) also recommends the use of respirators for healthcare workers who are at high risk of exposure to airborne infectious diseases.

In addition to protecting healthcare workers, the use of respirators can also benefit patients. For example, respirators can help to prevent the spread of respiratory infections from patients to healthcare workers, which can help to reduce the risk of complications and death. Respirators can also help to protect patients from exposure to harmful environmental pollutants, such as dust and fumes.

Given the evidence, I urge you to strengthen the universal protection standards and implement masking/respirator use globally in all medical and healthcare settings. This is the best way to protect healthcare workers and patients from infection.

Thank you for your time and consideration.

Sincerely,

Janine Ryan (*M.A., Justice Studies; B.S., International Business & Economics)*

Project Manager, Therapeutics & Infectious Disease Epidemiology | Department of Population Medicine, Harvard Medical School

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We are 4 years into this and still we are massively failing. I demand:

-Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vax status -Respirators are more effective than surgical masks -Clean air tools like HEPA filters -Involve aerosol experts and increase transparency

Thank you

My public comment:

My sister died after getting Covid 6 mths later)she had blood clots, strokes and diagnosed with cancer despite being healthy before Covid).

It’s inexcusable that you are not blasting the fact that Covid is airborne! MAKE IT KNOWN CLEARLY AND SIMPLY SO PEOPLE CAN PROTECT THEMSELVES!

Recognize aerosol transmission -Respirator requirements in healthcare regardless of vax status -Respirators are more effective than surgical masks -

Clean indoor acts needed for schools and businesses. Clean air tools like HEPA filters -Involve aerosol experts and increase transparency.

Hold the businesses and schools accountable for less than perfect clean indoor air

Thank you,

Georgia Santos

Tampa FL

It's been proven that COVID is airborne and even CDC's website has been updated throughout years to reflect this fact. If HICPAC is meant to meet about infection control (which again, on CDC's website states that is, in fact, the point of HICPAC meetings), it's incredibly disingenuous to not discuss the following:

- recognizing aerosol transmission

- respirator requirements in healthcare regardless of vax status (CDC has also acknowledged asymptomatic transmission of Covid)

- respirators are more effective than surgical masks

- clean air tools like HEPA filters

- involve aerosol experts and increase transparency

1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

2. I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

3. HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A

protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

4. The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

6. CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

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With Kind Regards,

Catherine Lee

We (nurses and patients) are demanding the CDC to recognize aerosol and micro-aerosol spread of diseases.

Respirators work, as a predictable matter of engineering. Only an N95 or better respirator can protect you from aerosol-transmitted disease. Suggesting that respirators are on par with surgical masks is a gross misrepresentation of the evidence.

If you, your parents, or your infant end up in an emergency room, you shouldn't have to worry about preventable airborne illnesses like tuberculosis, measles, or COVID-19.

Finally, let's not forget about the safety of healthcare workers. They deserve protection just as much as patients do. Besides, if we keep disabling or killing healthcare workers with preventable illness, who will be left to treat patients?

Please do the right thing to protect healthcare workers and patients!

Shana C. Bates, RN

“All dental settings, regardless of the level of care provided, must make infection prevention a priority”

Since dental patients must remove their masks to receive dental care, it is essential that all dental staff wear unvented N95s or half face elastomeric respirators with source control filters such as RU8500x. As someone who is high risk and currently wear a half face respirator with P100 filters in all shared air settings, dental care is my highest risk exposure.

However in the future if I were to need surgery that would also be extremely risky. All healthcare settings from retail pharmacies to dentists to hospitals need respirator mandates for employees. That means every single employee in healthcare settings: receptionist, doctor, janitor, nurse, billing specialist, CNA, cook, etc. No just during patient care. Previously CMS used their power to enforce an ineffective vaccine mandate for all those individuals. The correct solution is respirators. Respirators work against every COVID variant, tuberculosis, Influenza, Strep A, common colds, RSV and every other contagious respiratory illness. In addition to protecting patients from infection while receiving medical care, this policy protects healthcare workers. In turn this will reduce staff shortages and lead to faster discharges.

Various sizes of respirators and surgical masks must also be provided and some form of masking required for all patients who are able to wear them. Fit testing services should be offered to patients.

Jamie Vineski

Colorado Springs

Hello,

I would like the following points to be strongly considered/discussed at the upcoming meeting:

-Recognize aerosol transmission of COVID

-Require respirator requirements in healthcare regardless of vax status

-Recognize that respirators are more effective than surgical masks

-Adopt clean air tools like HEPA filters and "safe" UV lighting in health care settings (and schools though I know that is not quite in your power!)

-Involve aerosol experts in info gathering and decision-making

Thank you for your time and attention.

David Soborski

Middletown, NJ

To CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has initiated a process to update the CDC's 2007 Isolation Precautions guidance. So far, CDC/HICPAC's draft updates have not been made publicly available and actually cause more harm than good.

HICPAC's presentation regarding the Work Group's draft updates is horrifying and dangerous. The proposed draft updates would weaken current infection control protections, fail to fully recognize aerosol transmission, and rely on a biased and incomplete review of the evidence on respiratory protection. Further, the Isolation Precautions Work Group meeting summaries make it clear that the Work Group's goal has been to weaken infection control protections for health care workers and patients to create more "flexibility" for employers to prioritize costs over care and protections. These proposals would put patients and health care workers at increased risk of a wide range of infections. Your guidance actually prioritizes a risk-based approach, while ignoring asymptomatic transmission of all airborne illnesses and putting the burden on the most vulnerable to mask.

Concerningly, CDC/HICPAC lacks effective mechanisms to engage expertise from the range of stakeholders that are required to create strong, science-based guidance. It is essential to incorporate the input and expertise of direct care health care workers and their unions, as well as that from aerosol scientists, experts in respiratory protection and ventilation, patient advocates, and other public health experts beyond the infection control practitioners and hospital administrators currently represented on HICPAC.

In order to create robust, science-based guidance and to facilitate public engagement in the process to update guidance, before any HICPAC vote, I urge you to:

(1) Publicly post HICPAC's draft Isolation Precautions guidance update in full, with ample time for review and consideration by the public,

(2) Host public meetings to engage input from all stakeholders on infection control guidance for health care settings, and

(3) Fully recognize the science on aerosol transmission of infectious diseases and respiratory protection to protect workers from hazardous exposures.
(4) Acknowledge that respirators (N95s and elastomeric) are far superior to surgical mask, as the CDC has previously acknowledged during TB and covid outbreaks in the past.

(5) Require respirators in all healthcare settings, including hospitals, rehab, dentists, and pharmacies

(6) Require medical settings to improve air quality, especially hospitals. We need better air quality with tools such as True HEPA filters with multiple air changes per hour, limited patients in waiting rooms, ventilation in all rooms, far-UV light, air scrubbers, CO2 monitors, and air sanitation tools.

Patients need protection. Two-way respirators are much more effective than making the patient do it. Vaccines do not prevent long covid and do little to stop transmission. Patients such as babies or those needing surgery cannot mask either. So if a doctor chooses not to mask, they

force the patient to assume needless risk.

I commend you for delaying HICPAC's vote and urge you to use the extra time to more effectively engage input from stakeholders like myself. CDC/HICPAC's infection control guidance impacts everyone who enters a health care setting, including patients, visitors, and health care workers.

Amanda Hennessy

Name: Paul Hennessy
Affiliation: None

CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC)'s current measures are a massive failure to public health. I urge updates and transparency.

The proposed draft updates would actually weaken current infection control protections. HICPAC and CDC must fully recognize aerosol transmission and rely on aerosol scientists to improve health precautions in all medical settings. This will lessen the spread of all airborne illnesses. No one should get infected with something because they are seeking care.

Your proposal puts patients and healthcare workers at a greater risk for all airborne infections. There is no excuse not to wear respirators in healthcare. Acute COVID deaths may be decreasing, but just because there are treatments doesn't mean we should roll the dice on infection risk. Medical staff and patients need to act in a preventative way. Vaccines only do so much. We need to go above and to protect patients. Environments in healthcare must be safe and sterile, and that includes the air. We didn't drop HIV protections because deaths went down. Additionally, there are many long-term effects from Covid infection. But many other viruses are airborne and pose risks to people in hospitals such as klebsiella, RSV, flu, acinetobacter, enterococcus, and TB. We must take what we've learned the past few years and keep the air clean.

Additionally, there are patients who cannot mask or get vaccinated, such as babies, or those receiving and endoscopy. Your lack of infection control not only puts the burden on vulnerable patients, but it also actively harms patients like that. It is unnecessary when we have tools that reduce transmission greatly.

CDC/HICPAC lacks effective mechanisms to engage expertise from the range of stakeholders that are required to create strong, science-based guidance. It is essential to incorporate the input and expertise of direct care health care workers and their unions, as well as that from aerosol scientists, experts in respiratory protection and ventilation, patient advocates, and other public health experts beyond the infection control practitioners and hospital administrators currently represented on HICPAC.

In order to create robust, science-based guidance and to facilitate public engagement in the process to update guidance, before any HICPAC vote, I urge you to:

(1) Publicly post HICPAC's draft Isolation Precautions guidance update in full, with ample time for review and consideration by the public.

(2) Host public meetings to engage input from all stakeholders on infection control guidance for health care settings.

(3) Fully recognize the science on aerosol transmission of infectious diseases and respiratory protection to protect workers from hazardous exposures. The majority f research on infection shows that aersolized particles spread diseases.

(4) Require respirators in all healthcare settings.

(5) Acknowledge that respirators are better than surgical masks and that two-way masking is more effective than putting the burden on the patient. There is decades of research to back this up.

(6) Improve air quality in healthcare settings, requiring HEPA filters with a high number of air changes per minute, install upper room far-UV light, ventilate waiting rooms, and install air scrubbers in HVAC systems.

Patients shouldn't have to protect themselves from their healthcare providers. Surgical masks leak a lot, but aerosols emitted from the mouth and nose are stopped by two-way well-fitted N95s or elastomeric respirators. Medical settings are notorious for additional infections, which puts patients at risk. You need to do better in improving air quality and protecting patients.

I am writing to request that HICPAC Committee members support the requirement for high quality masks, aka respirators, rated KN94 or better, in all healthcare settings to stop the spread of airborne infectious diseases. We know that respirators work to stop transmission of infectious diseases, and that the commonly worn blue surgical masks to not offer the same level of protection. I would guess that most of you have seen the recent 60 Minutes segment on ventilation as well as the 60 Minutes Overtime segment where Professor Linsey Marr demonstrates the spread of airborne particles and explains how respirators work to protect the wearer and others. In addition, there are many recent articles on the efficacy of respirators, some of which refute the findings of the Cochrane study that casts doubt on such efficacy. This requirement would protect not only patients and their families but would also greatly decrease spread among the healthcare staff. This requirement needs to be directly tied to Medicare and Medicaid reimbursement so that it is enforceable.

I am a former hospital social worker (MSW) who understands the power dynamics between healthcare personnel and the patients and their families. There have been suggestions that patients/families just need to ask healthcare personnel to mask if they need accommodations, but I believe it is unreasonable to place this burden on patients and their families. In addition, I have witnessed and read about too many incidents where healthcare personnel outright refuse these requests and, in some cases, take retaliatory measures in response to such requests.

On a personal note, two of my fully vaccinated and boosted family members died as a result of contracting Covid in healthcare settings, one in Michigan and one in Florida. My Florida relative was in skilled nursing following a fracture from a fall and staff dismissed my polite requests to mask while caring for her. Please consider that you could face a similar situation, and that the policies that you support could have a direct impact on you and your loved ones.

Hello,

Please recognize that covid and other viruses are AIRBORNE and require airborne infection control measures. Please recognize that we are still in a covid surge within a covid pandemic, and that covid is dangerous for everyone -- it's been shown to damage the vascular system, brain, other organs, and immune systems of anyone and everyone regardless of their "vulnerability", age, or whether they immediately present with "long covid" -- it's bad for everyone's health. Please recognize that being infected with covid and other airborne viruses during medical visits is very common these days. It is unacceptable that receiving medical care now comes with a high risk of infection with an airborne virus.

To fix this problem: REQUIRE respirators in healthcare. Regardless of vaccination status. For providers, staff AND patients. In ALL areas of the facilities. RESPIRATORS, not surgical masks, which are the wrong tool for airborne hazards. Clean the air with HEPA filters and ensure ventilation. Monitor and maintain these systems in real time. Increase transparency. Involve experts on aerosols and airborne transmission. Educate healthcare workers on how airborne viruses spread.

Thank you,

A. Sigler

Dear HICPAC,

COVID-19 is spread through aerosol transmission. Healthcare agencies should have staff masked (N95s) to protect vulnerable patients. Everyone who breathes is vulnerable. Not all patients can mask themselves when hospitalized. It is distressing to think that CDC guidance allows healthcare staff (who may be infected) to care for vulnerable patients unmasked and expose them to a BSL3 virus.

I personally can attest to the stress and agony of trying to convince hospital staff to mask around my critically ill spouse, who had an unknown (nonCOVID) respiratory illness. He eventually died from Norovirus, which he contracted in the hospital. Hospitals have become lax on infection control in general, citing "CDC" guidance as their reasons. I personally know that the sick policy of the hospital where my spouse was hospitalized was very punitive, and staff came to work ill regularly.

To that end, please consider decisions and public messaging that:

-Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vax status

-Respirators are more effective than surgical masks

-Use of clean air tools like HEPA filters (there should be considerations of short-range transmission as well). The hospital argued they had good ventilation, but ventilation is not helpful for unmasked staff providing care when standing within 12 inches of the patient's unmasked face!

-Involve aerosol experts and increase transparency

Have we not learned anything over the past 3.5 years! Masks work! They should be reinstituted in healthcare!

Sincerely,

Peggi White

Esteemed committee members,

It is imperative to protect our healthcare workers with a safe workplace and preserve what remains of our healthcare system. We know how to prevent nosocomial infection from airborne viruses. These infections increase hospital stays and lead to poor outcomes (including long term disability and death).

Everyone deserves safe access to healthcare. Many are avoiding care, especially when they can't mask (babies, colonoscopy, dental and orthodontic care). Important screenings and immunizations also get skipped because of the risk of entering a high infection zone. Deferred care further strains urgent and emergency care centers.

Just like we now expect clean water, we need clean air. Respirators should be standard in healthcare. We need aerosol and micro aerosol protections. Mechanical air cleaning like HEPA filters are also important.

Sincerely,

Sara

I am writing to ask you to please consider carefully the infection control guidelines in health care facilities.

Covid19 is airborne, that has been established. Please recognize aerosol transmission. Respirators should be required for staff and patients regardless of vaccine status.

There is an urgent need for aerosol and micro aerosol protections

Respirators are more effective than surgical masks in preventing infection. We also need to clean their air by upgrading ventilation systems. There are many experts who have formulated guidance on this.

I need surgery. I (and others like me) are terrified of hospital-acquired COVID when we go for medical care. This should not be happening. Please do the right thing.

Margaret May (individual)

Port Angeles, WA

To whom it may concern:

This is a comment regarding the topic of Aerosols and Clean Air Standards in healthcare settings.

Thank you for your time and attention. It is of the utmost importance that your body supports the health of patients and healthcare workers nationwide at a time of unprecedented confusion and misinformation surrounding airborne illness.

I'm a person with multiple loved ones with long-term healthcare needs in medical settings. I'm asking you to help me keep my family alive.

I request that you:

- Formally recognize the aerosol transmission of COVID-19 / SARS CoV 2
- Recommend respirator (N95+) requirements in healthcare settings, regardless of vax status
- Specifically state that "saggy blue" surgical masks are not as effective as respirators and in fact are not sufficient protection at all
- Recommend high HEPA filtration standards of ~8 ACH in all areas of healthcare buildings (even nonpublic areas)
- Involved aerosol experts in your research & recommendations, and increase the transparency around how this collaboration is being conducted

Thank you for your time. I'm grateful for what you do.

All my best,

Shannon Copfer Brace

Cleveland, OH

As a citizen of the United States, I am very concerned about contracting an airborne pathogen (especially Covid) when trying to access health care. HC institutions, business leaders and the citizenry look to the CDC for appropriate guidance to prevent contagion of airborne pathogens (especially in healthcare).

The CDC is very aware that primary mode of transmission of COVID is by aerosols. And that the virus is VERY contagious, with an R naught of maybe 16-18. Perhaps it is actually higher, since data reporting, testing and contact tracing has all but disappeared.

We urge you to recommend aerosol contagion prevention methods for health care settings, especially hospitals, doctors' and dental offices .

Especially that the CDC ;

Recognize aerosol transmission

-Implement Respirator requirements in healthcare

-Officially recognize that Respirators are more effective than surgical masks

-Recommend implementing Clean air tools like HEPA filters

-Involve aerosol experts

and increase public education regarding the nature of airborne transmission of pathogens (especially Covid) and the importance of avoiding infections/ reinfections

Sincerely,

Susan Frederick

Napa, Ca

To the members of HIPAC/CDC

My name is Leah, and I am the math and science department head at my school. I am writing this comment to appeal for the implementation of guidance that N95 masks be worn by healthcare professionals. It is my educated opinion that, in the midst of a severe pandemic of airborne nature, these masks are effective and necessary for the mitigation and prevention of the transmission of Covid-19 and other airborne diseases.

Currently, there are studies indicating the ability of Covid to avoid the defenses of our immune systems. The high mutation rate, the syncytial properties, and evidence that Covid can kill several different types of adaptive immune cells are all properties that allow Covid to avoid our adaptive immune defenses regardless of vaccination and/or previous infection. The consequences of Covid infections extend beyond the acute phase into chronic issues. As we know, Covid is more than a respiratory virus. It is a cardiovascular virus. Being that every single cell in the human body is maintained by our blood vessels, there is a natural implication that Covid can cause what may be countless devastating diseases and disabilities. Disability activists are referring to this as a mass-disabling situation. People are dying from their chronic Covid conditions months to years later. The only other virus I know that infects/harms T-cells is HIV. This means that we are nowhere near the end. This is only the beginning. People may find themselves immunocompromised years later, resembling the experience of people who develop AIDS years after an acute HIV infection. This means that it is not just “vulnerable” people who are at risk. We are seeing this virus take previously healthy people and creating vulnerability in them. Covid has been implicated in heart disease (including but not limited to heart attacks), diabetes, cancer, genetic mutations, viral persistence, kidney failure, liver disease, lung damage, blood vessel damage, digestive disorders, brain disease, and more.

Covid is not the only airborne disease. Other diseases exist and will increase in prevalence and mutational opportunities in the bodies of the newly immunocompromised. The Hippocratic oath of any doctor is to “Do no harm”. No one should be afraid to visit a hospital or other healthcare facility for fear that they will leave in worse condition (due to contagion) than held when they arrived. Doctors and the public are looking to the CDC for guidance. Please show that you are worthy of their trust. Please recommend that N95 masks be worn in healthcare settings. Ideally, N95 masks should be worn in workplaces as well. The number of deaths and disabilities in this country continues its troubling upward trend. If the concern relates to the economy and/or interests of employers, then masks should have a greater priority. The masks would certainly decrease responsibility of employers and institutions while protecting them and the economy from the devastating effects of an ever-decreasing workforce diminished by death and disability. I would like to again urge HIPAC/CDC to do the right thing for the wellbeing of Americans and side with science in pushing N95 masks in their official guidance. Please also encourage the increased use of ventilation and HEPA air filters for cleaner indoor air. Please also consider extending the isolation period back to two weeks as it is clear the contagion is still happening when people return, especially considering that most are not wearing masks upon return to their workplaces. Some estimates indicate that between 40-60% of Covid infections are transmitted by asymptomatic people. Thank you for hearing my concerns.

Hello,

I am reaching out to submit my public comment requesting that better infection control in the form of mask wearing be enforced, encouraged, and rightfully funded in healthcare settings.

I visited my local hospital yesterday to see my oncologist and when she left the room to get a mask she came back wearing a baggy surgical mask.

It is well known that masks like n95s and better do help prevent viral transmission by a significant degree, surgical masks are largely ineffective.

It is quickly becoming common knowledge that Covid is wreaking havoc on the health of people who might otherwise be healthy and we owe that to apathy and self interest of organizations ranging from media to the cdc itself. Please do the right thing and save lives by enacting policies and requirements for air quality renovations to healthcare facilities.

It's never too late to have some integrity and live by the oath to "Do No Harm"

Sincerely,

Ky Thompson

I am a two time lung cancer survivor and my husband is immunocompromised.

I'm an actor, not a doctor.

Yet I know that:

Covid is airborne, as are several other viruses. Surgical masks are not effective at protecting against aerosol transmission. N95 respirators are crucial in preventing infection not only in medical settings, but yes, ESPECIALLY in medical settings. Air quality/filtration is another tool that should be employed. HEPA filters and upgraded HVAC systems.

As a patient, I presently do NOT FEEL SAFE going to the doctor and have postponed several necessary procedures/tests because I have to BEG for proper common sense protection. Surgical masks are NOT ENOUGH.

Healthcare workers also need and deserve a higher level of protection than what is currently employed, NOT LESS.

I urge you to do the right thing, the thing that will actually protect healthcare workers and their patients. Do not lower standards for infection control.

Thank you,

Leslie Hendrix

San Rafael, CA

This is not disease control competency!

COVID spreads like smoke. Respirators like N95s protect against it.

But CDC committee (HICPAC) is trying to make it easier for hospitals to avoid protecting patients from aerosol-based diseases.

To whom it should concern(although it appears you dont.) I'm a 60 year old chronically ill, mostly bedbound person from Ohio.

I'm unable to tolerate the stimulation & visual energy required to watch or comment in any other manner.

I'm medically advised to not get any of the vaccines currently available. My health/immunity is never good enough to not have a high chance of vaccine injury.

I don't have the luxury of pretending this virus won't negatively impact my health because I'm still severely incapacitated by a weird little "cold" I got in June of 2000.

23 yrs later I have continued to get progressively worse year after year.

I now am diagnosed with myalgic encephalomyelitis, MCAS, POTS, EDS, fibromyalgia etc.

My husband and I are still taking every precaution & have avoided Covid.

I refuse to attend in person medical appointments because the risk is to high. Healthcare was damaging enough before Covid now it's truly potentially deadly.

The name "centers for disease control" is misleading & inaccurate! The agency continues in its eugenics campaign by doing exactly the opposite of controlling disease in this pandemic.

Do your job & educate the public on how damaging Covid will likely be for those who continue to have infections on top of infections.

Valuable research has been lost from the beginning of the pandemic & billions wasted on redoing old research.

The least you can do is require masking in medical facilities & hospitals.

Require air quality standards in medical facilities, government offices & businesses. You know……Davos or President Biden safe standards.

You should be requiring masks & ventilation standards in pharmacies & grocery stores.

In addition, the idea that I'm supposed to ask the doctor to put on a mask is not recognizing the power differential in that relationship or the fact I had to carve through respiratory droplets to get into that office.

Why is it I understand the risk better than an agency that is designed for disease control?

It's maddening that you continue to be derelict in your duties.

How about you change that now?

Bazia & Bobby Zebrowski

Newbury Oh

Good morning HICPAC members:

I'm writing to you from California for the second time about the issue of respiratory guidelines in hospitals, particularly around masks.

There is significant data and scientific consensus about the fact that surgical masks are not adequate in protecting people from airborne diseases like COVID and TB. People who must enter a clinical setting are at the mercy of that organization's safety rules. If the standard of that clinical setting is surgical masks, they will be at much higher risk of exposure to airborne pathogens.

It is insane that members of the public are having to write in to beg you to follow the science and to keep people safe. Infection control is literally your job. It shouldn't even be a question. Imagine if we had to write in to convince you to create guidelines around washing hands or sterilizing instruments.

You know that N95 respirators provide far better protection than surgical masks.I urge you to follow the data and make N95 respirators the standard PPE in all clinical settings.

Tara Komar

-you must recognize aerosol transmission of COVID-19 -N95 or better respirators should be required for employees and patients in healthcare settings regardless of vaccination status -Respirators are more effective than surgical masks, you should be making that CLEAR to the public -require clean air tools like HEPA filters and a ventilation standard of at least 6 air exchanges per hour -Involve aerosol experts and increase transparency

We must have true infectious disease mitigation in health care settings. no US citizen should have to worry about being infected with tuberculosis, measles, flu, or COVID while seeking vital health care.

Thank you,

Cheryl Colan

Since the onset of COVID-19 there has been conflicting information as to the efficacy of utilizing respirators in preventing aerosol infections within hospital environments. I am commenting that since the initial spread and ongoing struggle to control rates of COVID-19 infection within a given community there has been a distinct lack of effort on the part of local healthcare institutions in implementing safe and effective means of controlling the aerosol infections of COVID-19.

There is a need to update and modernize the healthcare system in which hospitals must recognize and utilize respirators and HEPA filters to provide adequate and functional prevention of aerosol infections (such as COVID-19). Not only would these steps be a boon to the patients, whom by their very status as

a patient, is perceived to be at a greater risk of these inflections and as such is reliant on the hospital and staff to prevent any further negative health impacts on the patient. This is the responsibility of the healthcare industry as a whole to operate in such a way to reduce their own liability and ensure the quality care in which they are meant to strive for by meeting a bare-minimum of practical prevention on the part of the hospital. \

These changes should be recognized as a necessity to continue operating as meeting these challenges 'head-on' will not only show to public that the healthcare system is operating in good

faith, but also to update in such a way that can make any future aerosol infections preventable going forward, as these are the sign of the times, and can only be considered as a net positive.

John Meszaros

Midlothian, VA

Private Citizen

Topic: Isolation Precautions Guidance

To the HICPAC,

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (“air” and “touch”) - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Further, the evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is unconscionable that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review.

Lastly, CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please make a strong recommendation on indoor ventilation standards, especially for places where the public gathers indoors such as restaurants, movie theaters, and other indoor activity spaces. As the current COVID vaccination-only campaign is struggling (only 7% of eligible adults have received the updated 2023-2024 booster), it is imperative that HICPAC works to improve indoor air quality to keep all Americans safe.

Thank you for your time, John Meszaros

Dear HICPAC, I am contacting you regarding the requirement to keep the use of respiratory protection in healthcare. Surgical masks do not protect against airborne hazards such as SARS-CoV-2, tuberculosis, and H5N1 avian flu. Healthcare workers should be wearing NIOSH certified respirators at all times to prevent them from being exposed to these airborne hazards. N95s have been found to be more effective than surgical masks as per Alkhalaf et al 2023 (linked here https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10186565/). Surgical masks should be replaced by N95s in healthcare moving forward to protect workers especially considering the recent increase in tuberculosis cases. It is negligence to give a healthcare worker a surgical mask to protect them against tuberculosis and that shouldn't change. Even this 1995 CDC publication (https://stacks.cdc.gov/view/cdc/6777) states that surgical masks are not protection from airborne hazards. Multiple of friends have been infected with SARS-CoV-2 at healthcare settings since the last meeting HICPAC becoming seriously ill. This should not be happening, and universal use of NIOSH approved respiratory protection in healthcare would prevent these adverse events from happening in the future. A decision to allow surgical masks in place of NIOSH approved respiratory protection in healthcare is a policy decision that has real victims and goes against OSHA goal of protecting workers. 9/11 responders have successfully sued New York City over not being provided adequate PPE and thus any decision that allows employees to not provide proper PPE tramples over their effort to save lives and repeats the injustice of not protecting workers from airborne hazards. Thank you for your time.

Thank you for the opportunity to provide feedback related to Infectious Control Practices. As the SARS-COV-2 pandemic has unfolded, I have been forced to become very familiar with the state of the art of aerosol transmission and how to illness. My wife is one of the vulnerable people that we are supposed to protect from the virus, and I have been utterly disappointed by the CDC guidance around the airborne (think smoke, not droplets) transmission of SARS2, which transmits just like SARS1 via particles that remain in the air long after the infectious person has left.

Every single healthcare encounter from vaccinations and dental work to outpatient or inpatient care all now create a huge risk to the health of my wife that she may contract SARS-COV-2, and if not die, at least have her chronic condition significantly worsen. It is unacceptable that masking to prevent airborne transmission has nearly universally left hospitals and clinics.

This is a great opportunity for HICPAC to step up and protect the patients and healthcare workers the committee was formed to protect.

I cannot comment on the actual draft guidance, because the CDC/HICPAC has not made this available. It is damning that I must comment based on what are best termed “leaks” or “rumors” about what is proposed.

Again thank you, and I wanted to make sure to emphasize these 6 points for this meeting and future meetings:

1. HICPAC’s process to develop updates has purposely excluded essential input from frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

2. HICPAC/CDC MUST increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. HICPAC's process has been closed to public access or engagement. For example, there are no copies of the draft guidance under review. It's impossible to have real public feedback, review, and engagement when it's impossible to access what we are giving feedback about until the day of the meeting. The deliberations and their conclusions during the meeting seem designed to make it impossible to engage with in good faith. Given that this affects the safety of healthcare workers, and the vulnerable people under their care this process needs to actually be open and involved. The current process seems designed to exclude feedback and constructive criticism instead of to provide space for it. This is in stark contrast to other federal advisory committees. It's hard not to conclude that this structure is designed to prevent the very process that advisory committees are organized to encourage and create.

3. The Work Group on the Isolation Precautions Guidance wants to use a "flexible" approach that only requires minimal protections and lets health care employers decide how to prevent infections. During the COVID-19 pandemic this approach allowed health care employers to skimp or withhold adequate protection for health care workers and patients, based on cost. I urge HICPAC and the CDC to keep an approach in the updated guidance that is clear and specific about the needed precautions to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the exposure level, choose suitable control measures (including PPE) for each job, task, and location, and write an exposure control plan following the hierarchy of controls. "Flexibility" especially regarding individual situations has been shown many times to mean that the least allowed protection is used, which is inadequate to protect healthcare workers, or vulnerable patients placed in their care from acquiring infectious diseases in clinic and hospital settings. Just as we use Biosafety Levels with different pathogens to control for all necessary safety precautions, we should use a hierarchical approach to safety where there is no question as to what is the correct and adequate protection for a given infection disease situation.

4. The Work Group on the Isolation Precautions Guidance wants to change the terms for infectious disease transmission to "air" and "touch" - but they ignore the science on aerosol transmission and how people inhale aerosolized pathogens. The new draft categories of "air" and "touch" are wrong for many health care-related infections. The CDC/HICPAC calls it "air" transmission, but they don't admit that inhalation is important and they still recommend surgical/medical masks, which don't protect people from breathing in infectious aerosols. They also need to update the list of diseases that are now known to spread through aerosol transmission/inhalation, not just airborne or droplet routes. The Work Group's suggestions would make health care workers less safe, even though the Covid-19 pandemic showed how much they need strong protection.

5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. For a detailed explanation of how some of these studies are deeply flawed in both math and prior assumptions, see https://www.researchsquare.com/article/rs-3486610/v1 . The evidence review prioritized

the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

6. The CDC/HICPAC does not recognize the role and value of basic measures to prevent the spread of infectious aerosols. They have ignored the strong evidence that respirators, ventilation and air filtration are effective in protecting workers from inhaling infectious aerosols. They do not give any advice on ventilation. They also limit the use of special rooms (AIIRs) or other methods to isolate patients who may emit infectious aerosols. Moreover, they do not consider how to reduce the source of infectious aerosols as a way to protect workers from breathing them in.

Best regards,

- Jonathan Huff

Hi - there is no lack of evidence now on the efficacy of wearing masks in healthcare settings, for the protection of healthcare workers, facility staff, and patients as well as preventative purposes to avoid further community spread of disease.

As the airborne transmission of covid has been established so has the superior performance and efficacy of N95/respirator masks over procedure/surgical masks (see recent article linked).

Healthcare workers are highly trained and are not easily replaced. Losing them due to temporary or long term illness is highly disruptive and costly. The impact of improperly mitigated spread of disease to patient and community health is equally significant.

Whatever the incremental cost to providing PPE appropriate to an airborne pathogen is exceeded many times over by the costs of increased illness and higher levels of death, disease, and disability that inevitably follow. As but only one example of this, I guide you to consider the 38% increase in the number of those in the workforce with a disability since the start of the pandemic.

Regards

Lissa Bjerkelund

https://www.researchsquare.com/article/rs-3486610/v1

Please:

Support ALL layers of mitigation. The Swiss cheese analogy is so helpful.

Recognize aerosol transmission. The smoke analogy works well.

Respirator requirements in healthcare regardless of vax status

Educate on the different types protection and their relative efficacy

Surgical < n95< PAPR…

Clean air tools like HEPA filters and simple ventilation by cracking windows open.

Involve aerosol experts and increase transparency.

Having dealt with ME/CFS POTS FM, I am painfully aware of some of the disabilities that covid infections can result in. It baffles me that I have to have the sole responsibility of protecting myself from infection while receiving healthcare.

Hoping for public health to refocus on the public,

Lisa Pfost

HICPAC Members,

I urge you to recognize aerosol transmission of SARS-CoV2 in accordance with current science and proceed accordingly, including requiring N95 equivalent or better respirators wherever possible in healthcare settings.

The evidence review on N95 respirator and surgical mask effectiveness must be redone-- it cherry picked flawed studies and failed to include work that showed the efficacy of N95 respirators.

Scientific researchers and experts in respiratory protection, aerosol science, and occupational health must be consulted in a new, better designed evidence review.

Thank you,

Kristin Block

Name: Paula Marks
affiliation: none
Comments:
My grandma was getting treatment for her skin cancer in a "masks encouraged but not required" treatment setting. She was fully vaccinated and wore a mask. 3 days later, she had Covid and didn't go anywhere else. She caught Covid at a cancer treatment facility, likely from an unmasked nurse or patient. She is now wheelchair-bound.

HICPAC must improve infection control measures. The current draft falls dangerously short of protecting patients.

Covid, flu, RSV, TB, chickenpox, cold, and mono are airborne. In fact, there are many illnesses that are airborne beyond that. So HICPAC's response to this by loosening infection controls is criminal. Respirators (either N95s or elastomeric) need to be required in all medical settings, including dentists, rehab, and yes, hospitals. No one should get infected with other illnesses when seeking medical help. The current draft of infection controls puts patients at risk by equating surgical masks to N95s and not implementing any clean air tools. There are numerous studies that show N95s are superior, and the CDC even admitted that in the 90s when TV was spreading. Surgical masks do not provide proper protection and easily leak. Your lack of mask mandates has led to discrimination of "you can wear a mask if you'd like" which puts vulnerable people at risk.

The current covid vaccines do little to stop the spread, and long term effects are incredibly dangerous. The medical practice should be preventative instead of waiting for things to get bad

to act. Beyond respirators, all medical settings need air filters, upper room UV lights, air scrubbers, ventilation, and more to keep the air clean. We have an airborne virus spreading unchecked that can cause permanent heart, organ, and blood vessel damage. We will not live in blissful ignorance and accept re-infection.

The committee must include experts who acknowledge new research on airborne spread and aresol science. A theraputics-based approach allows illness to spread, as does a risk-based approach. Asymptomatic carriers can spread the virus.

Hosptial-acquired infections are dangerous, no matter what illness is catch. One study estimates hospital-acquired infections run as high as 19% in the ICU with a rate of 4% for general patients. We should never relax guidelines. They should become more strict in order to keep patients safe. Healthcare is more important that profit and you need to protect patients in any way possible.

Dear Sirs and Madams,

It is clear that SARS-CoV-2 (COVID) is propagated among people by airborne transmission in droplets AND aerosols. There is no longer any debate to be had about this. Any denial of aerosol transmission, at this point, amounts to incompetence if not outright malpractice.

All personnel employed in healthcare settings need to be required to wear an N95 or equivalent respirator when they are in those settings. We know that respirators are effective in interrupting aerosol transmission, we know that SARS-CoV-2 is transmitted through aerosols, we know that people an be asymptomatically infected with SARS-CoV-2 even if vaccinated, therefore, it is in the interest of the health and well being of patients, those accompanying them AND healthcare providers that ALL persons should be required to wear a respirator when on the premises of a healthcare setting.

Surgical masks are not sufficiently effective at preventing the aerosol spread of a vascular neurodegenerative virus such as SARS-CoV-2. We have known this since 2003 with SARS-CoV-1. There should be no debate about this, either.

In addition, healthcare facilities should employ all effective measures to clean the air in healthcare settings to include HEPA grade filtration, ventilation with outside air, and far UV illumination. Four years into this pandemic, given the volume of hospital/healthcare acquired infections, there should be no debate about this, as well.

As an entity, HICPAC needs to rehabilitate its image and make efforts to regain public trust. Towards this end, aerosol experts should be engaged to determine how best to achieve a safe environment for all who enter the doors of any healthcare facility. And, the outcomes of that engagement needs to be made public in real time to improve the transparency of this process.

Frankly, we the public are beyond tired of the gaslighting and the misinformation being propagated by many public health authorities. Engaging outside experts with specific skills in aerosols, atmosphere, and fluid dynamics and making their recommendations known in a time sensitive manner will encourage public trust and public participation, thereby, putting the "public" back in public health.

Respectfully,

Mary Kay Woodward

Fort Collins, CO

Christiane coopman, Chilliwack bc I am an ordinary citizen who had to deal with rude unmasked nurse,theatre performing doctors while showing us how to wear a flimsy blue. MASKS IN HEALTH CARE SHOULD NEVER BEEN REMOVED,BUT WE ELDERS HAVE NOW BECOME A BURDEN ACCORDING TO BONNIE HENRY (she even wrote it down in a medical paper) the citizens of bc have been abandoned by HC “YOU DO YOU “ is not health car.

Hopefully you will read this and act on it! RECOMMENDATIONS AND LIES DONT WORK

Hi,

If you are serious about preventing disability and death from airborne diseases such as COVID, tuberculosis, flu, etc, you will strengthen rules, not loosen them.

We need federal recognition of the aerosol transmission of diseases. Respirator requirements in healthcare regardless of vax status since the current vaccinations do not halt transmission. To NOT pretend that surgical masks are good enough when respirators are much more effective. We need to require clean air tools like HEPA filters, CO2 monitoring, etc. And to work with aerosol experts to make sure systems are built correctly. And increase transparency so that people know that they are safe when they go to a hospital for help or send their kids to school.

Hospitals are places you go when you need help. The last thing we need to for people in need of medical attention getting sicker in the hospital or delaying needed care until wastewater is lower (if it ever gets low enough to be safe).

If you don't do all of this then you would be the people keeping poop in our water because it's too expensive. You would be the doctors refusing to wash hands to prevent infection in the 1900s. And thousands upon thousands of people will continue to be disabled and die on your watch. Please do the right thing.

Thank you,

Lillian Medviille

Dear Members of HICPAC,

I am writing to you today with a simple request: Please keep masks (respirators) in health care!! Why would a person willingly breathe in the air from another sick person while waiting to seek health care?? I have taught college for 30+ years, and I routinely got sick 2-3 times per semester, along with bronchitis during the summer breaks. Wearing a mask never occurred to me - it wasn’t what you would see on the streets, at work or on TV.

BUT …

Now that masks have been shown to be effective in reducing infections like colds, the flu, RSV and SARS, it seems odd that health care facilities would celebrate not having to wear a mask. This happened to me at a doctor’s appointment over the summer - the mask mandate was

dropped by the local hospital system the morning of my appointment - with NO warning or signage on the doors. I walked in, saw that no one was masked, and asked them why. The nurses and staff all responded with absolute delight that masks were no longer required and wasn't that just great. I stood up, announced to the staff (loudly) that this was not a safe place for me, and I left. Why should I have to avoid seeking medical care in order to keep myself safe? This makes absolutely no sense. Do better.

Arlene Stillwell, PhD

Waddington, NY

I write to provide comment on Infectious disease control protocols in healthcare settings ahead of the November 2nd meeting of the HICP advisory committee.

In 2020, in the face of a global pandemic, healthcare facilities began using N95 masks for all personnel in the building, especially front-line health workers such as Doctors & Nurses. Thankfully, supply chains expanded to allow access to N95 and other high quality masks by non-healthcare workers to prevent the spread in all communal settings including workplaces, stores and gatherings.

This led to a reduction in the cases of influenza, colds and other airborne viruses.

While the public health emergency declaration has ended, COVID has not. Influenza is not gone and airborne viruses continue to spread in our healthcare facilities. While nationwide, mask mandates have been removed, healthcare facilities have an explicit role to play in protecting public health. During the public health emergency, facilities were supported and backed by federal requirements for masking that protected both patients and staff from transmission while giving the facilities the legal standing to enforce requirements. while the federal mask mandate was dropped, community spread of COVID, influenza, RSV and more have not. With limited testing access, well-fitted respirators are the first line of defense for immunocompromised patients, those seeking care, and healthcare workers repeatedly exposed to pathogens.

I urge the committee to increase transparency in their process to update guidance as well as to

maintain and strengthen respiratory protection and other PPE as critical methods for preventing health care personnel inhalation of infectious aerosols.

Thank you,
Sarah Voska
Long COVID since 12/28/21

Please consider the cost of chronic illness.

COVID-19 is an airborne infection.

With aerosol transmission we need masking to protect patients and healthcare workers alike. Respirators should be a requirement in healthcare regardless of vax status. N95 or KN95 Respirators are more effective than surgical masks.

Please upgrade all medical settings ventilation. Utilize clean air tools like HEPA filters.

Thank you,

Cathie

Hello. Please accept my comments below re the above-referenced meeting.

Infection control in healthcare settings is paramount in reducing the spread of disease. The strongest standards should be set to protect both the healthcare workers and those seeking care.

We are currently in a pandemic (even though the emergency declaration has not been renewed) of a novel virus spread primarily through aerosol transmission. It's imperative that a multi-layered approach be used in reducing its spread, including improved ventilation, vaccination and masking with respirators.

Masking with respirators has been shown time after time to be effective at controlling the spread of illness.

Healthcare facilities are short-staffed and unable to provide best care when their providers are out sick. Having them come to work when infectious only puts them and the public at greater risk. Since greater than 50% of those infected with Covid-19 are asymptomatic or pre-symptomatic, the only way to prevent spread of infection in healthcare settings is the consistent, proper use of respirators in all areas of the facility.

Not implementing or reducing the strictest standards will only result in the increased overburdening of healthcare settings and a sicker population of healthcare workers and patients. A healthcare setting is not the place to set personal preference or convenience above infection control.

I urge you to act to protect the public health by increasing, rather than loosening, infection control standards in healthcare settings. Thank-you. Karen Modell

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Dear FDA HICPAC –

I'm writing today because I am 100% in favor of having universal masking (respirators like n95s) in healthcare settings, improving ventilation and filtration (such as HEPA filters) in healthcare settings, and reporting the number of healthcare acquired infections that are Covid-19.

No one should go to a healthcare appointment and become infected there with Covid. That is absolutely the opposite of centering patient care; patients should not catch a preventable disease when accessing healthcare for their needs.

There are a lot of people clamoring that masks aren't needed or that masks are too hard to wear or that surgical masks are enough or that they need to see smiles so that their mental health can be assuaged. While some of these points may have some slight component of truth to them, when the entirety of the situation is evaluated, the weight of evidence for universal wearing of masks (respirators such as n95s) in healthcare settings vastly outweighs any of these other poorer arguments. Indeed, it becomes apparent that protecting the health of patients is paramount and that the entire purpose of healthcare is to ameliorate a condition, then it can only be reasoned that the ameliorating of catching diseases during healthcare visits is itself paramount.

Masks (n95s, and similar) are needed. We know better now that a good number of viruses and pathogens are spread in an airborne manner. People breathe out the virus and it stays in the

air, circulating, until something happens to it (dilution, filtration, time until decay). One infected person sitting in a corner of a room is going to breathe out virus and eventually that virus will fill the entire room. Early in the pandemic there was a concept of droplets and that 6 feet of separation would be enough, but so much data have come out to support and bolster the airborne understanding that hanging on to the 15 minutes/6 feet concept is only a vestige and is doing real harm. Masks both protect the wearer and also stop outward virus when it is exhaled from an infected person. Doing both of those jobs is a huge component of mitigating spread.

Masks (n95s and similar) are a bit of an inconvenience and certainly some people legitimately cannot wear them. Those of us who can should be wearing them so that we can better protect those who cannot. As a scientist working in a laboratory setting, I wear a mask throughout my day. It is important that when I am asking healthcare professionals to mask that I understand what it means to mask all day, every day, because I am already doing it. Sometimes it takes trying more than one maker of a mask, but people can find a respirator that is comfortable for them to wear for long periods of time. I know, because I have had this experience. I have now gone years wearing a respirator at work, to protect the samples I work with from contamination from me, and also to protect me from my samples.

Certainly the medical field has quite a history of having people wear things that are uncomfortable. Both my grandmother (a nurse) and my mother (also a nurse) wore a nurse's cap for decades and decades. By all telling, those were very uncomfortable and had to be severely bobby-pinned in place. That's in addition to the white shoes and the uncomfortable white stockings that nurses had to wear as part of them ensemble before transitioning to wearing scrubs. I would never argue to bring back those things, those items don't have a use. But it is a point to be made that the medical field certainly was okay with workers being supremely uncomfortable day to day and that change happens in the medical field. Respirators are a slight inconvenience and provide a huge benefit of reducing infectious forward transmission. Now that we know better about airborne transmission, it is time that we act better and use the engineering tool that we have access to.

The greatest fallacy might be that surgical masks are enough. Certainly any mask is better than no mask, and certainly the material that surgical masks are created from are the right type of material. However, surgical masks tend to loosely fit around people's faces creating a lot of opportunity for virus-laden breathe to escape out of the sides and into the room. Universal masking with surgical masks can reduce viral load quite a bit, but to get to a standard precaution of care is going to require respirator use. And the truth is that even a non-fit tested respirator is going to work better than a surgical mask, so there is no reason to go all-or-nothing with the concept that respirators must be fit tested to be implemented at all. It is an emotional, last-ditch argument to collapse mask wearing at all and should not be entertained. There are so many arguments about this, mostly because people want to make it look like masks don't work so they can avoid using them. There is smoke and mirrors and specious arguments aplenty trying to make it all seem unnecessary. But, respirators have long been in use in many professional sectors, including the medical field as well as engineering and manufacturing. Respirators are recommended for home use, for protecting a person while performing DIY projects in the garage. That is because of how the respirator works, which is not just like a sieve, but with an electrostatic component that captures particles both large and small.

Respirator use is particularly important because in healthcare settings individuals are obligated to sometimes be very close to each other for examinations, surgeries, and the like. The HVAC

system in buildings and additional HEPA systems cannot compensate for people immediately breathing on each other while conversing. This makes ventilation and filtration important, but also makes it insufficient in many common situations.

Additionally, because Sars-CoV-2 (Covid-19) can cause asymptomatic (no symptoms at all) and pre-symptomatic (no symptoms yet) illness where that infected person is infectious and thus capable of forward transmission, it cannot be counted upon to use symptoms as a signal of when to wear a mask. Earlier in the pandemic, symptoms such as a fever were used to try to distinguish when someone had Covid, but these approaches failed to contain lines of transmission precisely because transmission happens even when an infected person has no symptoms. Therefore, mask use even when not feeling ill becomes an important component and dictates universal masking use. And we know from numerous scientific journals that Covid is not the equivalent of a cold or a flu; it frequently causes much more systemic harm and more deaths.

The last common excuse is that of seeing smiles. While it may be important socially in our culture for such an exchange, there are other opportunities outside of the healthcare setting for individuals to exchange social pleasantries. The person coming to the healthcare setting takes precedence for not getting additionally sick while they are receiving care for the primary reason they came to the appointment. Healthcare's focus must be on first taking care of the person. While bedside manner is important, it is something that can take place while people are wearing a respirator. Many difficulties with communication can be modulated in other ways, such as written directions. As masking becomes more accepted, it will become just something else that we all we become accustomed to. The transition may be bumpy, but it will be overcome until it is just the normal, every-day way that interactions take place in a healthcare setting.

Not to minimize the importance of the healthcare providers by highlighting the patient, but the healthcare professionals also deserve not be made sick while at work. They are exposed to every person that comes in the door that day and they deserve to not become infected with Covid and to not take it back home to their friends and families. There is significant presenteeism within the healthcare community—of showing up for work while sick—and by reducing the opportunities to catch something then it will also reduce being sick at work. No one is at their most efficient or sharpest while not feeling well. Healthcare employees have important tasks and must be able to provide the right care to people, not care at less than proper because they are ill themselves that day. Such illness can take a toll on healthcare professionals and cause great use of sick days as well as leaving the profession. Nationally, we have what is commonly referred to as a Nursing Shortage. Being constantly infected at work will contribute to more burn-out and leaving the healthcare profession.

Covid is a serious illness. It is not a minor cold. It is far deadlier than the flu, even when being undercounted. Every Covid infection comes with a risk of Long Covid Syndrome. There are dangerous outcomes to Covid infection and repeated Covid infection, such as vascular issues, immune system issues, increase in diabetes in children, increase in strokes and heart attacks, neurological damage, and many other damages. Just because it is now a more commonly caught disease, because of its high infectivity, does not make it less pernicious.

Sadly, I have several acquaintances with family members who went to the hospital for some surgery or emergency event and would most likely have been perfectly fine but caught Covid in

the hospital and subsequently died. News stories are coming out carrying this data, especially in New Zealand and England, where this data is more readily available. We know that transmission in hospitals is happening: https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/healthcareassociated-respiratory-viral-infections-after-discontinuing-universal-masking/E3B1E21AFB9D9BA4C535F7BB810A3D1C

From the above article: “When our hospital moved from universal masking in all clinical buildings to masking for all patient encounters only, we observed an immediate, substantial, and sustained increase healthcare-associated respiratory viral infections. These observations are informative regarding the impact of masking because—unlike rapid simultaneous implementation of numerous mitigation strategies in healthcare settings and the community early in the pandemic—no other changes in infection prevention strategies or staffing levels were implemented at our facility in late 2022.”

President Biden decreed that hospitals in the US don’t have to disclose hospital acquired infections of Covid: https://www.politico.com/news/2022/06/25/biden-officials-to-keep-private-the-names-of-hospitals-where-patients-contracted-covid-00042378 . If we aren’t counting the numbers for such a problem then it may appear that there is no problem. But the funerals of the family members of my acquaintances show that it is a problem. We need to count these infections so that we can know where we need to make improvements. Pretending there is no problem is no solution at all.

And while many people believe that it won’t happen to them, it can happen to any of us. We are all vulnerable, and possibly one infection away from an unfortunate outcome. Hubris and pride are commonalities of the human condition, but we don’t have to succumb to that. We have knowledge and empathy and can make decisions that will protect patients and protect staff. And we have an important tool to do so, which are respirators.

Please—universal masking with respirators is now a minimum of standard precautions needed in healthcare settings—make it so.

Sincerely,

Tracey Canino

Vermont, USA

Respirator should be a requirement in any healthcare situation regardless of vaccinated status of the person given that most people who are visiting doctors and hospitals are already in a compromised health situation.

Proper fitting N95 Respirators are far more effective than ordinary surgical masks and should be mandatory for all healthcare providers and visitors (provided to visitors if they don't have their own).

We should also prioritize clean air tools like MERV 13 or higher HEPA filters that can remove viruses from the air and proper ventilation.

When making policies you need to involve aerosol experts and increase transparency so that information is clear and easy to understand by the general public as to why these policies exist.

You all know what happened with the **Mars Climate Orbiter** right? One unit conversion error, a human error, outside of engineering specifications, doomed the entire spacecraft.

These RCTs do not control for massive variable of human error. Not wearing the respirator consistently, not fit testing with a condensation particle counter…you *have* heard of the term *fit factor* right? 44 CFR part 84.

We don't ask manufacturers to do RCT on airplane safety equipment, like life jackets, without giving passengers information on how the safety equipment works. And when we inform passengers accounting for human error, guess what: they always work, making an RCT study completely useless.

The point is, we don't subject **engineered objects**, like **respirators**, to randomized control trials. The job of engineers is to make sure these devices as *perfectly as possible without human error*.

This means: CPC tests every 6 months, no ear loops (*cough* KF94), no self-certifying respirators (*cough* KN95), and constant auditing of respirators from an authoritative entity (NIOSH! N95!).

TL;DR: There's a reason why the TSI PortaCount, a devices that tests respirators, has been sold since the late 1980s. This is before 44 CFR too (28 CFR), which means TSI made this back when MSHA (mining safety and health administration) and NIOSH jointly certified respirators as 'Type A,' what would later become the 'N95' specification.

If what I said was too boring: This video from TSI on the PortaCount was released in the late 1990s: https://youtu.be/PJXLOzwyAZE?si=Nx6k2ZooqSNMODMR&t=10

Did I say 28 CFR? I meant **30 CFR**. And 44 CFR is **42 CFR** Part 84. Sorry…I'm not used to doing ***your work*** and reading the Federal Register. https://www.cdc.gov/niosh/docs/96-101/default.html

Oh, don't forget to watch the video:
https://youtu.be/PJXLOzwyAZE?si=Nx6k2ZooqSNMODMR&t=10

Mandating masking in healthcare is imperative for getting COVID and all other airborne pathogens under control!

To Whom it May Concern:

Please find attached a summary of the Preventing Aerosol Transmissible Diseases in Healthcare Workshop. Recordings and other materials can be found on the workshop website: https://rutgerstraining.sph.rutgers.edu/PreventATD/

The report includes the following recommendations for CDC and HICPAC's update to the 2007 Guideline for Isolation Precautions:

1. **Ensure guidance is based on science by conducting a thorough review of the peer-reviewed literature from all relevant disciplines.**
2. **Gather wider input from all groups who will be impacted by the updated guidance.**

○ Include patient advocates and healthcare personnel from a wide range of healthcare settings in development and review of the guidelines.

3. **Ensure guidance includes strong, clear, science-based requirements for infection prevention that do not allow flexibility for health care employers to prioritize costs over protecting patients and healthcare personnel.**

4. **Fully recognize the role of aerosol transmission for many infectious pathogens.**

○ Correct the false dichotomy of near/droplet vs far/airborne transmission.

○ Recognize that respiratory aerosols are emitted in a wide range of sizes, can travel long distances, may stay suspended in the air for long periods of time, and can be inhaled near and far from a source.

○ Incorporate expertise from industrial hygienists and aerosol scientists.

5. Recognize that numerous pathogens are transmissible via inhalation.

○ Update the guidelines to include influenza, RSV, adenovirus, MERS, SARS-CoV-2, norovirus, and pertussis, among others, as aerosol-transmissible diseases.

○ Recognize that endemicity and seasonality do not determine protective measures for aerosol-transmissible pathogens.

6. **Adopt the precautionary principle that novel pathogens are aerosol transmissible until demonstrated otherwise.**

7. **Recognize and account for the role of asymptomatic/presymptomatic cases in aerosol transmission for diseases (e.g., influenza and SARS-CoV-2).**

○ Consider pre-procedure/pre-admission testing of patients for such pathogens.

8. **Collaborate with the Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) for essential expertise on occupational protections for healthcare personnel.**

○ Require compliance with the OSHA Respiratory Protection and other applicable standards.

9. **Incorporate a multi-modal infection control strategy that relies on the hierarchy of controls.**

10. **Establish prevention measures for the full range of healthcare settings.**

○ Establish appropriate measures across hospitals, long-term care/nursing facilities, home health, outpatient clinics, physician offices, prisons and jails, dental care settings, etc.

11. **Establish clear, explicit, and robust standards for all healthcare facilities to improve indoor air quality through ventilation, filtration, and other measures.**

○ Review relevant existing recommendations and standards and incorporate expertise from ventilation engineers and experts.

○ Require updates to ventilation, filtration, and similar measures in all healthcare settings.

○ Increase capacity for isolation of patients with aerosol-transmissible diseases.

○ Require reporting of air quality measures to patients and healthcare personnel.

12. **Recognize that NIOSH-approved respirators must be used to prevent healthcare personnel exposure to aerosol-transmissible diseases**.

○ Acknowledge. that surgical/medical masks cannot be used as respiratory protection against hazardous aerosols.

○ Require employers to conduct a risk assessment and prepare an exposure control plan, including identifying higher-risk situations where higher levels of respiratory protection are warranted.

○ Emphasize that respirators must be worn within the context of an OSHA-compliant respiratory protection program.

13. **Consider universal masking for source control for all healthcare personnel, patients and visitors and broader use of respirators for healthcare personnel, patient and visitor personal protection.**

14. **Address preparedness for outbreaks and pandemics of novel pathogens.**

○ Require personal protective equipment (PPE) stockpiles, emergency staffing plans, and plans for expanding or modifying ventilation and isolation practices.

○ Require stockpiling of NIOSH-certified N95 filtering facepiece, elastomeric, and powered air purifying respirators.

Thank you.

Sincerely,

Lisa M Brosseau, ScD, CIH

Professor (retired)

Research Consultant, University of Minnesota, Center for Infectious Disease Research and Policy

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I know you are doing the best you can and want the best possible infection control measures, which is why you're a member of HICPAC. As someone who knows many people terribly affected by COVID, I want to reach out and ask you to improve infection control measures, as the current HICPAC draft falls dangerously short of protecting patients and healthcare workers.

I know many people who have gotten infections by simply getting routine surgery. Hospitals are notorious for spreading infections, and I beg you to go above and beyond with clean air tools and protections to avoid needless infection. Patient protection is more important than profits and there are too many unknowns with the long term effects of Covid.

COVID and many other illnesses spread through micro aerosols. CDC must acknowledge this. Respirators work. An N95 or elastomeric respirator is the best tool we have that isn't being utilized to protect patients and healthcare staff. Surgical masks leak and are not as effective.

Recommending masks in healthcare settings doesn't go far enough. Respirators must be required by staff and patients, as one-way masking puts the burden on the most vulnerable and vaccines do not prevent transmission. Additionally, medical centers (which include rehab and dentists), must minimize the spread of airborne pathogens by installing air filtration tools like True HEPA filters, air scrubbers, far UV lights, and more. Your committee must involve the expertise of aerosol scientists.

My wife ended up in the emergency room and had to worry about preventable airborne illnesses like drug-resistant TB, measles, COVID, etc. There are a slew of viral, fungal, and bacterial illnesses that spread through micro aerosols. Improving aerosol protections protects healthcare workers too. If they are sick or disabled, who will be left to treat patients?

I beg you to increase the transparency of HICPAC and improve micro aerosol infection protections. It will save lives and keep Americans healthier, including yourself.

Thank you.

-Paul Hennessy

I'm not sure where to start. This pandemic has been handled so extremely poorly, there are zillions of areas to address.

1. We NEED masks in health care facilities.
2. We NEED DATA. The CDC removing nearly all data is reprehensible. Dr. Walensky began that and qualified it with "make your own decisions". Then, she immediately dismantled data availability, which Dr. Cohen has continued to do.
3. We NEED improved therapeutics. I don't need to elaborate.
4. PUT AERSOL EXPERTS ON THE COMMITTEE.

But more than any of those, WE NEED IMPROVED VENTILATION AND FILTRATION. This is not speculative. This is proven. The virus can evade immunity, but it cannot evade recirculated air that is diluted with fresh air and filtered with MERV-13. Far UVC would be great, also.

This virus is airborne despite Tedros correcting himself a couple of years ago, and despite our CDC Directors' inability to say the awful "A" word. We all know why—because it would hurt capitalism.
Thank you,

Mark Wall, Gloucester, VA. I am affiliated with myself.
TOPIC: STOPPING AIRBORNE TRANSMISSION OF SARS CO-V2

Members of the HICPAC,

I am writing to you today as a concerned citizen who recognizes the urgent need for enhanced infection control measures in medical settings. The ongoing challenges presented by infectious diseases, especially in the wake of the COVID-19 pandemic, require a heightened level of awareness and preparedness. I implore the Healthcare Infection Control Practices Advisory

Committee to address several crucial issues that, if addressed comprehensively, will contribute significantly to safeguarding the health of both patients and healthcare workers.

First and foremost, I urge HICPAC to formally recognize the potential for aerosol transmission of infectious diseases within healthcare facilities. Aerosol transmission is an insidious pathway for the spread of diseases, as it can lead to infections even when patients and healthcare workers maintain physical distance. Acknowledging this mode of transmission is vital for implementing effective preventive measures.

Additionally, I strongly urge that HICPAC mandates the use of high-quality respirators for all healthcare personnel working in medical settings, irrespective of their vaccination status. Respirators have consistently demonstrated their superiority over surgical masks in filtering out airborne particles, offering a higher level of protection. Ensuring their use is a critical step in safeguarding healthcare workers and reducing the risk of disease transmission.

Furthermore, the implementation of clean air tools such as HEPA filters within healthcare settings is paramount. These filters can help eliminate harmful airborne particles, further reducing the risk of infection. The integration of such technologies should be encouraged and incentivized within healthcare facilities.

In order to make well-informed decisions and strategies in combating infectious diseases, I strongly recommend the involvement of aerosol transmission experts and an increase in transparency in the decision-making process. Experts in the field of aerosol transmission can provide invaluable insights and recommendations for crafting effective infection control measures.

Lastly, I would like to emphasize that the proposed protections, encompassing the recognition of aerosol transmission, universal respirator usage, the integration of clean air tools, and the involvement of aerosol experts, have the potential to significantly reduce the transmission of all airborne illnesses, not just COVID-19. This holistic approach to infection control will undoubtedly save lives, prevent outbreaks, and enhance the resilience of our healthcare system.

In conclusion, I implore the Healthcare Infection Control Practices Advisory Committee to take immediate and decisive action on these critical matters. The urgency of the situation demands a proactive response. By recognizing aerosol transmission, mandating respirator usage, promoting clean air tools, and increasing transparency, we can collectively protect the health and well-being of both healthcare workers and patients. These measures are not only necessary for the ongoing fight against COVID-19 but also for mitigating the risks associated with other infectious diseases.

I thank you for your dedication to public health and your commitment to safeguarding our communities. I trust that you will consider these recommendations with the utmost urgency and seriousness they deserve.

Sincerely,

Natalie

Members of HICPAC,

I'm writing to provide public comment for the HICPAC meeting on November 1st.

HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has been unnecessarily opaque, and to date, HICPAC/ CDC has failed to solicit or incorporate essential input from aerosols experts, patient safety advocates, Industrial hygienists, occupational health experts, safety professionals, HVAC engineers, scientists, and experts in respiratory protection. HICPAC/CDC must acknowledge the inadequacy of this process, open it up and engage the aforementioned experts in developing the next drafts of this important infection control including the 2007 Isolation Precautions guidance.

HICPAC must increase transparency and public engagement in the process of updating the 2007 Isolation Precautions guidance. Meeting presentations and documents used to make recommendations to the CDC have not been posted publicly like they are for other federal advisory committees, including many of those at the CDC. There is no acceptable excuse for keeping this process closed and not seeking the input of subject matter experts on aerosol spread of viruses and the public who deserve access to safe medical care and do not want to and cannot afford to be repeatedly infected by COVID19 and other airborne illnesses. Patients should not have to worry about nosocomial infections and "you do you" medicine.

HICPAC/CDC must improve infection control and indoor air quality in ALL medical facilities, including ERs, doctors offices, hospitals, and dental / orthodontic facilities. This includes proactively and sufficiently cleaning the air and requiring all medical staff, patients (that are able) and visitors to medical facilities to wear unvented N95 or better respirators, regardless of vaccination status. These respirators should be provided for free to those who are not already wearing them before entering medical facilities. Free respirator fit testing should also be provided through insurance to patients and by employers to all medical staff. CDC's HICPAC should NOT lower infection control for airborne pathogens like COVID-19 / SARS2, the long term impacts of which are, at best, suboptimal and at worst, life threatening and altering.

CDC/HICPAC has so far failed to acknowledge the importance and function of key control measures for infectious aerosols. As a result, the public and many medical professionals remain largely unaware of the large body of evidence showing the effectiveness of N95 or better respirators, fit tested N95+ respirators - worn properly - are effective in stopping the spread of airborne diseases, surgical masks are not effective against the spread of diseases like COVID 19 and therefore N95s should be worn.

CDC/HICPAC fails to acknowledge that the CDC's new recommendation of 5 air changes per hour, while better than nothing, is not sufficient in medical or other heavily trafficked environments for infection control. I say this knowing that the California Department of Public Health recommends 6-12 ACH in schools, so it defies reason to believe 5 ACH is sufficient to protect patients and medical staff from the spread of airborne pathogens.

Likewise, the proposed use of airborne infection isolation rooms or other approaches to isolation when the use of AIIRs is not possible is significantly limited. CDC/HICPAC must solicit the expertise of ASHRAE HVAC experts in identifying the appropriate types and level of ventilation and filtration to limit the spread of airborne pathogens.

Given the asymptomatic spread of COVID 19 in the population, HICPAC/ CDC must acknowledge that it is insufficient to rely on symptom checking alone - particularly in dental, orthodontic, surgical and other environments where it is not possible for patients to wear respirators. Patients must be protected at all times by their medical providers and staff. Patients should not be subjected to medical care from providers who are not wearing N95s or be forced

to be surrounded by other possibly sick patients who are not wearing N95s (ex: in waiting rooms and open bay dental/orthodontic facilities).

HICPAC/CDC must be clear to the public and medical providers that COVID19 is airborne and airborne infection control is a necessary part of keeping the disease under control and minimizing the harms of repeat infection. Specifically, it must explain:

- SARS 2 is a novel virus that is constantly mutating. The short, medium and long term sequelae of each variant may vary and aren't fully understood.
- Having "mild" acute illness is not indicative of long term prognosis with SARS2. Vascular, brain, organ damage can occur after the acute phase of illness, viral persistence happens, and for these and many other reasons, it is wise to pursue the precautionary principle.
- Current vaccines aren't enough to adequately protect people from "Long Covid" and the frequent long term vascular, brain, immune system, and other longer term damage of COVID19.
- Children and adults are both harmed by COVID19, and often the damage to the body cannot be seen during the acute infection, felt by the patient, or discovered right away.
- It is wise to protect oneself and others by wearing a fit tested unvented N95 respirator indoors.
- Fit tested N95s are much more protective than surgical or cloth masks, and properly fit tested and worn N95s can prevent the spread of aerosolized diseases like COVID19. PAPRs are even more protective than N95s and P100s.
- How to fit a N95 respirator.
- That there (wrongly) is no respiratory standard of protection for children in the US (even though there should be during BSL3 pandemics, epidemics, wildfire smoke and pollution events). Parents need to know what they can do to select and fit respirators that protect children from COVID19 until a US standard is developed (e.g. tightly fitted KF94, KN95 or similar high filtration respirators, not cloth masks or loose fitting masks)
- HEPA filters and DIY portable air filters like Corsi-Rosenthal boxes and SAFE boxes effectively clean the air of viruses. However the number and speed at which they need to operate varies based on the size of the room.
    - CR Boxes and SAFE boxes can be made in less than 8 minutes, and for less than ~$130 each. For less than $300, you can build enough DIY air filters to deliver the 6+ Air changes per hour recommended by the California Department of Public Health in schools for a classroom or large conference room.
    - Info on SAFE boxes here: https://www.patientknowhow.com/safe.html. Info on Corsi-Rosenthal cubes here: https://corsirosenthalfoundation.org/wp-content/uploads/Build-a-Box-Eng-1.pdf

In summary - Airborne infection control protocols and universal respirator wearing should be in place in all healthcare settings, and HICPAC/ CDC must be transparent and do all it can to

solicit and incorporate the advice from experts on aerosols, industrial hygiene and others on modern day infection control and isolation precautions guidance.

Sincerely,
Lisa Oshima

MSc Oxon

Hello,

Please;

-Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vax status -Respirators are more effective than surgical masks -Clean air tools like HEPA filters in all indoor spaces -Involve aerosol experts and increase transparency -Recognize health risks due to Covid illness, the public deserves to know

Thanks,

Erica Riley

Please make masks in hospitals required! COVID is airborne. People who wish to avoid contracting it, anyone with rationally, should be able to get hospital care without risking this dangerous infection.

Science is still learning about the multiple ways that this pathogen harms bodies. Please do no further harm.

Thanks, Elizabeth Gibbon

Arlington, Virginia

Hi, your intention to weaken infectious control measures in clinical setting has no quality studies behind it, and it will not go unnoticed. Many of us track the decisions made and their reasoning.

The idea that N95s are as effective as surgical masks are based on cherry-picked data and RCT studies which are inappropriate when it comes to predictable models in the physics field (unlike the medical field). You refuse to consider interdisciplinary collaboration when it comes to airborne bioaerosols, refuse to look at the pre-2020 literature for comparable pathogens like measles and tuberculosis (in terms of transmission) and who is qualified to study those bioaerosols and only consider experts who have been politically captured and who have something to lose by admitting that we are not using the proper tools.

To top it all off, this decision process is very quiet and unknown to the general public. I'm aware you know this will come to the surface sooner or later; the idea is merely to stall as long as possible to muddy the waters and make it harder to find who is to blame, and to erode public services like health-care and public education.

Existing literature and quality emerging literature proves time and time again that respirators, ventilation and air purifiers are the appropriate airborne precaution in every public and clinical setting. Airborne pathogens necessarily require collective actions. Every day you refuse to

recognize it is another day where people die or get disabled by preventable Sars-Cov-2 infection and now joining more pathogens that are crossing the containment lines due to weaker standards. The people dying now from Sars-Cov-2 reinfections have been told it was safe, that they could move on. You told this to single mothers, to caretakers, to vulnerable individuals, to patients, to parents, to children. You can turn it around.

I wish you all the health and safety you provide for the public. I wish you all the accountability you deserve.

Hi there,

I've been reading a lot about plans to make it easier to contract illnesses in the hospital.

Weaken infection precautions?

IN A PANDEMIC?

You're sending a clear message:

You don't care about us. And it's OK if we die.

By "us" and "we" I mean AMERICAN citizens. Because how many of us are now at a heightened risk because of countless COVID infections?

People trust you to protect them. Do your jobs.

Sincerely,

Chris Henson

Hello,

I am emailing to submit my written public comment for the upcoming HICPAC meeting on November 2, 2023.

It is critical that patients and healthcare workers are properly protected from infections in healthcare facilities; as of now HICPAC and CDC have given no indication that they understand transmission via aerosols or plan to incorporate proper infection controls in their guidelines. Hospitals must deploy respirators, air filtration and other technologies to minimize the spread of viral, bacterial, and fungal illnesses that are spread through aerosols.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation. Suggesting that surgical masks are as effective as respirators is a gross misrepresentation of the evidence.

My family members who are at increased risk from severe Covid-19 outcomes deserve protection. Our community members who are immunocompromised deserve protection.

Healthcare workers who are risking their lives to care for us deserve protection. My children deserve protection from infection when they seek medical care. We deserve protection.

Thank you,

Jenifer Steinmeyer

To CDC:

The CDC must not claim that surgical masks are as effective than respirators. By the CDC's own former infographic, respirators far outperformed surgical masks. The CDC has lost trust amongst the American public, and it's time to do the right thing based on science. By suggesting the inefficacy of respirators, the CDC will only be encouraging anti-science rhetoric in the US.

It's a crime to do harm within healthcare settings and infect patients. Masks should be required in hospitals to prevent the spread of COVID, flu, and RSV, especially from physicians to patients. We are in a scenario where the CDC has accepted doctors and nurses killing their patients through the spread of infectious disease.

Physician disability is at an all time high due to long COVID and by restricting the use of respirators, that will only increase. HCW's should be able to protect themselves properly, and it would be an OSHA violation to not do so.

The CDC should work with government agencies to implement requirements for higher ACH in all buildings due to aerosol transmission of pathogens.

To the CDC ~

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols.

The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation.

The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please rectify!!

Jason George

Brooklyn, NY

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing as a concerned citizen to strongly recommend and support the adoption of comprehensive measures to improve ventilation and require the use of N95 masks in all healthcare settings. These critical steps are essential to combat the aerosol spread of diseases, reduce hospital-acquired infections, and ultimately save lives.

In healthcare environments, where patients are already vulnerable due to illness or injury, the risk of acquiring additional infections can be life-threatening. Hospital-acquired infections are a significant concern, and it's crucial to recognize that these infections can result in severe consequences, with an estimated 10% leading to fatalities.

Aerosol transmission is a well-documented route for the spread of infectious agents, and it poses a significant threat in healthcare settings. Improved ventilation is a fundamental component of mitigating the risk of aerosol-based transmission. Adequate air exchange and filtration systems can help reduce the concentration of infectious particles in the air, providing a safer environment for patients and healthcare workers.

In addition to ventilation improvements, the requirement for N95 masks is vital to protect healthcare workers and patients from aerosolized pathogens. These masks offer a high level of filtration efficiency and should be considered a standard of care in settings where aerosol transmission is a concern.

The COVID-19 pandemic has demonstrated the importance of these measures. However, the risk of aerosol-based transmission extends beyond COVID-19 and includes various other infectious diseases. By mandating improved ventilation and the use of N95 masks, we can establish a strong defense against a range of pathogens, reducing hospital-acquired infections and their associated mortality rates.

I urge HICPAC to take a proactive role in setting guidelines and standards that prioritize ventilation enhancements and N95 mask requirements in all healthcare settings, not just during pandemics but as part of routine infection control practices. These measures can have a profound impact on patient safety and significantly reduce the incidence of hospital-acquired infections.

In conclusion, the requirement for improved ventilation and N95 mask usage in healthcare settings is a critical step in ensuring patient safety and preventing the devastating consequences of hospital-acquired infections. Your leadership and guidance in this matter are essential for protecting lives and advancing infection control practices in healthcare.

Thank you for your commitment to safeguarding public health, and for considering this important recommendation.

Sincerely,

Gyda Sabaugh

I am concerned about the November 2nd-3rd HICPAC meeting as switching from N95s to surgical masks as the standard is harmful to everyone by making healthcare facilities unsafe. It is vital that NIOSH-certified respirators remain the standard for protecting against Tuberculosis as surgical masks don't protect against airborne hazards such as tuberculosis, H5N1 avian flu, and SARS-CoV-2. I know many people who acquired infections of airborne diseases at healthcare facilities and airborne precautions need to be routine to stop these adverse events from occurring. Thank you for your time.

Regards,

Devin Kreitman

I am writing to request that HICPAC Committee members support the requirement for high quality masks, aka respirators, rated KN94 or better, in all healthcare settings to stop the spread of airborne infectious diseases. We know that respirators work to stop transmission of infectious diseases, and that the commonly worn blue surgical masks to not offer the same level of protection. I would guess that most of you have seen the recent 60 Minutes segment on ventilation as well as the 60 Minutes Overtime segment where Professor Linsey Marr demonstrates the spread of airborne particles and explains how respirators work to protect the wearer and others. In addition, there are many recent articles on the efficacy of respirators, some of which refute the findings of the Cochrane study that casts doubt on such efficacy. This requirement would protect not only patients and their families but would also greatly decrease spread among the healthcare staff. This requirement needs to be directly tied to Medicare and Medicaid reimbursement so that it is enforceable.

I am a former hospital social worker (MSW) who understands the power dynamics between healthcare personnel and the patients and their families. There have been suggestions that patients/families just need to ask healthcare personnel to mask if they need accommodations, but I believe it is unreasonable to place this burden on patients and their families. In addition, I have witnessed and read about too many incidents where healthcare personnel outright refuse these requests and, in some cases, take retaliatory measures in response to such requests.

On a personal note, two of my fully vaccinated and boosted family members died as a result of contracting Covid in healthcare settings, one in Michigan and one in Florida. My Florida relative was in skilled nursing following a fracture from a fall and staff dismissed my polite requests to mask while caring for her. Please consider that you could face a similar situation, and that the policies that you support could have a direct impact on you and your loved ones.

Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation

- Research scientists, including those with expertise in aerosols and respiratory protection.
- Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
- Patients, patient advocates, and disability justice groups.

- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
  - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
  - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
  - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
  - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
  - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
  - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
  - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
  - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
  - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit

testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.

- Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
- Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).

- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Edderic Ugaddan

Waltham, MA

People's CDC

Dear CDC,

The public needs protections in Health Care settings for patients to be not exposed to Micro Aerosol Airborne Covid 19 or SARS2. Also in all public places and air HEPA cleaners.

Please mandate this for Hospitals and Doctors, Dentist office’s.

Seniors such as myself with underlying issues have put off going to health visits due to not wanting to be exposed to this deadly pathogen.

I know several family members have contracted Covid19 from Dr. office and hospital stays and visits. Which has lead to them having many new health issues. My sister has had 4 heart attacks since getting Covid19 from the hospital.

A good friend had caught Covid 19 from Dr. office and now has Stills and heart problems.

Please change your guideline to say ALL healthcare settings must wear N95 Respirators to keep their oath of DO NO HARM.

Thank you,

Carol Reid

Dear HICPAC Team:

I'm writing you to strongly plead for your help in improving public and individual health when it comes to all airborne disease, but particularly SARS-2.

Presently it's literally a danger for all of us to go to receive care and treatment in most US healthcare settings. Whether in hospital, physical therapy, dentist care, urgent care, or just

going to the family doctor, we are risking our very health every time due to the massive amount of airborne viral disease like COVID, RSV, TB, and others.

We beg you to address this crisis by doing the following:

1. Publicly recognize that aerosol transmission of SARS-2 is real and happening right now

2. Reinstate respirator requirements in healthcare regardless of vaccination status

3. Make clear that respirators are more effective than surgical/other masks

4. Mandate and fund clean air tools like HEPA filters and FAR-UV in all healthcare settings

5. Involve aerosol and air quality experts in CDC policy and rules and increase transparency and accuracy of the information we the public receive.

Please take action on these items immediately.

Thank you,

Jef Buehler

Frenchtown, NJ

Hello I am writing as a member of the public, and as a patient in Healthcare settings.

I am immnocompromised and although I wear a n95 mask to every appointment or procedure, the dropping of masks in Healthcare settings makes me less safe. Less safe seeking the care I need to stay alive. At my last infusion, I was the only one in the entire infusion center wearing a mask. I would guess every patient there was immnocompromised, yet no masks. Regardless of political nonsense surrounding covid; Flu, RSV, TB are all on the rise in the fall and circulating in communities. Emergency room waiting rooms, urgent care centers, are all places where every single person is put at unnecessary risk by the failure of the CDC to publicly acknowledge aerosol transmission of potentially deadly viruses and encourage people to take precautions for themselves and others. That reasonable public health message has been erased. There is little transparency of risk within communities of any diseases from any authority so people rely on rumors which rarely benefit anyone.

Healthcare centers, are not required to filter or treat the air we must breathe, risking patients, providers, and employees equally. How is this reasonable in the very places we must go to safeguard our health?

I urge the CDC to fully recognize aerosol transmission to ensure health care workers and patient protection. If the American public could be made to accept the need for seatbelts, Don't Drive Drunk, and the need to protect the public from second hand smoke in my lifetime, you can do this. Work to protect the American public from known risks to our health. It's literally disease control which is certainly under your mandate.

Andrea Rademacher

Lafayette, IN

Urge the CDC to Fully Recognize Aerosol Transmission to Ensure Health Care Worker and Patient Protection

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Hi,

This is regarding the CDC's plan to weaken infection controls in healthcare settings.

If you are serious about preventing disability and death from airborne diseases such as COVID, tuberculosis, flu, etc, you will strengthen rules, not weaken them.

We need:

- federal recognition of the aerosol transmission of diseases.
- Respirator requirements in healthcare regardless of vax status since the current vaccinations do not halt transmission.
- To NOT pretend that surgical masks are good enough when respirators are much more effective.
- We need to require clean air tools like HEPA filters, CO2 monitoring, etc.
- And to work with aerosol experts to make sure systems are built correctly.
- increase transparency so that people know that they are safe when they go to a hospital for help (or send their kids to school).

Hospitals are places you go when you need help. The last thing we need is for people in need of medical attention getting sicker in the hospital or delaying needed care until wastewater is lower (if it ever gets low enough to be safe).

If you opt to weaken infection controls as opposed to strengthening them, you would be the people keeping poop in our water because it's too expensive to filter it out. You would be the doctors refusing to wash their hands to prevent infection because "a gentlemen's hands are always clean" in the 1900s. If you weaken infection controls, thousands upon thousands of people will continue to be disabled and die on your watch. Please do the right thing and make healthcare safer.

Thank you,

Lillian Medville, no organizational affiliation

Union City, NJ

Dear committee members,

I'm writing in regards to the meeting being held on November 2, 2023. I'm concerned about the relaxation of infection control measures in medical settings. Aerosol transmission of pathogens, including Covid 19, measles, tuberculosis and many other bacterial, viral and fungal infections, must be recognized as proven science and measures must be taken accordingly.

We now have solid evidence that respirator masks, such as N95s, protect against aerosol transmission. Aerosol scientists agree that N95 respirators are needed and surgical masks will not suffice. We also need HEPA filtration and ventilation. Aerosol scientists should be consulted when setting guidelines.

I will not feel safe in medical settings unless we have these measures as the standard of care. I do not have any major health issues as of now but I am not even comfortable to receive preventive care and will be reluctant to access emergency care should that situation be necessitated.

All citizens have the right to receive medical care without the danger of acquiring an infectious disease as a result of such care. Please do what's right and recognize aerosol transmission and act accordingly.

Sincerely,

Michele Jordan

Port Washington, NY

Hello,

As someone who has asthma and an autoimmune disorder, I would like to be able to seek medical care, dental, eye care and routine cancer screening without the risk of catching Covid or any other respiratory illness. There are scenarios (surgeries, colonoscopies, upper endoscopy) where you cannot mask to protect yourself. Any medical provider that is in your personal space examining you, looking in your ears, mouth, eyes, dental work, etc) should be masking to mitigate the risk of infecting patients…especially if they are immunocompromised patients. These small patient rooms have no airflow, nothing cleaning the air or bring in fresh air. We deserve to have access to healthcare without being infected or exposed by healthcare providers. Please reinstate N95 masking in healthcare settings for healthcare workers

Thank you

Tara Urbanovitch

To whom it may concern:

Time and time again, it has been proved and tested that N95 masks offer significantly better protection than a surgical mask, even more so than no mask at all. It is astounding that we are here today discussing the topic of health care workers and masking during an ONGOING PANDEMIC. It is irresponsible for our leaders to expose the public to a life threatening disease, one which has long term effects. Both patients and health care workers deserve protection, and the current guidelines exposes all parties to a incapacitating virus, one that KILLS. All in all, you lot should remember you are here to serve the public, and currently you are killing us. Leaving your credentials at the door is not an option anymore.

Kindest regards,

Jorge Angeles

I'm writing in regards to the meeting being held on November 2, 2023. I'm concerned about the relaxation of infection control measures in medical settings. Aerosol transmission of pathogens, including Covid 19, measles, tuberculosis and many other bacterial, viral and fungal infections, must be recognized as proven science and measures must be taken accordingly.

We now have solid evidence that respirator masks, such as N95s, protect against aerosol transmission. Aerosol scientists agree that N95 respirators are needed and surgical masks will not suffice. We also need HEPA filtration and ventilation. Aerosol scientists should be consulted when setting guidelines.

I will not feel safe in medical settings unless we have these measures as the standard of care. I do not have any major health issues as of now but I am not even comfortable to receive preventive care and will be reluctant to access emergency care should that situation be necessitated.

I urge you to please take these points into consideration for the good of us all and our family members.

Thank you,

Michele Jordan

To whom it may concern:

In your upcoming meeting, please do not loosen restrictions on respiratory infections and undo half a century of public health progress.

We need better infection control measures in medical settings then what we currently have since many people are hospitalized and getting diseases from other infected patients and staff. Please address and consider the following:

1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

2. I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

3. HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select

appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

4. The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of **aerosolized** pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

6. CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please know that many of us are concerned and believe new direction is necessary for the future of public health.

Sincerely,

Timothy Massaro

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1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

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Cordially,

Racy Peters

Dear Committee Members,

I am writing to ask that you consider aerosol and micro aerosol protections when you meet tomorrow and keep N95 respirators as the standard in healthcare settings.

We know that SARS-CoV-2 is airborne and that N95 respirators work to help prevent infection at a much higher level than other masks.

We know that SARS-CoV-2 can remain in the air for 12 hours.

We know that the more often a person is infected with SARS-CoV2, the more likely it is that they will develop long Covid. We know that the consequences of long Covid are disability and death.

We are all at risk as mitigations are lifted and SARS-CoV-2 remains an ever present threat.

Thank you for your consideration,

Lisa Pellegrino

The ongoing work being done by the CDC to sacrifice the greater public health to the unbound greed of corporations is a disgusting abdication of a moral duty and it is past time the organization return to its duty of Disease Control and Prevention.

Since the beginning of the COVID pandemic the American public has consistently been misled regarding the dangers posed by the disease as well as how to best protect themselves. The years since have shown and continue to show us that this path is never going to successfully rein in the ongoing spread or danger of COVID: all that lays ahead on that road is further disability and death.

Among informed individuals there is no doubt that the CDC's failure to act according to its obligation to public health has led to the death and disablement of countless thousands of Americans.

While COVID is a terrible and dangerous disease, there are many effective ways it can be combated. The CDC needs to pick up the mantle of leadership and begin anew a crusade against this disease that threatens to not just destroy individual lives but destabilize our entire way of life. We must:

-Recognize aerosol transmission: misinformation cannot slow or stop the spread of COVID. Handwashing as an effective tool for not getting infected is an atrocious lie and must be abandoned in favor of a scientifically informed campaign of providing information about aerosol spread and how it can be combated—cleaning the air at scale and wearing respirators at the individual level.

-Maintain respirator requirements in healthcare regardless of vax status: the science is abundantly clear: respirator usage being mandated in healthcare settings leads to a dramatic reduction in healthcare setting acquired infection. Where respirator use can limit spread by 86% and the lethality of a nosocomial COVID infection has been observed as being as high as 1 in 10 there is simply no defensible position for suggesting these mandates should be weakened or removed.

-Stop being unclear that respirators are more effective than surgical masks: another place where the CDC is clearly not following the science with its recommendation is uttering the merest hint that surgical masks can be equally effective at slowing the spread of COVID. It has been known since at least January 2022 that respirators offer dramatically stronger protection against the spread of COVID and American lives are lost each day to the laughably false equivalence of the two that continues to be perpetrated by the CDC.

-At scale invest in clean air tools like HEPA filters: there are clear tools for significantly slowing the spread of COVID and it is only out of seeking to shift the burden of public health onto individuals that we are not demanding these be widely implemented. Improving standards for air quality and air changes in public places could dramatically slow the spread of COVID in locations people cannot avoid visiting: public venues, healthcare, public transportation. We must implement standards for such places that will reduce the likelihood of Americans catching a deadly or disabling disease while going about the required asks of citizenry.

Thousands of deaths if not millions can be ascribed to the CDC's abdication of its service to public health as its greatest goal, instead preferring lies and half-truths that will allow the American economic machine to lurch back to its feet after the brief blow of lockdowns. Yet the scale of the ongoing death and disablement of the American citizenry has made it clear: with a dead or disabled workforce we will see much greater setbacks than would be imposed by a stretch of efforts to stamp out the ongoing pandemic. The CDC has a duty to return to being the flagbearer for the crusade of public health and must dramatically improve its messaging and reinforce the scientific backing of its COVID spread reduction campaign. We must reject any further efforts to water down protections and leave behind the failed attempt to return to a pre-pandemic normal that simply no longer exists in the wake of the unchecked spread of a multi-organ vascular disease spread through the air we have thus far refused to clean.

It's time to do better. It's time to do your job to protect the health of Americans and of America as a whole.

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing as a concerned citizen and advocate for patient safety to strongly recommend and support the adoption of comprehensive measures to improve ventilation and require the use of N95 masks in all healthcare settings. These critical steps are essential to combat the aerosol spread of diseases, reduce hospital-acquired infections, and ultimately save lives.

In healthcare environments, where patients are already vulnerable due to illness or injury, the risk of acquiring additional infections can be life-threatening. Hospital-acquired infections are a significant concern, and it's crucial to recognize that these infections can result in severe consequences, with an estimated 10% leading to fatalities.

Aerosol transmission is a well-documented route for the spread of infectious agents, and it poses a significant threat in healthcare settings. Improved ventilation is a fundamental component of mitigating the risk of aerosol-based transmission. Adequate air exchange and filtration systems can help reduce the concentration of infectious particles in the air, providing a safer environment for patients and healthcare workers.

In addition to ventilation improvements, the requirement for N95 masks is vital to protect healthcare workers and patients from aerosolized pathogens. These masks offer a high level of

filtration efficiency and should be considered a standard of care in settings where aerosol transmission is a concern.

The COVID-19 pandemic has demonstrated the importance of these measures. However, the risk of aerosol-based transmission extends beyond COVID-19 and includes various other infectious diseases. By mandating improved ventilation and the use of N95 masks, we can establish a strong defense against a range of pathogens, reducing hospital-acquired infections and their associated mortality rates.

I urge HICPAC to take a proactive role in setting guidelines and standards that prioritize ventilation enhancements and N95 mask requirements in all healthcare settings, not just during pandemics but as part of routine infection control practices. These measures can have a profound impact on patient safety and significantly reduce the incidence of hospital-acquired infections.

In conclusion, the requirement for improved ventilation and N95 mask usage in healthcare settings is a critical step in ensuring patient safety and preventing the devastating consequences of hospital-acquired infections. Your leadership and guidance in this matter are essential for protecting lives and advancing infection control practices in healthcare

Thank you for your commitment to safeguarding public health, and for considering this important recommendation.

Sincerely,

Jennifer Cole

Brooklyn, NY

Dear committee members,

I'm writing in regards to the meeting being held on November 2, 2023. I'm concerned about the relaxation of infection control measures in medical settings. Aerosol transmission of pathogens, including Covid 19, measles, tuberculosis and many other bacterial, viral and fungal infections, must be recognized as proven science and measures must be taken accordingly.

We now have solid evidence that respirator masks, such as N95s, protect against aerosol transmission. Aerosol scientists agree that N95 respirators are needed and surgical masks will not suffice. We also need HEPA filtration and ventilation. Aerosol scientists should be consulted when setting guidelines.

We all have a right to medical care without the danger of contracting an infectious disease. We all have loved ones that we want to protect as well. Please consider me, yourselves and your loved ones in making these decisions. We may not be patients now but we could be at any given moment.

Thank you for you consideration.

Paul John

Port Washington, NY

Hi HICPAC,

From:

Lazarus Long

SEATTLE WA

There are 457 words, including these. 500 words is a single spaced page. Please include all.

Letter:

My apologies, but please acknowledge that the HICPAC is in violation of FACA and its own charter. Its current recommendations have been made without aerosol scientists, IAQ engineers, Industrial Hygienists, PPE Experts, and other relevant fields' input - all needed for a "fairly balanced membership".

More here:

https://whn.global/hhs-complaint-on-hicpac

Any immediate steps should be halted till that is remedied. But in the meantime:

To be blunt, your previous recommendations have been made by members who have an inherent conflict of interest working for major hospital corporations who are trying to minimize costs by reducing the need for respirators.

These sentiments are mixed in with what appears to be a concern for communication, as written by Dr. Shenoy, Babcock, Doron et al here:

https://www.acpjournals.org/doi/10.7326/M23-0793

Yet, there are clear N95s available for those who have those communication concerns. Such as the Savewo Smile.

https://twitter.com/masknerd/status/1425178471911809033?t=kK3l8VzgVgzTXV9ju7F9dQ&s=19

This is why having actually PPE Experts as members is essential to identify solutions to trivial problems like this.

Shenoy et al call for masking when respiratory symptoms are shown. Prima facie, their proposal fails as the CDC reports that 58% of transmission is presymptomatic prior to any symptoms showing.

Your current members also appear to have an inherent conflict of interest by not believing in aerosols as the major mode of transmission, despite many studies demonstrating this, but in droplet transmission and fomite transmission.

Yet, the CDC has shown not one single droplet transmission study of COVID, and reports fomite as 1 in 10,000.

Here is just one sample of 16 studies showing long-range airborne - not including short-range which is also aerosol.

https://www.bmj.com/content/377/bmj-2021-068743.long

This is relevant to the transmission principles to be discussed in the November 2/3, 2023 meeting.

It should be noted that Covid was thought to be primarily fomite in the very beginning. Yet, it is now known to be airborne (as listed by the World Health Network).

The precautionary principle calls for all pathogens to be handled as airborne. If you protect against airborne? You protect against all.

To wit - MPOX. Said to be sexually transmitted, yet the CDC is now reporting that it can be transmitted prior to any symptoms. Meaning with no lesions or coughing? It is simply being breathed out.

Universal Respirators:

Please recommend universal N95 usage for all HCWs and patients, donning on entry to the health care facilities, until having left.

Surgical masks are NOT respiratory protective equipment per NIOSH. Both patients and HCWs need to be protected from Covid, and N95s provides both Inward and Outward Protective Efficiency.

Link:

https://www.cdc.gov/niosh/npptl/pdfs/UnderstandingDifference3-508.pdf

Thank you,

Lazarus Long

Cody Hsu
Poway, CA
Not affiliated

Please use current data to guide infection control measures as many of the draft's proposed recommendations are terrifyingly antiquated (ie surgical masks acceptable for treating airborne infections like COVID & TB)

Please add these key pillars to your considerations:

-Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vaccination status -Respirators are more effective than surgical masks, especially in handling airborne viruses like COVID that can linger in less ventilated/ filtered air for hours.

- acknowledge COVID can be spread via a high % asymptomatic & pre symptomatic infections so wearing respirators in Healthcare facilities as a general rule is critical because we can't always "see" illness.

-Clean air tools like HEPA filters & farUV

- * Extremely * important step to better legitimize HICPAC’s role in infection control which is beginning to appear biased based on known data about SARScov2- Involve aerosol experts and increase transparency ASAP

I'm writing as an immunocompromised person whose life was destroyed by a Covid infection 3.5 years ago. Among the many ways my life has been turned upside down by Long Covid, one of the most disturbing is that I'm unable to safely access healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC has the well being of patients like me at heart and is working to increase infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.

I urge you to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

Thank you,

Emily Fraser

Please reinstate masks in all healthcare settings. I have a colonoscopy in two weeks and I am terrified that the healthcare workers will not be wearing masks. I have just become a breast cancer survivor and can not imagine getting Covid in a healthcare setting trying to prevent colon cancer! It is imperative that healthcare workers protect themselves and patients. Masks are an easy preventative measure.

To the HICPAC Board,

I write to urge the board to recognize aerosol (and micro aerosol) transmissions within healthcare settings, resulting in hospital acquired illness.

Only an N95 respirator or greater prevents transmissions of viruses, fungal and bacterial illnesses that spread via aerosol (and micro aerosol) transmission.

I also urge HICPAC to involve aerosol experts in the decision making process in order to educate those on the board who are not experts in this area.

Finally, transparency should be a requirement. All proposes changes should be presented to the public for comment prior to any final decisions.

Not only are patients seeking medical care (which includes members of HICPAC and their families) affected by HICPAC and its decisions, health care works will also be affected.

Please prioritize the safety of patients by preventing aerosol transmission of illnesses in health care settings by requiring N95 respirators or greater and tools such as HEPA air filters.

R. Mills (Individual)

Los Angeles, CA

Hi there,

I'm dismayed that HICPAC is considering downgrade medical standard to guard against infections, especially since HICPAC already decided (against the evidence-based research consensus) that aerosol transmission of diseases is not a concern and that surgical masks are as effective as N95s respirators.

As this conversation moves forward, I strongly request that HICPAC reconsider its guidelines and standards to recognize that aerosol transmission is a huge factor in the spread of disease, especially of COVID-19. Additionally, all health care settings and workers should be required to wear N95 respirators (or better), regardless of their vaccination status, especially given the level of in-hospital transmission of respiratory diseases (particularly bad outcomes for immunocompromised patients seeking care). And, finally, the federal and state governments should fund the upgrade of HVAC and air filtration systems in health care settings to improve the quality of indoor air and, therefore, significantly decrease the chance of infection.

Of course none of these approaches by themselves will completely eradicate the spread of disease, but they are effective tools at our disposals to keep patients safe and prevent further infections (and mutations) of viruses like SARS-CoV-2. We cannot continue this path towards mass infection, disabling healthy citizens and risking the lives of immunocompromised ones.

Enrique (Henry) Suarez
South Hadley, MA

I shouldn't have to worry about getting sick while seeking healthcare. And it's not just COVID. There's MRSA, C-Diff, RSV, and fungus among us.

Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vax status

-Respirators are more effective than surgical masks

-Clean air tools like HEPA filters

-Involve aerosol experts and increase transparency

Please mandate the need to improve indoor air quality.

Janina Pepe

CDC

Please require Healthcare workers to wear N95 or better masks.

Our hospitals are killing and disabling patients by not requiring this simple prophylactic.

-Recognize aerosol transmission -Respirator requirements in healthcare regardless of vax status -Respirators are more effective than surgical masks -Clean air tools like HEPA filters -Involve aerosol experts and increase transparency

Do you job and protect us.

Concerned Citizen

Micah Lyon

This is an urgent plea for HICPAC to institute and maintain responsible disease mitigation measures in all healthcare settings. COVID unfortunately remains an ongoing danger to doctors and patients. We know that it is ubiquitous now. And it's transmitted through aerosols, which means that layered protections are our only hope of mitigating the spread, and no healthcare setting is free of the threat of COVID spread. Mitigations include: 1) respirators, i.e., N95 or better (Surgical masks are virtually useless for preventing infection by aerosols, because they can't form a proper seal to the face.; 2) HEPA filtration of healthcare spaces; and 3) vaccinations. I beg the committee to not remove PPE standards from healthcare settings, but to make them more robust. At the very least, there should be the minimum standard of N95 masks, to be worn at all times by all healthcare workers in healthcare settings.

In addition, it's urgent that you be more transparent in your methods and decisions. Too much of the public still knows too little about the threat of COVID (not to mention other illnesses or disabilities to which COVID infection -- however mild -- renders one susceptible). I recently went to pick up food at a restaurant, and the young man at the register saw me wearing my mask and asked me, "Is COVID back?" I responded, "It never went away."

Please don't throw caution to the wind. The healthcare system is already strained as it is, but if mitigation standards are lifted, I fear that it could collapse at a time when it is especially important for it to remain effective. Without responsible mitigation measures and public health information, five or ten years from now, we sadly may realize how many more lives will have been cut short in the foolish effort to favor profitability over public safety. Thank you for your consideration.

Patricia Walters

Bowie, MD

No organizational affiliation; this is an individual request.

Hello,

Thank for for the opportunity to speak.

I am a chronically ill individual with elderly parents who are severely high risk due to their chronic illnesses and pre-existing conditions. Both I and my parents have had to postpone major medical events, as well as routine appointments, due to there being no precautions taken for the transmission of airborne viruses in healthcare settings. The few times I have managed to go to an appointment, I have been fearful surrounded by healthcare professionals who do not wear respirators, worrying that I will come out more ill than I was when I went in. I especially worry for my parents, who now more than ever need to have access to SAFE proactive health services given their age and conditions.

I urge you to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical

masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

Thank you,

Maggie Treants

Name: Nicole Bruno

Address: San Diego, CA

Affiliation: No Affiliation

Topic: Clean the Air

I care about clean air, and given your role in shaping public policy, you should, too. I'm concerned about the total disregard for COVID. We have seen 4 years of data of what COVID can do to the body, we have no idea what this virus will do over the course of the next few decades. You have a responsibility to protect and educate the public. You've known that COVID is airborne and transmissible through aerosol particles.

There are no biomarkers to understand who will be affected by long COVID. It could be you, your kids, your loved ones. Why aren't you requiring high quality respirators (N95 or better) in healthcare settings? People have the human right to safely seek healthcare, regardless of health status. Why aren't you educating the public on mask quality? Why are you still pushing for surgical masks? Why haven't you invested in HEPA filters? Why haven't you involved aerosol experts and increased transparency?

You have the moral and ethical responsibility to protect Americans.

I'm writing as an immunocompromised person whose life was destroyed by a Covid infection 3.5 years ago. Among the many ways my life has been turned upside down by Long Covid, one of the most disturbing is that I'm unable to safely access healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC has the well being of patients like me at heart and is working to increase infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.

I urge you to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

Thank you,

Emily Fraser

Oakland, CA

My name: Dr. Dawn Kaczmar
Address: Ypsilanti, MI
Organizational affiliation: none
Topic addressed: respirators in hospitals and aerosol-based diseases

The CDC needs to recognize that COVID transmission takes place via aerosols, and that because of this, all healthcare settings must require respirators regardless of vaccination status (since it is now well documented that vaccination does not prevent one from catching COVID). Immunocompromised patients, as well as any other patient, deserve to be treated by doctors in a place where they are safe, and that includes taking very basic measures, like requiring respirators, to minimize risk. Respirators are necessary because they are more effective than surgical masks, and this has been well documented at this point as well. Healthcare settings also need clean air tools like HEPA filters. Aerosol experts should weigh in to increase transparency around this.

If the CDC no longer cares about the lives of certain populations in America, they honestly no longer deserve their status as an organization. It is only by requiring respirators and clean air tools that we can take important and also basic and obvious measures to keep people safe from harm and disease.

Thank you,

Dr. Dawn Kaczmar

It is negligent to have inadequate guidance that exposes clinically vulnerable patients concentrated in healthcare facilities to infections when proven airborne infection control techniques exist . We call on you to re engage & comprehensively study the science around airborne infection . Thank you , Clara stringer auld

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Victor Garcia, Saint Cloud, FL. No organizational affiliation. Comments on the topic of The Healthcare Personnel Guidelines.

To whom it may concern,

I am a concerned citizen of this country. Since early 2020, the SARS-COV-2 Virus, which causes COVID-19, has been allowed to proliferate at a rate that accounts for many thousands of deaths every month. It is imperative that the CDC continue working to mitigate the spread of this virus in general. In particular, the spread of said virus in healthcare settings must be halted immediately. Perhaps it is so that there is no way to contain this plague in the general public, although I do not believe that is the case. It is, however, assuredly possible and in fact vitally necessary to minimize the spread in healthcare settings. American citizens are, as a result of multiple infections, vulnerable to further infection. Healthcare is the one setting that we should feel safe in terms of our health and wellbeing. However, the decisions being made to allow healthcare workers to dispose of any SARS2 mitigations are causing vulnerable people to limit or forego necessary visits to hospitals, doctors offices, clinics, and pharmacies. In addition to the SARS virus, there are a number of bacterial, fungal, and viral pathogens contaminating the air that we breathe today. These pathogens can be mitigated by use of N95 respirators and a focus on sanitizing the air, especially in healthcare settings. There is no logical reason to loosen

up mitigations on the spread of COVID or any other infectious airborne disease, and much less so in the context of healthcare. I, as with a great deal of Americans, urge this committee to reassess the risks to the most vulnerable people and realize that, first of all, we could be your family members or friends or even you. Secondly, that we have the technology available to prevent more mass death. It is the responsibility of the CDC to control the spread of disease, not to pretend there is no disease to control as thousands die weekly.

Please consider the citizens who you have sworn to protect.

Best,

Victor Garcia.

Please DO NOT recognize surgical masks as equivalent to N95 respirators. They are not and never have been. And there's mounds of research - including a recent meta analysis - clearly demonstrating their superiority.

We also need more emphasis on cleaner air - better ventilation and filtration.

These combined with greatly reduced all manner of hospital acquired infections.

My name is Leah McCaskill, and I am the math and science department head at my school. My address is Addison TX. I do not speak as a representative of my school. I only represent myself. The purpose of this communication is to provide public comment regarding potential revisions of Covid-related healthcare guidelines. My comment is as follows:

I am writing this comment to appeal for the implementation of guidance that N95 masks be worn by healthcare professionals. It is my educated opinion that, in the midst of a severe pandemic of airborne nature, these masks are effective and necessary for the mitigation and prevention of the transmission of Covid-19 and other airborne diseases. Guidance promoting ventilation, HEPA filtration of common spaces, and extension of the current 5-day isolation period be extended back to two weeks will further provide much-needed protection. Currently, there are studies indicating the ability of Covid to avoid the defenses of our immune systems. The high mutation rate, the syncytial properties, and evidence that Covid can kill several different types of adaptive immune cells are all properties that allow Covid to avoid our adaptive immune defenses regardless of vaccination and/or previous infection. The consequences of Covid infections extend beyond the acute phase into chronic issues. As we know, Covid is more than a respiratory virus. It is a cardiovascular virus. Being that every single cell in the human body is maintained by our blood vessels, there is a natural implication that Covid can cause what may be countless devastating diseases and disabilities. Disability activists are referring to this as a mass-disabling situation. People are dying from their chronic Covid conditions months to years later. The only other virus I know that infects/harms T-cells is HIV. This means that we are nowhere near the end. This is only the beginning. People may find themselves immunocompromised years later, resembling the experience of people who develop AIDS years after an acute HIV infection. This means that it is not just "vulnerable" people who are at risk. We are seeing this virus take previously healthy people and create vulnerability in them. Covid has been implicated in heart disease (including but not limited to heart attacks), diabetes, cancer, genetic mutations, viral persistence, kidney failure, liver disease, lung damage, blood vessel damage, digestive disorders, brain disease, and more. Covid is not the only airborne disease. Other diseases exist and will increase in prevalence and mutational opportunities in the

bodies of the newly immunocompromised. The Hippocratic oath of any doctor is to “Do no harm”. No one should be afraid to visit a hospital or other healthcare facility for fear that they will leave in worse condition (due to contagion) than when they arrived. Doctors and the public are looking to the CDC for guidance. Please show that you are worthy of their trust. Please recommend that N95 masks be worn in healthcare settings. Ideally, N95 masks should be worn in workplaces as well. The number of deaths and disabilities in this country continues its troubling upward trend. If the concern relates to the economy and/or interests of employers, then masks should have a greater priority. The masks would certainly decrease the responsibility of employers and institutions while protecting them and the economy from the devastating effects of an ever-decreasing workforce diminished by death and disability. I would like to again urge HICPAC/CDC to do the right thing for the well-being of Americans and side with science in pushing N95 masks in their official guidance. Please also encourage the increased use of ventilation and HEPA air filters for cleaner indoor air. Please also consider extending the isolation period back to two weeks as it is clear the contagion is still happening when people return, especially considering that most are not wearing masks upon return to workplaces. Some estimates indicate that between 40-60% of Covid infections are transmitted by asymptomatic people.

Name: Paul Hennessey

Affiliation: none

Address: Jackson, MI

Topic: Improving Infection Controls

Comment:

I urge CDC/HICPAC to improve infection controls. The current proposed draft falls dangerously short and puts patients at risk. Please do the following:

-Recognize micro aerosol transmission of a wide variety of airborne illnesses

-implement respirator requirements in healthcare regardless of vax status. This can not be a risk analysis because it allows hospitals to put profits over healthcare and take unnecessary risks to save money.

-Acknowledge respirators are more effective than surgical masks. The CDC has previously acknowledged that they are more effective.

-Clean air tools like HEPA filters must be a requirement in all medical settings. HVAC systems must be updated with MERV 13 or higher with multiple air changes per minute. Air scrubbers must also be installed in HVACs. Far UV lights must be installed in medical settings as well. Ventilation and isolation of infectious people must be stressed.

-Involve aerosol experts in future meetings and increase transparency on the process.

Hi,

Guidelines must prioritize effective prevention measures to safeguard the well-being of both patients and healthcare professionals. Safety should never be compromised, just as we cannot tolerate any negligence in delivering medical care.

These guidelines should be rooted in the precautionary principle, which underscores the importance of risk reduction in policy decisions. Unlike individual choices, policy decisions have far-reaching consequences for society, demanding a heightened focus on minimizing potential risks for a broader population.

The development of infection control guidelines should involve experts from various disciplines who specialize in studying airborne transmission. Furthermore, it should engage those at the highest risk, including patients and healthcare workers, as well as their representative organizations.

These guidelines should fully embrace the established science of airborne transmission and its prevention. This includes the use of effective masking methods such as N95 respirators, elastomeric respirators, and PAPRs. There is no justification for adopting non-airborne precautions when dealing with airborne pathogens.

Comprehensive measures within these guidelines should cover ventilation and HEPA air purification, masking, testing, and reducing unnecessary air sharing among those who may be infected with those who are susceptible.

Additionally, it is appropriate to share personal experiences within the healthcare system to highlight the importance of stringent safety measures and to advocate for the active involvement of at-risk individuals in the policy-making process.

Thank you,

Evan Berry

As a biomedical scientist, I implore you to greatly *increase* the requirements for infection control in all healthcare settings. Please require that ALL STAFF PROPERLY WEAR N95 MASKS AT ALL TIMES, other than in **negative-pressure** break rooms. Please also issue guidance calling for aggressive ventilation (to no more than 600 ppm CO2) and/or highly effective HEPA air filtration in all areas.

This should obviously include outpatient clinics and offices as well as inpatient facilities.

My husband and I have delayed and canceled numerous medical appointments because we are immunologically vulnerable, and are presently not safe from contracting airborne diseases in our healthcare settings.

This is a public health travesty that directly contradicts the Hippocratic oath.

You can help correct the situation and allow millions of vulnerable Americans to receive the healthcare we need and deserve. PLEASE MAKE INFECTION CONTROL STANDARDS FAR MORE STRINGENT, in accord with well-established science!

Sincerely,

Janine Perlman, Ph.D.

Wildlife Nutrition Consultant

Alexander, AR

Dear Healthcare Infection Control Practices Advisory Committee (HICPAC):

I am using my university e-mail because I write as an educator concerned about my students' long-term health.

Below are some points that I fully endorse and urge you to consider when determining appropriate infection control measures in health care settings:

"HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting

outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation."

Thank you for your attention. Respectfully yours,
--
Anne-Lise François
Associate Professor, English and Comparative Literature
University of California, Berkeley

Hello,

My nane is Veronica Iordanova and I'm writing to you today to ask that you please reinstate and maintain infection control for respiratory illnesses in healthcare settings such as but not limited to hospitals, clinics, school nurse offices, and pharmacies.

To do that you must recognize aerosol transmission and require respirators in healthcare regardless of vaccine status.

Respirators are more effective than surgical masks! Clean air tools like HEPA filters and MERV13 filters remove viruses and irritants such as smoke from indoor air which would do much to control respiratory infections in healthcare settings. Please involve aerosol experts in your decision making processes and increase transparency such as having public meetings, opening them to public comment, recording the meetings, and leaving them up online for people who would like to review them at any time. Thank you.

Best Regards,

Veronica Iordanova

Please keep our healthcare workers and patients as safe as possible.

Air quality and masking are helpful. Please err on the side of caution.

Sincerely,

Lee Ann Bryant

I am submitting a comment for the upcoming HICPAC meeting during which updates on the CDC's activities for prevention of healthcare-associated infections will be discussed. During the June 2023 HICPAC meeting, there was discussion of draft guidelines from the "Isolation Precautions Guidelines Working Group." The draft guidelines included discussion of N95 masks vs. surgical masks.

I would like to make a few points. I would like the guidelines to recognize aerosol transmission and the need for respirators/N95 masks regardless of vaccination status. In healthcare settings, I believe it is important for two-way masking for best protection; N95 masks are more effective than surgical masks. I have seen so many people wearing surgical masks and there are too many gaps around the edges. And one-way masking is not as effective. I also support public health guidelines to be in place to implement N95 respirator use when there are viral airborne transmissions – I believe if this had happened much sooner when public health officials learned how serious the SARS-2 virus was, it could have been dealt with much faster and there would have been less long-term injury and death.

I would also like to see a lot more focus on improving indoor air quality and use of HEPA air cleaners. Aerosol experts and industrial hygienists should be involved in developing standards/regulations for shared indoor spaces such as shopping centers, restaurants, hotels, office buildings, medical facilities, etc. I would also like to see standards for multi-family high rises (apartments and condominiums as examples) where there is recirculated air. I have worked in air-tight office buildings my entire career and the ventilation is never adequate and it has impacted my health.

Sincerely,

Torre Taylor

Hello,

I am emailing to re-submit my written public comment for the upcoming HICPAC meeting on November 2, 2023. My previous email mistakenly omitted my full information.

My information is as follows:

Name: Jenifer Steinmeyer

Address: Rochester, MN

Affiliation: none

Topic: Infection Control

It is critical that patients and healthcare workers are properly protected from infections in healthcare facilities; as of now HICPAC and CDC have given no indication that they understand transmission via aerosols or plan to incorporate proper infection controls in their guidelines. Hospitals must deploy respirators, air filtration and other technologies to minimize the spread of viral, bacterial, and fungal illnesses that are spread through aerosols.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation. Suggesting that surgical masks are as effective as respirators is a gross misrepresentation of the evidence.
My family members who are at increased risk from severe Covid-19 outcomes deserve protection. Our community members who are immunocompromised deserve protection. Healthcare workers who are risking their lives to care for us deserve protection. My children deserve protection from infection when they seek medical care. We deserve protection.

Thank you,
Jenifer Steinmeyer

Hello -

I have a relative who works in a hospital. Shortly after the COVID-19 pandemic arrived and mandatory masking was implemented at her workplace, she commented that she didn't think that the hospital would ever drop masking. The administration had noticed that they were having fewer issues with staff off sick and with HAIs.
The hospital has since dropped masking as admin is "following CDC guidelines". Staff sickness rates and HAIs have increased again.

After the COVID-19 public health emergency ended, my opthalmologist chose to keep mandatory masking for everyone in the practice/surgical center because they saw improvement in the number of post-op infections and in staff sick days.

If you were a patient, which institution would you have more confidence in?

I wear an N95 respirator in all indoor public places because I have researched and witnessed the effects of a COVID-19 infection, and protecting my health is important to me.

The times I am most at risk of becoming infected with COVID-19 (or any other pathogen) are when I am receiving medical care. I couldn't wear my respirator for an endoscopy, I had to unmask for a dermatology appointment, and I took my N95 off to eat and drink in the hospital.

I couldn't protect myself. I needed my care team to protect me, and they didn't.

They didn't because they were following flawed guidelines that do not account for aerosol and asymptomatic transmission. The science on both is crystal clear.

Not wearing respirators during patient care and refusing to implement sufficient air filtration and ventilation is announcing that the patient's well-being is not worth the cost or inconvenience.

- or

It is announcing that the decision-makers at the institution are unqualified because they are not staying abreast of medical and scientific developments.

In the face of this apathy and ignorance, patients will avoid care. I know I have.

I recently found out I might be undergoing a major surgery and multi-day hospitalization. Instead of thinking about my actual medical issue, I'm thinking about how much harder and more complicated a hospital-acquired infection (particularly COVID-19) could make my recovery. I'm thinking about any and all measures I can take to protect myself when I can't wear my respirator. I'm thinking about the healthcare professionals who will be looking after me- good people who are risking my safety and health due to shotty infection control guidance and a lack of continuing education on aerosol infection control.

Please help frontline healthcare workers help us.
Please give them the science-based infection control guidance they need to keep the patients in

their care safe and healthy.

Please acknowledge aerosol and asymptomatic transmission.

Please save lives and preserve health.

- Allison Swearengen

To Whom It May Concern,

I am writing to provide input for the forthcoming virtual meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC). As someone living with pulmonary fibrosis, my concern for stringent infection control measures in healthcare settings is deeply personal. I believe a focus on rigorous respiratory protection and genomic surveillance can significantly enhance our infection control strategies.

Robust Respiratory Protection:

The inconsistent use of effective face coverings, particularly among healthcare personnel, is alarming. It is essential to mandate the use of fitted N95 respirators for all healthcare personnel interacting with patients, to prevent potential transmission of infectious agents.

Genomic Surveillance:

Enhanced genomic surveillance can provide invaluable insights into infection transmission dynamics, helping to identify the origins of spreading events. This data can pinpoint buildings and facilities where transmission occurs, holding building owners accountable and guiding necessary upgrades to ventilation and filtration systems.

Stakeholder Engagement:

Involve a diverse array of stakeholders, including patients, healthcare personnel, and experts in ventilation design and aerosol transmission experts like Prof. Donald K. Milton, MD at UMD, to ensure a holistic understanding and robust discussion on effective infection control measures.

Transparency and Open Dialogue:

Utilize virtual town hall meetings and the Federal Register public notice process to foster open dialogue, ensuring a comprehensive and inclusive discussion on infection control practices.

Scientific Assessment:

Continuously update guidelines based on the latest scientific evidence, emphasizing the importance of layered control measures, including proper ventilation, respiratory protection, and other PPE.

Indoor Air Quality Standards:

Adhere to ASHRAE's minimum indoor air quality standards to control infectious aerosols, ensuring a safer environment for both healthcare personnel and patients.
I trust that my comments will contribute to a constructive discussion during the HICPAC meeting, promoting a safer healthcare environment for all, especially those with pre-existing conditions like myself. I appreciate the opportunity to provide input and am looking forward to the live webcast of the meeting.

Thank you for your consideration.

Sincerely,

Thank you!!!

Kind Regards,

David EldrEdge

Co-Owner

NALTIC Industrials, LLC

Heber City, UT

Take a cancer patient fighting for his life with chemotherapy, who faces a waiting room receptionist with a hacking cough; an immunocompromised girl braving biological infusions, seated across from a sneezing man getting his blood drawn; a 70-year-old grandmother who falls, breaks her hip, and while recovering in the hospital, contracts Covid-19 and dies of the complications.

I know of people in each situation who've acquired infections while receiving care, incidents which could be prevented if the committee agrees that healthcare workers and settings should do no harm — which means requiring physicians, nurses, and staff to wear N95 respirators or elastomeric respirators to prevent the spread of airborne disease.

By this point in 2023, we know that, per the EPA, SARS-CoV-2 is airborne and travels like smoke, spread via inhalations and exhalations, as is tuberculosis, influenza, and measles. We know that N95 respirators are made for airborne diseases, while surgical masks are suited for droplet-borne illnesses. We know that, per the CDC, wearing an N95 mask makes people 82% less likely to contract COVID-19, compared to a 66% reduction from surgical masks.

I'm one of many people who got Long Covid after immunization. Despite vaccination and a booster dose, one infection with SARS-CoV-2 left me with postural orthostatic tachycardia syndrome, as well as chest pain that remains over a year later. I'm 30 years old, and every time I go to a doctor, I'm scared of picking up a reinfection that could make my autonomic nervous system further deteriorate and shorten my life. I am not alone, and yet after going to the ER with chest pain and pressure, the head of the unit told me that if N95 masks worked, the CDC would recommend them; he pulled down his baggy blue to indicate how loose it was to denigrate the

efficacy of masks in general, and said that if people didn't get Covid from each other, we'd get it from rats.

That's the state of medicine, and the power imbalance already-vulnerable patients are left to reckon with in the absence of testing and masking recommendations that would limit the spread of Covid, a disease that is not mild for many, and gives anywhere between one in five and one in ten people long-lasting organ damage and chronic conditions. Anywhere from 40 to 60 percent of infections are asymptomatic, yet they still damage our endothelial linings and create microclots, which is causing the spike in cardiac events and strokes among young people. It causes long-lasting inflammation, and increases in diabetes and autoimmune conditions; it infects our neurons and causes them to fuse, leading to memory and cognition problems.

We must fight this constantly-evolving iteration of SARS with every tool we have: N95 respirators, HEPA filters, UVC light, frequent tests, and recurrent vaccinations to compensate for waning immunity and viral evolution. Anything less is accepting death and mass disablement, both for the currently well and those already in compromised health. HICPAC needs to do what's right: pull our hospitals out of the 18th century, provide clean air, and restore the public's trust that seeking care won't sicken them.

Thank you,

Rachel Nussbaum

Topic: HICPAC Meeting - November 2, 2023 - Masks in Healthcare Settings

Name: Lisa M. Pellegrino

Address: South Weymouth, MA

Organizational Affiliation: None

Dear Committee Members,
I am writing to respectfully request that respirators be the standard mask worn in healthcare settings regardless of vaccination status.

We know that SARS-CoV-2 is transmitted through aerosols and can remain in the air for up to 12 hours. We know that respirators offer superior aerosol protection in comparison to other types of masks. We know that vaccination does not prevent transmission of SARS-CoV-2. We know that immunity to one SARS-CoV-2 variant does not confer immunity to another SARS-CoV-2 variant. We know that long covid risk increases as an individual's number of infections increase. We know that long covid can lead to disability and death. We know that we are all vulnerable to long covid.

Keeping respirators as the mask standard will help prevent illness, disability and death. Additionally, respirators protect against aerosols of other infectious agents present in healthcare settings protecting both patients and healthcare workers.

Thank you for your time and consideration.

Lisa M. Pellegrino

The CDC is guilty of crimes against humanity by willfully and repeatedly spreading misinformation about the nature of Sars-Cov-2 transmission, and appropriate PPE and other measures to combat it.

In the 1990s, as tuberculosis was spreading, the CDC realized that 'baggy blue' masks were inadequate, and that elastomeric N95 or better respirators were required. Thus, such PPE has been standard in TB settings for almost 30 years.

The CDC wilfully, or with such brazen incompetence it is tantamount to willful, disregarded its own science in handling Sars-Cov-2. They knew the virus was airborne, and that respirator masks of N95 or better would be required to contain it.

Going forward, the CDC must:

-Recognize aerosol transmission
-Establish respirator requirements in healthcare regardless of vax status
-Admit loudly and repeatedly that respirators are more effective than surgical masks, and that surgical masks do not protect the wearer or others
-Invest in and promote clean air tools like HEPA filters
-Involve aerosol experts and increase transparency

Thank you,

Derek Dexheimer

Seattle

Please recognize aerosol transmission. Please require respirators in healthcare regardless of vaccination status. Please require clean air tools like HEPA filters. Please involve aerosol experts in decision making and increase transparency.

-Shannon Alires

Albuquerque, NM

-No affiliations

To the HICPAC members:

COVID-19 is spread by aerosol transmission as the research shows. That means that it can spread in a healthcare facility without the proper mitigations.

Please protect the elderly, immunocompromised, and other vulnerable people who may need to enter a healthcare facility or remain in one to get treated. No one should be expendable.

As we have learned, vaccination for Covid does not prevent transmission. However, wearing an N95 mask does. Surgical masks do not prevent aerosol transmission. Funding should be provided so that healthcare workers can wear N95 masks to protect their patients. Covid PCR testing should be required in every emergency room, and should be done for newly admitted patients. Repeat testing will also be required since asymptomatic transmission is so very common.

All healthcare facilities should have additional air filtration and purification provided through the HVAC system or through portable air purifiers installed in all common areas and in exam rooms and patient rooms. What this costs will be balanced out over time in healthcare savings. And removing Covid from the air is not the only benefit as many other bacterial, viral, and fungal infections can also be present in aerosol transmissions.

My comments here are informed by respect for scientific expertise.

I am a doctor, but not “that kind” of doctor. I have a PhD in English. However, I am trained to review, analyze, and evaluate research literature and to examine source credibility. I teach the scientific method and consensus through peer review. I urge everyone on HICPAC to consider the most current, credible evidence on aerosol transmission and the need for N95 masks and air purification to prevent COVID-19, and to include these mitigations in preparing for future pandemics.

I would like to be invited to any public comment opportunity.

Thanks for your consideration,

Dr. M. Emma Cornell

We demand a fair process and science-based protections for healthcare workers and patients!

CDC/HICPAC needs to delay the vote until they have given the public ample opportunity to review the draft Isolation Precaution guidance updates. CDC/HICPAC must hold public meetings—ahead of any vote—to hear from health care workers, patients, and experts outside of infection control, who have essential perspectives for updating the Isolation Precautions guidance.

CDC/HICPAC must fully recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is unconscionable that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed adopting a more “flexible” approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A

protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thank you,

Megan Doherty, Disability Lead

Chicago, IL

Comments related to your upcoming meeting of Nov 2-3, 2023.

I sincerely urge and implore the committee to: -Recognize aerosol transmission route of Sars-2 and other respiratory viruses.

Therefore we request and demand: -Respirator requirements (N95 or better) in healthcare settings for all workers and visitors regardless of vaccination status -Respirators are more effective than surgical masks. This is not up for debate. This is settled aerosol science. Please confer with aerosol scientists if you need clarification on this point.

-Clean air tools like HEPA filters and far-UV in ALL public places. -Involve aerosol experts and increase transparency in all decisions moving forward. This must be a collaborative and collective effort.

Sincerely,

Frances Ellsworth, MSc

My name is McLaine White and I live at Rochester, NY. I have no organizational affiliation. I'm writing today to urge the committee to recommend airborne precautions in healthcare settings for COVID-19 and other airborne diseases.

At this point there is an overwhelming amount of evidence that COVID is spread primarily through aerosols, meaning effective mitigations need to include N95 respirators (which are far more effective than surgical masks), elastomeric respirators, and PAPRs, as well as clean air solutions such as HEPA filtration and ventilation. These protections are essential for the safety of both patients and healthcare workers.

This issue is personal to me because I have Long COVID, which comes with a variety of health issues that might eventually put me in a hospital. It is despicable to me that I currently cannot safely seek healthcare because medical facilities aren't taking even the most basic of precautions. Hospitals are supposed to be places of healing, not dangerous places that make already sick patients worse by exposing them to deadly and disabling pathogens.

I join National Nurses United and the World Health Network in condemning the lack of transparency in this process and the lack of aerosol experts on the committee. It's time to acknowledge that COVID is airborne and take the appropriate precautions.

Thank you for your time.

Dear Sir / Madam:

I am writing with consternation about reports that HICPAC may be poised to make recommendations loosening guidelines for protecting patients in health care settings.

The evidence is unambiguous and overwhelming that SARS-Cov-2 is spread via aerosol transmission. There is no debate on this issue.

As such, health care workers should be required to wear masks to protect the vulnerable population who frequent health care facilities.

We know that surgical masks are not sufficient to prevent transmission so respirators such as N95 masks should be required.

Please recommend investments in clean air equipment and expertise.

Sincerely,

Ahmadali Arabshahi

Vienna, VA

Dear HICPAC,

I am writing again because I have learned that you only accept very short letters of public comment. So I will keep it short.

1. Universal masking is needed in healthcare settings, masks should mean respirators (n95s); nobody should go into a healthcare setting and come out more ill. They should not catch Covid at the hospital.

2. We need to keep track of these nosocomial infections of Covid; it is part of the layered mitigation effort to know which hospitals are performing poorly in this regard and need to take steps to keep people safer. Without this data there can be no progress to infecting fewer people

3. A layered approach is better, ventilation and filtration are also needed to reduce concentrations of airborne viruses in the air that patients and staff are breathing. Healthcare locations, including hospitals, need to monitor their air (CO2 and PPM) to know if they are achieving adequate ventilation and filtration

4. We are all vulnerable to Covid, every one of us. It isn’t a cold and it is not the flu, it is far more dangerous. We are past the point of ignoring it and pretending it is nothing serious; it is serious. This is the moment where we need to move forward and do the right thing and protect people.As a committee, this is your opportunity to step up and move the country forward in the direction of safer healthcare and protecting the citizens of this country. As experts in your fields, you know that Covid is airborne. You know that respirators are proper PPE and protective. You

know that dithering about this and taking steps backward will cause so many people to be harmed.

I'd like to take a moment to reference pop culture. Think for a moment about the origin story of Peter Parker, Spiderman. He didn't use his powers to stop a thief and that thief went on to kill his Uncle Ben. Peter didn't do anything because he thought it wasn't his problem and wouldn't affect him, but it did. His inaction caused him great grief, and terrible grief for his Aunt May. We are right now at that moment where Peter Parker can stop the thief. This is the metaphoric moment where we must exercise the great power that comes with great responsibility.

Sincerely,

Tracey Canino, citizen

Montpelier, Vermont, USA

Name: Rebecca Krikorian
Topic: HICPAC Recommendations
Address: Malverne, NY
Organization Affiliation: member of the public

To whom it may concern,

I am submitting my comment in regard to the guidelines for Healthcare Infection Control Practices set forth by HICPAC and CDC. Upon review, it seems the updated guidelines are simply a way for hospitals to save money, and not rooted in protecting public health - the health and safety of both patients and staff. It is grossly irresponsible to not only not recommend consistent masking during an airborne pandemic, but in the instance where masks are even mentioned, claiming that surgical masks are just as effective as higher quality respirators (N95) in protecting people during an airborne pandemic (sars-cov-2) and other assorted airborne viruses is flat out wrong. Yes, something is better than nothing, but N95 masks by far are superior in protecting against airborne viruses and this has been well established by those in the scientific and medical communities. As someone who has firsthand experience on how effective masks are in healthcare settings, it is grossly irresponsible to not recommend consistent masking. Why should I, as a patient seeking emergency care for kidney stones, for example, have to worry about acquiring a covid infection on top of it? A covid infection that could potentially kill or disable me. Why should my vulnerable prematurely born child have to worry about acquiring a covid infection when going to regular doctors appointments to treat her scoliosis condition? Why should my in-laws, my parents, or anyone else seeking care have to worry about becoming sick with hospital acquired covid on top of it? The list of people this affects goes on and on. I shouldn't have to beg a medical professional to put on a mask when treating my child or myself or a family member, or anyone else. I won’t even get into why masking and other mitigation measures such as clean air, should be in place also in public spaces such as schools, office buildings, and public transit but the absolute bare minimum is that it should 100 percent be required in ANY healthcare setting. From hospitals, to primary care doctors offices, to radiology and physical therapy offices, dentists, etc - any space where people are getting any kind of health care, it should be required. Shame on you for making recommendations based on money and not based on public health. The science is clear on how dangerous covid is, the damage it causes and rather than strengthen guidelines to protect

people, you want to weaken them? Why? DO BETTER. We know the virus is airborne. The recent piece on 60 Minutes even spoke in great detail about this and things that can be done to slow or even eliminate transmission. We know the damage Covid can do to people of all ages. We know this. Again, DO BETTER. When we know better, we should always do better. Please update the guidelines to include use of N95 respirators and clean air filtration. There are plenty of experts in the medical and scientific communities that you can consult with on this topic that will be all too happy to help adjust the guidelines to make healthcare safe and accessible for all. Thank you.

Respectfully,
Rebecca Krikorian

My name is Kate Pitroff. I live in Redmond, WA, and I have no organizational affiliation.

I have chronic health conditions that make it unwise for me to contract COVID. I do my best to protect myself, but I can't do it alone.

When I scheduled my mammogram this year, I asked that my image tech wear an n95, like me. I was told that would be "no problem". I then received a call back from the hospital where the imaging would take place that notified me that n95's were not recommended for staff use, but the tech would wear a kn95 on request.

When I pushed back to advocate for my safety, I was told "[my] mask would protect [me]", and, tellingly, "n95s are expensive".

To be clear: the imaging was taking place in a hospital. I walked past hospital signage at several points that encouraged mask use. None of the hospital staff, or other patients, were masked, not even with procedural masks. The tech wrinkled her brow at me when I asked her to wear a kn95 until I told her I had been told there would be no problem accommodating my request. She put on a kn95 but did not fit the nose wire appropriately. At that point I was too tired to keep asking for reasonable treatment - I had initiated multiple phonecalls and emails to this point already, and made my appointment as early in the day as possible to avoid other people and breathe cleaner air. The imaging took place in a small room with questionable ventilation, and the process required me to press my face against the imaging machine, which deformed my mask and possibly compromised its fit.

This is ridiculous.

- We know SARS-Cov2 is airborne and carried via aerosol.
- We know that surgical/procedural masks are built to protect against droplets, not aerosols.
- We know that two-way mask use is more effective at preventing transmission than one-way use.

We have access to masks that can protect patients and healthcare workers from illness, disability, and death. WHY ARE WE NOT RECOMMENDING THEIR USE? Because "it's expensive".

I can't tell you how demoralizing it is to be told so plainly that my tot on a balance sheet is insignificant.

Respirators are an important part of the multi-layered defense necessary against SARS-CoV2. We need clean air, we need effective vaccines, and we need respirators in healthcare.

Please *do your job* and *control disease*.

Kathryn Pitroff

Redmond, WA

My name is Kendra. This will be my second public comment in regards to the HICPAC team's lack of transparency regarding your forthcoming decision to roll back not only general practices of the precautionary principle in medical settings, but also your lack of appropriate guidance on airborne transmission and necessary protections. As I previously stated, I formerly worked in healthcare and with aspiring healthcare professionals within higher education. I am also a member of the WHN, the organization that has recently filed a complaint against you. I would implore you to reconsider your position and do the right thing by acknowledging the on-going state of the current SARS-COV-2 pandemic and the need for improved ventilation and N95 (or higher) respirators for healthcare workers and patients alike in all medical settings. Last time I spoke of my grandmother's passing from SARS-COV-2. I recently lost my other grandmother due to metastatic cancer. I recall the confusion as other family members remarked that the home health nurses donned the Aura N95s that myself and my husband always wear. Shortly thereafter, they told me that they no longer had to wear masks on the oncology ward when my terminally ill grandmother went for cancer treatments. They don't believe me when I attempt to educate and protect them. I am no longer just appalled, but furious. You KNOW better than this. I'm not sure whom, but someone on your committee stated it perfectly clear in August at the previous HICPAC meeting that costs should be a main factor in these decisions. I am of the mindset of people over profits, period. I also reviewed the August minutes and several people added up the supposed cost of keeping everyone as safe as possible through at LEAST N95 (or higher) PPE vs. the increased cost of care for those with serious SARS-COV-2 infections and skyrocketing numbers of disability in the form of what has been termed "Long COVID". It is a no brainer if you worried about costs that prevention is the much more cost effective route. Let me also be clear, SARS-COV-2 is NOT a cold or a flu. It is SARS. SARS-COV-2 can cause immune system damage akin to HIV or HEP C. It can damage your blood vessels and every major organ in your body. We have known that SARS is airborne for some time. The lack of appropriate guidance was not a mistake or miscalculation. The lies are intentional. I told my husband very early on that taking into account asymptomatic spread (we now know is >59% of cases) and the airborne nature of the virus, we should assume that anyone we come into contact with is infectious, no matter if they have symptoms or not and behave accordingly by wearing respirators. If I knew better, I KNOW that all of you do as well. While I am forever grateful to have an educational and professional background in healthcare and public health, it is not my chosen profession. However, in order to keep myself and my husband safe I had no choice but to spend countless hours further educating myself over the past 4 because of the CDC's dereliction of duty.The CDC was sending internal communication regarding the seriousness of the situation and the impending lockdowns as early as February 2020. Meanwhile, the CDC,

government, and media were saying everything was fine publicly. This is criminal. It seems as though there is a determination being made in terms of how much illness and death the general populace will accept and corporate interests are capitalizing on the perceived apathy. It seems as though you are asking the question of how much can you get away with rather than how we can best protect healthcare workers and patients. Everything seems to boil down to greed and power. I don't know how you sleep at night. If you vote to further roll back infectious disease protections both for airborne viruses such as SARS-COV-2 or otherwise, you will have more blood on your hands than you already do. Your actions not only impact healthcare, but all industries. You have an opportunity to turn the tide, to do the right thing, to come clean, and to start saving lives. Which will you choose?

Rosemary Schneekloth

I am a person with AFIB married to a cancer patient currently receiving chemotherapy. Since March 2020 when the SARS-CoV-2 (COVID-19) pandemic began, we have both worn masks. We purchased HEPA quality air filters for our home. We have stopped dining inside restaurants. We either go very early in the morning to do a quick shop for groceries or we order online for curbside pick-up. We mostly shop online for other items. At church, where my husband is the pastor, we both mask, run HEPA quality air filters, and open windows when the weather allows. (We would keep windows open year round, but because of the failures of the government, public health and the media, most of our church members are unaware of the dangers of COVID-19 and think the pandemic is “over.” They are not educated about the effectiveness of masks and the necessity of ventilation and cleaning the air/air exchanges to stop the virus in its tracks as we are. That lack of awareness, education and dearth of accurate guidelines from public health organizations like the CDC is also why they voted to make masks optional several months ago. Now that my husband is being treated for cancer, some people are wearing them again.) We are now unwilling to risk seeking dental care because we do not have a COVID safe dentist. Every healthcare visit, including my husband’s several hour chemo infusions and pump disconnections, is fraught with risk. We’ve seen a few other patients wearing masks. Few of the health care workers do, not even our oncology doctor and her staff, although they can plainly see my husband’s KN95 mask and my N95 respirator. And yet, they have warned us to avoid the ER and call them directly if he has an emergency. But what about me if I have an episode of AFIB or dangerous heart rate? How do I access healthcare without putting us both at risk? I’m his primary caregiver, chauffeur and support. I was dismayed to learn of the failure of transparency, lack of input from key stakeholders, and absence of concern for patient and employee health through the process of updating HICPAC’s infection control guidelines. SARSCoV-2 (COVID-19) is airborne and moves through the air like smoke. I urge you to consider aerosol transmission of COVID-19 and other commonly circulating pathogens and to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the superiority of respirators over surgical masks, especially when the latter are worn without braces, to require such tools as free or low cost N95s, PCR testing, increased ventilation, HEPA filters, and far UV lights, to increase transparency in decision making, and to involve aerosol experts as well as representatives from among those most impacted by these guidelines. Thank you.

Hello,

Please advise, support and educate the public that the Covid pandemic is not over. We have known for over three years that it's airborne. Please support and advise for ventilation and air purifiers to help reduce virus loads in hospitals, clinics and other medical facilities. Please bring back masking! We know masking is effective.

Thank you,

Stephanie Skenandore

As a patient who has battled the challenges of long COVID being bed-bound for 18 months, I would like to ask the HICPAC to take concerted action in raising awareness about the risks associated with COVID-19 transmission. My experience has underscored the necessity of transparent and inclusive guideline updates. I want the HICPAC to engage in a comprehensive process with extensive consultation with a diverse group of stakeholders. This process should ensure public accessibility through announcements on the Federal Register, sharing of meeting details, and the swift publication of reports, comments, and transcripts on the CDC website.

Firstly, it is vital to acknowledge the role of aerosol transmission and to underscore the importance of implementing multiple control measures(clean air, masks, etc), continuous education for healthcare personnel, and awareness campaigns for the public with an emphasis on schools and childcare centers. Universal precautions, recognizing the potential for asymptomatic transmission, should be included.

Furthermore, I advocate for stringent testing protocols and clear guidelines on contagiousness. The use of fitted N95 respirators and adherence to ASHRAE indoor air quality standards in healthcare settings are measures that can significantly enhance safety.

These recommendations, when incorporated, will contribute to developing comprehensive and transparent guidelines that prioritize the well-being of all citizens, with particular attention to those who are most vulnerable. In the ever-evolving landscape of Covid, RSV, TB, Influenza, etc., understanding maintaining public trust and safety through open and thorough guidelines remains paramount.

Shannan Riemer

Austin, Texas

Dear HICPAC Committee,

Thank you for undertaking a review of the 2007 Guidelines for Isolation Precautions. With increasing knowledge about ways to mitigate the spread of airborne infections, it is timely that HICPAC is addressing this matter.

I attended HICPAC's last meeting and noted that the use of N95 respirators was recommended for healthcare workers who suspect that a patient has Nipah virus. Based on the slide presentation, it was clear that the early signs of Nipah virus would be difficult to distinguish from the early signs of many other illnesses. Therefore, it seems logical that those healthcare workers who come into contact with a patient before viral tests have confirmed infection with NIpah should all be wearing N95 respirators at a minimum to prevent airborne spread. It is clear that surgical masks are not designed to nor adequate for protection against airborne

viruses. Additional ventilation and filtration do not protect against near-field transmission. UVC lighting or far-UVC lighting might also be considered.

While Nipah is not present in the United States to date, measles, tuberculosis, and Sars-cov-2, all airborne viruses, are present with varying prevalence rates. All of these viruses may lead to disability and death. The costs to the healthcare system are also formidable. To mitigate the spread of those airborne viruses and Nipah, increased ventilation, filtration, UVC, and N95 or better respirators need to be mandated in healthcare settings. The introduction of the proper mitigations for airborne viruses will protect healthcare workers, patients, and the community at large.

Thank you for considering my comments and my request that N95 respirators or better protection and better ventilation and filtration be mandated in healthcare settings.

Martha Young, JD/MBA

Rockville, MD

"First, do no harm."

Dear CDC Committee,

I am writing out of concern for the anticipated revisions to the Isolation Precautions Guidance. Two friends recently contracted COVID while in the hospital for other illnesses. Hospitals often post their rates of Hospital Acquired Infections. Why is COVID not on these lists??? Why aren't hospitals tracking and publishing the data on how many patients are contracting COVID while in care for other conditions? And if patients are getting COVID in the hospital, surely hospital staff are getting infected as well. How can you possibly view this as acceptable?

As a 65 year old retiree with multiple health issues, I would like to be able to make informed decisions about which health care facilities I go to for care. I cannot do this if the hospitals are not required to publish this data.

I am asking you to delay the vote until the public has had adequate time to review the Isolation Precautions Updates.

I am also asking that you hold public meetings with all stakeholders (patients, health care workers, etc.) before voting to finalize these updates.

We now have plenty of studies showing that N95 respirators are superior to the flimsy, leaky surgical masks commonly used before COVID. Aerosolized viruses like COVID are easily spread where N95 masks are not used. Please take these studies into account as you modify guidelines.

Why are there no recommendations regarding ventilation and filtration? We have learned from COVID that frequent air exchange prevents the spread of aerosolized viruses. Why are you not including recommendations regarding ventilation???

Half of the non elderly among Americans have pre-existing conditions that make them likely to have worse outcomes with viruses like COVID. They deserve to access care without risking another illness.

Please delay the vote. Please make this process more transparent. Please, please, please, do no harm.

Sincerely,

Linda Brown

Quemado, NM

Name: Mariah Boyle

Address: East Wakefield, NH

Org Affiliation: None

Topic: Infection Control Guidelines Must be Strengthened

To best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.

The development of infection control guidelines should involve both:
- those who are most at risk, including patients and healthcare workers and their representative organizations
- experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.

Guidelines should be comprehensive and include ventilation, HEPA air purification, masking, testing, and minimizing air sharing.

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

Thank you,
Mariah

Dear CDC HICPAC Committee:

While I am employed by a healthcare organization, my comments do not reflect their position in any way and are my own. I am a non-clinical corporate employee who does not provide patient care. I am also a patient.

I understand that your committee has initiated a process to update the CDC's 2007 Isolation Precautions guidance. So far, CDC/HICPAC's draft updates have not been made publicly available.

HICPAC's June 2023 presentation regarding the Work Group's draft updates caused significant concerns. The proposed draft updates would weaken current infection control protections, fail to fully recognize aerosol transmission, and rely on a biased and incomplete review of the evidence on respiratory protection. Further, the Isolation Precautions Work Group meeting summaries make it clear that the Work Group's goal has been to weaken infection control

protections for health care workers and patients to create more “flexibility” for employers to prioritize costs over care and protections. These proposals would put patients and health care workers at increased risk of a wide range of infections.

Concerningly, CDC/HICPAC lacks effective mechanisms to engage expertise from the range of stakeholders that are required to create strong, science-based guidance. It is essential to incorporate the input and expertise of direct care health care workers and their unions, as well as that from aerosol scientists, experts in respiratory protection and ventilation, patient advocates, and other public health experts beyond the infection control practitioners and hospital administrators currently represented on HICPAC.

In order to create robust, science-based guidance and to facilitate public engagement in the process to update guidance, before any HICPAC vote, I urge you to:

(1) Publicly post HICPAC’s draft Isolation Precautions guidance update in full, with ample time for review and consideration by the public,

(2) Host public meetings to engage input from all stakeholders on infection control guidance for health care settings, and

(3) Fully recognize the science on aerosol transmission of infectious diseases and respiratory protection to protect workers from hazardous exposures.

I commend you for delaying HICPAC’s vote and urge you to use the extra time to more effectively engage input from stakeholders; including patients like myself who do not want to become infected with illness when seeking healthcare due to inadequate clinician PPE and poor air quality. CDC/HICPAC’s infection control guidance impacts everyone who enters a health care setting, including patients, visitors, and health care workers.

Thank you,

Kimberly Ratliff

Charlotte, NC

No organizational affiliation

Dear HICPAC committee members:

My name is Wayne Wu, and I listened with great interest to the live stream of the HICPAC meeting in August.

I understand the importance of the committee’s work, and thank you for your dedication to protecting the health of the public and this nation. It is in that spirit, and precisely because of how important CDC guidelines are to protecting people’s health that this letter is written.

I urge the committee to take the necessary and appropriate time to engage additional subject matter experts in relevant fields that are not represented among the committee, when discussing and evaluating evidence in formulating guidelines.

Specifically, the committee has a responsibility to engage experts in the following fields, to be able to make informed guidelines on appropriate protections against aerosol infection in healthcare settings:

- Aerosol science
- Industrial hygiene
- Engineers and safety professionals with expertise in clean indoor air
- Respiratory protection

Medical professionals without backgrounds in the above fields cannot responsibly be the sole evaluators of related evidence, and then alone craft guidelines that provide appropriate levels of protection. An example is the discussion in the last meeting that seemed to equate surgical masks with N95 respirators as providing equivalent respiratory protection. This is simply false. There was also a lack of discussion and understanding around how aerosols in the air behave.

Additionally, I believe there needs to be more transparency and engagement with the public on the process to update guidance on infection control, and drafts of guidance prior to votes must be released. A vote should NOT be taken without adequate time for public comment, review, and making sure guidelines follow the most current scientific evidence. The process must show that it is free of influences and biases and serve ONLY the goal of protecting the public's health— including those who are disabled or at risk (which is by some estimates more than 75% of the population in the US).

Finally, guidelines should be clear and based on objective criteria, and not up to anyone's or any organization's personal judgement. This is because we know that when there is a choice between doing the right thing and the bare minimum, the vast majority of the time is the latter. CDC guidelines are often used as a reason why more protections are "not allowed".

Please set a high, evidence-based standard, principled on "Do No Harm" and the precautionary principle, that can be a model for the world to follow that will be looked upon as forward-thinking by future generations.

We are counting on you.

Sincerely,

Wayne Wu

Member of the Public

New York, NY

Hello HICPAC Advisory Group,

I am writing about CDC guidelines for infection control in healthcare settings.

It is imperative to recognize aerosol transmission, and require respirators in healthcare settings, regardless of vaccination status. It must be respirators, not surgical masks, which are subpar in preventing aerosol transmission.

Further, healthcare facilities must clean the air with tools like HEPA filters and publicly visible CO2 monitors, and include aerosol experts in maximizing high quality air.

COVID is deadly and dangerous. There are thousands of studies showing how harmful COVID is, and not a single one showing that it is good or safe to catch. Respirators prevent against so many other diseases, too.

Protect people's health!!

Sincerely,

Doris

Dear HICPAC and CDC members,

Infectious aerosols pose a serious threat to health care workers and patients. Therefore, I call on HICPAC and the CDC to provide clear and specific guidance on how to prevent and control these hazards. The guidance should include a comprehensive approach that involves exposure assessments, control measures (including PPE) tailored to each job, task, and location, and a written exposure control plan that follows the hierarchy of controls.

This information from the CDC's website:

Understanding the Difference (cdc.gov)
(https://www.cdc.gov/niosh/npptl/pdfs/UnderstandingDifference3-508.pdf)

Shows the important difference between a surgical mask:

Does NOT provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection.

and a respirator:

Filters out at least 95% of airborne particles including large and small particles.

This is just one example of the measures that need to be implemented to protect our most vulnerable from getting illnesses spread through airborne transmission. As patients, we should feel that every precaution is being taken to protect us.

Require respirators in healthcare settings. Protect our most vulnerable. Keep healthcare workers safe.

Respectfully,

Angela Craytor

Broadlands VA

HICPAC,
We should be strengthening, not weakening infection control.
I have a friend who believed 5 MRNA vaccines was sufficient to keep him safe. He recently ended up in the hospital for 2 months with Covid, contracted sepsis and almost died, because measures to combat aerosol transmission of Covid are not understood & not being followed.

I was horrified by the summary of the workgroup draft update released in June on how to deal with infection control. One part, in particular basically saying surgical masks were no different than N95 respirator masks. Now is not the time to let down our guard on infection control.

HICPAC needs to consult with, or have aerosol scientists in the work group, or on the voting committee.
Employers should have to provide N95 respirator masks to healthcare workers and patients. Along with OSHA compliance for workers. We cannot thumb our nose at Covid transmission. There's a mountain of data showing that vaccines do not eliminate the risk of COVID's long-term ramifications.
Patients should not have to worry about contracting other illnesses or Covid, while being treated in medical facilities.
We should be learning from the ongoing pandemic that all of our health is interconnected, and thus, be protecting each other.
We should not be doing a cost benefit analysis on human health. We should be removing all the stops and recognizing aerosol transmission, protect each other including HEPA filtration, ventilation, along with N95 respirator masks across the board in healthcare. Let's keep it simple. We are all vulnerable. Mask up N95.

Thank You,
Jesse Jacobs
Los Angeles Ca

To Whom It May Concern:

I write this as a frontline healthcare emergency medicine physician with more than a decade of clinical experience. I have cared for many COVID patients, and because I have maintained airborne precautions since March 2020, I have yet to be infected with SARS-CoV-2. I am also a researcher with a background in microbiology, public health, and epidemiology, and I have 2 years of fellowship training in patient safety and quality improvement.

I watched with horror in the early stages of the pandemic as old, unfounded "droplet" dogma was pushed out and then reinforced, clearly driven by concerns regarding the cost and access to N95s and other appropriate PPE and NPIs. No thought was given to long-term planning, as the assumption was that the pandemic would magically disappear. Voices who pointed to mounting evidence to the contrary were summarily and repeatedly silenced and pushed out, to all our detriment. Those of us who continued to work clinically despite these conditions did so while quietly changing our infection control practices, often at considerable personal financial cost.

Since January 2020, it has been clear that SARS-CoV-2 spreads through the air, in the same way that smoke spreads.

We have known - and now have a veritable mountain of evidence to *further* back up assertions based on well-known and well-documented experiences from SARS-1 - that N95s are necessary for healthcare workers, regardless of vaccination status. Ideally, healthcare workers should have access to and be encouraged to use reusable elastometrics that provide N95 or better protection - this provides the minimum appropriate level of safety while reducing waste and has been shown repeatedly to a cost effective strategy.

A bare minimum of surgical masks are needed for patients, in that they provide source control. In order to keep patients safe from nosocomial SARS-CoV-2 infection, however, N95s are required.

In addition to well fitted N95 or better masks, clean air tools including HEPA filters, Corsi-Rosenthal boxes, and optimized ventilation, are tools that are cost effective and necessary to protect the health of healthcare workers as well the health of patients.

Aerosol experts must be involved all stages of management of indoor air in healthcare settings. Transparency regarding indoor air quality are also necessary, preferably with posted CO2 or other particulate monitors, similar to availability of thermostats.

In the same way that hard hats and steel toed boots are assumed PPE at construction sites, these are the bare minimum standards necessary to ensure the safety of both healthcare workers and patients - going forward indefinitely.

C.D. McNaughton, MD PhD MPH

Adjunct Associate Professor, Department of Emergency Medicine, Vanderbilt University Medical Center

Associate Professor, Department of Medicine, University of Toronto

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Name: Melissa Vosen Callens, PhD

Address: Fargo, ND

Comment for Minutes: I'm writing as a chronically ill person. It upsets me that I am unable to safely access healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. It is unacceptable that I must choose to either forgo needed care or risk COVID exposure. The proposed guidelines are atrocious and put me and others at further risk. Please require n95 respirators for airborne disease - including COVID - and listen to aerosol scientists!

I am writing because I am an RN who is disabled by Covid for almost three years. Before I was disabled in the second year of the pandemic, my career was on an upward trajectory as an oncology and hospice nurse. There are many factors to consider as an oncology nurse. One of the main things is infection prevention due to immune status of some patients who undergo various types of chemo. There needs to be proper barriers for the patients. N95 masks have been synonymous with airborne pathogens for quite some time now and for good reason. Every measure needs to be put in place to protect vulnerable people in a place of medicine. Honestly I am surprised that downgrading infection prevention measures is even being discussed. We should not have tax dollars being put into this type of committee. Instead let's improve patient safety and put dollars into that. Thank you for your time.

Marisa La Piana

Oakland CA

To whom it may concern,

I am writing as a disabled person whose health has been negatively impacted by a covid 19 infection causing an autoimmune condition.

It is unacceptable not to be able to access safe healthcare due to rampant covid spread and lack of consistent airborne protections in place in healthcare settings including mandatory masking with high quality n95s and kn95s and ventilation.

Instead of being able to trust that the CDC has the well-being of patients at heart and is working to increase infection control. We are put in a position to weigh or health status against the hazardous dangers of COVID 19 when thinking about seeking care. These are unacceptable calculations for us to make. I was dismayed to learn about the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health.

I urge you to recognize the aerosol transmission of COVID-19 and other community circulating pathogens, to require respirators in healthcare regardless of covid 19 immunization status. To require clean air tools like HEPA filters and increased ventilation. Also to increase the transparency of decision making and to involve aerosol experts, key stakeholders and the most impacted including disabled, chronically ill folks and healthcare workers in the decision making process.

Thanks for your consideration,

Marisa

Subject: infection control guidance

To whom it may concern:

I am writing to the committee today to encourage you to institute high standards of prevention against COVID and other airborne diseases. This is essential in medical settings, for many reasons. First, unlike a restaurant or a concert, a doctor's office or hospital is not a place that people can simply choose to avoid in order to prevent infection. People must either go to the doctor and risk infection (since no precautions are being taken), or delay needed health care. Second, many people who go to the doctor or hospital are there because they are ill. It is a place where many contagious people are likely to be, therefore increasing the spread of illness unless controls such as masking and ventilation are in place. Third, many people who go to the doctor are there because they have a problem that compromise their immune system (e.g. cancer patients) and they need particular care and protection. Fourth, medical facilities are also workplaces where doctors, nurses, and others must spend many hours every week. They deserve to be safe from infection while they are carrying out their essential jobs. When these workers are ill, it places further strain on the health care system as a whole. It is cruelly ironic that hospitals and doctors' offices have become a vector for dangerous sickness, rather than a place of healing.

It is particularly concerning that HICPAC has offered limited transparency into its procedures around recommendations for infection control. From what we can see of these procedures, they are not truly robust. In order to provide good recommendations, the committee should include people with relevant expertise such as aerosol scientists. Members of the public should also be able to view and comment on the guidance updates before any vote is taken.

Thank you for your consideration.

Jaime Cleland

Brooklyn NY

No affiliation — speaking as a private citizen

HICPAC must:

- Recognize aerosol transmission of disease including SARS-COV-2

- Recommend respirator requirements in healthcare regardless of vax status (N95 or better, both patients and staff)

- Acknowledge the scientific fact that respirators are FAR more effective at reducing transmission of airborne disease than surgical masks

- Promote clean air tools like HEPA filters and CR boxes (which leverage less-than-hepa filtration but higher CFM to produce superior air changes per hour):

- Involve aerosol experts and increase transparency of the groups decisions

Sincerely,

James David Daily

To CDC:

I care about clean air, and given your role in shaping public policy, you should, too. I'm concerned about the total disregard for COVID. We have seen 4 years of data of what COVID can do to the body, we have no idea what this virus will do over the course of the next few decades. You have a responsibility to protect and educate the public. You've known that COVID is airborne and transmissible through aerosol particles.

There are no biomarkers to understand who will be affected by long COVID. It could be you, your kids, your loved ones. Why aren't you requiring high quality respirators (N95 or better) in healthcare settings? People have the human right to safely seek healthcare, regardless of health status. Why aren't you educating the public on mask quality? Why are you still pushing for surgical masks? Why haven't you invested in HEPA filters? Why haven't you involved aerosol experts and increased transparency?

You have the moral and ethical responsibility to protect Americans.

To good health for all Americans!

Sincerely

Tara Fitzpatrick

New Paltz NY

Attached is a letter from ISEA expressing concerns with a potential recommendation to use face masks to provide respiratory protection. As the letter notes, ISEA are “concerned this would set a new precedent – one that is potentially damaging to worker health and safety, without fully-developed foundations in respiratory protection science – by recommending that a device be used for respiratory protection that it not in fact a respirator.”

We would be please to speak with you about this.

Biosafety eyewear

In addition, we would like to point your attention to a new standard for biosafety eyewear. A copy of that standard is attached. The ANSI Z87.1 Committee designed this standard for healthcare and medical workers, who could be exposed to splashes and spurts. We would also be pleased to speak with you about this standard. We believe CDC should recommend use of these devices for healthcare workers who could be exposed to biological splashes and spurts.

Thank you for your attention to this matter.

Sincerely,

Daniel Glucksman

Senior Director for Policy

Int'l Safety Equipment Assn

www.safetyequipment.org (http://www.safetyequipment.org/)

Attachment:

Re: Comments on HICPAC's respiratory protection recommendations

Dear Director Cohen and Dr. Wright,

Members of the International Safety Equipment Association (ISEA) are global leaders in the design, testing and manufacturing of safety equipment and PPE. Our industry protects 125 million U.S. workers, supports 350,000 jobs, and generates economic activity of $71.6B. ISEA proudly represents a majority of the nation's respiratory protection manufacturing[1].

We understand the Committee's desire to make a recommendation for low-level risk exposures and appreciate the time and effort that went into establishing June's draft "Routine Air Precautions." However, our members are concerned that this would set a new precedent – one that is potentially damaging to worker health and safety, without fully-developed foundations in respiratory protection science – by recommending that a device be used for respiratory protection that it not in fact a respirator.

This would be fraught with risks, including:

1. It would lead individuals and employers to use medical masks as respiratory protection (which these devices are neither tested nor approved to be), in settings with respiratory hazards. This poses a health and safety risk to the nearly 14 million healthcare workers requiring respiratory protection on the job.

2. Manufacturers may be compelled to add prominent warnings to these devices informing users these products are not to be used for respiratory protection. This would be necessary to avoid future liability for worker illnesses arising from medical masks being used outside of the intended design parameters. In fact, such manufacturer warnings would contradict any HICPAC and CDC recommendation to use medical masks as respiratory protection, further confusing the subject, and confusing users.

3. The potential recommendation to use medical masks for respiratory protection against seasonal influenza and coronaviruses would violate the occupational health standards

promulgated by the Occupational Safety and Health Administration. This would place employers in the impossible position of having to choose between violating OSHA standards or acting counter to CDC recommendations.

Recommendation: HICPAC should seek to adopt the forthcoming "Public Safety Respirator" standard

The ASTM F23 Committee on Protective Apparel is currently writing a standard for a new device that is intended to combine certain features of medical masks and N95s[2] to create a "public health respirator" (aka "respirator lite"). The intended use case for this standard aligns closely with the "Routine Environment" we believe is being contemplated by HICPAC in its draft Routine Air Precautions document. Products compliant with this potential standard would be designed and tested to provide respiratory protection against commonplace "endemic" hazards (such as seasonal influenza and seasonal coronaviruses) while also aiming to offer the comfort and user-acceptance features of medical masks. We encourage the Committee to monitor the ASTM activity and to please consider, when feasible, incorporating the new ASTM "public health respirator" category into its recommended guidance as appropriate. ISEA suggests HICPAC create a mechanism, such as a reserved section (similar to Federal regulations) to update the Routine Environment recommendations from medical masks to the new public health respirators, once the ASTM standard for these devices is published.

Recommendation: ISEA urges HICPAC and CDC to expand the ex-officio federal agencies to include OSHA

ISEA urges CDC to invite OSHA as an ex-officio HICPAC member. This action would add a critical voice to the Committee deliberations. In addition, occupational hygienists, aerosol scientists, ventilation engineers, and respiratory protection experts – all of whom have unique expertise and skill sets that are essential to the task of controlling infection risk – would help ensure the health and safety of the nation's healthcare workforce is interwoven with infection control practices.

Recommendation: Reference relevant biosafety eyewear standards

CDC and HICPAC should be aware of the new ANSI/ISEA Z87.62-2022, the American National Standard for Occupational and Educational Eye and Face Protection Devices for Preventing Exposures Cause by Sprays or Spurts of Blood or Body Fluids. This standard sets forth criteria related to the general requirements, testing, permanent marking(s), selection, care and use of protectors to minimize or prevent exposure to the wearer's eyes and/or face (mucocutaneous exposures, nose and mouth) caused by spray or spurt of blood, body fluids and/or other potentially infectious materials (OPIM).

ISEA and the Vision Council would be pleased to provide more information on this new standard and answer any questions CDC staff members might have.

ISEA asks CDC and HICPAC to reference biosafety eyewear meeting ANSI/ISEA Z87.62-2022 in recommendations for infection control and protection measures.

Thank you for your time and attention to this letter. I can be reached at xxx if you have any questions to set up a time to discuss Z87.62 or other matters mentioned here.

Sincerely, Cam Mackey

President and CEO

[1] ISEA respiratory protection group members include 3M, Bullard, DeltaPlus, Draeger, Gentex, Honeywell, Ironwear, JSP, Kimberly-Clark, Moldex, Milwaukee Tool, MSA, Economy, PIP, Pyramex and SureWerx.

[2] ASTM public mask is currently being treated as a harmonization task group between F23.40 and F23.65 subcommittees.

To: CDC Healthcare Infection Control Practices Advisory Committee (HICPAC)

As the federal advisory committee tasked with providing advice and guidance to the Centers for Disease Control and Prevention (CDC) on infection control practices in healthcare settings, I urge HICPAC to fully recognize aerosol transmission of COVID-19 and other viruses to ensure healthcare worker and patient protection.

As a newly disabled person due to the COVID-19 vaccine and a COVID-19 infection, I require regular medical care. Now that healthcare facilities and hospitals have dropped mask mandates, I risk my current health, safety, and life every time I enter a medical office. I also have many nurses and healthcare workers in my family, and their safety and lives are very important to me.

The COVID-19 pandemic has taken a massive toll on healthcare personnel – millions have been infected, thousands have died and tens of thousands are suffering the disabling impacts of Long Covid. Under your leadership, I urge CDC and HICPAC to change course and develop updated guidelines and recommendations, in consultation with key stakeholders, based on the full body of scientific evidence confirmed during the COVID-19 pandemic that will fully protect healthcare personnel against infectious aerosols.

HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open up the process to effectively engage these experts in developing drafts.

Based on the current science, we know that isolation, ventilation, and NIOSH-approved respirators are effective control measures to prevent the transmission of infectious aerosols. I was recently exposed to a person testing positive for SARS-COV-2. My use of an N-95 respirator helped protect me from infection; I never tested positive despite significant exposure. Yet, CDC/HICPAC inexplicably fails to acknowledge the large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols. There are **no** recommendations on ventilation. By adopting your current draft recommendations, you WILL put healthcare workers and patients at serious risk of harm, and even death, from exposure to infectious aerosols. Do not use an approach that recommends only minimal protections and allows healthcare employers broad and undefined discretion in creating and implementing their infection control and prevention plans. Maintain an approach in any updated infection control guidance that is clear and explicit on the precautions that are needed in situations where infectious pathogens are or may be present in healthcare settings. Follow the science.

I appreciate your attention to this issue and hope the CDC will enact recommendations that protect the health of workers and the public.

Sincerely,

Camille Marcotte

Syracuse, NY

Disabled United States Citizen

Thank you for taking feedback regarding masks in healthcare. When patients seek health care what we want is relief from what is bothering us, we want attention and medical intervention. And we certainly want to be safe. In order to be safe, we need to be seen by healthy masked medical providers who care about protecting their patients. Please keep masks in healthcare.

Thank you,

Sue Winkler

HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends minimal protections and allows health care employers broad discretion to create their infection control plans. A similar approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing protections for health care personnel and patients based on cost considerations. I urge HICPAC and the CDC to be explicit about the precautions that are needed to protect health care workers and patients from infectious diseases in the updated guidance. It should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and include a written exposure control plan following the hierarchy of controls.

Matthew Glassman

Hamilton, NJ

No organizational affiliation

Hi CDC - HICPAC,

This is my written public comment as a US citizen. I beg you to beef up infection control measures in US hospitals. We need HEPA filters, respirators and high quality masks and access to experts with the most recent information on airborne disease control. Patients, whether they are our parents, children, friends, co-workers, or ourselves should not be exposed to life threatening diseases like SARS-COV-2, tuberculosis, RSV, Flu or any number of fungal or bacteria infections while seeking treatment at any US hospital. Surgery and treatment is already stressful and expensive enough and we are meant to trust in our hospitals. A number of infections are airborne and can be mitigated with high quality masks (n95 and above) on our healthcare workers and fellow patients.

We know that Covid-19 is airborne now and can be transferred as an aerosol! This means doctors and hospital workers must adopt the strictest levels of prevention. N95 respirators and better are tested and proven to stop airborne infection at much higher levels than surgical

masks. We must ask our hospitals to lead the way to keep our patients save and guarantee their best path of care. According to current data, vaccines do not stop the spread of airborne viruses like Covid, so we must implement respirators at hospitals around the country.

HEPA filters as well have been proven to lower the transmission of viral particles spread through the air. These are a huge measure that must be implemented in our hospitals for patient safety and comfort. We are on the cutting edge of so much technology here in the US and there is no reason not to expand HEPA filtering to keep our hospitals safe.

I do not want to drop these standards in the face of the minimization of the ongoing Covid-19 pandemic, nor will I condone the spread of controllable airborne viruses beyond it! Do not walk medicine back into the 19th century! Let's make changes that put us leading the way to the 22nd! Require airborne infection control at the highest level in hospitals where our most vulnerable have to go!! Keep us safe with masks for the quality of care we deserve.

Please consult with experts in airborne infection during this ongoing pandemic and implement tested mitigation strategies (HEPA filters, respirators) in all of our hospitals. Do not leave patients behind.

Thanks for your time,

Camille Kolodziejski

Half of all healthcare workers attend work while sick. Due to staff shortages and insufficient paid sick leave, many have no choice. Rather than single out the individuals forced to work while sick, all healthcare workers should simply wear N95 masks.

https://www.cidrap.umn.edu/covid-19/study-notes-high-rate-covid-infected-healthcare-workers-still-caring-patients

Christopher Vineski

Colorado Springs, CO

Not affiliated with any organization

I have a serious chronic illness that puts me at greater risk from Covid and other infections. Because of this chronic illness, I also have to access health care more frequently than my peers. It is imperative that healthcare settings are safe for me to access.

In addition, I have multiple friends and family members who work in the healthcare field (as RNs, LPNs, respiratory therapists, PAs and ultrasound technicians). Science-based guidelines protect our precious healthcare workers and ensure that their employers provided them with the most effective PPE.

I urge the CDC's HICPAC members to involve aerosol experts, increase transparency, recognize aerosol transmission of SARS-2, and to require airborne precautions that include source-controlled respirators and PAPR's, ventilation, filtration, adequate ACH, and isolation in healthcare settings.
Thank you,
Stephanie Mass
Springfield, VA

This is a comment re the updating of guidelines for health facilities.

To best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.
The development of infection control guidelines should involve both:
- those who are most at risk, including patients and healthcare workers and their representative organizations
- experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.
Guidelines should be comprehensive and include ventilation, HEPA air purification, masking, testing, and minimizing air sharing.
The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

Hello,

I am not a healthcare worker, but I am a highly concerned patient. And I have many loved ones working in the healthcare industry. It is apparent to me that decisions impacting the quality and safety of our healthcare are being made with a focus on making money for administrators, corporations, and shareholders, rather than focusing to the utmost on protection for patients and the healthcare workers.

I am alarmed to read statements from a highly reputable organization, National Nurses United, about the CDC's plan to change infection control guidance by weakening protections for healthcare workers and patients. In addition, the CDC's apparent lack of transparency while making decisions that will impact us all is unacceptable and highly concerning.

The CDC needs to:

- be fully transparent and welcome public input
- listen to the experts and make use of their evidence-based research and recommendations,
- recognize, review, and respond to research on aerosol transmission and respiratory illness,
- provide a full draft to the public and allow ample time for review and response,
- ultimately, strengthen and expand current infection control protections and policies,

Please do not remove or weaken any infection protections. Instead, carefully review and incorporate the evidence being presented to you by experts on airborne infection control and other pressing healthcare challenges. Do not focus on saving/making money for the corporations and shareholders but focus on providing the most excellent care possible for patients and safe working environments for our healthcare workers.

Thank you,

Debra L. Wilson

Oakland, MO

Dear HICPAC Committee Members,

I am writing to urge the HICPAC Committee to give due attention to the recommendations of aerosol scientists in revising and strengthening guidelines for medical facilities to better safeguard patients against the transmission of COVID-19. The ongoing global health crisis necessitates a comprehensive and vigilant approach to protect both patients and healthcare workers from potential exposure.

As highlighted by many aerosol scientists, there is growing evidence suggesting the significant role of aerosol transmission in the spread of COVID-19. This airborne transmission can occur beyond the traditionally recognized close contact and droplet spread, thus heightening the risk of infection within medical facilities. The current guidelines, while effective, might not comprehensively address the airborne nature of the virus, potentially leaving gaps in the protection of vulnerable patients.

In light of this, I strongly encourage the HICPAC Committee to consider the following points for a revised set of recommendations:

1. Acknowledgment and Emphasis on Airborne Transmission: Incorporate the growing body of evidence regarding aerosol transmission into guidelines for medical facilities. Address the importance of adequate ventilation, air filtration, and air quality maintenance to minimize the risk of infection.
2. Enhanced Personal Protective Equipment (PPE): Consider recommending enhanced PPE standards, especially for situations involving aerosol-generating procedures. This may include higher-grade respirators or masks to better protect healthcare workers and prevent potential transmission.
3. Updated Facility Protocols: Revise protocols for patient care areas, waiting rooms, and other high-traffic sections within medical facilities to mitigate the risk of airborne transmission. This might involve reassessment of spatial configurations, airflow dynamics, and air purification systems.

The commitment to patient safety and the well-being of healthcare workers is paramount in the face of this unprecedented health challenge. Incorporating aerosol scientists' findings and revising guidelines accordingly will significantly strengthen the defense against COVID-19 in medical settings.

I urge the HICPAC Committee to take these recommendations into serious consideration and to expedite the necessary revisions to ensure a safer environment within healthcare facilities.

Thank you for your attention to this critical matter. I am hopeful that the CDC, through the HICPAC Committee, will continue to lead in implementing measures that reflect the most current scientific understanding and best practices in safeguarding public health.

Sincerely,

-Rachael Shapiro Majka

To whom it may concern,

I am writing as a member of the public to submit my comment to the Healthcare Infection Control Practices Advisory Committee meeting on November 2, 2023.

Messaging on infection prevention and control, especially in relation to Covid-19, has been confusing and unclear to medical personnel and the public. I have spoken to physicians, pharmacists, nurses and technicians that are still unclear on how the airborne virus spreads and the buildings they work in are unprepared to deal with airborne illness.

Meanwhile, much progress has been made in private industries, showing that infection control and prevention is possible. The spread of airborne illness within our hospitals is then a failure of leadership and guidance combined with a lack of investment and trying. It does not make any sense that office buildings have better infection control systems in place than our hospitals, which are meant for our most vulnerable. .

As a patient in hospital in December 2022, I was told that I should not be asking for an N95 respirator because they are hard to come by and expensive. None of the medical staff wore respirators and I did not see any HEPA filters, even as we were in the middle of a Covid surge. In fact, many of the nurses commented on the respirator I brought, and I--a patient--had to educate them on how an airborne virus spreads. They were still under the impression that Covid-19 could only be acquired via surfaces.

It is a running joke among medical staff I know that both the emergency department and general floors will only provide a curtain, which is not adequate protection from an airborne virus, between patients that may or may not have active Covid-19 symptoms and a positive test result.Even with the tuberculosis patients, PPE and airborne precautions (such as placing them in a negative air pressure room) comes only after the patient has interacted with staff and other patients prior to admission.

In contrast, Institutional real estate investors have long prepared for the threat of airborne illness. Even prior to the current pandemic, the real estate industry launched standards for adequate air filtration and air exchange. The international WELL building certificate has been adopted by corporations such as Brookfield Properties, CBRE, Hines and Colliers. Companies understand that prioritizing the health of workers leads to greater real estate value and profit. The certificate is backed by more than 7,000 peer-reviewed studies and citations, and the locations are tested and verified. Requirements include keeping carbon dioxide levels below 800 ppm at intended occupancies.

Taking my own measurements, I know clinics, hospitals and pharmacies that have failed to meet this basic requirement. I understand that cost is always an issue, but it is criminal to not provide medical staff with adequate PPE and to not upgrade medical buildings to at the very least, meet the standards of many Class A office buildings. Our healthcare systems are woefully behind and we are running out of excuses.

Thanks,

Lisa Fu

Dear member,

RE: key control measures for infectious aerosols

It is unconscionable that the CDC are looking at a proposal to weaken infection control guidelines for all healthcare settings. This is nothing short of criminal negligence. Despite their considerable influence and authority over our lives, this committee doesn't have a single expert who acknowledges new research on airborne spread or aerosol science and yet, they decide minimum standards for hospitals going forward, determining when doctors and nurses have to wear a well-fitted N95 mask and the minimum standards for ventilation and isolation. All of these play a key role in whether or not we get sick.

More than 900 experts and healthcare workers sent a letter to the CDC this summer, urging them to reconsider their stance in light of current research but they were dismissed

https://www.cidrap.umn.edu/experts-say-cdc-not-getting-right-advice-hospital-infection-prevention?ref=okdoomer.io. This is not acceptable.

It's concerning when public health guidance does not adequately address key control measures for infectious aerosols. Ventilation, air filtration, and source control are essential components in mitigating the spread of infectious diseases, especially when dealing with aerosols. Recognizing the importance of these measures and incorporating them into recommendations is crucial for effective public health strategies. It's important for health authorities like CDC/HICPAC to regularly update their guidelines and incorporate the latest research and evidence to provide comprehensive and effective guidance to protect public health.

You need to respect & recognize aerosol transmission of SARS2.

We cannot conflate baggy blue surgical masks with N95 respirator masks.

Patients need expert voices to stand up for logic and common sense health protections. Ultimately, we are fighting against Biden administration's policy. Until and unless people are willing to criticize him directly, nothing will change.

Warm regards,

Puja Singh

I am a member of the general public.

Wolverhampton, UK

To HICPAC:

My sister, a former hospice nurse, has gone from working 12-hour night shifts to being effectively disabled since 2020. As her brother, I ask that HICPAC adopt guidelines that help prevent airborne transmission in all healthcare settings. These guidelines should reflect sound scientific study about the effectiveness of masking with N95s, elastomeric respirators, and PAPRs. Furthermore, the guidelines should include widespread utilization of ventilation, air purification, and testing. In addition, there should be a diverse range of interdisciplinary participants in establishing these guidelines, including building engineers and aerosol scientists. The healthcare system can ill-afford to lose more healthcare workers through insufficient measures. Future guidance must address the complexity and breadth of respiratory dangers in healthcare settings. Thank you for your consideration.

Sincerely,

Mike McVicker

Washington, DC

CDC has a responsibility to set the bar for COVID and disease prevention. People should not be put at risk by healthcare providers not wearing masks or hospital transmission. 60 minutes should not be a more reliabke place to get COVID information than the CDC. Stop playing games with public health.

Cover these areas:

-Recognize aerosol transmission

-Respirator requirements in healthcare regardless of vax status

-Respirators are more effective than surgical masks

-Clean air tools like HEPA filters

-Involve aerosol experts and increase transparency

Dawn Barron

Name: Molly partridge

Address: Glendale Arizona

Topic: Infection Control Guidelines Must be Strengthened

To best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.

The development of infection control guidelines should involve both:

- those who are most at risk, including patients and healthcare workers and their representative organizations

- experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.

Guidelines should be comprehensive and include ventilation, HEPA air purification, masking, testing, and minimizing air sharing.

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

Hello,

I would like to request the following be considered and included in your guidelines:

- Acknowledge that COVID is spread via aerosol transmission.

- Engage aerosol experts and take their recommendations into consideration before finalizing any guidelines.
- Require N95 or equivalent respirators in all healthcare settings regardless of vaccination status.
    - This would make a huge impact for many who have been putting off necessary medical care due to the risk of getting COVID, myself being one of them.
    - Immunocompromised people should not have to unnecessarily risk worsening their health while trying to get care, especially when masks are an easy, cheap, and accessible solution.
- Require the use of clean air tools such as HEPA filters in healthcare settings and encourage their use in all indoor settings.
    - While more costly than requiring masks, this is a good long-term solution which may be able to reduce the necessity of masks if properly implemented.
    - Even outside of COVID, cleaner indoor air would be hugely beneficial - it can reduce the spread of other viruses and bacteria and reduce allergens and particulates.

Name: Caitlin Hinshaw

Address: Lakewood, CO

Organizational Affiliation: No affiliation

Topic: Healthcare Safety & Air Quality

Thank you.

Mandate N95 masks for all public places and outside. Also mandate N95 masks for healthcare facilities.

Terry Barber

I'm writing to urge the CDC to strengthen safety practices in healthcare settings in order to guard against viral (and other) infections.

It has now been established that SARSCoV2 is an airborne virus that can cause both death and severe damage to organs and body systems. The CDC and healthcare providers have an ethical duty to safeguard the public's wellbeing. They can do this by educating the public on the threats of infection and the importance of personal & public precautions.

It is also imperative everyone has access to healthcare that reduces (instead of increases) the threat of infection. As SARSCoV2 is airborne, protections would include the wearing of appropriate respirators by everyone on site as well as improved ventilation and filtration.

The American people have put their trust in our government and the medical community to help keep them safe. I urge the CDC to do everything in their power to honor that trust.

Respectfully,

Leslie Christianer

Amboy, WA

Name: Robyn Saldino

Address: New York, NY

Affiliation: Organizing for a Better Tomorrow

Topic: Proposed updates to *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007),* Nov. 2-3, 2023

HICPAC's Isolation Precautions Guideline Workgroup has proposed a "flexible" approach to precautions,
which echoes the CDC cost-consideration policy used early on in the COVID-19 pandemic. This approach does not protect healthcare personnel or patients.

My sister has 3 children that will grow up without a father because "flexibility" only protects capitalism. Their father, my brother-in-law, was the first Line-of-Duty COVID-19 death in his county. He was a Driver Operator with Cy-Fair Fire Dept. for 12 years. He was a generous, kind-hearted, patient, silly, hardworking man, who played on his department softball team, and played alto saxophone and varsity football in school. He was infected on the job and spent weeks in the hospital before dying at age 31. Those children had to see their father's casket draped in a flag, put onto the back of a fire truck, driven to a cemetery, and disappeared into the ground. Gone.

I strongly urge HICPAC to maintain clear guidance that explicitly outlines the precautions that are needed to protect healthcare personnel and patients in every setting. According to National Nurses United, a protective approach should include: "assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls."

In order to make these assessments, select these control measures, and make these exposure control plans, there must be accurate and up-to-date terminology in *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007).* The Isolation Precautions Guideline Workgroup has proposed updates with some regard to infectious disease transmission, but these changes are far from sufficient. The proposed updates fail to acknowledge the role that aerosol transmission and aerosolized pathogens play when it comes to infectious disease. In order to truly protect healthcare personnel and patients, HICPAC must carefully and thoroughly update all sections of *Guideline for Isolation Precautions (2007).* These updates cannot occur until *Appendix A*, *Type and Duration of Precautions Recommended for Selected Infections and Conditions,* is up-to-date. The current *Appendix A* has significant errors in individual disease transmission routes. Only once *Appendix A* has been updated can HICPAC begin to work with stakeholders to update *Guideline for Isolation Precautions (2007). Ideally, this would include frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in*
aerosols, and experts in respiratory protection.

You may not feel that the choices you make over the next two days are going to directly impact your own life, and therefore have no reason to admit that you are relying on heavily biased

studies and flawed data to make your decisions. We have been seeing the effects of reduced PPE in healthcare settings for a while, but I need you to understand how devastating any further reduction in PPE would be.

When the day comes that you rush a loved one to the emergency room with shortness of breath, fever, high heart rate, and low CD4, your choices right now will determine whether or not their healthcare providers wear PPE. Your healthcare provider's baggy surgical mask or complete lack thereof doesn't care if you're generous, kind-hearted, patient, silly, and hardworking. It doesn't care if you play softball, football, or the alto sax. Diseases don't discriminate, they don't care if you're a firefighter, a father, or a HICPAC committee member.

We need clear, protective guidelines for healthcare personnel and patients that provide respiratory protection against the inhalation of infectious aerosols, or "flexibility" will continue to allow healthcare providers and patients to share deadly, infectious air.

Dear HICPAC members,

My name is Jodie Eason. I am an immunocompromised member of the public, who is currently taking medication which further compromises my immune system. As a disabled person dependent on frequent medical care, I urge you to reject any loosening of infection control practices in healthcare settings. My health is dependent on community action to limit infection, and any reduction in standards poses a significant increase of risk to my wellbeing well receiving standard medical care.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Sacrificing our devoted health care professionals, as well as citizens seeking healthcare, is inexcusable. The HICPAC should protect all people impacted by its decisions, and reject pressure to relax infection control measures.

Thank you,
Jodie Eason
Evanston, IL

Dear HICPAC representatives,

As a licensed physician in the state of California, I urge you not to lower the isolation precautions guidance (from 2007) for patients with infections diseases. Specifically:

HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to

infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Best Regards,
Dana Ludwig, M.D.
Berkeley, CA

TO: HICPAC members
FROM: Frann Michel, Ph.D., private citizen/person who uses healthcare; Portland, Oregon
RE: DO NO HARM: Strengthen Infection Control Guidelines

I am appalled that I may lose more loved ones than I already have to hospital-acquired infections--of SARS2 or the next airborne pathogen--because their otherwise manageable illness required them to be around unmasked vectors of disease. Do you really want to go down in history as the people who destroyed the remaining public confidence in the modern American healthcare system? Do you really want to be the people who said Yes, we are fine with allowing hospitals and other healthcare settings to be filled with free-floating pathogens, potentially sickening anyone who enters them and thus driving away the very people who need to access safe healthcare (and who are, n.b., a source of revenue for hospitals). Do you want to be the people who did nothing to forestall the possibility that so many healthcare workers got so sick, so often, that the whole system collapsed? Do you really want to go down in history as the people who enabled the next pandemic--the one that, before we even know it exists, may pass invisibly among vulnerable people in healthcare settings because you failed to listen to those who have learned from the current pandemic?
Please ensure science-based protections for healthcare workers and patients.

More specifically, please delay voting on updated Isolation Precaution guidance until the public has had time to read and study the draft updates (you need to make the draft publicly available well in advance); please hold public meetings before voting, and hear from health care workers, patients, and experts outside of infection control, who have essential perspectives for updating the Isolation Precautions guidance; please recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.

Please re-do the extremely flawed evidence review on N95 respirator and surgical mask effectiveness, this time with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is unconscionable
that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review.

Please do not leave Infection Control decisions so 'flexible' as to allow health care employers to cut costs by endangering workers and patients; please maintain an approach to Infection Control in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.

Please acknowledge the importance and function of core control measures for infectious aerosols. As far as we can tell, you have neglected the large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols. There appear to be no recommendations on ventilation and no adequate consideration of source control (limiting outward emission of infectious aerosols) in
the context of personal protection from inhalation. Please ensure a
fair process and science-based protections for healthcare workers and patients!

Frann Michel, Ph.D.

Since the onset of COVID-19 there has been conflicting information as to the efficacy of utilizing respirators in preventing aerosol infections within hospital environments. I am commenting that since the initial spread and ongoing struggle to control rates of COVID-19 infection within a given community there has been a distinct lack of effort on the part of local healthcare institutions in implementing safe and effective means of controlling the aerosol infections of COVID-19.

There is a need to update and modernize the healthcare system in which hospitals must recognize and utilize respirators and HEPA filters to provide adequate and functional prevention of aerosol infections (such as COVID-19). Not only would these steps be a boon to the patients, whom by their very status as a patient, is perceived to be at a greater risk of these inflections and as such is reliant on the hospital and staff to prevent any further negative health impacts on the patient. This is the responsibility of the healthcare industry as a whole to operate in such a way to reduce their own liability and ensure the quality care in which they are meant to strive for by meeting a bare-minimum of practical prevention on the part of the hospital. \

These changes should be recognized as a necessity to continue operating as meeting these challenges 'head-on' will not only show to public that the healthcare system is operating in good faith, but also to update in such a way that can make any future aerosol infections preventable going forward, as these are the sign of the times, and can only be considered as a net positive.

From,
Joshua Justus
Lake in the Hills IL

Airborne transmission is the primary driver of COVID-19 (SARS-CoV-2) transmission, followed by fomite transmission. Many patients who are coming to hospitals for other treatments are being infected at hospitals every day and needlessly, tragically, dying of COVID infections. Their deaths could easily have been prevented by doctors, nurses and healthcare workers wearing properly fitted N95 masks, and the use in hospitals of clean air mitigations (such as HEPA filtration devices, upper air UV, and Corsi-Rosenthal boxes). Masking standards and clean air mitigation standards should be increased by HICPAC, not relaxed or lowered. Requiring N95 respirators and clean air filtration mitigations in healthcare settings would save lives of many vulnerable patients, who currently often are deferring and avoiding needed health care due to the high likelihood of contracting a deadly case of COVID at hospitals and healthcare settings. Mandating fitted N95 respirators and clean air mitigations would also protect the health of our valued healthcare workers and would reduce sick time and disabilities among healthcare workers. Please make decisions based on saving the health and the lives of patients and

healthcare workers, rather than being focused on cutting costs for employers as the only consideration. -Lori

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Hi,

To be honest, when this pandemic started, I never would've believed that things could get worse and would get worse. I'm so unbelievably tired and sad that I have to send in a public comment just to get the bare minimum of protections. My mom is very sick and is currently seeking treatment at one of the best hospitals in the US. At least, it's supposedly the best, but they don't really care about COVID or wearing respirators much. Somehow, the researchers in the clinical trial don't think that their extremely ill patients catching a BSL-3 pathogen will skew their results at all. Watching my mom get treatment there has been one of the most mind-boggling things for me. The hospital is filled with highly intelligent doctors and individuals, but they can't grasp the danger that fills their halls. They insist that someone with measles wears a respirator, but that doesn't apply with spreading COVID. I just want my mom to be safe while she's getting treatment. I'm so tired of worrying about her every time she goes and worrying about how another infection will affect her. A hospital needs to be a safe place for people to go for treatment; it shouldn't be a hot box of disease where sick individuals have to play Russian roulette with their health. I want it recognized that COVID-19 is primarily transmitted through aerosols. I want respirators (N95s) to be required in healthcare settings regardless of the vaccination status of healthcare workers or patients. My mom shouldn't have to risk her life to seek treatment. I want it recognized and made clear that respirators (N95 and better) and more effective than surgical masks. I want there to be better guidance to the public regarding respirators and how to fit them. Clean air tools like HEPA filters need to be utilized in healthcare settings as well as other public spaces. Lastly, for goodness' sake, involve aerosol experts in the decision making process and increase your transparency. I'm so sick of being lied to and the truth being hidden. I want everything to be out on the table. If the plan is to kill and disable us all, then at least be upfront about it.

Kerstin Wolf
Champaign, IL

We need better infection control standards in healthcare. We shouldn't be weakening those standards but strengthening them. Aerosol transmission needs to be recognized. There should be aerosol experts involved and on the committee. We need proper respirator requirements in all healthcare settings regardless of vaccination status. Respirators are much more effective than surgical masks. We should be wearing respirators to protect the vulnerable among us including the immunocompromised. They should be able to obtain medical care safely. No one should be forced to risk infection to meet their healthcare needs. What happened to 'do no harm'? We also need to have proper ventilation and clean the air we breathe by using clean air tools such as HEPA filters. HEPA filters should be required in all medical settings to protect everyone. We should have a standard for acceptable indoor air quality including air changes per hour.

T. D. Thomaston

HICPAC,

We should be strengthening, not weakening infection control.

I have a friend who believed 5 MRNA vaccines was sufficient to keep him safe. He recently ended up in the hospital for 2 months with Covid, contracted sepsis and almost died, because measures to combat aerosol transmission of Covid are not understood & not being followed.

I was horrified by the summary of the workgroup draft update released in June on how to deal with infection control. One part, in particular basically saying surgical masks were no different than N95 respirator masks. Now is not the time to let down our guard on infection control. HICPAC needs to consult with, or have aerosol scientists in the work group, or on the voting committee.
Employers should have to provide N95 respirator masks to healthcare workers and patients. Along with OSHA compliance for workers. We cannot thumb our nose at Covid transmission. There's a mountain of data showing that vaccines do not eliminate the risk of COVID's long-term ramifications.
Patients should not have to worry about contracting other illnesses or Covid, while being treated in medical facilities.
We should be learning from the ongoing pandemic that all of our health is interconnected, and thus, be protecting each other.
We should not be doing a cost benefit analysis on human health. We should be removing all the stops and recognizing aerosol transmission, protect each other including HEPA filtration, ventilation, along with N95 respirator masks across the board in healthcare. Let's keep it simple. We are all vulnerable. Mask up N95.

Thank You,

Jesse Jacobs
Los Angeles Ca

Name: Patricia Umbricht
Address: Buffalo Grove, Illinois
Topic: Infection Control Guidelines Must Be Stregthened

I urge you to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

I'm writing as an immunocompromised cancer patient and asthmatic, with multiple other factors that put me at higher risk of infection. I am unable to safely access healthcare in a timely manner due to rampant Covid spread and no consistent airborne protections. My cancer is very aggressive, and ever since masks are no longer required, it takes on average 2-4 weeks for a new office or hospital to respond to my ADA requests regarding staff masking with me. And sometimes they are unwilling to ensure their staff are wearing masks with me, which means I have to start the process over with a new doctor or facility. My cancer is extremely aggressive,

inflammatory breast cancer, and this wait to safely access healthcare puts my health at higher risk. Already being disabled from cancer treatment and the emotional stress of being in a pandemic but unable to access safe healthcare, I am scared to know how much worse a covid infection will leave me if I tried to access healthcare without proper aerosol transmission prevention.

Written Comment to CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) Standard Precautions against Transmission of Airborne Pathogens, per instructions at https://www.federalregister.gov/documents/2023/10/10/2023-22327/healthcare-infection-control-practices-advisory-committee-hicpac, submitted via email to HICPAC@CDC.GOV by Rebecca Payne on behalf of COVID Safe Maryland (1) on November 1, 2023

We stand by the statements we submitted in August that you published. In addition:

1. Transparency and public input have improved. The June meeting materials have been published, although late, and the August meeting materials have been published in time. More public oral comments are being allowed during the November meeting. However, the unreasonable and unusual limit on the length of public comments remains. The details of the internal CDC meta-analyses that were presented at the June meeting, working group deliberations, and draft guidelines to be voted on in the November meeting are still unavailable. It is hard to know what comments might be relevant if we don't have access to those documents. Our comments seem to have little potential influence since they will be accepted during November 1-6, and the voting will occur on November 2 or 3. This perceived lack of impact defies the intent of the Federal Advisory Committee Act to incorporate public input into decisions. HICPAC must open its deliberations, including the review and response to public input.

2. The General Overview of Framework & Proposed Sections A, B, and C presented at the June meeting should add transmission by touch via ingested media such as liquids and food, devices inserted into body cavities, and air contact with eyes.

3. Airborne transmission needs to be acknowledged and appropriate experts need to be added as voting HICPAC members. According to the listing on https://www.cdc.gov/hicpac/roster.html, you still haven't added: experts in airborne transmission control (air cleaning and ventilation engineers, aerosol scientists, occupational safety and health experts, etc.) to Members, federal occupational health experts to the Ex-Officio members, or healthcare unions or more patient groups to the Liaison Representatives. You should be asking them to offer their expert opinions while you develop and deliberate airborne infection standard precautions.

4. The point of precaution is to take action to prevent disease, even if the action might not be fully effective. In the case of respirators vs surgical masks, we have every reason to trust the higher effectiveness of respirators because of the results of ample laboratory studies (2) and evidence-based regulations already put in place by OSHA (3). There was an implication that HICPAC should wait for better-conducted randomized controlled trials (RCTs) of respirators vs surgical masks before taking action to put respirators in the guidelines. The problem with waiting is that at this point, RCTs would be unethical because we have good laboratory studies showing that we are not in equipoise and that respirators are more effective than surgical masks.
The meta-analysis questions left out the impact of precautions on patient nosocomial infections. Hospitalized or care-home patients are in environments controlled by the facility and don't leave everyday to expose themselves in other environments, while healthcare workers do (thus contributing to bias towards the null). Yet, the patients are the most vulnerable to serious

consequences of COVID-19 if they catch it. (4,5,6) The Standard Precautions need to consider patient health and vulnerability, in addition to healthcare workforce health.

5. Standard Precautions need to include safe staffing levels. Safe staffing levels are essential for infection control in healthcare: they ensure workers have sufficient time to don and doff PPE, take necessary precautions when engaging with patients, and perform other parts of their job related to workplace infection control. Staffing levels and standard precautions should not be written to the level of "staffing crisis", to avoid creating staffing crises due to infections.
We sincerely hope that all our comments are moot because you have already incorporated them into the draft guidance and voted to accept them. If you haven't, please re-examine your processes to understand why you are resisting the overwhelming majority of public comments such as ours.

Sincerely, COVID Safe Maryland (covidsafemd@gmail.com, https://covidsafemd.com/)

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1 COVID Safe Maryland. https://covidsafemd.com/.
2 Rashid, TU, et al. ACS Chemical Health & Safety. https://doi.org/10.1021/acs.chas.1c00016.
3 OSHA. https://www.osha.gov/respiratory-protection/general. Accessed Oct 31, 2023.
4 Ramos-Rincon et al. Gerontology. 2023; 69(6): 671-683. DOI: 10.1159/000527711.
5 Ponsford et al. Frontiers in Immunology. 2021; 12. DOI: 10.3389/fim-mu.2021.744696.
6 Hall and Clement. Surgeon. 2022 December; 20(6):e429-e446. DOI: 10.1016/j.surge.2022.02.009.

Name: Sandy Do
Address: San Francisco, CA Org Affiliation: not applicable
Topic: Public Comment for HICPAC November 2nd Meeting Regarding Infection Control Guidelines

I am writing as a former bench scientist experienced in infection control and a current patient who is bedridden and no longer able to work due to ME/CFS, POTS, MCAS, and neuropathic pain, all conditions that SARS-CoV-2and other viral, bacterial, and fungal infections can cause.

I am dismayed by the lack of transparency and concern for the health of patient and employee health settings.

To update HICPAC's infection control guidelines to best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.

The development of infection control guidelines should involve:
- the recognition of aerosol transmission of Covid and other respiratory infections -experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.
-those who are most at risk, including patients and all workers in the facility and their representative organizations -full transparency in developing guidelines

Guidelines should be comprehensive and include:
- increased ventilation and HEPA air purification to achieve the number of air changes per hour as recommended by aerosol scientists for optimal airborne infection control -source controlled

respirator and/or PAPR use in all healthcare settings regardless of vaccination and infection status, -regular PCR testing of patients and workers -isolation rooms for the infected

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

Subject: Covid-19 Mitigations, Infectious Disease Precautions.
Name: Victoria Coble
Address: Greensboro, NC
Organization: Graduate Student | UNCG | MSIA.

My name is Victoria Coble and I am a graduate student at the University of North Carolina, at Greensboro, studying informatics and analytics.

I am making a public comment, issuing a request that HICPAC recognizes aerosol transmission as the primary source of SARS_CoV_2 (Covid-19) transmission.
I am requesting that this panel ensures that patients and providers have respirator requirements in place for hospitals and all healthcare facilities, regardless of vaccination status, given that vaccination cannot stop Covid-19 transmission.
The EPA has shown that surgical masks are only 38.5% effective, and this information has been made available on the EPA website since 2021.
Source: https://www.epa.gov/sciencematters/epa-researchers-test-effectiveness-face-masks-disinfection-methods-against-covid-19

Respirators (n95 and above) are far more effective (95%) than surgical masks (38.5%) and should be required to protect both staff and patients from nosocomial infections. It should be required that all nosocomial cases be reported to the CDC and published for public viewing.
Additionally, I am requesting that clean air tools like HEPA filters, Corsi-Rosenthal boxes, and updated HVAC systems be mandated to further reduce the risk of transmission in healthcare settings.
This panel has failed to include aerosol experts and increase transparency around their findings that n95s are effective and safe to be worn to reduce risk of Covid-19 infection. Please correct this egregious error immediately.

Sincerely,
Victoria Coble

Dear HICPAC:

I am dismayed that the process of drafting revised infection control guidelines has been opaque and that input from interested parties and subject matter experts was not solicited or considered.

The CDC must adopt science-based protections for healthcare workers and patients, based on the current, established knowledge about the aerosolized spread of infectious diseases.

CDC/HICPAC needs to delay voting on the new guidelines until they have given the public ample opportunity to review the draft Isolation Precaution guidance updates.

CDC/HICPAC must hold public meetings—ahead of any vote—to hear from health care workers, patients, and experts outside of infection control, who have essential perspectives for updating the Isolation Precautions guidance.

CDC/HICPAC must fully recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.

The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, **aerosol science**, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is **unconscionable** that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to **avoid** providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. **There are no recommendations on ventilation**. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

As you are well aware, all employers, very much including those in healthcare, rely on CDC guidelines as the basis for their protocols. Issuing protocols that are so weak that they cannot fail to enhance the spread of infectious diseases - rather than mitigate it - is morally reprehensible and will reverberate throughout society with terrible repercussions for everyone, especially the most vulnerable. The CDC's stated mission is to Save Lives and Protect People. Adopting the Guidelines as drafted will do the complete opposite.

Throughout the pandemic, the CDC has expressed too much concern for the health of the economy and not enough concern for the health of the people. There are many other government departments that address the economic concerns of the country. The CDC should

leave those concerns to them and focus on Protecting the People to the best of its ability, using the best science currently available.

Respectfully,

Tamara King
Portland, Oregon

Dear HICPAC committee members and work group,
My name is Constance Wold, Portland OR. Thank you for this opportunity to share my concerns regarding updating the 2007 Isolation Precautions Guidelines.
1. HICPAC/CDC must increase transparency and public engagement in this process, which has been very closed to the public. HICPAC meeting presentations, the documents used to make its recommendations must be posted publicly, with adequate notice, as is done with other federal advisory committees. The public relies on the CDC's guidance to protect health care personnel, patients, and their families from infectious diseases. It is therefore alarming that CDC/HICPAC's process has been so closed, even secretive.

2. It is critical that any updated guidance include significant input from relevant stakeholders, including frontline healthcare workers and their unions, patient safety advocates, industrial hygienists, occupational health and safety professionals, engineers, scientists with expertise in aerosols and airborne transmission, and experts in respiratory protection. The lack of inclusion of these stakeholders/experts as members of the HICPAC committee itself raises grave concerns about objectivity and delegitimizes both HICPAC and the CDC. Procedural barriers must be eliminated. HICPAC must sincerely engage with the full spectrum of experts and impacted stakeholders in developing its draft guidelines.

3. The guidance must update the list of infectious diseases currently classified as transmitted via aerosolized transmission/inhalation. It must acknowledge that SARS-C0v-2 is an airborne virus. The "flexible" approach HICPAC's Work Group has proposed recommends only minimal protections, giving health care employers overly broad discretion to create their infection control plans. Such an approach enables employers to avoid providing necessary protections, based on cost considerations, rather than best practices. I urge HICPAC/CDC to be clear and explicit in the updated guidance about the precautions needed to protect health care workers, patients, and their families from infectious diseases.

4. The work group's proposed updated terminology on infectious disease transmission ("air" and "touch") fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. HICPAC's reliance on the flawed Cochrane report (in its insistence that there is insufficient "proof" via RCTs that N95 respirators are superior to surgical/medical masks) abandons the precautionary principle, is ill-informed, and dangerous. It ignores the importance and function of core control measures for infectious aerosols. The body of credible evidence on the effectiveness of respirators, and the importance of ventilation and air filtration in reducing and controlling exposure to infectious aerosols, has not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

5. My mother is 91. She came through cancer surgery recently, without acquiring a nosocomial infection, due to being in a facility where robust airborne protocols were in place. I am grateful and want that same robust protection for others. Thank you for your consideration.

Name: Carlo Lata
Address: San Francisco, CA
Org Affiliation: not applicable
Topic: Public Comment for HICPAC November 2nd Meeting Regarding Infection Control Guidelines

I am writing as the healthy spouse of an immunocompromised person who is at high risk of complications and death from any infections I bring home from visiting health care settings for routine outpatient health care.

I am dismayed by the lack of transparency and concern for the health of patient and employee health settings.

To update HICPAC's infection control guidelines to best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.

The development of infection control guidelines should involve:
- the recognition of aerosol transmission of Covid and other respiratory infections
-experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.
-those who are most at risk, including patients and all workers in the facility and their representative organizations
-full transparency in developing guidelines

Guidelines should be comprehensive and include:
- increased ventilation and HEPA air purification to achieve the number of air changes per hour as recommended by aerosol scientists for optimal airborne infection control
-source controlled respirator and/or PAPR use in all healthcare settings regardless of vaccination and infection status,
-regular PCR testing of patients and workers
-isolation rooms for the infected

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

I am writing to express my deepest concern regarding the HICPAC's proposed revision of isolation precautions guidelines and strongly urge the committee to recognize, prioritize, and mandate the following:

- COVID is transmitted via aerosols. Cleaning indoor air, including via tools like HEPA filters, is imperative.
- Respirators are far more effective than surgical masks in protecting against airborne infectious diseases, including COVID

- Requiring the use of respirators in healthcare settings for staff, providers, patients, and visitors, regardless of vaccination status, is of the upmost importance
- Aerosol experts must be included in deliberations regarding healthcare guidelines, and there must be increased transparency regarding these deliberations

Patients should not have to choose between receiving health care and preventing infection. Your primary allegiance must be to protecting the health and wellbeing of the American people, and I urge you to vote accordingly.

Respectfully,
Alissa Kissler

San Diego, CA
Organizational affiliation: N/A
Topic Being Addressed: Revised Isolation Precautions guidelines

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Hello,

My name is Grace Quinn and I live in Leominster, MA. I am not affiliated with any organization but am a member of the public who is impacted by loosening infection control in hospitals.

I am 29 years old and have been putting off having children since the pandemic started. I don't like the idea of having to give birth in a hospital with no mask requirements and having myself, my husband, and my baby's lives put at risk because the air isn't clean. I can't believe we live in a world right now where we have to make these types of decisions because our public health has utterly failed educating us on how to stay safe from an ongoing pandemic.

We need the CDC to clearly acknowledge that COVID is spread through aerosols, and the only way to protect ourselves is by cleaning the air with HEPA filters and wearing N95 masks, regardless of vaccination status, as we know that even those vaccinated can catch and spread COVID.

There is a precautionary principle in healthcare which is to "Limit actions that may pose a risk of threat to human health or the environment, even if that threat has not yet been fully established scientifically."

We have plenty of evidence suggesting just how dangerous COVID is. But even without the evidence, the precautionary principle should still be respected in regards to COVID and other viruses. HEPA filters and N95 mask requirements belong in hospitals, and every human deserves the right to healthcare without risking their health and well-being.

Dear HICPAC members,

I'm writing to urge you to reject any loosening of infection control practices in healthcare settings.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission for health care-related

infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The health and safety of not only health care professionals, but also the vulnerable patients in their care should be a priority. My family and friends who either work in healthcare or who are immunocompromised shouldn't have to worry about becoming ill with COVID or other air-borne illnesses while in health care settings. The HICPAC should protect all people impacted by its decisions, and reject pressure to relax infection control measures.

Vanessa Reese
[No affiliation, writing as a private citizen]
Chicago, IL

To staff: Please ensure that these comments are entered into the record and made available to Committee members. Thank you.

Dear Committee Members,

I am writing to urge that the Committee take all actions possible to ensure a higher degree of protection of both patients and medical personnel in medical settings, from hospitals to doctors' offices. I was obliged to continue going to a retina specialist from the very beginning of Covid and I did all that I could to remain safe, and continue to do so, even as medical settings in many locations exhibit no concern with viral transmission, even as thousands of Americans continue to become ill, and even die, with Covid.

I want to ensure that I am protected as I continue to be obliged to go to doctors' appointments and to ensure that I do not again have to fear going to a dentist for so long, that I have the kind of expense I have endured recently, simply because of concern over improper remediation by medical practices. I am also concerned for those working in medical settings, where peer pressure to stop masking or measuring air quality could lead to constant illness or death.

Please take actions that acknowledge the known science including:

Recognize that transmission of Covid and other viruses is by aerosols.

Requiring respirators in healthcare settings should be mandatory, regardless of vaccination status.

Acknowledge that high quality respirators are more effective than surgical masks.

Require clean air tools like HEPA filters.

Require consultation with or guidance from aerosol experts.

Demand that medical setting are transparent with patients and those who might wish to become patients.

If the CDC would finally adopt rules and guidance along these lines, American would stay healthier--and the economic impact that is already revealing itself in disturbing and negative ways could be reduced.

Helen Starr
Palm Beach, FL

Dear CDC,

I urge the CDC not to weaken infection control in health care workers. We must prevent prioritizing costs over care. This whole process has lacked transparency and the committee contains industry members with conflicts of interest while lacking a single voting member with expertise in aerosol science.

I urge the CDC's HICPAC members to involve aerosol experts, increase transparency, recognize aerosol transmission of SARS-2, and to require airborne precautions that include respirators (NOT surgical masks), ventilation, filtration, and isolation in healthcare settings. Respirators work. Only an N95 or better respirator can protect you from aerosol-transmitted disease. Suggesting that respirators are on par with surgical masks is a misrepresentation of the evidence. Respirator requirements in healthcare regardless of vax status must be implemented.

Healthcare workers and patients deserve safe employment access and healthcare access. Creating a COVID-hazard will deny access to healthcare care for the vulnerable and those trying to avoid airborne infections, like COVID.

People are already going into hospitals and healthcare settings and acquiring Covid and other infections which is leading to death, disability, long term complications and/or newly acquired illnesses.
People have been delaying preventative and even urgent healthcare needs for far too long—waiting for safety improvements. Patients have a human right to access to healthcare safely, one that is free from infection.

Thank you for your time and consideration.

Rosaura Crottogini

To Whom it May Concern,
My name is Angela and I'm an Engineer, longhauler and a member of the World Health Network. I would like to discuss my real world experience and how we can mitigate infection risk using engineering. In engineering, I have worked on things that can't fail as it is a life or death situation. This means, you must mitigate risk with a layered approach to make success 99.99%. We need several things for people like me to be included and be able to even exist in this world(easiest to more complicated):

1. **Respirators:** N95 on everyone in a hospital/medical care setting. Education is needed that you do not wear masks off nose and no entering without a mask as you have contaminated the air.

2. **Updated Policies to Match the Data, Instead of Wishful Thinking:** Update policies to make sure everyone home at least 10 days (per CDC's own data) and test negative multiple times. Everyone should get adequate sick leave.
3. **Accurate COVID Tracking:** Right now, measuring whom is in the hospital it is too late, as it already spread. Recording at home tests and increased waste water monitoring with quick turn around should be happening.
4. **Adopting Sensor Tech:** Sensors installed in hospitals/schools that sense covid and alert to risk in the air to leave room. Another option is install sensors at doorways you blow into or scan. Technology already exists from PNNL and Opteev, plus perhaps others. Why are we not adopting technology? Our own govt funded PNNL.
5. **Adopting Further Mitigation Tech:**Far UVC lights adopted to zap the covid out of the air to minimize exposure, even with above.
6. **Ventilation Improvements:**ASHRAE air standards followed for ventilation/filtration to prevent covid spread. Even having hepa filters in each room improves air quality.

I would like to share my experience now and how it has impacted my life for the past 3+ years. I caught COVID in first wave Feb 3, 2020. It sent me to the dr multiple times throughout the years with staff working sick and in surgicals off face. I have subsequently caught covid now 5 times. This is with me not sending my kids to school, WFH and avoiding going indoors anywhere except the dr and seeing my family once a year. I no longer celebrate the holidays with them and we have been completely cut off from this world. I want to be a part of this world again and cant be with one way masking and pretend it isnt happening.
Angela Bartholomaus
Issaquah, WA

Deer Hicpac,

I support universal respirator use in healthcare settings and increased ventilation and filtration to reduce concentrations of pathogens including Covid in the air of healthcare settings. I also support tracking healthcare acquired infections of covid.
Sincerely
Scott Robertson
Montpelier, Vermont citizen

Dear committee,

As a patient with multiple underlying conditions that render me high risk for catching COVID and suffering severe outcomes, I am begging you to include aerosol experts in the decision-making process surrounding infection control. Myself and many other patients like me have to choose between getting necessary care and risking getting sicker because hospitals lack adequate infection control, or risking our health by avoiding care to avoid getting COVID. People are dying. Hospital acquired respiratory infections are clogging up the healthcare system and resulting in completely avoidable new or exacerbated disabilities or death. As a teacher, I want to be able to keep supporting my students, but if I get long COVID it may end my ability to work like it has so many teachers I know. Please do the right thing and ensure that the highest standards of infection control are in place — including universal N95 masking throughout hospitals.

Respectfully,
Heather Ringo

Terrie Weeks, RN, JD, Member of the Public
St Petersburg, FL
Re: Updating of CDC Guidelines re: Prevention of HAI

I am writing to express my concern about the proposed Guidlines. These recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during the COVID-19 pandemic. They do not adequately provide for the proper control measures – isolation, ventilation, and NIOSH-approved respirators – to protect against transmission of infectious aerosols. They are weaker than existing CDC infection control guidelines and contradict years of infection control best practices. The guidelines, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols.

It appears that the Committee is relying on deeply flawed studies which claim there is no difference between surgical masks and N95s in preventing respiratory infections. This contention ignores the latest science of aerosol virus transmission, flouting decades of advances in this science. The flaws in these studies include the fact that they did not look at full-time wear and did not observe whether health care personnel were actually wearing the respirators and using them correctly, including whether N95s were repeatedly redonned (which undermines protection) and whether the respirators were fit-tested. CDC/HICPAC left out an important RCT conducted by Dr. Raina MacIntyre with no explanation. This RCT found clearly that continuous N95 respirator use significantly reduced the risk of respiratory virus transmission to health care personnel, while intermittent N95 use and surgical masks did not.

Surgical and certain medical masks are intended as protection from splashes and sprays only, not against the inhalation of infectious aerosols. 2022, NASEM concluded that: “Based on its review of the literature on the performance of respiratory protective devices, the committee believes the filtration and fit characteristics of face coverings and masks currently do not adequately protect workers facing inhalation hazards. Therefore, in the context of workplace exposures to inhalation hazards, recommendations regarding the use of face coverings (including barrier face coverings) and masks should be avoided, and employers should be advised to institute an RPP and provide employees with respirators as described by OSHA’s Respiratory Protection Standard (1910.134).” The report formally recommended that agencies that develop guidelines, such as CDC, recommend only NIOSH-approved respirators in their guidance for protecting workers facing inhalation hazards.

By limiting aerosol precautions for some infectious aerosols, healthcare facilities may face outbreaks among patients and health care workers. The proposed guidelines also fail to acknowledge the importance of upgrading ventilation to prevent COVID and other respiratory virus transmission.

I urge you not to use an approach that recommends only minimal protections for health care personnel and allows health care employers to continue to use a “flexible approach,” which ultimately will be based on cost rather than safety. This approach was adopted by the CDC during the COVID-19 emergency and enabled health care employers to provide inadequate protection based on cost considerations, instead of safety, leading directly to an uncounted number of SARS2. Embracing this approach in all infection control programs will have disastrous impacts on health care worker and patient safety.

The CDC/HICPAC fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the

importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation. As a family that has so far avoided Covid, and as a family that would like to keep it that way for a multitude of reasons, I find it very anxiety inducing to make healthcare appointments. Most often I have to request now that my doctor wear a face mask and then they usually don a typical surgical mask - which we all now know is not as protective as an N95. We have Director Cohen on video saying so. Healthcare workers may have decided to take their own fate into their own hands and not wear a mask for themselves, but as someone who should be striving to do no harm, this is not considerate of their patients. They see *many* sick patients daily and could be carriers of any virus at any time. Seeing our doctors should be safe, not risky.

Thank you for your time and consideration.

Jennifer Mullins
Wake Forest, NC

Members of the HICPAC Committee,

Infection control practices are crucial to protect the health and life of both patients and healthcare workers. The emergence of SARS-CoV-2 has put in the spotlight the importance of such measures.

The continuously expanding knowledge regarding SARS-CoV-2 itself and the widespread consequences of (re)infections on the health, quality of life, livelihood, and life expectancy of individuals highlight the necessity to address SARS-CoV-2 with a sense of purpose and appropriate means. In addition to this, preventing infections in healthcare settings is also supported by the need to address the burden of disease and the chronic disruptions from a family, schooling, and workforce perspective as they all contribute to substantial costs over time at a societal level.

It is also crucial to acknowledge that although progress has been made, the status quo is unsustainable. Second-generation vaccines, prophylactic treatments for the immunocompromised, additional first-line treatments, treatments for Long Covid, and treatment protocols for the population at high risk (e.g. combination of treatments in the early phase of the acute phase of infection for the immunocompromised to prevent chronic infection and/or the development of new health conditions) are needed.

Moreover, it is of the utmost importance to remember that accessing care, quality care, is a must for all - not a matter of privilege nor of being, in retrospect, fortunate to have received care without being infected. This therefore includes the vulnerable population and communities (based on age, health status, specific medical conditions associated with higher risk for severe complications and death, treatments received, and/or socioeconomic status). Americans must not avoid nor limit needed care as a result of an unsafe medical environment. The HICPAC Committee must keep this in mind every step of the way when it comes to infection control practices.

Given all of the above and the fact that SARS-CoV-2 is airborne, mutates at a fast pace, is highly transmissible, and circulates at high baseline levels throughout the year, it is crucial to

use the preventive/control measures indicated for aerosolized transmission. The systematic usage of N95s and indoor air quality measures are therefore not only necessary but also a low cost investment compared to the sum of the individual and collective costs associated with infections, poorer health, disability, social disruptions, and premature deaths.

Finally, it is imperative to include in the HICPAC Committee professionals such as aerosols specialists and occupational hygienists in order to have multidisciplinary discussions recognizing the expertise and limitations of each represented profession while meeting the needs associated with the challenges faced in the healthcare environment. This goes hand in hand with transparency in the decision making process - which entails making information accessible to the public ahead of making final decisions leading to changes in guidelines/policies - as decisions made impact the life of all Americans.

In sum, SARS-CoV-2 contributed to significant harm these past years. It is to the benefit of all to integrate the acquired experience and knowledge, adapt to the changed context and the continuously emerging knowledge, and make decisions with the clear objective of lessening preventable harm. This will protect the health and life of Americans, the healthcare workforce, the quality of care, the hospital capacity, and society as a whole.

Health is a cornerstone of society. We must treat it as such.

Regards,

Caroline Blanchard
Citizen
Naperville, IL

Both CDC [1] and WHO [2] have stated that COVID can be transmitted via airborne route through inhalation of infectious aerosols. For other airborne infections, such as measles and TB, CDC guidelines specify the use of respirators (N95, N99, N100, etc.) for airborne infection control [3][4]. For SARS, which is from the same family of Sarbecovirus that COVID is in, CDC guidelines also specify the use N95 respirator or better [5].

According to NIOSH, "surgical masks, sometimes referred to as facemasks, are different than respirators and are not designed nor approved to provide protection against airborne particles. Surgical masks are designed to provide barrier protection against droplets, however they are not regulated for particulate filtration efficiency and they do not form an adequate seal to the wearer’s face to be relied upon for respiratory protection. Without an adequate seal, air and small particles leak around the edges of the respirator and into the wearer’s breathing zone." [6]

Similarly, OSHA states that "facemasks do not seal tightly to the wearer’s face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection." [7]

Is it clear from NIOSH and OSHA guidance that surgical/medical facemasks are not designed to seal tightly to the wearer's face and are not adequate when airborne infections, such as COVID, are present.

Furthermore, patients in hospitals and healthcare settings include immunocompromised patients, cancer patients, and other highly vulnerable patients. For example, the mortality rate of patients with nosocomial acquired COVID at a hospital was over 8%, significantly higher than

the mortality rate in the general population [8]. In Australia, more than 600 patients have died after suffering from hospital-acquired COVID [9]. As seen from these examples, patients in healthcare settings can be highly vulnerable to nosocomial acquired COVID infections.

Patients who are in hospitals and healthcare settings should have reassurance that airborne infection control measures are deployed to prevent the spread of airborne infections, such as COVID. Subjecting patients to nosocomial infections due to inadequate airborne infection control measures is not consistent with the ethical principles in the American Medical Association Code of Ethics.
In addition, healthcare providers who expose patients to nosocomial infections due to inadequate airborne infection control measures may be held liable.
As an example, a senior care facility and 3 managers were criminally charged in connection with 14 COVID-related deaths at the facility due to negligence [10]. As explained in [11], hospitals have a duty to take reasonable measures to protect patients, and failure to deploy appropriate infection control measures, including airborne infection control, can expose hospitals to liability.

1. https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html
2. https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted
3. https://www.cdc.gov/measles/hcp/index.html
4. https://www.cdc.gov/tb/publications/factsheets/prevention/rphcs.htm
5. https://www.cdc.gov/niosh/npptl/topics/respirators/factsheets/respsars.html
6. https://blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/
7. https://www.osha.gov/sites/default/files/publications/OSHA3767.pdf
8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10056618/
9. https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html
10. https://www.foxla.com/news/senior-care-facility-charged-in-connection-with-14-covid-related-deaths
11. https://blog.petrieflom.law.harvard.edu/2023/02/20/hospital-liability-covid-infection/

To Whom it May Concern,

My name is Tara Gavardinas. I'm both a licensed RN and APRN in the United States who's worked in both the inpatient and outpatient settings prior to and after the outbreak of SARS-CoV-2 virus in 2019. It is reprehensible that the CDC and/or HIPAC is considering recategorizing modes of transmission in an manner that would allow the routine use of surgical or level III masks in any healthcare (including dental) setting given we know these masks "leak" no less than 58% of the time (Blachere et al., 2022). Green-lighting a product like ear loop masks with a known **58% rate of "source control" failure** within healthcare given the context of persistent community transmission of SARS-CoV-2 when no less than a 1/3 of that transmission is known to be **asymptomatic** is egregious (Shang et al., 2022). Just within the hospital setting, nosocomial SARS-CoV-2 infection is associated with an 8.4% mortality rate (Kim et al., 2023). I'm not yet finding data for how dental patient's do against level III ear loop masks against asymptomatic SARS-CoV-2 transmission, but we must use the precautionary principal and expect airborne precautions in that healthcare setting as well given patient's cannot wear respirators and hygienists/dentist work close to a patient's mouth (gross).

Cloth, surgical, procedure, and level III masks have **no place in healthcare** at a time when there is any level of community transmission. As a healthcare worker myself, I utilize a fit-tested, ventless N95 NIOSH approved respirator while indoors at work at all times. No exceptions. Within my office I provide an extra layer of safety for my patients and myself with True HEPA air filtration that guarantees an additional 6-8 filtered air changes/hour. If I can do this with no harm or discomfort to myself, everyone who works in healthcare can. Using a respirator is as easy and comfortable as wearing shoes and pants.

We know from China that HVAC and HEPA alone are no substitutes for NIOSH approved, ventless N95 respirators within healthcare as SARS-CoV-2 virus even transmits outdoors (Qi et al., 2022). Australia has taught us that "fleeting" contact with a person infected with SARS-CoV-2 virus is enough to confer an infectious dose (Haseltine, 2021). Therefore, the use of an "HVAC-only" approach also has **no scientific basis**.

My recommendations are as follows:

1—Admit when a pathogen replicates in the human airway that we produce pathogen-laden aerosols, otherwise known as "airborne transmission".

2—Within healthcare ban all level III masks, surgical masks, and procedure masks (which have a 58% rate of failure as "source control" against SARS-CoV-2 virus) and replace them with fit-tested, NIOSH approved N95, ventless respirators.

Masks are analogous to drop-front baby cribs. The only difference is that drop-front baby cribs have a demonstrably lower rate of failure resulting in disability/death versus ear loop masks have, yet they have already been pulled from the market. We already have precedent for failure rates if we look at drop-front baby cribs. Ear loop masks exceed that rate of failure. Pull them from all healthcare settings and replace them with fit-tested, ventless respirators.

3—Require annual employee compliance training of all healthcare staff licensed or not about the known risks of both SARS-CoV-2 exposure and infection, but also healthcare acquired SARS-CoV-2 infection. No healthcare employee or contractor should be allowed to work without documentation that they understand SARS-CoV-2's mode of transmission, rates of asymptomatic transmission, and ability to deplete naive T cells, cause cortical thinning/brain damage, ability to increase risks of heart attacks/stroke, increase risk of neurological disorders like dementia/MS/Parkinson's, orphan children, and kill/disable patients.

4—Issue a recommendation for a Patient's Bill of Rights that ensures all patients have right to SARS-CoV-2 free care and universal/standard, mandated airborne hygiene standards that effectively halt transmission indoors.

5—Require dentists to have individual patient rooms with doors and walls that go up to the ceiling and all the way down to the floor on all sides. Require that all dentists and their staff to wear ventless N95s at all times when indoors. Require training so they understand that having front office staff that doesn't wear NIOSH PPE is the same as having "smoking" and "non-smoking" sections in a restaurant—nonsense policy. Require 222 nm UVC indoors in spaces where patients must walk to access the dentist's CT scanner, etc. Require independent True HEPA filters in each exam room with in between patient 222nm UVC disinfection. Require staff test out of isolation before being allowed back to work. Require patient's to have on a ventless respirator before being allowed entrance into a dentist's office.

6—Stop green mapping! Issue a single map of the U.S. in the color red to emphasize the importance of persistent community transmission and the need to always **prevent** infection using standard, universal airborne hygiene standards in all healthcare settings. Transient hygiene and infection prevention standards anywhere in healthcare is simply gross, disgusting, and regressive.

7—Educate the public about the known risks of "routine, mild" SARS-CoV-2 infection. Use longitudinal data collected from the SARS1 patients to illustrate the high, known risk of lifelong morbidity with SARS-CoV-2 virus.

8—Provide a recommendation for safe fit-testing so that employees are fit tested outdoors and not in a group of people. Require the fit tester to wear a ventless NIOSH approved N95. Provide recommendations for SARS-CoV-2 free break/lunch rooms for healthcare workers as well.

9—Educate the public about short range airborne transmission as well as long-range airborne transmission. Acknowledge that all "long-range" transmission initially begins as concentrated short-range viral laden aerosols.

10—Educate the public that they too must wear a respirator when a visitor within healthcare. For those medically unable to wear one, have procedures in place that ensures no transmission occurs when they do visit a healthcare setting.

11—Recommend that all hospitals, LTACs, dental clinics, and outpatient offices should be required to keep track and publicly report their HAIs with SARS-CoV-2. Recommend that Medicare and Medicaid should withhold funding from institutions which allow this practice of healthcare acquired SARS-CoV-2 infections.

Regards,

Tara Gavardinas, PMHCNS-BC, RN, MSN, BSN

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Hello,
We would like to submit this public comment to HICPAC on behalf of the People's CDC.
Best,
Andrew Wang, PhD, MPH and Raj Chaklashiya
…
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

To Whom it May Concern,

SarsCov2/ COVID-19 is Airborne. We have known this since 2020. The recent COVID UK inquiry only underscores that those in positions of power have known it since then, as well.

Recently, the CDC has changed data reporting guidance:
"Number of Data Elements. The CDC will reduce the number of data elements that hospitals must report from 62 to 44. Specifically, CDC will make the following data fields optional for federal reporting:

-
    - Total hospitalized pediatric suspected or laboratory-confirmed COVID-19 patients
    - Hospitalized and ventilated COVID-19 patients (patients currently hospitalized in an adult, pediatric or neonatal inpatient bed who have suspected or laboratory-confirmed COVID-19 and are on a mechanical ventilator)
    - Total ICU adult suspected or laboratory-confirmed COVID-19 patients
    - Hospital onset (total current inpatients with onset of suspected or laboratory-confirmed COVID-19 14 or more days after admission for a condition other than COVID-19)
    - Previous day's adult admissions with suspected COVID-19 and breakdown by age bracket
    - Previous day's pediatric admissions with suspected COVID-19
    - Previous day's total ED visits
    - Previous day's total COVID-19-related ED visits"

Why, if not to further obfuscate data and manipulate people to destroy their health for the sake of business interests? TO COVER UP YOUR EGREGIOUS ERRORS IN HANDLING THIS PANDEMIC FROM THE START?

I demand the right to access healthcare and public spaces without fear of contracting a deadly virus.
I demand clear guidance from the CDC for indoor air quality and workplace safety.
I demand enforceable air quality standards in all public settings - medical facilities, schools, public transportation, and pharmacies, to start. Anywhere that provides a public service.
Your actions throughout the pandemic have directly contributed to the dire state of the world. When your children, grandchildren, neighbors, colleagues ask you - WHAT DID YOU DO TO SAVE LIVES - don't you want to have an answer?

Make this happen, CDC. The failure on the part of public health leadership, primarily the CDC, to advocate for clean indoor air in public settings is an absolute dereliction of duty. The blood of every person who has died, become disabled, immunocompromised, or developed long-term incurable sequelae from SarsCov2 infection is on your hands.
You still have time to do what's right.
It's not too late!
Even now.
It's YOUR HEALTH, too.
IT'S ALL OF OUR CHILDREN.
IT'S EVERYONE'S FUTURE.

- Nicole Yeager

Hello,

I am writing in regard to the healthcare infection practices that are in place to prevent illness. As a person who has not had Covid, and does not want to get it, I have been extremely disappointed in the lack of care and protection the healthcare community has provided to their patients.

Data support the use of masks in congregate settings such as schools and care facilities. Because of this, I believe masking should be reinstated in healthcare settings. While masking is not something people want to do, it does save lives and this is shown in the data. I have discussed this with healthcare workers who did not get sick until after mandated masking was dropped.

As a patient who frequently is in a doctor office, I still mask. I ask medical workers to mask. Some do and some don't. Nurses will cough at their stations as I walk by. How is this a safe space to be in?

At some point I know that I will likely be in contact with someone who has covid, and this will likely be in a medical setting, as I have still been avoiding public places. I make my doctor appointments first thing in the morning to avoid as many people as possible. The point is- I shouldn't have to do this.

With the relatively high percentage of patients contracting Covid through medical settings, I actually feel it is not safe to go to a medical facility. Why should the person who is supposed to help, be the one that ultimately gets me sick?
The data on masking is clear, the messaging is not. Masking with high quality masks does work. This should be mandated in all medical facilities because a medical facility should be a place of improved health and science. The medical field was a place of "health care" prior to covid. Now, medical facilities post covid look at it as "survival of the fittest"-(actual quote of a phlebotomist in regard to Covid spread).

Until there is some way to prevent spread, or infections become so mild they do not do damage to people, there needs to be some way to mitigate Covid in healthcare. Bring back masks.

Thank you.

To Whom It May Concern:

It has been known for years that transmission of COVID and other diseases is airborne. People have been infected at hospitals, resulting for some in long-term debilitating symptoms. Others postpone essential medical procedures.

- It is essential that respirators be required indoors, especially in healthcare settings.
- Adequate ventilation should be mandated in commercial and public buildings.

Thank you,
Michael Atzmon
Ann Arbor, MI

It is beyond my comprehension that any government agency wouldn't implement safer infectious disease protocols, in healthcare in America.

I am a Immunocompromised patient.
As someone who frequents hospitals, healthcare providers, labs, pharmacies, I feel my life has become worthless to the government I have worked hard to support my entire life.

I should not have to visit an emergency room, wait for hours upon end, filled to the brim with patients with infectious diseases, without regard to my own frail health conditions. Whether I am experiencing an AFIB episode, or LUPUS attack, I should be allowed safe access to treatment without further harm.

I have been in the ER and hospital 8 times this year. They no longer bother to even wash their hands. There is no recognition of airborne aerosols.
From Covid, Flu, RSV, TB, I am not able to mount an adequate response to fight off these airborne diseases.
We need N95 respirators mandatory, clean air, clean facilities.
I have done my part. I feel I'm fighting odds that will eventually be my demise. For the workers that seem to have no sensible guidance is abysmal. You a government agency hasn't met the standards of enough qualified experts on your panel.

It's shameful.
I don't have a choice. I need healthcare. I should not have to chose life or death by a preventable infectious disease.
Where are my rights?

Please protect people who seek to feel better, by first do no harm.
Make standards, we know work mandatory. Masks, N95's, clean air, disinfecting, separation of patients that are infectious by more than a drape in a filthy exam area.

Sincerely
Diane Herron
Pinson, AL

Hello,

This is a written comment for the upcoming HICPAC meeting. Please mandate N95 respirators for all healthcare and nursing home workers, to protect all patients from airborne illness, especially those who are immuno-compromised, at high risk for severe illness/death, and children who are too young to be vaccinated. It is unconscionable for vulnerable patients to be exposed to contagious airborne illnesses while seeking healthcare, which compromises their health even further.

Thank you.

Sincerely,
Catherine Wing

Dear HICPAC,

Please protect patients and healthcare workers by requiring that N95 respirators be used at all times in all healthcare settings. N95 respirators provide the best defense when compared to surgical masks for preventing the spread of airborne viruses. They are much more effective at stopping the spread of disease “at the source” especially when patients who are often compromised/ill/immuncompromised are often unable to wear a mask/respirator due to the type of treatment or procedures being performed. Or, they are babies or young children unable to mask.

It is difficult to understand why long standing masking in cancer treatment situations, maternity wards, nurseries, icu’s, surgical recovery areas, etc have unexplainably been reversed after decades of infectious disease research and standards - especially in the current pandemic/endemic. Masking with N95 respirators should instead be expanded to all healthcare environments.

It is unconscionable that hospitals have become one of the most risky places to contract Covid19 and other infections. This is exasperated by healthcare workers being pressured/required to come to work while still infectious.

Please make all healthcare settings safer by requiring N95 respirators by all healthcare workers, patients, and visitors. And resume testing for Covid 19 in these settings for all.

Thank you,
Laurie

I am writing to ask that public health policies include:

1. Recognition that viruses like SARS-COV-2 are spread via aerosol transmission.

2. Require respirators in ALL healthcare settings, allowing all persons safe access to needed medical care.

3. Require aerosol expert input in all of your meetings.

4. Your guidance should recommend clean indoor air (HEPA air filtration and UVA cleaners) for home use and, more importantly, when people gather in numbers (shopping, eating, leisure activities).

Thank you,
Elizabeth Rosales

It's difficult to fathom that this needs to be said, but requiring respirators that are actually effective in protecting health care workers and patients from airborne diseases in hospital and healthcare settings should be a minimum standard to stop the spread of disease. The CDC needs to take the lead in explicitly letting the public know about the risks of aerosol transmission and how to reduce it (respirators, not surgical masks, cleaning the air with HEPA filters or far UVC). Please consult with experts on air quality and start recommending the tools that will keep everyone healthier and ensuring that the public knows the facts and the research. Your organization could save so many lives and ensure high quality of life for everyone just by doing this.

Thank you.

Dr. Lynn Zubernis
Clinical Psychologist and Professor
Drexel Hill PA

Dear HICPAC members,
My name is Jordan McClure, Evanston, IL. I am a member of an immunocompromised household with a family member who is currently taking medication which further compromises their immune system. Living with a disabled person dependent on frequent medical care, I urge you to reject any loosening of infection control practices in healthcare settings. My family's health is dependent on community action to limit infection, and any reduction in standards poses a significant increase of risk to our wellbeing while receiving standard medical care.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (“air” and “touch”) - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Sacrificing our devoted health care professionals, as well as citizens seeking healthcare, is inexcusable. The HICPAC should protect all people impacted by its decisions, and reject pressure to relax infection control measures.

Thank you,
Jordan McClure

Written Comment to CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) Standard Precautions against Transmission of Airborne Pathogens, per instructions at https://www.federalregister.gov/documents/2023/10/10/2023-22327/healthcare-infection-control-practices-advisory-committee-hicpac, submitted via email to HICPAC@CDC.GOV

I stand by the statements I submitted in August that you published. In addition:

1. Although HICPAC mildly improved transparency and opportunities for public input, more must be done. Some of the June meeting materials got published late and other materials from that meeting, including the draft guidelines to be voted on at the November meeting, remain unavailable to the public. Please provide all HICPAC materials to the public in an expeditious, timely manner. Additionally, remove the severe restrictions on the length of public comments and allow more time to submit comments ahead of scheduled meetings. Currently, it remains extremely challenging to provide comments to HICPAC and commenters feel little assurance that our perspective will get any attention prior to HICPAC votes. This does not align with the intent of the Federal Advisory Committee Act to incorporate public input into decisions. HICPAC must open its deliberations, including the review and response to public input.
2. Add transmission by touch via ingested media such as liquids and food, devices inserted into body cavities, and air contact with eyes to the General Overview of Framework & Proposed Sections A, B, and C presented at the June meeting.
3. HICPAC must acknowledge airborne transmission of pathogens. Additionally, HIPAC needs to include voting members with appropriate expertise in airborne transmission control (air cleaning and ventilation engineers, aerosol scientists, occupational safety and health experts, etc.). Based on the listing on https://www.cdc.gov/hicpac/roster.html, you still haven't added: the aforementioned experts to Members, federal occupational health experts to the Ex-Officio members, or healthcare unions or more patient groups to the Liaison Representatives. HICPAC must actively seek expert opinions and the perspectives of the people directly impacted by airborne infection standard protocols.
4. Precautions like respirators prevent disease. We can trust that respirators are highly protective because of studies (1) and regulations made by OSHA (2). At this point, randomized controlled trials (RCTs) of respirators vs surgical masks would be unethical and a waste of our resources. Respirators are better than surgical masks. Additionally, respirators must be used by all staff, patients, and visitors to any healthcare facility regardless of vaccination status. Finally, be sure to consider the impact of precautions on patient nosocomial infections. Patients are the most vulnerable to serious consequences of airborne pathogens, including COVID-19 (3,4,5).
5. In addition to respirators, require implementation of air-cleaning and air-monitoring technology, such as: appropriately filters installed to HVAC, portable HEPA filters, carbon-dioxide monitors. Do not use bipolar ionization or other ionizers to clean air.
6. The Standard Precautions need to consider patient health and vulnerability, as well as healthcare workforce health.

Include safe staffing levels in the Standard Precaution. Safe staffing levels ensure that workers have sufficient time to don and doff PPE, take necessary precautions when engaging with patients, and perform other parts of their job related to workplace infection control. Staffing levels and standard precautions should not be written to the level of "staffing crisis", to avoid creating staffing crises due to infections.

Finally, please listen to all the comments. I've personally been avoiding healthcare settings as much as possible because I do not want to risk infection with an airborne pathogen like COVID-19. So many people in these comments are begging for their lives and safety. We all deserve healthcare that is better than this. It should not have come to this. Do better.

Sincerely,
Seifer Almasy

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1 Rashid, TU, et al. ACS Chemical Health & Safety. https://doi.org/10.1021/acs.chas.1c00016.
2 OSHA. https://www.osha.gov/respiratory-protection/general. Accessed Oct 31, 2023.
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4 Ponsford et al. Frontiers in Immunology. 2021; 12. DOI: 10.3389/fim-mu.2021.744696.
5 Hall and Clement. Surgeon. 2022 December; 20(6):e429-e446. DOI: 10.1016/j.surge.2022.02.009.

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hi

please recognize aerosol transmission of sars-2 and require fit tested respirators in healthcare settings.

i mask everywhere, as i am high risk with 5 brain surgeries to date.

two way masking is much more effective than one way masking. different staff and providers have made it very clear to me that they are no longer required to mask (and so they do not mask)

they clearly need to be told from leadership, and you can help on that front.

respirators are more effective than surgical masks, and vaccinations do not prevent transmission.

i have had to put off a biopsy because the procedure requires a cannula, therefore i would have to unmask and share healthcare workers exhaled air and risk an infection. not worth the risk yet.

per dr fauci, 40 - 60% of cases are from asymptomatic spread.

you can also require healthcare facilities to clean the air with hepa filters.

involve aerosol experts or air quality engineers and increase transparency.

this is a well studied field and these experts have solutions

i used to do multi disciplinary engineering and these are the same experts i would look to, to gain a better understanding of the aerosol physics at play.

one example of such an expert is dr. richard corsi.

https://www.pdx.edu/profile/richard-corsi

i really hope you consider these points, it has been 4 years, we have the knowedge and information, we just have to put protocols in place to keep us safe and for better or worse, it needs to come from leadership (you) to actually be acted on.

-- daniel Mijares

Please support masking (N95 respirators) or better in healthcare facilities. People seeking to address one medical issue should not have to experience the unnecessary risk of COVID and other airborne diseases while doing so. Masks reduce the risk! Other people masking is needed to make it safer for patients who need to remove a mask to receive health care for their nose or mouth, such as dental care.
Please show that you are on the side of "do no harm".

Topic: HICPAC meeting on November 2, 2023

I urge HICPAC to:

- Recognize aerosol transmission of disease including SARS-COV-2
- Recommend respirator requirements in healthcare regardless of vax status (N95 or better, both patients and staff)
- Acknowledge the scientific fact that respirators are FAR more effective at reducing transmission of airborne disease than surgical and cloth masks
- Promote clean air tools like HEPA filters and CR boxes (which leverage less-than-hepa filtration but higher CFM to produce superior air changes per hour), opening windows, and ventilation
- Involve aerosol experts and increase transparency of the groups decisions

Sincerely,
James David Daily
Whitehouse Station, NJ

Dear HICPAC:
SARS-CoV-2 is an airborne virus. You must establish guidelines for infection control in hospitals that acknowledge this reality and take actual steps to mitigate it. N95 respirators (not surgical!) for all healthcare workers and all patients, active ventilation, and filtration must all be required in healthcare settings. The droplet precautions you appear to be poised to recommend are not only not backed by science, they are ludicrous and negligent.

If you do not take steps to mitigate airborne transmission, your committee directly responsible for the many hospital-acquired infections that occur every day due to lax infection control. Make no mistake: thousands of patients have died, and will continue to die, because of hospital-acquired infections. SARS-CoV-2 and other airborne viruses have no place in hospitals. We can prevent their transmission, but it depends on you to establish guidelines.

You literally have one job and this is it.
Thank you,
Max Feingold
SEATTLE WA

Dear Committee,
My 80-year-old father, an atomic veteran, is a stage III lung cancer patient, already a two-time cancer survivor, fighting for his life. He was diagnosed with lung cancer in March, and in June contracted COVID because of the sheer inability of the CDC to uphold BSL-3 precautions against an aerosolized SARS virus and to require oncology practices and other medical centers to use respirators. He caught COVID when his only activity outside the home was visits for chemo treatments. These decisions to ignore the science about aerosol transmission of viruses

may not kill us all with SARS-CoV-2, but we all know well that this and other viruses are not static and will certainly create more mischief in future. Please. We are watching every step you take to mitigate the spread of infectious disease. History will not be kind to those who ignore the science we're already aware of today. I beg you not to weaken and in fact to strengthen precautions that will simply allow more people to live, and more people to live disease-free. Please don't equate cloth face coverings or surgical masks with N95s. This is the United States of America. If we can't do better, who will?

Marie Reinke Gray

Good evening!

I'm writing to encourage you to incorporate better infection control measures in medical and healthcare settings. There are many medically vulnerable individuals who are either hospitalized or must visit on an outpatient basis for treatments and procedures that can't be delayed or avoided. Others who aren't immunocompromised or fragile also seek care in these settings and may be exposed to Covid and other airborne pathogens, so it's important to have precautions in place.

Along with many others who are aware of the danger Covid continues to pose in medical settings, I urge you to:

- Recognize aerosol transmission
- Implement respirator requirements in healthcare regardless of vaccination status
- Recognize that respirators are more effective than surgical masks
- Use clean air tools, such as HEPA filters
- Involve aerosol experts in decision-making and increase transparency

Thank you for considering these factors when making healthcare policy decisions supported by research that provide the greatest possible protections in medical settings.

Sincerely,
Michele Garber

Please do the right thing to protect patients and recommend that healthcare workers wear highly protective N95s instead of "surgical masks" or so called "baggy blues", which have been repeatedly demonstrated as ineffective in protecting against aerosol transmissible diseases. Se PR\rofessor Lindsay Marr's statements on the research and effectiveness of N95s.

Thank you
Christina Huff
Garberville, CA

This week's episode of 60 minutes featuring aerosol scientist Linsey Marr was timely considering the current attempt by the CDC and HICPAC committee members to roll back hospital infection controls during our continuing battle with SARS CV-2 and other deadly viruses. During her interview, Marr demonstrated what many of us have known for years - the fact that airborne viruses are not spread by droplets that fall to the ground. Instead, these viruses linger in the air - and travel - like cigarette smoke. Additionally all pathogens have the potential to become airborne at some point.

In light of this information, I am writing to request that the CDC update its preference for the use of the outdated "surgical mask" and recommend hospitals supply staff and visitors with n95 respirators.Hospitals should also be advised to update their air quality standards in favor of mitigating aerosolized viruses. This would include MERV13 air filtration retrofitting and portable air filters such as those recommended by OSHA. In the interest of transparency, aerosol scientists should be included in these discussions.

It is also self-evident that doctors and nurses deserve a voice at the table. HICPAC needs members who work in hospitals and understand the current challenges faced by staff in regards to safety and infection control.

As our pandemic continues, the American public is increasingly more aware of the recent failings and lack of transparency of the CDC. It appears that HICPAC is prioritizing the wishes of for profit hospitals over the safety of the public. I urge committee members to familiarize themselves with the current science regarding how viruses are transmitted and act decisively in this moment.

-Lisa Herzig

Members of the HICPAC Committee,

SARS-CoV-2 infections impact the health, quality of life, livelihood, and life expectancy of people. The regular disruptions at a family, school, and work level are also significant and lead to substantial collective costs both in the short and long term.

Protecting the health and life of both patients and healthcare workers is crucial. The emergence of SARS-CoV-2 has clearly highlighted the importance of infection control measures during these past years and also what happens when we remove masking in the health care settings.

It is clear the status quo is unsustainable. It is why infection control measures addressing airborne transmission in the health care environment play such an important protective role in addition to the other mitigation layers used in the everyday life such as masking, testing, getting vaccinated, treating, ventilating/aerating indoor spaces, and staying home when sick. Second-generation vaccines, prophylactic treatments for the immunocompromised, additional first-line treatments, treatments for Long Covid, and treatment protocols for the population at high risk (e.g. combination of treatments for the immunocompromised) are needed and will lead to much needed progress.

It is of the utmost importance to prevent putting the vulnerable population and communities in a position of avoiding or limiting needed care as a result of an unsafe medical environment. It is the responsibility of the HICPAC Committee to take this at heart and ensure the access to care is safe and equitable. This means that given SARS-CoV-2 is airborne and present all year long, improving the indoor air quality in medical settings and using N95s in a systematic manner (as a source of protection and source control) is essential to the wellbeing of patients and healthcare workers.

Lastly, it is critical to include aerosols specialists and occupational hygienists in order for decisions made to benefit from the expertise of each of the HICPAC Committee specialists. This is in the interest of Americans, families, healthcare workers, hospitals, employers, and the country as a whole. Transparency in the decision making process - which includes sharing

information with the population before making decisions impacting existing guidelines - is also key.

To conclude, much harm resulted from the emergence of SARS-CoV-2 in 2020. SARS-CoV-2 infections lead to more complicated recoveries, poorer health, disability, loss of wages/livelihood, and largely preventable premature deaths. It is the duty of the HICPAC Committee to ensure decisions made aim to significantly lessen and prevent the detrimental impacts of SARS-CoV-2 on the health of Americans.

Thank you for your attention.

Regards,

Henry Venneman
Citizen
Naperville, IL

Name: Peter Finwork
Address: New York, NY
Organizational Affiliation: None; Individual
Topic: SARS-CoV-2 is Airborne

PUBLIC COMMENT:
SARS-CoV-2 (also known as Covid 19 or SARS-2) needs to be classified as an airborne virus that requires the use of N95 respirators and negative pressure rooms to prevent spread, regardless of the vaccination status of the individuals involved.

This is critical as the current vaccines do not prevent against the transmission of SARS-CoV-2. SARS-2 is airborne and lasts for hours as micro aerosols in the air. Transparency and accountability is needed to ensure that patients and healthcare professionals have access to clean, virus-free air. Corporate interests to cut costs should not come at the expense of clean, virus-free air.

Dear Madam or Sir:
As you are no doubt aware, coronavirus spreads by aerosol, and it evolves to become ever more contagious. I urge you to promote and protect public health by these means:
1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.
2. I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

3. HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.
4. The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.
6. CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.
COVID will not go away by ignoring science nor by willing it to be so. Please do the right thing.
Thank you.
Riley Cleets

These comments are regarding the upcoming HICPAC meeting. My name is Michael Morgan. I write for myself, not for my institution. I am a physician at University Hospitals, Cleveland, Ohio where I am a neurologist practicing neuro-ophthalmology.

Effective precautions against the transmission of respiratory infections hold great potential if pursued well. With knowledge gained since 2020, standards for infection control should be updated and strengthened.

HICPAC must recognize the role of aerosol transmission in the COVID-19 pandemic as well as other infections such as influenza.

A combination of methods to reduce the inhaled pathogen concentration will reduce infections and prevent the rapid spread of future respiratory pandemics. Personal respirators are one such method as shown by https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8635983/ and http://ijomeh.eu/Sources-of-healthcare-workers-COVID-19-infections-and-related-safety-guidelines,132898,0,2.html for high quality PPE filtration and not for reliance on less effective means such as procedure masks or even homemade cloth masks.

Improving indoor air quality through ventilation and filtration also serves as a means for improving health. ASHRAE has improved recommended standard for systems, and hospitals and other healthcare facilities should have a higher standard given the known need for infection source control.

Solutions to these problems benefit from engineering approaches in addition to infectious diseases physicians and public health experts. These proceeding should include experts from engineering and aerosol science fields. The CBS news program 60 Minutes featured Linsey Marr of Virginia Tech and Joseph Allen of the Harvard T.H. Chan School of Public Health. Kimberly Prather of UCSD, Richard Corsi of UC Davis, Jose-Luis Jimenez of the University of Colorado and Donald Milton of the University of Maryland have been other leading advocates.

Sincerely,
Michael Morgan

My full name is Juni Rachael Hamlet. I am a retired lawyer. My address is Falls Church, VA.

I am writing to urge you to recommend that health care providers and facilities take adequate precautions against transmission of airborne pathogens. That means setting standards for ventilation and filtering of air in facilities and the use of respirator (at least N95 level) masks for all in person interactions. Anything less is a failure to protect public health in a place where vulnerable people have no option to avoid. I have personally been unable to access needed health care services without exposing myself to unacceptable risks from unmasked health care workers in poorly-ventilated facilities.

Please acknowledge that (1) Covid-19 is airborne, (2) that the risks to even young and healthy people are significant and to the old and immune-compromised are severe,and (3) that mitigations such as respirators and proper indoor air quality control are practical and effective means of reducing risks.

Rachael Hamlet

Name: Annalisa Schaefer
Address: Trumbull, CT
Organizational affiliation: The World Health Network
Topic: Advice on medical standards for the CDC

I'm a concerned citizen who has been following SARS-CoV-2 pandemic developments closely since 2020. I am very concerned that instead of learning from the ongoing airborne pandemic to improve safety of patients and medical workers, HICPAC is considering dismantling flawed

hospital safety protocols even further. It is crucial that the public health authorities do what they can to protect people from the continued spread of SARS-CoV-2 and establish an effective paradigm for handling airborne pathogens.

Using ineffective methods not only causes material harm to people but it also discredits medical science itself. If people follow directives to wash their hands to protect themselves from a virus they breathe in and they get sick anyway, what lessons do they come away with?

I'm writing to urge HICPAC to update infection control in mode congruent ways. First, it's crucial to recognize aerosol transmission and explain it to medical workers and regular people in a way they can understand, such as using the simile "it lingers in the air like smoke." Second, it's important to require respirators in healthcare regardless of vax status. We all know that vaccinated people can catch and spread it. Third, it must be recognized that respirators are more effective at stopping airborne transmission than surgical masks. Their seal is crucial for superior protection. Fourth, clean air tools like HEPA filtration must be explained and implemented widely, with the understanding that they must be turned on and filters must be periodically changed. Fifth, we need to see HICPAC involve aerosol experts and increase transparency to your processes.

Dear HICPAC,

COVID-19 is spread through aerosol transmission. Healthcare agencies should have staff masked (N95s) to protect vulnerable patients. Everyone who breathes is vulnerable. Not all patients can mask themselves when hospitalized. It is distressing to think that CDC guidance allows healthcare staff (who may be infected) to care for vulnerable patients unmasked and expose them to a BSL3 virus.

I personally can attest to the stress and agony of trying to convince hospital staff to mask around my critically ill spouse, who had an unknown (nonCOVID) respiratory illness. The hospital cited "CDC" guidance as their reason for not requiring masking at the hospital and made accommodating the family's request that staff mask very difficult.

To that end, please consider decisions and public messaging that:

-Recognize aerosol transmission
-Respirator requirements in healthcare regardless of vax status (not surgical masks)
-Respirators are more effective than surgical masks
-Use of clean air tools like HEPA filters (there should be considerations of short-range transmission as well). The hospital argued they had good ventilation, but ventilation is not helpful for unmasked staff providing care when standing within 12 inches of the patient's unmasked face!
-Involve aerosol experts and increase transparency

Have we not learned anything over the past 3.5 years! Masks work! They should be reinstituted in healthcare! A patient should not put their health in danger by seeking medical care. Healthcare should be masking!

Sincerely,
Peggi White
Ogden, Il

No affiliated with any organization

Dear HICPAC,
My name is Kathleen Gadd and I am a librarian and volunteer advocate. While I am heartened to see the CDC recognize pathogens that spread through the air, I am deeply concerned about the composition of your committee and the absence of subject matter experts. There is excellent scholarship in aerosol science, and in the field of airborne disease transmission dating back decades. As a Northern neighbour I must also point out the incredibly relevant report from SARS (2003 outbreak), which emphasized the importance of the precautionary principle and understanding airborne transmission. You can read Campbell Commission's SARS-1 report here: https://www.archives.gov.on.ca/en/e_records/sars/index.html

While the US was fortunate to avoid SARS, in Canada we had cases and deaths, including deaths of healthcare workers. In order to protect workers and patients, we must respect colleagues from other disciplines and consult subject matter experts on aerosol science, industrial hygiene, and respiratory protection. Please, learn from the experience of SARS in 2003 in Canada. Surgical masks are not sufficient protection for an aerosolized hazard. While some researchers previously understood that various pathogens spread by inhalation of aerosols - influenza, RSV, adenovirus - the pandemic has brought this understanding of transmission into the mainstream, particularly after the recent 60 Minutes investigation on the topic. There are so many reasons to protect our bodies via our airways - there are many aerosolized hazards to health, especially in healthcare settings.

You have a rare opportunity today to advance science and put in place protections for workers and patients that will save lives. Please don't turn away from the various interdisciplinary experts who have reached out to help your committee understand how respirators are the appropriate PPE for aerosolized hazards. Thank you,

Kathleen Gadd, MLIS
Miramichi NB, Canada
Organizational affiliation: Canadian Aerosol Transmission Coalition, Protect our Province New Brunswick

Good evening

I am writing to you tonight to please recommend respirators in all medical settings, to reduce instances of transmission of any pathogens spread via aerosols. Whether a pathogen is novel has nothing to do with the risk of transmission & the risk that can pose patients & the greater community.

I am a voice teacher & professional opera singer with over a decade of experience. This may not make me a medical expert, but it DOES make me an expert in the ‘aerosol generating procedure’ known as breathing and vibrating the air inside my body. I know a lot about the larynx & how it functions. I imagine my well hydrated vocal tract & vocal folds produce a fine, consistent mist of aerosols.

I have been masked with a KN95 or N95 in all indoor settings outside of my home since March 2020, ESPECIALLY when singing or entering a medical facility. I have personally experienced a choral superspreader of ~25 which began with an asymptomatic teenager, singing directly behind me. She was less than a foot away from me, breathing in sync, for 2 hours. I was not

infected because I wore an N95. Everyone infected was maskless. This occurred just two weeks after the CDC new community levels map lowered to happy green “low” in my area (Essex county, Massachusetts), allowing the choir to justify dropping mandatory masking. The church we rehearsed in had upgraded ventilation to the outside, yet that still wasn’t enough to prevent the chain of transmission that resulted in nearly 30 choir personnel & their family members getting infected with covid. This was in May 2022. Many of these singers are elderly — the teenager was the only minor in the group. Not exactly a closed experiment, but an anecdote that clearly suggests the usefulness of N95s in high risk settings with high concentrations of aerosols, such as a choir rehearsal or perhaps relatedly, a hospital full of sick people. It also clearly demonstrates the high likelihood of a child beginning a chain of transmission to their families, estimated to be about 70% (https://www.cidrap.umn.edu/covid-19/more-70-us-household-covid-spread-started-child-study-suggests). This may also suggest that pediatrics is one of the riskier specialties for transmission.

Beginning in 2020, every major music education organization in the USA commissioned a study (https://smtd.colostate.edu/reducing-bioaerosol-emissions-and-exposures-in-the-performing-arts/) or two (https://www.nfhs.org/articles/unprecedented-international-coalition-led-by-performing-arts-organizations-to-commission-covid-19-study/) to lay out specific safe rehearsal procedures that were implemented for a time, before the cdc began to signal that infection control was no longer a priority. These included masking, bell covers for wind instruments, ventilation between groups, and increased time between rehearsals in general. HEPA purifiers (https://www.newscientist.com/article/2398713-schools-cut-covid-19-sick-days-by-20-per-cent-using-hepa-air-filters/) have also shown to be very beneficial in filtering aerosols from the air. There also have been studies measuring aerosols between breathing/talking/singing (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7875408/) There is a plethora of information about aerosolized transmission now, 3 years later.

As you may well know, singers are at a special risk (https://www.sciencedirect.com/science/article/pii/S0892199720301831) from COVID not only because of the heightened chance of transmission, but because of the optimal functioning required of the larynx, attaching muscles, and lungs to have a consistently healthy & efficient vocal technique. Singers are athletes on both a macro & micro muscular level. The vocal folds are highly vascular & have a layered epithelium that requires tons of hydration and is sensitive to inflammation. To sing an A above middle C, the vocal folds must vibrate 440 times a second, which they cannot do if chronically inflamed & fighting a pathogen, especially one like Covid that infects the endothelial lining of the blood vessels themselves. Because of all this, I am acutely aware of the risk each reinfection in a singer can pose. I have heard it, daily, in my students, who get reinfected with Covid & other viruses (often provably in their music classes) frequently. I have never heard this much persistent vocal inflammation before. Covid is a different virus than the ones of my childhood — the inflammation is lasting & can be the catalyst to more serious vocal pathology, which is rare with other, actually mild, cold viruses.

I contextualize my knowledge of disease transmission this way because one, this is why I have a special interest in pathogens & conditions affecting the voice, which DOES make me an expert in the very tangible & real affects of forever covid transmission, and two, because of the unique relationship a voice teacher or singer has with their voice doctor, much like an athlete with their personal trainer. Our body is our instrument. Medical care to maintain it is unavoidable, and important.

Which brings me to the fact that I sometimes have to recommend students to see a vocologist, otolaryngologist, or ENT to get their vocal folds scoped. With the current state of infection

control in medical settings, this has become a catch 22 — a voice damaged from COVID, they need to see if a more serious pathology has formed (such as hemorrhage, paresis polyp, nodes, edema, GERD/LPR, etc), but then they could get covid AGAIN at their unmasked medical appointment, exacerbating their condition further. I currently have a student who has been intermittently dysphonic since MAY who got reinfected starring as Cinderella in *Into the Woods*. She is 15. Her progress has been temporarily stunted due to the ongoing inflammation her instrument has sustained, due to completely unmitigated spread of illness in her high risk rehearsal environment (maskless & no improvement in ventilation, much like many medical facilities). She is only one example of several I have heard personally.

Now, obviously, music ensembles aren't the same thing as hospitals, but that's kind of my point — why am I, a voice teacher, taking higher infection precautions than medical settings? Why have music educators set out clear guidelines that WORKED to reduce transmission, only to then defer to and be undermined by medical guidelines that are resulting in rampant & increasing infections? Why are we LOOSENING precautions in the most high risk, but also supposed to be the safest, setting? Where people go to receive CARE and HELP? Why has there been an acute awareness of aerosol transmission in music ensembles but not throughout every level of the medical profession? Why is safety considered a luxury at a hospital? Is it just to save money because surgical masks are cheaper?

How many more fields of expertise have to come into this inbox & plead for you to do the right thing by recommending masking with N95 or KN95 respirators & controlling infections in medical settings, which is the BARE MINIMUM of the CDC? Surely I don't need to tell you the tale of Semmelweis. My job is singing, but even I don't want the stain of infecting a beloved student or colleague with a deadly, disabling, virus. I will not steal their voices. You should not either. You are the last line of defense a singer has to maintaining their vocal health when it is in crisis. If you don't care about the long term health of your staff or patients in your facilities, at least care because of the damage covid is causing to musicians. You like music, right? Care so when singers seek help with their chronic Covid induced dysphonia or acid reflux that they aren't reinfected with the very same pathogen causing their discomfort, when they are literally seeking help after many months of frustration. If I can sing opera in an N95, certainly medical professionals can practice medicine using one, too.

There is no reason to not take the highest level of precautions for the safety of ALL patients and ALL medical staff, which ultimately results in a healthier community overall. Keep KN95 or N95 respirators as the default in all medical settings. Surgical masks aren't enough (https://www.cureus.com/articles/139376-efficacy-of-surgical-masks-versus-n95-respirators-for-the-prevention-of-covid-19-in-dental-settings-a-systematic-review#!/). Ventilate with open windows at the very least, HEPA or Corsi-Rosenthal boxes (https://en.wikipedia.org/wiki/Corsi%E2%80%93Rosenthal_Box) preferably. There is a net benefit to filtering the air with masking & ventilation in the transmission of all respiratory pathogens, not just Covid.

Please do the right thing.
Kristen Keymont
BM, Music Education, University of Massachusetts Lowell
MM, Vocal Performance, The Longy School of Music of Bard College

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Name: Rachel Nussbaum
Topic: Infection control
Address: New Haven, CT

Think of a cancer patient fighting for their life with chemotherapy, an immunocompromised child braving biological infusions, a 70-year-old grandmother who falls, breaks her hip, and while recovering in the hospital, contracts Covid-19 and dies of the complications. All of them have been victims of hospital-acquired infections, which could be prevented if the committee agrees that healthcare workers should do no harm, and requires them to wear N95 respirators or elastomeric respirators to prevent the spread of airborne disease.

By this point in 2023, we know that SARS-CoV-2 is airborne and travels like smoke, spread via inhalations and exhalations, as is tuberculosis, influenza, and measles. We know that N95 respirators are made for airborne diseases, while surgical masks are suited for droplet-borne diseases. We know that, per the CDC, wearing an N95 mask makes people 82% less likely to contract COVID-19, compared to a 66% reduction from surgical masks.

Despite vaccination and a booster dose, one infection with SARS-CoV-2 left me with postural orthostatic tachycardia syndrome, as well as chest pain that remains over a year later. I'm 30 years old, and every time I go to a doctor, I fear picking up a reinfection that could make my autonomic nervous system further deteriorate — an area of medicine we know so little about, that Covid clearly dysregulates. I am not alone, and yet after going to the ER with chest pain and pressure, the head of the unit told me that if N95 masks, or any masks worked, the CDC would recommend them; he pulled down his baggy blue to indicate how loose it was, and said that if people didn't get Covid from each other, we'd get it from rats.

That's the state of medicine, and the imbalance of power already-vulnerable patients are left to reckon with in the absence of recommendations that would limit the spread of Covid, a disease that is not mild for many, and gives anywhere between one in five to one in ten people long-lasting organ damage and chronic conditions. Anywhere from 40 to 60 percent of infections are asymptomatic, yet it still damages our endothelial linings and creates microclots, which is causing the spike in cardiac events and strokes among young people. It causes long-lasting inflammation, and increases in diabetes; it causes our neurons to fuse, leading to memory and cognition problems.

We must fight this constantly-evolving iteration of SARS with every tool: N95 respirators, HEPA filters, UVC light, and recurrent vaccinations to compensate for waning immunity and viral evolution. Anything less is accepting death and mass disablement, for the currently well and those already with compromised health. HICPAC needs to do what's right: pull our hospitals out of the 18th century, provide clean air, and restore the public's trust that seeking care won't sicken them.

There is a tipping point.
When does society and the economy crash because too many have died or been disabled by covid? When our medical community has lost their expertise due to death, disablity and burn out. When our engineers can no longer utilize math due to brain damage from covid.
We need masks, air flirtation, monitoring air quality and public displayed.
Do better.

Donna M. Herinya
Columbus, NJ

I implore the HICPAC committee to consider the critical importance of maintaining respirator masks in healthcare settings. SARS-CoV-2, like measles, is aerosol-transmitted, remaining suspended in the air for hours.

To protect healthcare personnel and patients, it's crucial that healthcare organizations maintain and strengthen respiratory protection and other PPE requirements. Universal PPE and masking should be employed to control the spread of aerosol-transmitted viruses, making healthcare settings more accessible to vulnerable individuals and those who cannot mask, such as those with prohibitive conditions and infants. Fitted N95 respirators provide superior protection compared to surgical masks, and HICPAC should emphasize proper implementation, including fit testing and widespread availability of various respirator types.

Healthcare facilities should adopt indoor air quality standards from ASHRAE to control infectious aerosols in all healthcare settings.

Respirators, particularly N95 masks, are engineered to work effectively against aerosol-transmitted diseases. Suggesting that they are on par with surgical masks is a misrepresentation of the evidence.

It's our shared responsibility to ensure that when anyone (you, your parents, an infant) seeks medical care, they shouldn't have to worry about preventable airborne illnesses.

The current approach to precautions prioritizes cost considerations over the safety of healthcare personnel and patients. We need clear, protective guidelines that provide respiratory protection against infectious aerosols, to avoid exposing everyone to deadly infections.

I urge HICPAC to maintain clear guidance that outlines necessary precautions. Your decisions today could impact your own loved ones, and it's essential to base those decisions on unbiased studies and accurate data.

The reduction in healthcare workers due to preventable illness will exacerbate the shortage of personnel to treat patients, endangering our healthcare system. Reducing PPE in healthcare settings has already shown its devastating effects. If a day comes that you rush a loved one to the emergency room, your choices now will determine whether their healthcare providers wear proper PPE. Diseases don’t discriminate; they don’t care if you’re a firefighter, a doctor, a mother, an infant, or a HICPAC committee member.

The importance of ventilation and air filtration for controlling infectious aerosols is overlooked, as is the role of source control in limiting outward emission of infectious aerosols.

In conclusion, I ask the HICPAC committee to prioritize the safety and well-being of healthcare personnel and patients over corporate interests. COVID-19 is airborne, N95 respirators work effectively, and diseases do not discriminate. We must continue to protect our healthcare heroes and those seeking care in medical settings.

Thank you.

Hello,

I’m horrified to learn you are considering weakening infection control affecting health care workers and patients. Requirements are already insufficient; without masking (with respirators)

and assurance of adequate ventilation/filtration, I'm already skipping my normal mammogram and bone density testing. Way too many people are getting Covid in health care facilities; I've avoided it so far and don't want to risk my health by going to a health care facility. It seems absurd to have to write that prior sentence.

Please be sure to listen to relevant experts regarding aerosol transmission when making your decisions.

Sincerely,
Jeri Dansky
HalfMoon Bay, CA

RE: HICPAC Public Comments – Improving Pathogen Controls in Medical Settings
My aunt, who had no significant underlying health conditions, went to the hospital for a broken arm, was treated and admitted to an in-patient rehabilitation facility, contracted SARS-CoV-2, and died just a few weeks later. She never returned home following her hospital admission. Her healthcare trajectory went from urgent care to inpatient rehab to the ICU to the hospital morgue. She was killed by nosocomial transmission of a BSL-3 pathogen. Her death was completely preventable, and she would still be alive today had her healthcare facilities practiced appropriate mitigations for airborne pathogens.
I contracted SARS-CoV-2 at my federal workplace in March 2020 and have never recovered. I was previously fit and healthy, with no underlying conditions. The SARS virus has totally upended my life, ruining my physical and financial health. As a single mother of two, this disease puts my entire family's livelihood at risk. There are no effective treatments for long covid, and there is no cure. I mask, but one-way masking is far less effective than two-way masking. My reinfection with Omicron, which happened right after my daughter's school eliminated mask mandates and she caught covid from a close contact school exposure, seriously reduced my baseline.
I cannot afford the effects of another infection, and because all healthcare facilities in my area have eliminated masking requirements, I cannot safely access the care I need as a chronic SARS-CoV-2 patient.
I ask that you:
1. Recognize that aerosol transmission of SARS-CoV-2 remains a serious threat to public health.
2. Institute N95 or equivalent masking requirements throughout all medical facilities for physicians, staff, patients, visitors, and anyone else in the airspace. This will greatly reduce the threat of nosocomial infections of all airborne pathogens, not only SARS-CoV-2.
3. Set standards and require the deployment of additional clean air tools, such as HEPA filters, in all medical facilities. This should be done in concert with masking requirements, not in lieu of them.
4. Include a more diverse range of technical experts in the HICPAC membership, including those with expertise in aerosol science, industrial hygiene, UV and HEPA filtration, ventilation engineering, respiratory protection, and occupational health and safety, to increase the technical competency of the committee and give these experts more of a voice in shaping policy than they would have as mere consultants.
5. Increase the transparency of HICPAC by improving communication with the public, enhancing opportunities for public input, providing the public with drafts of any proposed guidelines and ample time for review and comment, providing the public with detailed minutes of all working group meetings in a timely manner, and providing solid rationales for all decisions.
Please restore the "health" and "care" in healthcare and make it safe for people to receive the full range of services they need.

Thank you.
Sincerely,
Kimberly O'Connor
San Diego, California
Private Citizen (no organizational affiliation)

Name: Andrew Lester
Address: Bloomfield, N
Org Affiliation:
Topic: Infection Control Guidelines Must be Strengthened

To best protect the public from airborne illnesses, the Guidelines should be based on the precautionary principle and prioritize risk reduction.

The development of infection control guidelines should involve both:
- those who are most at risk, including patients and healthcare workers and their representative organizations
- experts across disciplines studying airborne transmission, specifically aerosol and micro aerosol protections.

Guidelines should be comprehensive and include ventilation, HEPA air purification, masking, testing, and minimizing air sharing.

The number of people, especially those at high risk, who are contracting COVID-19 and other viruses in healthcare facilities is unacceptable. People should not have to choose between the benefits of a medically necessary appointment or procedure and the severe risk of contracting COVID-19.

Hello;

Please ensure that minimum clean air standards are met in all medical facilities per ASHRAE. Please ensure that the standard for mandatory healthcare masking is respirators in all facilities (not just hospitals). Because patients and staff must sometimes be without masks (procedures/cafetera), please ensure that all rooms are plentifully supplied with portable HEPA units.

Thank you,

Eaton Hamilton

Dear Members of HICPAC,

I am writing to express concern over inadequate infection control measures in healthcare settings, notably against airborne diseases like COVID-19. Ongoing health care acquired infections highlight a disregard for scientific evidence, bordering on institutional negligence and systemic ableism.

The airborne nature of COVID-19 necessitates universal respirator usage within healthcare facilities. Respirators like N95 significantly mitigate airborne pathogen risks.

It's unacceptable that individuals face risks of preventable diseases in places of healing. Whether oneself, a parent, or a child requires medical attention, the fear of airborne infection should not add to already trying circumstances.

The apparent disregard for robust infection control measures seems a byproduct of cost-cutting at the expense of public health.

I urge HICPAC to advocate for a policy mandating universal respirator use in healthcare settings as basic infection control.

Sincerely,

Sara Woodard
Madison, WI

I'm writing as a disabled person who has still not recovered from my January 2023 Covid infection. I went from being able to walk about 50 steps to just 10, a devastating loss of function and needless to say, one I cannot risk repeating. This has meant I have foregone healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC will protect the wellbeing of patients like me through robust, science-based infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.

I urge HICPAC to recognize airborne transmission of Covid and other commonly circulating pathogens and to put in place the common-sense precautions that flow from that reality: requiring respirators and not inferior surgical masks in healthcare settings regardless of vaccination status or known infection status; requiring clean air tools such as HEPA filters and increased ventilation; and involving aerosol experts as well as the stakeholders most impacted in the transparent development of these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

You have scientific obligation here, to the fact of airborne transmission, as well as a moral obligation: do not leave disabled people to “fall by the wayside” as Dr. Fauci so callously put it.

Catherine Romatowski, MA, DEA
McLean, VA

To HICPAC:
Since 2020, it has been widely known that Covid-19 is airborne. It is transmitted by breathing in infected air. Pretending that covid is spread by droplets has had wide ranging consequences.

First of all, you gaslit the American people. You deliberately lied to us and told us that hand-washing would keep us safe from an airborne virus. Millions of us are now disabled and working less than we could have before you forced us to get infected.

Second, you spread misinformation about the effectiveness of fit-tested respirators. You want to know why Americans don’t trust public health experts? BECAUSE YOU LIED TO US! For many of us including myself, your deceitful policies have cost us our livelihoods and health.

Your policy must reflect settled science: COVID is airborne and a well- fitting n-95 respirator reduces the chances of covid transmission. Surgical masks lack the seal that makes n-95 respirators effective, and are therefore inappropriate in healthcare settings. One-way masking is not enough. The burden must not be put on patients to protect ourselves from covid in healthcare settings.

I caught my first of six covid infections from my cardiologist because respirators were not required in healthcare settings. Ironically, I have had to see this cardiologist much more often after the covid infection he gave me turned into pericarditis.

Your policy must also require the use of n-95 or equivalent respirators in healthcare settings for patients and providers regardless of vaccination status. Patients are often required to remove masks in order to receive healthcare or dental work. Receiving healthcare should not require being exposed to covid.

In addition to n-95 respirators in healthcare facilities, HEPA filters must be added to healthcare facilities. Covid is airborne and it is settled science that increasing ventilation amd HEPA filtration reduces spread. Additional tools like CO2 detectors (a proxy for transmission risk) and far UV light should also be deployed. Using all of these tools together will keep healthcare workers and patients alike from getting sick.

Lastly, all of this is settled science. Involve aerosol experts and increase transparency.

Please require n-95 or better respirators (not ineffective surgical masks) in healthcare settings for patients and providers, increase air filtration and ventilation in healthcare facilities and listen to aerosol experts. Anything less will only serve to sicken, disable and kill many more and the blame will rest on this committee.

Best,
Gina Ruth

Hello,

I am a front line health care worker, working with medically fragile preterm and term infants in NICU and medically complex children in home care. All of my clients are at increased risk for adverse outcomes. Many of the infants are unvaccinated. It is unconscionable that health care workers and those who enter health care settings are not required to wear high quality, effective masks (respirators) to help reduce the potential exposure of ALL, but especially those who are at increased risk.

SARS-CoV-2 is transmitted by aerosols (this is established science), for which surgical masks offer inferior protection and no masks, of course, offer none. Vaccines cannot be relied upon as a sole measure of defense when we know clearly now that they are not as protective against the variants as they were against the original virus. Breakthrough infections occur often and can lead to poor outcomes, including long covid. It is difficult to understand why Infection, Prevention and Control officials would not want to follow the science to preserve the health and safety of the staff and patients that they are presumed to be trying to protect.

In addition to requiring masking in health care facilities, air quality improvement measures such as enhanced mechanical ventilation AND HEPA filtration should be standard as an additional layer of mitigation. ASHRAE has updated guidelines which should be incorporated.

There are many, many experts in aerosol science who are available and readily willing to contribute to the development of evidence based guidelines for infection prevention and control of airborne viruses like SARS-CoV-2. I emphatically urge you to include those scientists in your consultation while developing your guidelines. To omit them is to willfully ignore the very experts you should be heeding.

Thank you for your time.

Sincerely,
Heather Moore

I am writing to express my concern about the upcoming HICPAC meeting and the reports that the committee is considering reducing the stringency of infection control precautions in hospitals and other health care settings.

I strongly oppose any loosening of infection control precautions and would be very supportive of more stringent recommendations particularly for airborne precautions.

I have been a physician for over 40 years and have worked in acute care facilities for my entire career. Although I worked in psychiatric settings, there were still many occasions when infection control was crucial whether due to contact precautions, antibiotic resistant colonization, bloodborne illnesses, or respiratory illnesses such as influenza or TB. When it became clear that HIV could be transmitted by needle stick injuries or blood contamination, everyone readily adopted universal precautions though it was more costly to institutions and sometimes made it more challenging to carry out blood draws or other procedures. In other situations, CDC recommendations and health care facility policies have also focused on protecting transmission of infection to health workers and reducing nosocomial infections. Even now, hospitals appropriately require N95s when working with a patient with active TB and influenza vaccination and other vaccines in healthcare workers.

Regardless of the current debates on social media and in political circles, evidence from industrial engineering models and other well formulated studies (not to mention common sense) supports the notion that wearing a well fitting mask such as a respirator or N95 (even without fit testing) is less likely to be associated with respiratory disease transmission than a poorly fitting surgical mask. Wearing no mask at all is commonly associated with transmission when one or more people are actively infected and in close proximity. Outbreaks still happen fairly often in assisted living and skilled nursing facilities for example and patients are still getting COVID in hospitals just as the spread of influenza led to appropriate infection control measures in years past. Similarly, with the continued propagation of COVID including intermittent waves and ongoing evolution of the virus, it is imperative to require greater attention to ventilation and methods to reduce transmission of all airborne infections (not just COVID). Although we already have increasing evidence of long term effects of COVID (including long COVID), we know from many other viral illnesses (e.g. HIV, varicella, herpes, EBV) that there can be long term effects on health that appear years to decades in the future. We need to make policies now that will reduce reinfections and reduce risk of future impacts on health. Health care facilities should be places where individuals can feel confident in seeking care without knowing they are risking infection with COVID or other infectious agents. Health care workers should

also be able to go to work feeling reasonably confident that their safety is not being intentionally jeopardized by regulatory agencies. Thus, we should be making every effort to decrease and eliminate hospital-acquired infections and to do that requires strengthening and not reducing our infection control measures.

Sincerely,
Laura J Fochtmann MD
SUNY Distinguished Service Professor
Stony Brook University

To Whom it May Concern,

I am very disappointed to see that the HICPAC working group continues to work on proposing updates to the 2007 Isolation Precautions guidance and operate without full transparency and providing access to healthcare experts, healthcare unions, and the concerned public.

Meetings should NOT be closed to the public, and public comment should not be turned off/closed early without giving all members of the public who wish to speak time to do so.

A vote should be delayed until the public has had sufficient time to review the draft Isolation Precautions guidance updates and proposed changes, and there should be publicly-accessible meetings to the public held in advance of any vote!

Why are there no experts in aerosol science, respiratory infection or ventilation engineering on the HICPAC committee as a voting member? COVID-19 is an airborne pathogen that primarily spreads by aerosol transmission - experts in these areas must be installed on the committee to provide critical guidance on this life and death matter!

It is complete negligence to ignore such a vital perspective when addressing isolation protocols for airborne infectious diseases.

It is also completely negligent to incorrectly equate the effectiveness of a surgical mask to a higher-grade N95 mask for airborne pathogen protection. The evidence review on N95 respirator and surgical mask effectiveness was flawed, pointing to a false equivalency, and must be redone to include input from scientific researchers and experts in respiratory protection, aerosol science and occupational health.

We know that there are vast risks to catching COVID-19; there's evidence that COVID affects the heart, lungs, brain, liver, and kidneys, possibly for years or even a lifetime with resulting Long COVID.

We now know that the latest variants are increasingly evading vaccines and reinfections are occurring within weeks of each other. The CDC has stated that Long COVID is affecting 1 in 5 cases of COVID, which our current vaccines sadly only prevent by 15%. Studies have shown that each successive case of COVID increases the risk of serious disease and Long COVID. This is also an equity issue, as we know that BIPOC communities are disproportionately affected by the virus.

We should be striving to do all we can to prevent transmission within hospitals and healthcare centers and protect our healthcare workers and patients!

Sincerely,
Kelly Byke
Los Angeles, CA
No organizational affiliation
Topic: Isolation Precautions guidance updates

SARS-CoV-2 is a microaerosol pathogen. Thus, respirators, negative airflow and HEPA filtration need to be in place and properly maintained.

This microaerosol evidence ought to be the primary basis brought to account in practicing prevention and general public education.

Medical settings are rife with pathogens. SARS-CoV-2 is an additional and highly virulent pathogen to weigh upon not only relatively healthy individuals, but especially those in their later decades of life, young children and citizens with immune disorders, cancer and other diseases.

Findings of SARS-CoV-2 impacting those infected with long-term disease, bring new concerns for wider infections throughout the population.

It becomes critical to care for these populations - and the healthcare providers and staff.

It is imperative that infection control begin in locations where infection occurs more broadly in an acute care setting, particularly hospitals, nursing homes and medical clinics where a wide population seek medical care.

Regards,
Sheila A Sullivan
Boulder, CO

The following is a comment for the HICPAC.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Thank you,
Angela Serwaa-Marfo, JHU student, Baltimore, MD

My name is Nathan Parr, I am a private citizen submitting comment on the proposed changes to masking policy and infection control protocols. At present I feel that the direction you are considering at this time is foolhardy, unscientific and deeply harmful. Airborne infections are

consistently aerosol transmissible. People go to doctors to get better and should not be required to risk getting sick when they go. N95 masks must be required for providers to contain the risk to both them and patients. A fit tested n95 or better is the only measure that can reliably prevent airborne transmission. Filtration helps, ventilation helps. Though those are great as additional steps, Neither is even close to as effective as consistent masking. There are hospitals with near zero airborne transmission of disease within the facility. All of those require usage of high quality (n95 of better) masks by staff. I wholeheartedly condemn the proposition to reduce the standard for airborne precautions to surgical masks. They are not remotely suited to that purpose. A top quality surgical mask removes 75% of aerosols from the air. A top quality n95 removes 99.5%.

If we require n95s, everyone wins. Hospitals win because they don't have to deal with the additional costs of sick staff. Physicians win because they don't get sick. Insurance companies don't have to pay for the cost of infection. Patients win because they have better outcomes. Please institute firm standards to prevent aerosol transmission of disease in hospitals.

Thank you for your time,
Nathan

P.S. I am unhappy with the length of time in which written comment can be submitted. If there is only a day to submit before the meeting, it makes it look like you're trying to get away with something.

I urge you to: -Recognize aerosol transmission of COVID and respiratory disease -Keep Respirator requirements in healthcare regardless of vax status -Respirators are more effective than surgical masks -Use Clean air tools like HEPA filters -Involve aerosol experts and increase transparency
People like me who need help in healthcare do not go because we can get SICK getting treatment.

Kari Samuels
Portland, Oregon

The CDC has an obligation to keep the public safe. That means not only informing the public that SARS-CoV-2 is airborne, but working to enforce proper masks in healthcare. Proper masks are not loose surgical masks that have gaps on the sides. Patients shouldn't have to risk their lives to obtain healthcare. Please do the right thing and vote accordingly.

Thank you!

Regards,
Bobbi Leder

Dear HICPAC Committee Members:

I am a substitute teacher in San Diego County, California, and I am unaffiliated with any organization.

I have a personal stake in the issue of infection control. Many of my relatives have had covid, including one who nearly died from it. Covid can trigger autoimmunity. I already have an

autoimmune disorder, covid can either exacerbate my autoimmunity or give me an additional disorder.

I am concerned that you may adopt guidelines that will endanger the public and healthcare professionals. Covid is airborne. Aerosolized SARS-CoV-2 can travel twenty feet or more and linger in the air for hours after an infected person has left the room.

I urge you to make using N-95 respirators (or better) a mandatory, everyday practice for all healthcare workers. In addition, healthcare settings should have a minimum of six air changes per hour (ACH) to reduce the likelihood of transmission of pathogens. HICPAC should consult engineers, physicists, industrial hygienists, and aerosol scientists for developing standards for cleaner, safer air.

Ultimately, seeking healthcare should not be a danger to one's health. "Living with covid" means not being repeatedly infected, and especially not being infected in a hospital or other healthcare setting.
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Best regards,
Robert Schwartz
Oceanside, CA

Dear CDC HICPAC,

I am writing to express my deep concern and frustration regarding the potential relaxing of infection control guidelines. It is imperative that, instead you take immediate action to update these guidelines to reflect the current scientific understanding and best practices. I demand the following changes:

1. **Recognition of Aerosol Transmission**: It is unfathomable that the CDC HICPAC has yet to officially recognize aerosol transmission as a significant route for COVID-19 spread. This failure to acknowledge reality puts countless lives at risk.

2. **Respirator Requirements in Healthcare, Regardless of Vaccination Status**: The importance of respirators in protecting healthcare workers should not be contingent on vaccination status. Your failure to mandate respirators for all healthcare personnel is reckless and unacceptable.

3. **Emphasis on Respirator Superiority**: The overwhelming evidence supporting the superiority of respirators over surgical masks in preventing the transmission of respiratory infections cannot be ignored any longer. It is negligent to downplay this crucial fact.

4. **Incorporation of Clean Air Tools such as HEPA Filters**: The absence of guidance on clean air tools, like HEPA filters, is a glaring oversight. Hospitals and healthcare facilities must utilize every available resource to ensure clean, virus-free air for the safety of both patients and healthcare workers.

5. **Involvement of Aerosol Experts and Transparency**: Your failure to involve aerosol transmission experts in your committee is inexcusable. Furthermore, the lack of transparency in your decision-making process erodes trust and undermines your credibility.

The lives of healthcare workers and the general public are at stake, and your failure to act promptly and decisively is indefensible. It is your duty to ensure that your guidelines are based on the latest scientific knowledge and are designed to protect the health and well-being of the population.

I demand that you act swiftly to implement these necessary changes. Lives are on the line, and you must take immediate action to reflect the reality of the COVID-19 pandemic. Anything less is unacceptable.

Sincerely,

Dana Whitfield

The health care industry is in the brink and that is due to poor information about the transmission of COVID. Every day health systems are spreading COVID to patients and the work force due to your ill informed recommendations. Your lack of understanding and adherence to the know science means that we are obliterating our workforce and harming or killing patients every day.

It is time for you to do the right thing.
Recognize aerosol transmission and require mitigations in health care
-strengthen masking by requiring respirators in healthcare regardless of vax status.
-Respirators are more effective than surgical masks period
-Clean air tools like HEPA filters must be in patient care and procedure settings
-Involve real aerosol experts and increase transparency
- demonstrate what it looks like to use current science and make better decisions

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Amid the horrors of 2020, it is easy to lose track of what we learned when experts from fields as diverse as public health, particle physics and history were asked to work together in the public interest. We made a very important discovery that year as a species: that most illnesses are transmitted, not primarily through droplets or fomites expelled during coughs and sneezes that fall to earth quickly and linger only on our hands, but through aerosols that linger in the air like smoke and become concentrated in spaces with poor ventilation.

Suddenly "flu season" makes sense, not as a pre-ordained mystery of nature, but as the ordered result of shutting windows and doors and reducing ventilation in winter months. Suddenly sickness does not have to be an inevitable fact of life. We are standing at the precipice of a medical revolution, with a golden age on the other side as different from what we have known as the difference after the development of vaccines or the purification of drinking water.

But to get there, we too must learn to examine what seemed clear and harmless to us before: not water, this time, but air. We must fully integrate this public health discovery into our institutions and harness the full power of technology to help us. We must:

-Monitor indoor air quality and ventilation through the use of tools such as CO2 monitors and by including experts in aerosol sciences in closed-door meetings.

-Purify the air through the standardization of HEPA-grade filters and upgraded ventilation standards.

-Empower workers and other members of society to learn the basics of particle physics such that the efficacy of aerosol PPE graded N95 and higher is common knowledge, and the difference between N95s and surgical or cloth masks is widely known. We should all know that masks work not like colanders, but like spiderwebs to trap particles on the micron level, and that N95 masks are more efficient because of their seal and static-electric properties that trap particles much smaller than the gaps between fibers.

-Standardize the use of N95-and-higher-rated respirators in healthcare settings, where the general public is at highest risk for respiratory transmissions and medically vulnerable people are disproportionately present. Without a sterilizing vaccination for every common respiratory illness, the vaccination status of health care workers does not protect patients from airborne transmissions.

Why go back to 2019 when we can move forward to a future better than anything we've had before? Be among the names schoolchildren will learn when looking back at the history of medical progress!

Sincerely,
Shielding Cournoyer

SARS Covid 19 has proven to be airborn, and needs to be acknowledged as such.To keep staff and patients safe we need respirator requirements in healthcare regardless of vax status. There is no reason immune compromised people or prenatal infants should be exposed to SARS Covid-19, RSV, TB or any airborn virus while they are recieving necessary and lifesaving healthcare. Respirators are more effective than surgical masks. We also need clean air tools like HEPA filters. This body needs to involve aerosol experts and increase transparency.

You are endangering the very important lives of healthcare workers by requiring them to work in an unsafe workspace. If this was a lab they would be using BSL-3 protocols but in many hospitals and medical settings they don't even have to wear a respirator.

Please do your job and make healthcare safe for me, my family and my community.

Mary Taylor
New Haven, MI

As a healthcare worker myself and a immunocompromised person watching the erosion of infection control that has happened since the normalization of SARS2 is beyond shameful. Bottom line accessing care should NOT lead to a single patient becoming infected. Clean the air ! Upgrade the HVAC systems and mandate masks on allllll healthcare staff.

If you can’t promote patient safety you have failed as an organization.

> I'm writing as a disabled person who has still not recovered from my January 2023 Covid infection. I went from being able to walk about 50 steps to just 10, a devastating loss of function and needless to say, one I cannot risk repeating. This has meant I have foregone healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC will protect the wellbeing of patients like me

through robust, science-based infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.
>
> I urge HICPAC to recognize airborne transmission of Covid and other commonly circulating pathogens and to put in place the common-sense precautions that flow from that reality: requiring respirators and not inferior surgical masks in healthcare settings regardless of vaccination status or known infection status; requiring clean air tools such as HEPA filters and increased ventilation; and involving aerosol experts as well as the stakeholders most impacted in the transparent development of these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.
>
> You have scientific obligation here, to the fact of airborne transmission, as well as a moral obligation: do not leave disabled people to “fall by the wayside” as Dr. Fauci so callously put it.
>
> Catherine Romatowski, MA, DEA
> McLean, VA

Why is Correctional Health Care participation not included in this committee.

Name =
Sue Medley-Lane

Organization =
Correctional Health Care / Centurion Serving 18 states

Questions =
CDC has continued to not include the correctional healthcare representation n the committees. As a congregate setting with millions of patients, this needs to be addressed. The specialty of correctional health care has been recognized as a specialty, but we still are not represented in any of the CDC committees with exception of the Correctional work group that was formed during the pandemic. This is an important part of healthcare, and we should have representatives in the guidelines. I have been in correctional healthcare for over 27 years, and I am the director of infection prevention and control in a large healthcare provider. I have over 50 years in the medical field with 30 years in infection control. I am willing to serve on any committee to give correctional healthcare a voice.

To the members of HICPAC,
SARS-CoV2 is transmitted via aerosolized particles in the air we all breathe. This must be publicly acknowledged and this information disseminated throughout the country. The American public has a right to know that they are risking their lives when breathing in unfiltered air in shared spaces so that they may protect themselves from SARS-CoV2 infection and advocate for cleaner air in shared, public spaces.
We, as a country, will not survive if we hide vital health information from the public. More and more people will continue to be infected with SARS-CoV2, die, become disabled, or chronically ill and the entire country will suffer because every infected person plays an important role in their family and community that cannot be easily filled especially when everyone is at one point or another becoming infected and developing long term health problems.

Thank you,
Heather Sroufe-Powers

I wear an N95 because I want to protect myself and others. I am privileged to afford a high quality level of protection. All Canadians should have access to the same protection. Where is health equity in the COVID protection communications and decision making?
Judy Woods RN

Dear HIPAC,

As you know, SARS-CoV-2 is one of many infectious diseases which can be transmitted person-to-person by the aerosol route.

Please publicly recognize aerosol transmission of SARS-CoV-2.

Please also recognize the public health burden, mortality and morbidity, and economic impacts downstream of extensive unmitigated spread and unrestrained mutation of these respiratory pathogens.

Recall that there was a time when hand washing was mocked as a ridiculous idea by those in the medical profession.

Hand washing is now universally required standard practice in all medical facilities, and even in schools and workplaces.

There will come a time, in the not so distant future, when air filtration and clean air are seen as equally important to public health.

Eventually, people will look back with shock on the contemporary disdain for aerosol precautions. Just as we now look back in horror, on the then medical field's disdain for the idea (and the "burden") of hand-washing, as it was seen back in the days of Semmelweis.

It is now in each of your individual hands. You each have the choice to vote to re-enforce the status quo; or instead, to be brave, to stand up against immense social and political pressure (bolstered by rampant misinformation and disinformation), and to valiantly stake your place on the right side of history, by voting to help us all collectively move towards this brighter future.

The evidence is clear: Masks can reduce the risk of spreading SARS-COV-2 and of being infected with it: (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811136)

From first principles of filter material properties and fit dynamics, respirators, even when worn imperfectly, offer improvements in source control and protection for their wearer compared to surgical masks.

Much like hand washing and glove wearing do for direct contact and fomites, respirators offer us the technology to dramatically reduce the spread of aerosolized respritory pathogens in healthcare settings such as ICUs, emergency rooms, surgical settings, including pre- and post-surgical settings, etc. There is so much to be gained by reducing aerosol transmission of respiratory viruses and bacteria in these healthcare settings, when at least some subset of patients are at their most vulnerable.

MERV 13, MERV 13-A, MERV 14, or better, air filtration is highly effective at removing > 99% of aerosolized respiratory pathogens > 0.3 µm, including SARS-COV-2, from breathable air (https://www.ashrae.org/news/ashraejournal/debunking-myths-about-merv-air-filtration). A higher number of air changes per hour confers greater reduction in transmission potential. Modernized air filtration systems meeting such standards, agreed upon by aerosol experts, should be required in all indoor public settings (healthcare, schools, workplaces, etc.), as a baseline of background defense.

Far-UVC is another technology which can be employed to help reduce the spread of aerosolized pathogens, by directly sterilizing the air, adding another layer of protection.

The combination of respirators, air filtration, and air sterilization, makes for a potent "defense-in-depth" strategy (https://labsafety.jhu.edu/2022/04/15/lab-safety-defense-in-depth/) to dramatically reduce the spread of airborne pathogens.

Recall: hand washing, gloves, and surface sterilization are universally required today, but they were not-only not always *required* - there was a time when many healthcare professionals argued that they were not necessary at all. The parallels to where we are today on the aerosol issue cannot be ignored forever. Please take your stand on the right side of history.

Thank you very much for your consideration,

Layla Mah
Lowell, MA
Unaffiliated

I am writing to express my deep concern regarding the proposed updates to the 2007 Isolation Precautions guidance and their potential impact on the safety of healthcare workers and patients. While I cannot address all the points raised, I feel compelled to highlight the following critical issues:

1. Lack of Stakeholder Involvement: It is disheartening to note that the development process for these updates has failed to include essential input from various stakeholders, such as frontline personnel, unions, patient safety advocates, industrial hygienists, and others. To ensure the effectiveness of the guidance, I strongly urge HICPAC and CDC to broaden the consultation process and actively engage these experts in developing drafts.
2. Lack of Transparency: The lack of public access and engagement in the update process is concerning. Transparency is essential to build trust and confidence in the guidance. I strongly encourage CDC/HICPAC to increase transparency and make meeting presentations and recommendation documents publicly accessible, in line with other federal advisory committees.
3. Flexible Approach and Protection: The proposal for a more "flexible" approach to precautions raises concerns about the level of protection for healthcare workers and patients. I urge HICPAC and CDC to maintain a clear and explicit approach, assessing the level of exposure and selecting appropriate control measures, ensuring a written exposure control plan.
4. Recognition of Aerosol Transmission: The proposed terminology on infectious disease transmission should acknowledge aerosol transmission. Failing to do so weakens protection for healthcare personnel and patients. It is vital to update classifications to

reflect aerosol transmission, particularly considering the lessons from the COVID-19 pandemic.

5. Evidence Review: The evidence review on N95 respirator and surgical mask effectiveness needs to be reevaluated with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. Prioritizing randomized controlled trials and overlooking other applicable data and studies is a significant concern.
6. Core Control Measures: The importance of respiratory protection, ventilation, and air filtration in controlling infectious aerosols cannot be ignored. Recommendations on ventilation and source control should be integrated into the guidance.

These concerns reflect the importance of ensuring that the updated Isolation Precautions guidance prioritizes the safety of healthcare workers and patients. I strongly urge you to consider these issues in your deliberations and involve a broader range of experts and stakeholders in the decision-making process.
Thank you for your attention to these critical matters.
Sincerely,
Brian Hanna-Sauro

It is well documented that aerosol transmission is the primary means of transmission in COVID as well as other viruses (RSV, flu, etc). HVAC and ventilation is crucial for clean air quality. We don't allow tainted water, why must we tolerate tainted air—-especially in public buildings. Air quality monitoring needs to be required in public buildings. Clean air tools like HEPA filters and Corsi Rosenthal boxes help to clean the air and reduce transmission.

ID doctors and Public health officials have not proven to be the ultimate answer in the pandemic. They have not been effective at changing public health during the pandemic. We need to involve aerosol experts, HVAC experts and increase transparency of issues regarding "sick" air in buildings, especially public (schools) and government buildings. We need clean air tools like HEPA filters and CR boxes (as effective and more affordable than HEPA) required when the air quality is poor.

We need to require healthcare to wear high quality masks, or at a minimum, wear high quality masks at the patient's request. There are too many stories of compromised patients acquiring an illness when they go for care. This does not further healthcare, but increases the likelihood of delaying health care! Vax status doesn't matter anymore! It reduces but doesn't eliminate transmission.

CDC can't be trusted if they don't acknowledge these points and seek to improve the air quality. Otherwise the CDC is just another political group with a healthcare focus. Please return to being doctors and scientists and appreciate the need for air quality specialists expertise in improving indoor air quality.

Penni Romero
Elkhorn NE
I'm just a semi-retired regular American with asthma that is tired of poor indoor air quality creating hazards in my daily health.

I'm writing as an immunocompromised person whose life was destroyed by a Covid infection 1 year ago. Among the many ways my life has been turned upside down by Long Covid, one of the most disturbing is that I'm unable to safely access healthcare due to rampant Covid spread

and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC has the well being of patients like me at heart and is working to increase infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.

I urge HICPAC to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

Thank you,
Lauren Bishop
Alameda, California

Hello, I am writing to ask that you:

- Recognize aerosol transmission
- Require respirators in healthcare regardless of vax status
- Respirators, not surgical masks which are significant less effective
- Require the use of clean air tools like HEPA filters
- Involve aerosol experts and increase transparency

Current conditions are unsafe. I shouldn't need to risk my health to receive healthcare.

Thank you,
Tania Henderson
Lauren, NY

Good morning,

My name is Kristen Arbogast, I am a Master of Social Work student at West Virginia University. The CDC needs to acknowledge airborne/aerosol transmission of SARS-CoV-2 and the need for N95 respirators to be worn in all healthcare settings at all times, regardless of vaccination status. I, on behalf of all West Virginians, low income individuals, and those with disabilities, am demanding the acknowledgment that N95 respirators work in preventing viral transmission, increased access to air filtration technology systems in healthcare, public schools, and public transportation. The pandemic has been grossly mishandled from the beginning and I am demanding transparency and the truth regarding Covid-19 (SARS-CoV-2). The truth needs to be shared with the public and shared in a way that they can understand; the majority of the United States reads at a 3rd grade level. I am demanding protection for myself, my family, and healthcare workers. I am demanding safety for the children in public schools who are forcibly being infected and re-infected. I demand a change. The powers that be WILL be held accountable for their negligence, it is time to stand up and do the right thing that protects ALL. Elderly, poor, disabled, or children; we all deserve to live.

Thank you for your time.

To: HICPAC
From: Erica Olson
Red Deer County, AB
WHN, Advanced Care Paramedic, Clinical Educator
Re: HICPAC IPC Guidelines

- Guidelines should recognize that adopting effective prevention measures has important implications for the health of patients and healthcare workers. There is no room for compromise or laxity in providing medical care safely.
- Guidelines should be based on the precautionary principle, which emphasizes the need for policy makers to prioritize risk reduction. Unlike individual decision-making, policy decisions have wide-ranging impacts on society, necessitating a greater emphasis on minimizing potential risks for many people.
- Development of infection control guidelines should include experts across disciplines studying airborne transmission.
- Development of infection control guidelines should involve those who are most at risk including patients and healthcare workers and their representative organizations.
- Guidelines should fully adopt established science of airborne transmission and its prevention. This includes using effective masking including N95 respirators, elastomeric respirators, and PAPRs. There is no justification for adopting non-airborne precautions for airborne pathogens.
- Guidelines should include comprehensive measures including ventilation and HEPA air purification, masking, testing, and minimizing unnecessary sharing of air of those who might be infected with those who are susceptible.
- It is appropriate to communicate personal experiences in engaging with the healthcare system and the risk of infection to point to the need for high levels of safety and that those who are at risk should be participating in the policy making process.

Please consider the immensity of impact outside your political sphere when deciding on national recommendations that ripple out to directly influence international IPC guidelines and medical access safety.

Erica Olson

My name is Rachel Adelson. I am a US citizen temporarily living in Ontario, Canada. My voting address is in Raleigh, North Carolina. I am a self-employed senior science writer with graduate study in Public Health at the University of North Carolina-Chapel Hill. As of today, my husband, young adult daughter, and I have not been infected with COVID due to our consistent use of precautions against this airborne respiratory virus, including respirators (N94/95 masks) and indoor air filtration and ventilation.

At the same time, we have needed to defer healthcare due to the lack of similar precautions in healthcare facilities. This is a major concern for us, of course, but should be a great concern for any healthcare system that will face increased illness among staff as well as higher burden from treating more advanced illness.

Infectious Disease "experts" appear to have obstructed whole-of-society reduction in the transmission of the SARS-CoV-2 virus by denying or suppressing information on its airborne characteristics. This undermines trust in the medical establishment, with grave (literally, for some) consequences for individuals and society, still

dealing with COVID now and looking ahead to future contagions. There is no guarantee plagues will not overlap. We may as well suck it up now and learn how to properly, appropriately, comprehensively reduce airborne spread of COVID, RSV, influenza, "ordinary" colds, TB, and all other known and future airborne diseases. We also need rebuild our medical workforce by keeping its providers *healthy*.

My requests of the committee are these:

• CDC/HICPAC needs to delay the vote until it has given We the People ample opportunity to review the draft Isolation Precaution guidance updates.

• CDC/HICPAC must hold public meetings—ahead of any vote—to hear from health care workers, patients, and experts outside of infection control, who have essential perspectives for updating the Isolation Precautions guidance.

• CDC/HICPAC must fully recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.

• The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

• I urge HICPAC and the CDC to maintain an approach in the updated Isolation guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.

• CDC/HICPAC fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered.

Thank you for your consideration. We'd really like for Public Health to do its job and help society get the ongoing disruption behind us. I am old enough to remember the CDC as a revered institution and would like it to earn that respect once again.

Best regards,
Rachel Adelson

Please comment on the covid precautions taken at the location of in person HICPAC meetings. For example, were the following noted, recommended or required:
1) masks/respirators for in person attendees
2) covid testing
3) virtual/ work from home option for those either confirmed sick or feeling symptoms
4) ventilation requirement of any type from the building (HVAC, windows, doors)
5) air quality monitoring (e.g. via CO2, PM, etc)

Regards
James Morris, PhD

Hello,

I'm writing to request that you require masks in hospitals and all healthcare settings, given that people go to these places hoping to be cured of what ails them, not to catch something new that can make their condition worse.

Especially with COVID-19 still rampantly circulating, it seems like the height of irresponsibility to not mandate something as basic as masking at hospitals and healthcare settings.

The facts don't lie, as evidenced by this recent study looking at levels of COVID infections obtained directly in hospitals: https://www.independent.co.uk/news/health/data-nhs-english-university-of-oxford-england-b2431909.html

We know that COVID is airborne, and as such need to be mandating masking and safe levels of air quality requirements in all hospital and healthcare settings - anything less than that is putting people at risk in places that are designed to help them, not hurt them.

Thank you,

Nathan Weatherford

We need stronger controls on airborne disease transmission in hospitals, not fewer and worse. Vulnerable populations should not have to choose between seeking necessary care and acquiring a debilitating, disabling, or deadly disease. Medical providers should not have to risk the same in order to do their jobs. There are currently zero (0) evidence-based treatments for so-called Long COVID, and if you don't know anyone whose quality of life has been eviscerated by this conditions, count yourself lucky.

I have a family with autoimmune disorders; we continue to take extraordinary precautions because we know our risk of severe adverse events from COVID is elevated. I myself have delayed a surgery to restore hearing in one ear because the hospital isn't doing anything to mitigate the risk of airborne disease transmission as the nation undergoes another surge in COVID.

Based on your actions to date, I can't and don't actually expect you to take public health concerns seriously; your abdication of that duty is flagrant, well-documented, and unconscionable. Your mission appears to be to protect your political leadership from criticism and to protect the financial positions of the large institutional stakeholders who comprise your only apparent constituency. Therefore, a financial argument, however ethically bankrupt, might give them and you pause: I will not risk an elective surgery in a US hospital under these conditions.

Please require masks in hospitals and all healthcare settings

Thank you,

Kevin Schultz
Fremont, California

As a member of the public and a parent, I feel abandoned by the CDC.

We have learned much from the sars-cov-2 pandemic. Instead of applying that knowledge to protect ourselves from Covid and other respiratory diseases, the CDC continues to roll back protections rather than making strong recommendations that could protect us all. Illness runs rife through our schools and workplaces, resulting in 1000s of avoidable deaths a week.
At a bare minimum people should be able to access healthcare without being exposed to airborne pathogens.
Standards for air quality should be a bare minimum. Masking in healthcare settings should be required as a bare minimum.

Ella
Brooklyn, NY

FROM
Sonia Rhodes
Rancho Santa Fe CA
NO Org Affiliation
I run a business that supports hospitals and health systems across the country

Humans of HICPAC,

Health care is in a downward spiral as health care workers and patients continue to be infected and harmed by dangerous conditions in hospitals and clinics. Health care settings should not be a danger zone for patients and caregivers due to lack of following science and evidence related to pathogen transmission .
You absolutely must:

1) Recognize COVID and other diseases are transmitted via micro aerosols - the data are clear! 2) Respirator masks must be required in all health care settings and for all people (surgical masks are not enough! The data are clear. Respirators are more effective than surgical masks. Studies equating them are flawed and you should know better. 3) Clean air tools like HEPA filters and upgraded engineering must be included in health care settings, and 4) Making any decisions or recommendations without involving aerosol experts is gross negligence and will continue to harm more people every day. I've lost two family members to hospital acquired covid. How many more will occur on your watch? -Involve aerosol experts

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I'm writing as a parent of an immunocompromised person whose life was destroyed by a Covid infection 3.5 years ago. Among the many ways my daughter's life has been turned upside down by Long Covid, one of the most disturbing is that she is unable to safely access healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC has the well being of patients like her at heart and is working to increase infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process of updating HICPAC's infection control guidelines.

I urge HICPAC to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks, to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities.

Thank you.
Donald Fraser
Purcellville, VA

Worldwide millions have died from Covid.
Millions more are permanently disabled.

We Demand: Rapid Molecular Testing, Ventilation, and Mandatory N95s in All Healthcare Settings.

Covid is transmitted in the air by aerosol transmission.
Masking with an N95 is scientifically proven to prevent transmission.
Ventilation, air filtration, social distancing, and N95 masking together have also prevented Covid transmission.

Thousands are at risk by healthcare facilities and healthcare personnel that do not control exposure to infectious aerosols by using preventative protocols.

The American College of Physicians declared, "Heath is a Human Right."

We stand by the ability for everyone to have safe, infectious-free, non-negligent healthcare.

The US healthcare system, governments, and global health organizations mismanagement of Covid is remarkable. The walk toward genocide and a total collapse of the healthcare system is remarkable.

We Demand: Rapid Molecular Testing, Ventilation, and Mandatory N95s in All Healthcare Settings.

Omm Office LLC

To whom it must concern,

People over profit! Masks in healthcare now!

HICPAC **needs** proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

Anyone can become disabled at any time - yourselves included! To not do what we can and use the tools we have is ignorant and rude.

Be better,
Jamie Sanin

Hello,

HIPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate.

Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force.
Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

As an immunocompromised person who relies on my medical team to keep me as well as I can be, I find myself canceling appointments that I NEED because no one will tale the necessary precautions to protect me and themselves. This is criminal to expect me to constantly ask providers to take the most basic of measures to keep me safe. Please keep this in mind when making your decisions.

Thank you,

Chris Covell

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate.

Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

I am immunocompromised and, frankly, tired of needing to get infusions of an immunosuppressant medication from a "top-rated" facility that does not require masking. I have long COVID in addition to my previous immunocompromising condition, but even long COVID specialist doctors do not mask. My elderly parents with chronic health conditions have had to have surgeries and other procedures where they cannot mask and are exposed to healthcare workers and other patients unmasked throughout the experience. I have friends who are preparing to deliver babies in hospitals this winter without masks to protect them or their newborns. This is absurd and the antithesis of "do no harm" - at the absolute least, it shouldn't be happening behind closed doors.

Thank you,
Hanna Kaufman

Dear Dr. Mandy Cohen, Dr. Daniel Jernigan, Dr. Michael Bell, and Dr. Alexander Kallen:

I urge you and your colleagues to appreciate and seriously consider the deleterious effects of foregoing aerosol control measures in healthcare settings. Without effective mitigation,

healthcare workers, patients, families, and the broader community will continue to face undue suffering, both from the spread of disease and the mental exhaustion of constantly navigating risk in settings where there is little personal choice or control over one's exposure.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. In my understanding, there are no recommendations on ventilation and source control is not adequately considered in the context of personal protection from inhalation. This is unacceptable, particularly in the face of so much evidence regarding effective protection measures.

Once again, I urge you and your colleagues to appreciate and seriously consider the deleterious effects of foregoing aerosol control measures in healthcare settings. I urge you to make recommendations and exercise the full extent of the CDC/HICPAC's power to encourage measures that protect healthcare workers, patients, families, and the community.

Thank you for your time,

Michael Manning
Cambridge MA
No relevant organization affiliations to report

Considering that the Covid-19 pandemic is not over and that it is transmitted through the air, it would protect medically vulnerable people like myself as well as stem the spread if medical facilities went back to proper infection control practices that included high quality masks (minimum N95/KN95).

In addition, the Hippocratic Oath says, "first, do no harm". One of my dearest friends went in to the hospital last year for one reason and contracted Covid while hospitalized. She died shortly thereafter at the hospital. This is unconscionable that my friend died because the medical community did not have proper transmission protocols in place.

Another friend of mine who was meticulous about mask wearing similarly went to a doctor's office and days later came down with Covid that they contracted at the doctor's office where no one else was masking but her.

I recently went to doctors appointments at medical offices and hospitals and none of the staff were wearing masks. While I continue to mask, I will have limited protection if everyone else around me is not wearing masks. The science is clear on that.

In addition, there is a toll on an already stressed medical system if staff are out because they catch Covid. The threat of long Covid still exists and also has an impact on the staffing and ability to provide adequate care. Long Covid is causing people to drop out of the workforce, including healthcare.

Please do the right thing and protect both medical staff and patients and upgrade the guidance to keep people safer. This is outrageous that it is allowed to continue like this.

Thank you.

With CDC studies and even a recent 60 minutes special demonstrating that the COVID-19 is airborne, HICPAC must consider the following to manage infection control
- recognizing aerosol transmission
- respirator requirements in healthcare regardless of vax status (CDC has also acknowledged asymptomatic transmission of Covid)
- respirators are more effective than surgical masks
- clean air tools like HEPA filters
- involve aerosol experts and increase transparency

1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.
2. I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.
3. HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.
4. The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The

evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.
6. CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Best,
Glenn Nagao

To Whom it May Concern,

I strongly urge you to recommend the required wearing of respirators in hospitals and healthcare settings. These place have become one of the main sources of COVID-19 and other viral infections. People often have no choice but to attend these settings to see their doctors and practitioners. Must one risk a life-threatening illness to stitch up a cut? Extract a tooth? Get a mammogram? Get vaccinations for their child? Of course not!

Further, people at risk of serious consequences for getting a COVID-19 infection are exposed to staff and visitors without regard for their safety - immune-deficient patients, pregnant mothers, and cancer patients, for example. It's a terrifying choice tohave to make, and completely unnecessary!

Further, simple air quality improvements can be employed to rid the clinic and hospital air of pathogens. The expense is nothing compared to the cost to our health system and society of continuing serious illness and long-term disabilities.

I trust you will do the right thing for us all.

Sincerely,
Wayne P Allen
Austin Texas

To Whom It May Concern:

I am an immunocompromised person living in Brooklyn, NY. Due to a single COVID infection in 2020, I have become severely disabled with COVID-induced POTS and the rapid progression of my underlying neurological disease. I can no longer work and have become very reliant on caregivers for my day to day life. If this is the outcome of just one COVID infection, I greatly fear what another might take from me.

As someone who frequently needs to visit multiple specialists for my disabilities, it is terrifying and unacceptable that I need to fear getting another COVID infection whenever I need to see my doctors because the standards for COVID mitigation have essentially become nonexistent. Nationwide mandates to mitigate the spread of COVID (and other infectious diseases) in medical settings need to be responsive to the needs of those who have long-COVID and

associated conditions. Research shows one way masking is not sufficient to fend off COVID infection, nor are surgical masks sufficient. The CDC needs to follow the leadership and guidance of hundreds of experts with scientifically backed knowledge on aerosol disease transmission. We need strengthened infection control standards, not weakened measures based on flawed studies that will cause more sickness and death in the very settings patients rely on to access care. It should not be the responsibility of the patient to advocate for infectious disease prevention while seeking care in medical settings. It is your ethical responsibility to follow the scientific evidence on preventing aerosol disease transmission that protects patients and medical staff alike. Weakened measures in healthcare settings go against the Hippocratic oath to “do no harm” - you know better and have thousands of deaths on your hands if you do not course correct immediately.

I demand all doctors, nurses, staff and patients who are physically able to wear a mask, be required to do so in all medical settings. Specifically, doctors, nurses, staff and patients should be provided access to N95 respirators and expected to wear them in all healthcare settings. I demand updated ventilation and air filtration in all medical settings, in alignment with the highest standards to prevent aerosol infectious disease transmission. I demand frequent PCR & rapid antigen testing for all medical staff, as well as isolation requirements consistent with the most up to date, scientifically accurate timelines to ensure medical staff do not transmit COVID and other infectious respiratory diseases to their patients.

COVID-19 is not endemic, no disease that mutates this rapidly will be endemic. The CDC must stop using this inaccurate and misleading framework. All future HICPAC meetings need to be responsive to your constituents, these meetings should be transparent and participatory, not hidden behind closed doors.

These demands are the bare minimum for the CDC and all medical providers to provide ethical healthcare. Please do right by all patients and healthcare providers.

Thank you,
iele paloumpis

Attention: Healthcare Infection Control Practices Advisory Committee (HICPAC)

I am one of the millions of Americans suffering with “long covid.” While we don’t know exactly what is happening in our bodies that cause our symptoms, we do know that it would seriously harm (or potentially kill) us to get COVID again. We expect and demand that CDC make healthcare spaces safe for us and for all. Since it is well known that COVID is spread through aerosols in the air, we need universal masking with N95 respirators to be the standard in healthcare settings. This will protect patients and healthcare workers alike. And it will stop the current terrible situation where patients must choose between accessing needed healthcare and risking getting preventable COVID or other respiratory infections.

Susan Burket
Potomac, Maryland

Good morning.

Have we learned ANYTHING from the past 3 years?

PLEASE:
Recognize aerosol transmission
Respirators should be required in ALL healthcare settings for patients AND providers regardless of vax status
Respirators are more effective than surgical masks
Ventilation needs to be improved to provide cleaner air in ALL public settings, especially healthcare.
Increase Telework/hybrid options which effectively eliminate potential exposure
REMEMBER: Many people are asymptomatic carriers of virus ... this can be transferred to others. PERIOD.
PRESSURE all public transportation to require masking and seriously campaign to educate w/ visible posters and availability of N-95 masks.
Encourage children to make a game of decorating their N-95s so they can proudly wear them to protect themselves and their loved ones and teachers.
https://www.ox.ac.uk/news/2023-01-31-covid-19-leading-cause-death-children-and-young-people-us
Masks help prevent variants from evolving!!
Sadly, without mandates, the default seems to be lazy and avoid 'recommendations'.
An agressive Public Health Campaign is warranted.

INVOLVE AEROSOL EXPERTS AND INCREASE TRANSPARENCY!

https://www.cbsnews.com/news/indoor-air-quality-healthy-buildings-60-minutes-transcript/?intcid=CNM-00-10abd1h

"... some companies are doing just that – for the health of their workers and the health of their bottom line.
Joe Allen: The original sin of the pandemic was the failure to recognize airborne transmission.
Professor Joe Allen of Harvard's T.H. Chan School of Public Health believes the rapid spread of COVID in early 2020 was preventable.
Joe Allen: Think about the public health gains we've made over the past hundred years. We've made improvements to water quality, outdoor air pollution, our food safety, we've made improvements to sanitation: absolute basics of public health. Where has indoor air been in that conversation? It's totally forgotten about. And the pandemic showed what a glaring mistake that was."
Thank you.
Rita D. Lewis, RN (Retired)

Hello,

I am a concerned citizen who is alarmed by proposals to weaken infection controls in healthcare settings. Covid is a disease that can cause long term, systemic diseases long after the initial infection has been cleared, and people visiting healthcare settings are likely to already have vulnerabilities or simply be sick. It doesn't make sense to weaken protections in light of the fact that Covid is airborne and even if everyone doesn't wear their mask perfectly, you are better protected the more people are wearing masks.

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate.

Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

I have seen firsthand the damage Covid can do. My brother nearly died of Covid and hasn't been the same since. Now I am afraid to ask him to lift anything heavier than a pillow because I'm afraid he'll have a hard attack right in front of me. He has a hard time just walking across the room. And this isn't uncommon; according to the CDC's own statistics, at least 10% of adults now have long Covid symptoms. This is a minority to be sure, but not insignificant.

Hand washing wasn't always a standard procedure in healthcare settings, but now it is. It's time to make wearning N95 respirators a similarly accepted standard procedure in healthcare. It will save lives.

Signed,

Fiona Abbott

Address is: Walkerton, Indiana

For attribution, my name is Brandie Ecker and I live in Indiana.

It is my understanding that the current draft of the Isolation Precautions Guidelines being discussed (1) fail to recognize the importance and implications of recent research regarding aerosol spread of respiratory diseases; (2) appear to treat the effectiveness of surgical masks and respirators as the same with regards to aerosol transmission of respiratory diseases; (3) do not recommend respirators be used regardless of vaccination status of patient or healthcare worker; (4) do not recommend the use of air purifier/cleaners or increased ventilation to reduce the spread of respiratory disease in a healthcare setting; and (5) generally have failed to include experts in engineering, HVAC, infectious disease epidemiology, and others who have extremely relevant and useful expertise in relation to these guidelines.

Since the COVID-19 pandemic, much research has been done showing the prevalence of aerosol spread of respiratory disease (most obviously COVID-19 itself, but also including the higher prevalence than thought of aerosol spread of things such as influenza). The implications of such aerosol transmission include the need for increased ventilation, increased air cleaning/purification measures, and the use of respirators. High quality research has shown that respirators are significantly more effective at preventing aerosol transmission of such diseases and should be recommended for health care workers in all settings to protect both healthcare workers and patients. This should be basic protocol similar to how handwashing and wearing gloves has become basic protocol for avoiding the spread of disease in healthcare settings. Failure to include the expertise of experts in relevant fields has resulted in these deficiencies in the draft guidelines. Failure to update the draft guidelines to significantly address these issues will cause significant harm to healthcare workers, patients, and the public, and create a much higher than necessary disease burden on society going forward.

To whom it make concern,
As an immunocompromised individual who has become highly informed about SARS-COV-2, please reinstate n95 masks in all health settings.

All doctor's offices, hospitals, dental offices and any services that provide medical services.
SARS-COV-2 is a Cardiovascular, Neuro degenerative Disease.
Those with the designation of "long COVID" are the canaries in the coal mine.
Society cannot function while so many people are continuing to be infected in settings that they have no actual choice to be in.
This isn't putting masks back in restaurants or shopping.

Understanding full well that the medical establishment has taken a great hit during all the controversy surrounding SARS -COV 2 politics... It is more than time to set aside all of that in favor of protecting those seeking health.
Thank you for your consideration,
Jane Dawson
Redway, California

Hello and Good Afternoon,

The past three years have provided an essential reminder that the public threat from infectious disease is serious and ongoing. The reckless speed at which the public health and medical professions in particular have moved away from explicitly and vocally supporting rigorous disease control measures has been disheartening to say the least and lethal on a global scale at worst. I am a student of public health at Rollins School of Public Health at Emory University and I do not support a regression of infectious disease mitigation away from the strong evidence supporting behaviors such as protected isolation for those infected for diseases like covid-19 and that effective respirators be required by hospital staff as disease transmission continues and continues to pose a threat to public health. Community health is not only at risk, but the help of essential healthcare workers that are themselves vital to public health. From nurses, who are vocally calling for strong workplace protections for themselves and patients, to the janitorial staff (including industrial hygienists, occupational health professionals, and public health researchers advocating for greater protections) that ensures sanitary conditions throughout healthcare settings — everyone deserves respect, dignity, and safe conditions from their workplace. And, importantly, accessing healthcare services should not put people at disproportionate risk of acquiring other diseases as we've seen so much recently with covid-19. I hope this committee and the CDC as a whole integrates more feedback from the working class impacted by their decisions and move towards a more open, transparent, and public decision-making process (as is widely demanded).

Best Regards,

Joel Lerner
Gangarosa Department of Environmental Health, Rollins School of Public Health
Emory University, '20Ox '22C '24PH

Nov 2, 2023

HIPAC members,

Tighten the rules around COVID, do not loosen them! Especially for health facilities.

1. PREVENT THE SPREAD - FINANCIAL REASONS

Preventing COVID is CHEAPER than the effects of getting COVID. N95 masks are CHEAP compared to losing a week of work. For companies, hospitals, doctor's offices, and for individuals.

2. PROVIDE HEALTHY WORK ENVIRONMENTS
COVID continues to reduce our workforce. Companies need workers. Hospital, doctor's offices, healthcare facilities, restaurants, retail, manufacturing, etc. all need workers. Healthy workers.

3. KEEP AMERICANS ALIVE
COVID is the 3rd highest killer in the US. Prevent the spread.

4. KEEP AMERICANS HEALTHY
Long COVID continues to create havoc in millions of lives here in the US. Disabling them.

5. IT'S EVERYWHERE
Every US state, every US territory.

6. REALLY????
People need to go to hospitals and health facilities to get HEALTHY. Not to get sick and potentially die.

Who is affected? Potentially everyone. My family, your family, everyone.

My family has been impacted greatly. Our daughter is at high risk, not able to receive the vaccine and is already dealing with many other health issues. If she gets COVID, it could really bad for her. We protect her at all costs.

Please … tighten the rules, especially in healthcare facilities.

Jordan Langner
Delmar NY

To: HICPAC
Re Nov. 2. 2023 Meeting

I ask that you:
-Recognize aerosol transmission and move to broadly address it
-Ensure respirator requirements in healthcare regardless of vax status
-Recognize that respirators are more effective than surgical masks
-Recommend clean air tools like HEPA filters
-Involve aerosol experts, and
-Increase transparency

Further, I urge CDC/HICPAC to understand how their proposals would harm health care workers and patients as detailed below.
1. HICPAC's process to develop updates to the 2007 Isolation Precautions guidance has failed to involve or incorporate essential input from many important stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, CDC/HICPAC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that CDC/HICPAC's process is so closed.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") - but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are **no** recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Sincerely,
Joe Banta
Anchorage, AK

Subject: N95s (or higher) respirators are the Precautionary Standard of Care

Dear Colleagues:

My name is Dr. Sarah Layton. I am a registered Health Service Psychologist. I am also a Healthcare Quality Professional working in Health Plan Quality and Safety.

These comments are to urge you to maintain the higher and now established standard of care in precautionary airborne infection prevention in healthcare settings. Wearing N95 (or higher) respirators, by definition of their design, is a **reasonable** precautionary measure in a healthcare setting in which airborne pathogens may be in circulation. Isolation/surgical masks or absence-of-masks may have been customary prior to 2020, but by virtue of the existence of a reasonable and better standard of care--with reasonableness made known by the urgent infection-prevention precautionary measures taken during COVID-19 healthcare utilization surges/waves, those less or non-effective standards have been rendered substandard. Please see the following publication for definitions regarding standard of care precedents: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3088386/

Thus, isolation/surgical masks or absence-of-masks, are a DEVIATION from the standard of care. And deviations should only occur when there is an equally effective alternative precautionary measure in place; the deviation is medically necessary; or the patient is requesting the deviation, is fully informed of the risks, and gives affirmative consent to the deviation. Otherwise, allowing a healthcare access model in which the deviation is the default, poses a violation to patient rights and infringes upon informed consent.

Further, allowing the deviation to be the default, codifies a dangerous precedent in which healthcare acquired airborne-pathogen infections are normalized as side-effects of treatment-as-usual, instead of a form of medical error. This allows for gross negligence and medical trauma to repeatedly occur. It also threatens to dismantle revolutionary patient-centered systems of prevention of healthcare-acquired-infections. This will only further push strained medical systems into disarray.

Healthcare without reasonable airborne infection precautionary prevention is like lifeguards trying to do open water rescue without rescue buoys. Even when the waves are calm, even if the lifeguard is an outstanding swimmer, a rescue buoy is always used. When better tools exist, which lead to better and safer outcomes for both rescuers and those being rescued, it is imperative to build systems of safety around use of those tools. It is a dereliction of duty to reject those tools and rhetorically justify a return to less safe practices.

Thank you for considering these comments,
Sarah Layton, PsyD
Berkeley, CA

Dear HICPAC:

Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions, including COVID-19. These layers of protection include high quality respirators such as N95s, ventilation, and air filtration. One-way masking is not enough to prevent the transmission of aerosolized pathogens. Preventing this transmission needs to be an effort involving everyone who is able to mask, patient and provider alike. No one should not have to risk disability or death to receive healthcare. No one should have to weigh the risk of acquiring COVID-19 when choosing whether or not to pursue care. The onus should not be on the patient to protect themselves from respiratory infections by themselves. This burden on the patient can put them in danger when they are physically unable to advocate for layers of protection, like when surgical patients are coming back to consciousness post-operation. While, under the ADA, patients can request healthcare providers to wear masks as an accommodation, there is still a chance that a provider would choose not to honor this request. We learned so much during the pandemic, and the introduction of masks in healthcare

was a positive change that the pandemic brought. I implore the committee to not undo this progress which protects both patients and providers from the spread of aerosolized pathogens.

Regards,
Riley Francis

Please, please, PLEASE require effective N95 or P100 masking by care givers and patients in all patient settings!

A woman I know caught Covid from her unmasked doctor and brought the virus home to her elderly father, WHO DIED.

the doctor "didn't know she was infected" because she "felt fine" and "had no symptoms" (until she did.) To her credit, the doctor did the right thing by informing all of her patients that she had exposed them... but this one patient's father was not protected by the after-the-fact test and trace.

He is still dead.

Sure, medical-facility-acquired infections happen. But LOWERING respiratory hygiene standards is akin to mandating that doctors NOT use soap when washing their hands before and after patient contact.

As you may know, the CDC itself has identified health care workers' insufficient hand hygiene a public health issue which causes unnecessary illness and death and works to resolve this issue: https://www.cdc.gov/patientsafety/features/clean-hands-count.html

Why, then, would you throw up your hands at respiratory hygiene? Please don't.

"Do no harm" is every professional health care provider's moral obligation.

Please protect patients from harm by making effective (N95, P100) respiratory hygiene every health care provider's professional obligation, too.

Thank you,

k muldoon

I am a disabled American with various autoimmune maladies, as well as physical disabilities. I am also an attorney, working full time in the tech industry. The messaging Americans have been hearing since soon after the pandemic began has consistently been that disabled people simply are not important. We were last in line for ventilators, told by the CDC's Director that we were "unwell to begin with" so our deaths didn't really count, and are constantly and consistently mocked and treated poorly by strangers. But rather than normalize mask wearing, and actually control the disease, the CDC made inconsistent statements, watered down masking mandates, and allowed itself to be politically manipulated rather than fulfill its own mandate of controlling disease.

It was not lost on the disabled that we were dying at highly disproportionate rates as compared to able bodied individuals in the United States. In fact, my doctors were extremely reluctant to

advise me to go to the ER early in the pandemic with extreme pain in the lower right quadrant. Of course, it was a burst appendix, but even with the early pandemic precautions, my doctors were concerned that I may become infected, and would not have a good outcome because I am disabled. I didn't go until it was clear there was no other choice. As far back as early 2021 dozens of reports came out tallying up the death toll for the disabled. The probability of worse outcomes than similarly situated abled bodied people is still much higher for disabled people. Many of us thought at least we could see our healthcare professionals or go to the emergency room and be at least marginally protected as everyone was required to be masked.

Until that changed.

A new study from the UK suggests between 95,000 to 167,000 people may have caught COVID in hospitals between Jun 2020 and March 2021. And that was with mask mandates. Dozens of people I know caught COVID in healthcare environments with mask mandates, including my disabled mother. COVID almost certainly hastened her death. We might have been able to run studies on how many people caught COVID in healthcare environments after masking mandates in healthcare were rescinded, but sadly we don't count infection data anymore in this country and don't always accurately track death data.

The upshot of all of this is that once again, the disabled are avoiding healthcare environments because our healthcare providers are by and large not masking, their staff is not masking, and their patients are not masking. High risk individuals are not offered accommodation, and even if our providers and their staff, and our fellow patients all put on their masks as we entered the facility, the virus would remain in the air, on surfaces, and on hands. Our disabled and high risk individuals should not be also required to attempt to advocate for a safer environment for themselves while they are trying to address an acute condition, or handle required maintenance of their chronic conditions.

It is not too late for the CDC to actually protect people as it states in your tagline "CDC 24/7: Saving Lives, Protecting People." Mandate masks in healthcare so vulnerable people feel safer at getting necessary care. If you continue to turn your back on the most vulnerable among us, the people who survive it will likely develop additional disabilities. When combined with the rapidly increasing numbers of disabled people due to Long COVID in this country, doesn't it make sense to at least try to prevent spread at the very places people go for help?

People are getting sick at the hospital and doctor's office. Staff deserve protection, as do patients.

Dr. Sheila Addison
Seattle, WA

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee,

The National Union of Healthcare Workers represents over 17,000 healthcare workers across California and Hawaii in hospitals, nursing homes, outpatient medicine and psychiatry clinics, correctional facilities, and home health and hospice. On behalf of our members, I would like to follow up on our May 31, 2023 and August 22, 2023 comments to urgently call for a delay in the vote on updates to the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. To date, direct healthcare workers and experts in

occupational health and aerosol science have not been meaningfully engaged in the process of updating this guidance. Moreover, proposed updates continue to have serious flaws.

Before HICPAC votes, these problems must be addressed. In particular, HICPAC must:

1. Fully recognize the science on aerosol transmission of respiratory pathogens; reclassify the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to transmitted by the aerosol/inhalation route; and, provide guidance on the use of multiple control measures proven to prevent transmission of respiratory pathogens including ventilation, filtration, and patient isolation in negative pressure rooms.

2. Redo the evidence review on N95 respirator and surgical mask effectiveness with input from experts in respiratory protection, aerosol science, and occupational health. Currently proposed updates are based on a deeply flawed evidence review resulting in guidance that is not grounded in the proven efficacy and superiority of respiratory protection.

3. Provide explicit guidance on the infection control measures needed *whenever* infectious pathogens are present or may be present. Guidance must not allow for deviation *at any time* from the infection control measures that are proven to prevent transmission of infectious pathogens. A “flexible” approach, which gives employers broad discretion to develop their own infection control plans, puts both healthcare workers and patients at risk. In contrast, clear guidance (that is not circumstantial) demonstrates to employers that they must maintain the staffing levels, engineering controls, and reserves of PPE (including respiratory protection) needed to both effectively deliver routine care and quickly respond to public health emergencies.

The update to CDC’s infection control guidance will impact the health and safety of healthcare workers and patients for years to come. I urge you to delay your vote and take the time to incorporate input from healthcare workers and the experts who know how to protect them.

Sincerely,
Sal Rosselli
President, National Union of Healthcare Workers

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing as a concerned citizen and advocate for patient safety to strongly recommend and support the adoption of comprehensive measures to improve ventilation and require the use of N95 masks in all healthcare settings. These critical steps are essential to combat the aerosol spread of diseases, reduce hospital-acquired infections, and ultimately save lives.

In healthcare environments, where patients are already vulnerable due to illness or injury, the risk of acquiring additional infections can be life-threatening. Hospital-acquired infections are a significant concern, and it's crucial to recognize that these infections can result in severe consequences, with an estimated 10% leading to fatalities.

Aerosol transmission is a well-documented route for the spread of infectious agents, and it poses a significant threat in healthcare settings. Improved ventilation is a fundamental component of mitigating the risk of aerosol-based transmission. Adequate air exchange and filtration systems can help reduce the concentration of infectious particles in the air, providing a safer environment for patients and healthcare workers.

In addition to ventilation improvements, the requirement for N95 masks is vital to protect healthcare workers and patients from aerosolized pathogens. These masks offer a high level of filtration efficiency and should be considered a standard of care in settings where aerosol transmission is a concern.

The COVID-19 pandemic has demonstrated the importance of these measures. However, the risk of aerosol-based transmission extends beyond COVID-19 and includes various other infectious diseases. By mandating improved ventilation and the use of N95 masks, we can establish a strong defense against a range of pathogens, reducing hospital-acquired infections and their associated mortality rates.

I urge HICPAC to take a proactive role in setting guidelines and standards that prioritize ventilation enhancements and N95 mask requirements in all healthcare settings, not just during pandemics but as part of routine infection control practices. These measures can have a profound impact on patient safety and significantly reduce the incidence of hospital-acquired infections.

In conclusion, the requirement for improved ventilation and N95 mask usage in healthcare settings is a critical step in ensuring patient safety and preventing the devastating consequences of hospital-acquired infections. Your leadership and guidance in this matter are essential for protecting lives and advancing infection control practices in healthcare.

Thank you for your commitment to safeguarding public health, and for considering this important recommendation.

Best wishes,

Sarah

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Thank you for your commitment to safeguarding public health, and for considering this important recommendation.

Best wishes,

Robert Huntley

Dear All,
Talking about COVID prevention and aerosol science, we use equipment to measure particles (airborne pathogens) and not by assumption.
Attached is a presentation deck which I talked with BARDA TechWatch team Dr. John Tegeris on June 16th. From it, you may know what we are doing.
It is very simple and low cost to protect people from COVID infection, but what can I say ? it is all God's will.
I am retired, so no conflict of interest is involved.

Regards,
James Hsu from Taiwan

Hello,

My name is Anita Gray. My address is North Bend, WA. I do not have any organizational affiliations (I am self employed) and I am writing to plead with the committee to keep respirators in healthcare and increase infection control measures rather than the opposite (which is being proposed).

Ever since the start of this pandemic in 2020, I've taken it upon myself to try to stay as informed as possible about SARS Cov-2 and its implications to my health and the health of those I love. Early on, I adopted the wearing of N-95's in all indoor spaces and I continue to do so to this day.

Watching as our country has rolled back protection after protection has left me infuriated and afraid. The virus has become more transmissible, fuses brain cells and causes all-organ damage, and the long term implications of letting it freely reinfect people over and over again is going to be witnessed by the public in real time. It is horrifying.

I never thought that I would ever need to be afraid of injuring myself or getting in an accident and needing to go to a doctor's office or to the hospital. I have actively avoided both of those things since universal masking became optional. One-way masking is, at best, good protection but is in no way as effective as two way masking. And when I state masking - I mean a tight well-fitting respirator NIOSH certified to at least an N95 level, NOT a floppy surgical mask which does not offer much in the way of protection from an airborne virus.

In the absence of mask mandates in medical settings, I consider my risk of exposure to another SARS Cov-2 virus to be incredibly high if I needed to go to an ER or a doctor's office. This is outrageous. Anyone in our community should not have to fear going to get treatment or healthcare and fear leaving worse off than when they arrived.

Wearing respirators is the LEAST healthcare workers can do to protect the vulnerable, elderly, those with cancer, the immune compromised along with the REST OF US since we are ALL vulnerable to the organ damaging pathogen that is SARS Cov-2. Please do not take our society back in time to having LESS protections than before the pandemic even started. This is so illogical it hurts me to even think about - the wearing of N95's, ensuring all indoor spaces are well ventilated and have HEPA filtration is going to be a necessity moving forward.

Please. Do the right thing and keep N95's NOT surgical masks in healthcare in ALL interactions with patients.

Thank you,

Anita

Greetings,

I am writing to urge you to make certain changes to your draft document, as we know that SARS-COV2 is an airborne pathogen that can persist in the hallways and public areas of health care facilities, causes deaths and disability due to long-Covid, and has shown a trend to increase deaths by blood vessel disease.

To put it simply, source control should be required in all health care settings at all times, as Covid-19 is often asymptomatic and highly transmissible. Since the disease will likely be with us for tne next several years before effective treatments and a vaccine that will cover all emerging variants is available.

I urge the following changes:

In your standard precautions section (line 320+) I strongly urge you to include personal protective equipment of respirators or enhanced performance BFCs for source control for all people in healthcare settings.

All medical professionals should be wearing respirators or at the very least KN95 masks to act as source control. There is no "risk assessment" necessary to evaluate the risk of asymptomatic

transmission of SARS-COV2, as we know the risks are high, have high pathogen-associated morbitity and mortality from infection, lack of effective treatment, and lack of a vaccine for emerging variants.

line 444 should say that a source control respirator or BFC should be worn on room entry. Source control should be used by everyone in the healthcare setting, not just patients and not just professionals in the room.

table 3, line 475 should have routine air precautions list a NIOSH-approved N95 or higher respirator, as SARS-COV2 is a disease thet generally leads to more than mild illness, and effective treatments are not available.

line 504 - facilities should use source control during all periods, not during periods of higher levels of community respiratory virus transmission. HCP and individuals should wear an N95 or better in all situations.

cristin pescosolido

Hello Hicpac team,
I'm an immunocompromised community member, with an immunocompromised partner who has bone marrow cancer We are urging you to protect both immunocompromised patients, and health care workers, by requiring universal high-quality (N95 or higher) masking at medical facilities, both for all employees, and all patients/visitors who are medically able to mask. The lives of immunocompromised patients, and the health of workers, depend on it.

Those of us at higher risk of Covid complications (including mortality) have isolated ourselves – I haven't breathed within 6 feet of anyone but my partner, in 3 years, with the exception of medical/dental procedures. We can avoid restaurants, gatherings, concerts, stores, and all other non-medical settings but it's unsafe to completely avoid medical care. My partner has a 20% chance of dying if exposed to Covid, due to bone marrow cancer, as Evusheld is no longer available, and has been postponing needed medical care, waiting for the surge to end, but now can't access health care if mask mandates are removed. Making medical facilities less safe for immunocompromised folks can be life-threatening (both through infection on-site and through avoidance of necessary medical care due to lack of universal protections at the medical facility). Mask mandates, and testing, and separation of Covid-positive folks from Covid-negative at-risk folks, should at least remain in places that immunocompromised people have no choice to avoid, especially places that folks can die from avoiding.

Failing to have mask mandates and other Covid precautions in hospitals and other essential medical facilities, is highly dangerous for people with disabilities, and can violate the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

I have had several at-risk friends who were infected in healthcare settings while one-way N95 masking (where others were unmasked or inadequately masked. They avoided all settings but couldn't avoid medical care, and were infected there. Please consider requiring well-fitting N95 or higher masks for medical settings.

Lifting health care mask mandates also risks the health of health care workers. The California Nurse's Association has spoken out against lifting the mask mandate. Please protect health care workers and their patients. https://www.nationalnursesunited.org/press/cna-condemns-state-decision-to-lift-mask-vaccine-requirements-in-health-care

Disability Right CA has also spoken out for the protection of immunocompromised patents and health care workers:
https://www.disabilityrightsca.org/latest-news/drcs-opposition-to-the-california-department-of-public-healths-updated-guidance-on

Please protect immunocompromised patients, instead of forcing us to choose between endangering our lives to access needed healthcare, or endangering our lives by avoiding healthcare because of inadequate protections. And, the times between surges is when immunocompromised people are most likely to try to finally complete long-postponed procedures (but not if mask mandates are taken away). I personally will not enter a medical facility if others aren't masked – and the lack of access of facilities would be violation of my rights to equal access under the Americans with Disabilities Act.

Please protect patients and families by requiring well-fitting N95 masks in healthcare facilities!

Sincerely, Irina Rivkin

Hello, my name is Jennifer Ritz Sullivan. I am disabled, chronically ill, and COVID bereaved.

I lost my 66-year-old disabled mom, Earla Dawn, to COVID. She was one of 77,000 people that we know of to die of COVID in December 2020 in the US alone.

My mom contracted the virus from a household member who did not wear a mask. Her death was preventable. My mom and the millions of others who have died from COVID have been treated as disposable and inconvenient statistics, as have all high-risk, disabled, and chronically ill people.

My husband works a high-exposure job and is frequently the only person masking with a respirator. We caught COVID for the first time this spring through my husband's job when cases were considered "relatively low."

Despite being up-to-date on vaccines and having access to Paxlovid and numerous over-the-counter medications, it is the sickest I have ever been, and I haven't fully recovered.

I am now further disabled by long COVID, which is debilitating and has no cure because one-way masking isn't enough to ensure safety from aerosol-transmissible viruses.

I didn't consent to COVID. Neither did my mother.

Although there are some medical needs I am currently able to put off until it is safer, I still require frequent office visits.

My healthcare center dropped masking in May, shortly after I contracted COVID, stating, "We hope we can continue to support and respect one another and allow each person to navigate their personal safety as they deem appropriate."

I remain at high risk for the same disease that killed my mom and further disabled me. My safety depends on others taking precautions, including masking in an n-95 or better.

I requested that my providers wear respirators when meeting with me, even offering to supply them, and I was told that staff only need to wear surgical masks if asked by a patient as they go by CDC guidelines.

Where is the support for my safety?

Surgical masks worn by a few providers in a large healthcare facility are insufficient to protect anyone from aerosol-transmissible diseases.

Every medical visit requires prompting, advocacy, and risk, which depletes me. With my masking request at the top of my file, I still have to state the request when I book my appointment, when I arrive for it, and when I meet the physician's assistant.

I've had providers become rude to me the second I ask them to mask, huffing, rolling their eyes, and one wearing a surgical mask under their nose the entire time as if they've never worn a mask before.

We need increased universal guidelines in healthcare settings for the safety of everyone.

No one should have to risk disability or death to receive medical care.

We must learn from the dead and disabled, and we must do better.

I agree with the People's CDC recommendations and hope you all will do the right thing.

Jennifer Ritz Sullivan

Up to 167,000 people caught Covid in hospital in second wave of pandemic (https://www.independent.co.uk/news/health/data-nhs-english-university-of-oxford-england-b2431909.html). People go to doctors and hospitals to get well, not to get sick. Many are especially vulnerable with compromised immune systems and other comorbidities that would increase their risk of infection or post-viral sequelae. And our health care workers deserve to work in safe environments where they are not repeatedly at risk of COVID and other airborne illnesses.

Please do the only sensible things and require masks in all the healthcare settings.

Thank you,

~ Laura Shapiro
San Francisco, CA

Good morning,

I am writing to you today to demand you follow scientific evidence and ethics as you provide guidance for infection prevention and control in healthcare and school settings.

As you are very well aware, healthcare facilities including hospitals and clinics are unsafe for patients as we have a high risk of acquiring infection from maskless healthcare providers in areas where the air is not appropriately filtered or ventilated. The majority of Healthcare

providers are ignorant to the dangers of a SARS2 infections because they follow your anti-health guidance. It's disturbing when I, a patient, know far more than them.

We are now in 2023 and we are far worse off than we were before the ongoing airborne pandemic began. Any aware person is now bullied in public for masking which ironically is keeping the very people who bully us, healthy. I can confidently say my family has not once contributed to any spread for anyone which is more than I can say for doctors, nurses, and teachers.

My child recently said to me, "I wish they cared about my health and we could all wear masks in schools so that we could bring down transmission and I could then sometimes take it off to eat". She told me this after telling me many children in her class are ill, coughing, runny noses, yet are welcomed to school to spread disease. Teachers look the other way, they are "following CDC guidelines" after all. In fact, my children's school district in Maryland, has gone out of their way to guilt parents into sending kids to school at all costs, they don't even recommend staying home while sick anymore. Each year gets worse.

As you know, waste water for Covid is at an all time high whereas there is very little flu. Are you not aware that Covid causes vascular damage in the MAJORITY of children infected? With our children being repeatedly infected in schools, this won't end well for their future health. Shall I forward you these studies? Do you not have them? I assumed since I can access them as a lay person, a mom, surely HICPAC are well aware of the dangers for our children's health.

Your guidance in healthcare settings for infection control has wide and vast repercussions for the rest of society, including schools, work places, services etc.
If you aren't educating the public and healthcare providers on the very real and common outcomes of infection along with how to prevent infection in healthcare settings, how do you expect the rest of society to behave?

I have better infection prevention and control in my home than you have or suggest for the public. Despite my children bringing home illness from school acquired infections, because of your lack of appropriate guidance, not once has anyone else in my household become sick. My children, 6 and 10 years old, do more than HICPAC to prevent infections. Sadly, they are on their own in Covid filled schools. Oneway masking is NOT enough when Covid surrounds them in unsafe schools.

Do your job and follow science,
evidence, and ethics to dictate guidelines. I am profoundly appalled with your anti-health/evidence stance on infection control. What exactly is going on at the CDC that you are completely beholden to corporate overlords (like Delta airlines) and outright refuse to follow science? Stop muddying the waters, people can't do their own assessments and shouldn't have to; healthcare providers shouldn't either because evidently they are getting wrong each time. They need clear and simple guidance as do schools. Covid is airborne, we need respirators and clean air. Full stop. This isn't complicated at all, but HICPAC is certainly making it so; why?

What you are doing now changes public health forever. In fact, as it stands, I do not think it is any longer appropriate to call yourselves the CDC or public health because you are literally doing the opposite of your mandate. You have a chance to change course, why would you not want to protect our health when you know you can? This is not hard and is not at all complicated.

Regards,

Nerissa Laing

HICPAC Comments – November 3, 2023
My name is Lisa Brosseau. I am an industrial hygienist with expertise in respiratory protection and aerosol exposures. Much of my academic career has been spent drawing attention to aerosol transmissible infectious diseases in healthcare settings.
I am appalled by the changes HICPAC is proposing to the 2007 Guideline for Isolation Precautions. Transmission by "Air" is simply a recasting of the airborne/droplet paradigm and fails to explicitly state that inhalation can occur both near and far from an infectious person. The scientific literature from well before the pandemic demonstrates there are many aerosol-transmissible infectious diseases in healthcare settings, including human influenza A, adenoviruses, RSV, rhinoviruses, pertussis, among others, in addition to TB, MERS, SARS, measles, chickenpox and of course COVID-19. HICPAC fails to recognize this. The workgroup's evidence reviews of respirators vs. surgical masks and adverse impacts of PPE are flawed and biased.
In an online workshop held on October 13, 2023 we addressed the science demonstrating aerosol transmission of COVID-19 and other diseases, recent developments in ventilation guidelines for infectious aerosols, and well-known scientific evidence demonstrating the superiority of respirators as source control and personal protection. Stakeholders representing healthcare personnel and patients discussed their personal experiences with COVID-19. Drawing on participant input, the workshop report includes numerous recommendations, many of which have been stated multiple times in letters to CDC and HICPAC and during public comments at this and previous HICPAC meetings.
It is egregious that HICPAC and CDC have refused all requests from multiple parties over the past few months to diversify membership, listen to and include more perspectives, expand scientific review beyond clinical RCTs, and open your minds to ideas that challenge your status quo.
I strongly urge HICPAC to postpone the vote today and reconsider your process and recommendations. I implore you to listen to the patients, workers, and communities whose health and lives you put at risk by ignoring their requests to be more inclusive, to consider ALL of the science, and to recognize the importance of aerosol transmission for many infectious diseases including COVID-19.
A letter to Dr. Cohen from the Society for Healthcare Epidemiology of America mischaracterizes requests from stakeholders left out of the decision-making. No one is suggesting that infectious disease physicians or hospital epidemiologists should not be involved. Of course they should. But patients and healthcare professionals and their advocates, occupational health and safety professionals, engineers, aerosol scientists, and many other stakeholders also need to be consulted and involved.

Lisa M Brosseau, ScD, CIH
University of Minnesota, Center for Infectious Disease Research and Policy

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RE: Written Comment for the Healthcare Infection Control Practices Advisory Committee (HICPAC)

To whom it may concern,

This week's CDC decision regarding new infection control guidelines will be nothing short of life changing for those who work in or frequent a healthcare facility. Granted the guideline needs to be published in the Federal Register, but if the CDC does not change course after the deluge of common-sense criticisms, it is doubtful the CDC will after publication.

The current CDC draft guidance appears to be conflicting and in some places in error:

-- The CDC is giving approval for the use of Surgical Masks to prevent the spread of Air-borne Pathogens such as seasonal influenza and coronaviruses. Surgical masks are not designed to stop airborne infections.

-- The CDC is not routinely recommending the use of negative pressure rooms for MERS, SARS-1 or, SARS-CoV-2.

-- And with Enhanced Barrier Precautions the CDC is allowing those with Candida auris to wonder around a facility and at the same time the CDC is warning of dangerous out-breaks of Candida auris.

There is also lack of provisions for air quality standards, such as ASHRAE Standard 241 for the "Control of Infectious Aerosols," and a lack of provisions for screening of these pathogens.

The back peddling of standards has often been justified by the imposed "burden" preventive strategies would place on facilities. However, the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, considers an intervention cost effective, if the cost is less than 9.6 million dollars per life saved. The Office does not measure burden in relationship to C-Suite and CEO salaries, or investor profits, nor should the CDC.

The proposed standards will also place the safety of immunocompromised individuals in healthcare settings at grave risk. This concern was further underscored by the findings of the recent INFORM and EPOCH research initiatives. The EPOCH study concluded that "Immuno-compromised populations appear to be at substantial risk of severe COVID-19 outcomes" and that "Effective prophylactic options are still needed for these high-risk populations."

For the immunocompromised the status quo is unacceptable, and weakening current regulations will result in a "direct threat to their safety and wellbeing and does not maintain accessible features for safe and adequate access to a facility as required by the Americans with Disabilities Act. The CDC must be "mindful of the provisions of the ADA and the impact their recommendations will have on vulnerable individuals and healthcare workers, along with patients who are experiencing reduced access to healthcare because of unsafe healthcare environments.

Thank you for this consideration,
Kevin Kavanagh, MD, MS Health Watch USA

Name: Ann Ellingson
Address: Ann Arbor, MI
Organizational Affiliation: N/A
Topic: Infection Control Guidelines Must Be Strengthened

SARS-CoV-2 is spread via aerosols and indoor setting, particularly healthcare settings, are highly risky for anyone trying to avoid Covid transmission, but particularly for people like me, who are at extremely high risk of death, or worse from contracting Covid. I have a rare disease that is very advanced, and there are few treatment options available to me due to the advanced

nature of my disease. If I survived a Covid infection, the infection would likely exacerbate my disease past the point of treatment. Due to the disabling nature of my disease, I live with my elderly, extremely high-risk mother. I doubt my mother would survive a Covid infection, and if she did, the possibility of her needing care that I am too sick to provide or that neither of us can afford is very real.

Seeking medical care is one of the very biggest decisions I have to make in my life. From blood work to testing to in-person office visits to monitor my disease progression, I have to weigh whether each individual potential exposure is worth my own or my mom‘s death. Both my mother and I have avoided routine and sometimes necessary healthcare, including routine dental care, due to the extreme risk involved now that there is no obligation for medical providers to mitigate Covid transmission risk.

The saddest, most frustrating part of my life and death healthcare choices is that I have finally, after years, found a medication that gives me back almost full functioning. If I continue on the current trajectory, I could return to becoming a fully functional member of society as I had been all of my adult life prior to this illness disabling me. There is nothing I want more in this world than to continue the fulfilling career that is so dear to me, and makes life worth living. However, none of my ambitions or potential remission count if I cannot access all of the medical care I may need, or worse, contract Covid while seeking the care that I cannot live without.

Layered mitigation strategies in healthcare, would allow myself, my mother, and others who are disabled and/or immunocompromised to access potentially life-saving care without the fear of imminent death.

I ask the CDC to allow me to be a contributing member of society, and of my field by enhancing mitigation strategies instead of rolling back the currently inadequate ones. A layered approach of air filtration, ventilation, as well as mandatory use of well-fitting N95 respirators by healthcare providers and blanket mask requirement of non-medical professionals in the healthcare setting as and patients and visitors would allow me to seek the care I need without fear of death or being bedbound.

Please allow me and the thousands of others like me with so much education, training and career experience to safely seek the care we need to keep our society, economy and country strong.

Name: Paul Hennessy
Affiliation: None
Address: Grass Lake, MI
Topic: Objection to vote

I fully object to the recent vote by HICPAC. You received hundreds of pages of testimony and heard every single oral comment object to your proposals and you still did not revise it.

The approved draft weakens infection control protections and does not implement a simple respirator and clean air requirement across the board. This process was flawed with no aerosol scientists involved and makes too many exceptions to masking and clean air in medical systems. I do not support this draft and neither should the CDC. Until you fully recognize the science on micro aerosol transmission of infectious disease and put as much emphasis on it as you do with handwashing, your proposals will fall short and put lives in danger. Hospitals do not need to be a place of infection.

If anyone at the CDC reads this, I urge you to reject this draft. HICPAC's recommendations are dangerous and do not listen to what the public wants.

- Your committee is illegally constituted and is violating the controlling legislation, as already noted in a complaint to the Inspector General.
- Your draft is unscientific and unfit for use. As were your previous "scientific reviews" -- this is something you were already notifed of, with extensive evidence. You have already been provided with accurate information and have refused to look at it. (Examples of accurate information: https://whn.global/doctors-should-not-infect-patients/ , fully citationed and peer-reviewed; AAirDS.com, featuring the Ferris, Ferris, Workman et al study.)
- Several of your committee members have conflicts of interest due to prior, unscientific opinion pieces opposing infection control and should resign immediately, including Shira Doron and Sharon Wright.
- Any purported regulations based on your unscientific draft would be without a rational basis, and will be overturned in court.
- Any hospital or doctor's office following your unscientific advice will infect, injure, and kill patients unnecessarily, and will be legally liable for it.
- Your committee members will end up being questioned in court and by Congressional committees if you continue down this path of science denial and violation of controlling legislation.
- Covid is transmitted by aerosols, which are stopped by N95, N99, or reusable P100 respirator masks, and are NOT stopped by "surgical" or "medical" masks. This is not complicated. My partner was infected twice by doctors wearing useless "surgical" masks.
- The committee's draft would infect more innocent patients by disregarding science. Committee members should consider their personal liability exposure before continuing down this path.

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Nathanael C. Nerode

I'm not a scientist or in the medical profession. I'm a mom of two kids, a daughter of high-risk parents, and a kindergarten teacher who cares about the safety of the most vulnerable in our community. Just like we have strong universal precautions to protect us against blood borne pathogens in medical settings, all people deserve universal precautions against airborne viruses in medical settings.

Decades from now, we will look back on this moment and wonder why we ever considered making medical settings less safe. Let's learn from the pandemic and make medical settings safer.

Best,
Mary Laura Calhoun
Washington, DC

Jane Thomason
National Nurses United
Oakland, CA

National Nurses United (NNU) condemns the unanimous vote by the Healthcare Infection Control Practices Advisory Committee (HICPAC) of the Centers for Disease Control and Prevention (CDC) to finalize a draft of infection control guidelines before giving the public ample time to review the draft or before seeking input from health care workers and patients whose health and safety will be directly impacted by this guidance.

The draft Isolation Precautions guidance was only released to the public on November 2. Initial review of the document identifies multiple serious concerns, including:

- **HICPAC's draft is oriented to frontline personnel, not employers—even though infection prevention programs are the employer's responsibility—and is written in a manner that maximizes "flexibility" for employers, not protections for health care workers and patients, thus shifting the risk and burden onto individual health care workers to protect corporate profits.** While the document should certainly be available to and written with frontline health care workers in mind, multiple recommendations made are outside the control of individual frontline health care workers, e.g., making PPE available in the right sizes and models, establishing procedures for when source control will be used. The draft recognizes the hierarchy of controls (i.e., the idea that built engineering controls and administrative controls should be used first and PPE should be a last resort), but then focuses almost exclusively on PPE, sidelining other essential measures, such as ventilation, patient screening, visitor screening, and isolation.
- **HICPAC's draft fails to fully comprehend the scientific evidence on aerosol transmission of infectious diseases and remains overly focused on short vs far range transmission.** Proposals for routine air precautions, special air precautions, and extended air precautions do not recognize current science on aerosol transmission and essentially maintain the current, disproven droplet-airborne paradigm. Airborne infection isolation rooms (AIIRs) should be implemented for any novel pathogen based on the precautionary principle.
- **HICPAC's draft inappropriately treats surgical masks as respiratory protection and personal protective equipment (PPE) for health care workers exposed to infectious diseases transmitted through the air.** Surgical masks are NOT respiratory protection—FDA, NIOSH, and OSHA are clear on this point, and yet CDC/HICPAC is proceeding to treat surgical masks as a default option for respiratory protection, reserving N95 and other respirators for only specific "special" circumstances.
- **HICPAC's draft fails to address the importance of safe staffing,** especially bedside registered nurse staffing, to infection prevention. The 2007 Isolation Precautions guidance includes a discussion about the importance of bedside nurse staffing. In the midst of the staffing crisis in health care, and with both patient and health care worker infection rates rising in recent years, this is a major omission by HICPAC.
- **HICPAC's draft marks recommendations as either "Standard Practice" or "Expert Opinion," but that is not the distinction that matters.** Standard practice on droplet is wrong—that's been proven. HICPAC needs to look at the evidence—all the evidence from the variety of disciplines with expertise on the matter, not just randomized control trials or clinical studies.
- **HICPAC's approach to assessing scientific evidence is overly focused on "real world" studies and fails to account for the current failures of employers to protect health care workers.** HICPAC limited evidence reviews used to formulate the draft to "clinical studies with infection outcomes" because they are focused on employer feasibility and user adherence under current, existing "real-world" conditions. This approach does not take into account factors that employers could change to improve user adherence, such as providing safe staffing levels, break relief, and complying fully with OSHA's Respiratory Protection

Program Standard. Thus, HICPAC's draft seeks to protect corporate profits at the expense of worker and patient safety.

HICPAC's draft is permissive and weak and seeks not just to maintain existing practice — which has been shown to be inadequately protective — but even rolls back the use of some important measures, such as airborne infection isolation rooms. This draft guidance will only further degrade the already dangerous working conditions of nurses and other health care workers and further contribute to high rates of moral distress, which will only serve to drive more nurses away from the bedside and further deepen the staffing crisis in health care.

NNU urges the CDC to reject HICPAC's draft and to actively engage the input of frontline nurses, other health care workers, their unions, patients, and public health experts, in addition to infection preventionists, in the development of a new draft of the updated guidance. NNU urges CDC to hold public meetings, similar to the meetings held in 1992 during the development of the multidrug-resistant tuberculosis infection control guidelines for health care, as soon as possible and, based on this input, to significantly amend HICPAC's draft to better protect health care workers and patients.

Jane Thomason
Lead Industrial Hygienist
Health and Safety Division
National Nurses United

I am asking for mask requirements to be brought back in health care. People should not have to risk illness and possible disablement while seeking preventive care or treatment at the doctors office or hospital. Masking is the bare minimum of prevention for Covid-19 which still has not effective treatment and is continuing unabated. The CDCs unwillingness to take a stand for basic public health measures is disappointing and frankly disgusting.

Rachel Rappaport

Christina Moore
Plano, Texas
November 3, 2023

Dear members of CDC/HICPAC,

As a patient who frequently accesses the US healthcare system, I join other commenters from the November 2-3, 2023, meeting in requesting that universal N95 or elastomeric masking in healthcare become standard in the same way that disposable gloves did due to HIV/AIDS, and as handwashing did generations earlier.

I am immunocompromised and immunosuppressed due to lupus and medications for it. Therefore, I am at high risk of severe COVID-19, of long COVID, and of an autoimmune flare caused by any infection. I am also a cancer survivor at high risk of recurrence. Additionally, I am caregiver to elderly parents, one of whom is clinically extremely vulnerable and not eligible for Paxlovid due to drug interactions.

My family has often been refused N95 masking by our healthcare providers, despite our prior written request for reasonable accommodation per the ADA. We have even been yelled at repeatedly by healthcare workers in medical offices for our request that they mask. This

happened even when I devoted a dozen hours prior to one appointment to requesting and obtaining approval for that accommodation. Repeatedly we have been told by healthcare workers, “The CDC says we don’t have to mask, and you can’t make us.” This has happened to us in specialties primarily or exclusively treating high-risk patients: gerontology, rheumatology, cardiology, mammography, and oncology.

As a result of this lack of mitigation against airborne pathogens and healthcare refusal of any kind of mask at all, even as a disability accommodation, doctor-patient relationships of decades are crumbling and I have been forced to cancel scheduled cancer imaging because I do not consent to unmasked care during an airborne pandemic. Even if the imaging were done and found cancer, no oncology center in my community is willing to protect patients from airborne pathogens.

Seven hospitals are within a 15-minute drive from my home; not one is willing to grant patients like me safe and accessible care. It feels like vulnerable patients are shipwrecked sailors, surrounded by water yet dying of thirst.

With very few exceptions, my providers have made it clear that they will not accommodate mask requests without clear, definitive direction from a higher authority like CDC/HICPAC. In the absence of such, providers in my area have defaulted to preference- rather than risk-assessment.

Self-advocacy is exhausting, time-consuming, traumatic, and increasingly futile, but what alternative do vulnerable patients have? Almost weekly we face risk calculations: which poses the greater risk, getting this unsafe care or risking the consequences of forgoing it?

COVID continues to surge in waves several times a year. Tuberculosis and measles are breaking out nationwide. Though 59% of COVID transmission is asymptomatic (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707), medical providers and patients no longer screen to find these cases. In addition to the high proportion of asymptomatic spread, workers face internal and external pressure to work when they are symptomatically ill (https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/sickness-presenteeism-in-healthcare-workers-during-the-coronavirus-disease-2019-covid19-pandemic-an-observational-cohort-study/C20BC892BAF9B9BDF26F9D81A24C7260). Multiple sources have documented the 10-20% frequency of post-acute sequelae of COVID (https://www.nature.com/articles/s41591-022-02051-3), removing millions (and counting) of newly disabled persons from the labor force (https://www.theguardian.com/commentisfree/2022/sep/15/long-covid-is-keeping-millions-out-of-work-and-worsening-our-labor-shortage).

This rate of disability and destruction of lives is not sustainable. Implementing clear, simple, universal N95 mask standards is a small step that would yield large benefits beyond the threat of COVID. A 2023 study found “immediate, substantial, and sustained increase in healthcare-associated respiratory viral infections” (https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/healthcareassociated-respiratory-viral-infections-after-discontinuing-universal-masking/E3B1E21AFB9D9BA4C535F7BB810A3D1C) as indoor mask mandates relaxed from universal to intermittent. In contrast, the tuberculosis center for the state of Texas has had no healthcare-acquired TB cases since they instated elastomeric respirator requirements for staff decades ago (https://www.kens5.com/amp/article/news/health/san-antonio-hospital-could-have-an-answer-to-the-ppe-crisis-elastomeric-masks/273-882e7ea3-e377-4776-906c-33ce89e193cc).

Airborne pathogens pose a grave present and future threat. The tools are available to protect healthcare workers and patients. Please, HICPAC members, put the tools into practice for public health and welfare.

Thank you for your time,
Christina Moore

I know why you're making infection control weaker, and it's not bc you care about patients and staff. It's bc you want as many people as possible to get COVID-19 in medical settings and "thin the herd." Plus surgical masks are cheaper. That's the only rationale I can think of.
I am terrified I'll need to go into a hospital someday and I'll leave with COVID. But you don't care about that either, no one has to report hospital acquired infections. No accountability. I am putting off routine care bc there's zero effort to slow the virus down now. N95s and HEPA should be the standard in healthcare. Maybe in a decade or two, those that survived will implement it.
How long did the medical community resist handwashing? I'm sure you know all about Semmelweis. You are all the equivalent of the doctors who mocked his "crazy handwashing theories."

Nice anti-science, eugenics you got going here, CDC. Shame on you all, every death from a hospital acquired COVID-19 infection is on you now. We know better, try to do better.
Melanie T. in Ohio

Good day,

My name is Anna White and I am a frequent user of healthcare due to multiple chronic illnesses. Due to the negligent lapse in mask requirements in healthcare regulations, not a single doctor office I visit continues to practice consistent infection control using N95 masks. We know that one way masking is not an appropriate standard of care for aerosol pathogens and that nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate.

It is unethical for the burden of infection control to be on patients and historically this has always resulted in abhorrent rates of preventable patient deaths. To pretend you can resist the need to make universal masking a standard of healthcare is futile and will bring you great embarrassment in future as people look back and see the damage done to both humans and the economy by facilitating the spread of such a dangerous disease as COVID.

HICPAC must resume public meetings and incorporate both public and academic feedback to guidelines. Doing so will mean requiring N95 masks in all healthcare settings so that patients like me do not have to choose between risking our health from nosocomial COVID or risking our health from delaying healthcare. It will mean publicly acknowledging that COVID and other diseases are airborne and what that means for transmission. It will mean increasing standards for ventilation and filtration in all healthcare settings. And it will matter.

Protect both patients and healthcare workers by listening to the science and to the people.

Signed,
Anna White

I offer this testimony as a National COSH Adviser. The National Council for Occupational Safety and Health (National COSH) consists of local workplace health and safety organizations, unions, worker centers and individuals, who fight for safe and healthy work.[3,4] I worked as an industrial hygienist for 35 years for the Commonwealth of Massachusetts, investigating many workplaces to evaluate worker protection. My goal is to highlight HICPAC's failure to adequately protect healthcare workers, the need for strengthening infection control practices in health care by including expertise from healthcare workers and their unions, industrial hygienists, occupational health and safety experts, aerosol scientists and ventilation engineers.

Healthcare workers are at high risk for airborne infections. COVID-19 may have been job related for one fourth of diagnosed adults;[5] healthcare workers got COVID at a higher rate compared to all other workers. COVID-19 caused worker illness, absences, contagion to patients, coworkers and families. It had severe impacts on access to care, staffing levels, as well as stress on the mental health of healthcare workers. In addition, a new study conducted by the Workers Compensation Research Institute showed long term harm to many workers from prolonged symptoms.

Six percent of workers who filed Workers' Compensation claims for COVID-19 had Long COVID, with an average cost of $29,341 in medical treatments and five months or more away from work. Pulmonary, cardiac and neurological conditions were among the most common effects, with some claimants having symptoms for more than 18 months. These data were based on 75,000 claims across 31 states, over one and a half years.[6] And we know that many workers who became ill never filed workers' comp claims or received needed benefits.

The absence of expertise was apparent in the proposed revisions. Statements that rooms should be "appropriately ventilated," do not provide minimum requirements for ventilation and filtration and fail to prioritize institutional steps that would protect all staff and patients in healthcare settings. Nor are requirements for AIIR rooms adequately spelled out. Reliance on personal protective equipment is the lowest level on the hierarchy of controls and cannot replace real interventions to prevent aerosol transmission. Nor are surgical masks adequate PPE protection in healthcare settings. The HICPAC updates were weakened by absence of attention to the more important protections that are needed to prevent transmission of disease.

Elise Pechter MAT, MPH, CIH
National COSH Adviser
Jamaica Plain, MA

[3] National Council for Occupational Safety and Health https://nationalcosh.org/

[4] https://nationalcosh.org/sites/default/files/documents/2021-02-national-agenda-worker-safety-and-health_0.pdf

[5] Leigh JP. COVID-19 may have been job related for one fourth of diagnosed adults. AJPH June 2023; 634-636 https://ajph.aphapublications.org/doi/10.2105/AJPH.2023.307299

[6] https://www.wcrinet.org/images/uploads/files/Slides_from_Oct._3_Webinar_on_Long_COVID_in_Workers_Compensation_.pdf

Masking should be generally mandatory in health care settings, the way that staff washing or sanitizing hands is mandatory. Multiple diseases are airborne, beyond SARS2, and we should not have to fear infection from going to see the doctor.

Reportedly it took doctors 20 years to accept handwashing. Please do better this time around.

-xx- Damien X-)

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. **Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force.** Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

I am a disabled and immunocompromised 28 year old Filipino person who has needed to visit my doctors at hospitals often over the past few months. Since the mask mandates in healthcare settings ended in August at my local medical system at UW Medicine in Seattle, I have been appalled and frightened to see almost all of the nurses, physicians, and staff not wearing masks let alone N95 or KN95 respirators or masks with higher filtration. I am disappointed but not surprised that medical professionals and policymakers who go through extensive education about health are so ableist and ignorant, enacting policies and moving through the world as if COVID-19 doesn't cause disability (i.e., Long Covid) in 1 out of 5 people after even just a mild Covid infection.

Please take action to prevent *truly preventable* illnesses, disabilities, and chronic conditions caused by COVID among other infections with these already proven measures and tools: **N95s, fit testing, rapid molecular testing, ventilation, and isolation.**

I hope in the near future through through **accessible public meetings**, you are able to include and listen to those workers, disabled and chronically ill people, and people with Long Covid who are most affected by this work of HICPAC.

Thank you,
Allison Masangkay

I was unable to finish reading my one page of comments I was invited to present. So I am sending them to you here.
I want to note that during the public comment section of your meeting on 11/2/2023, several of the HICPAC members spent most of the time during that section of the meeting looking at their phones and computers. I don't see any way they could have been paying attention.

Here are my comments in full:

My name is Jay Herzmark. I am a registered nurse and certified industrial hygienist. I have a master's degree in occupational health nursing. I am retired. I ran a consulting company called SafeWork Washington. Our goal was to help protect workers from occupational hazards. I continue to do that type of work but now as a volunteer.

I worked for many years with infection control practitioners associated with hospitals in the Seattle area. They were consistently very smart and knowledgeable. One thing I did notice about some of them was a frequent inability/unwillingness to consider knowledge from outside their own profession.

There is a huge quantity of knowledge about exposures to asbestos, lead, silica and other particulate health hazards. The use of certified respirators and ventilation for exposure control is very well studied for all these hazards. Unfortunately, many infection control practitioners hear those words and can only picture factories and construction sites.

But the laws of physics are the same in health care. Viruses and bacteria are both particulates. They float through the air too. They penetrate leaks, can be flushed out with dilutional ventilation and can be sucked out with local exhaust ventilation. As an industrial hygienist, I attempted to provide information to infection control practitioners about respiratory protection and ventilation as it related to tuberculosis, SARS, Swine flu and Covid. It was as if I was talking to a television. I could hear them but they didn't hear me.

But let me try again. The laws of physics apply in health care. Viruses and bacteria are particulates. They float through the air. They penetrate leaks in surgical masks. They can be flushed out of a room with dilution ventilation. They can be sucked out of a space with local exhaust ventilation. You don't have to believe me. Talk to other industrial hygienists, or aerosol scientists or ventilation engineers. They all work on air contaminant controls.

But you must talk to them. While they work on stuff that is different from hand washing, antivirals and case surveillance. What they work on can control infection too.

Don't just listen to your own echoes. Don't let your science be inbred. Converse with folks who know solid science beyond traditional hospital infection control.

Your job here is to protect both patients and health care workers. No one said your job was to protect your employer's bottom line. That is not your job here. Protecting people is your job here. You are here to consider the science-all the science - and make recommendations to protect these people based only on the science.

Your employers will have many opportunities to have their say. They will try to weaken the protections; to claim the safety measures will put them out of business. That they might as well just blow up their hospitals because adequate infection controls will destroy them just as surely. We have heard all those statements before. Yet, just like every other regulated industry, health care continues to chug along, paying their managers handsomely.

What I'm asking you to do is don't break the first and oldest rule in health care…because the current proposal WILL do harm.

Name: Margo Sara Krindel
Address: San Francisco, California
Organizational Affiliation: U.S. Citizen

I am appalled that you voted in guidelines which you only released to the public the day before, on November 2. Furthermore, you have failed to incorporate input on experts on airborne

transmission of pathogens such as aerosol scientists and industrial hygienists, and you have also failed to include input from frontline healthcare workers and patients into your guidelines.

Instead of having complex guidelines around when to use what PPE based on which infections are suspected or confirmed, it's much simpler to require all healthcare workers to wear N95s or better respirators whenever they are in the same building as patients. That way, people are protected even if someone comes in with covid, tuberculosis, influenza, or any other airborne pathogen before anyone is aware of the exposure. The Texas Center for Infectious Disease, which specializes in TB care, has not had a single case of a worker acquiring TB since they required all workers to wear P100 respirators in the 1990s. It's a simple guideline which works.

People go to health care facilities to become healthier, not to become sicker. Incorporate scientifically-informed guidelines for stopping airborne infections in healthcare facilities.

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People go to health care facilities to become healthier, not to become sicker. Incorporate scientifically-informed guidelines for stopping airborne infections in healthcare facilities.

It is irresponsible to allow hospital and other medical care facilities to continue promoting an environment that is inherently dangerous to both patients and healthcare professionals by allowing individuals to remain mask-less while in such settings. The Hippocratic oath states that medical professionals shall do no harm, and requiring masks for all individuals in healthcare settings is an important first step in fulfilling that oath.

Thank You,
Keith Hoodlet

I was featured on the front page of The New York Times, alongside medical and scientific experts demanding that N95 making in healthcare be codified in the standard infection protocols. I made a public comment in August about my personal (but common) experience as an immunocompromised person who is unable to access safe healthcare and who caught COVID three times in 2023 from unmasked HCW.

Mine and others' testimony apparently fell on deaf ears despite the fact that were spoke on behalf of the most vulnerable populations: the elderly, the very young, and chronically ill people everywhere. There are millions of us.

Perhaps the reason we were ignored is because the membership composition of HICPAC currently stands in violation of the Federal Advisory Committees Act (FACA) and the Committee's own Charter and has been in violation for a number of years. The Committee has also failed under FACA and its own Charter to be properly transparent to the public.
These recommendations have no legal standing and no place in the CDC's process of updating the Agency's guidance.

Date: November 4,2023
Re: HICPAC's Proposed Infection Control Guidelines
From: Mark Nicas, PhD, MS, MPH, CIH, Emeritus Adjunct Professor,
School of Public Health, University of California, Berkeley
There is no need to repeat the ample technical information you have received concerning: (i) the evidence for aerosol transmission of infection with SARS-CoV-2 and other pathogens, (ii) the need for wearing proper respiratory protection (not inferior surgical/medical masks and "enhanced" barrier face coverings) against airborne pathogens, and (iii) the need to isolate within negative-pressure rooms infectious patients emitting airborne transmissible pathogens. Instead,
I simply observe that HICPAC's inadequate recommendations for infection control measures constitute a threat to homeland security. Further, given that HICPAC is entrenched in its position and/or lacks the willingness to propose adequate infection control measures, HICPAC itself should be disbanded and infection control decision-making should be placed in different hands, for example, the U.S. Army DEVCOM Chemical Biological Center. U.S. Army personnel do not take the same cavalier attitude toward infection control that HICPAC has evidenced, and I believe they would be less swayed by complaints from healthcare facility managers that N95 filtering-facepiece respirators cost more to purchase than do surgical/
medical masks, and that it costs additional money to fit test respirator wearers.
Terrorists planning an attack on our citizenry with a highly pathogenic virus that can be transmitted person-to-person by inhaling respiratory aerosols would be heartened by the HICPAC proposal. Why? Because healthcare facilities adhering to HICPAC's recommendations and treating the first waves of sick people would be excellent environments for infecting healthcare workers, other staff, other patients and visitors. Staff attending infectious patients close up will wear surgical masks allowing substantial inhalation of aerosol carrying the virus. And because the facilities will concentrate scores of sick patients, and house them outside of negative-pressure isolation rooms, the airborne pathogen will spread throughout the facilities. One result is that prior to being hospitalized themselves, infected healthcare workers and facility visitors will become secondary sources of infection for family members and contacts. The facility itself will serve as a Broad Street pump in disseminating the infectious agent and promoting the epidemic within the community. Because a terrorist attack would likely occur at multiple locations, there would be multiple facilities involved and multiple loci of epidemic spread. A second result is that the number of front-line healthcare workers will be depleted due to illness, thereby creating a chaos of staffing shortages within the facilities. If the mortality ratio among those infected is high, healthcare workers who are not sick will understand that facility management are not protecting them against an acutely deadly disease, and may stop showing up for work altogether.
The ensuing public and political outcry will eventually focus on CDC and its infection control guidelines. In response, the CDC might proclaim it relied on HICPAC's expert advice, but

the CDC will own the recommendations. As a result, not only will substantial morbidity and death among our citizens be promoted, but public faith in the reliability of what the CDC and, in turn, State and local health departments recommend will take another ill-afforded hit. CDC administrators should think long and hard about adopting HICPAC's proposals.

These Guidelines Proposed will Disable & Kill People have the right to be safe while seeking care in all medical settings. Both Covid infections that I have gotten have been in medical settings when I was masking, Taking every precaution I could, spoke to the doctors beforehand, wore a proper mask myself, brought a portable HEPA filter, spoke to management before hand… I still got Covid and now I have long Covid and have a very low quality of life.

I can't access dental. I can't access a grocery store. I can't access emergency medical services. I was coughing up blood all day Monday and couldn't go to the ER because I knew there was more waiting there for me. That would only make me more sick. This isn't healthcare this isn't "do no harm", Is the exact exact. Instead … Just like me …. people are being infected at their doctor's office, dentist and I'm even while in the hospital. Covid, Flu & RSV are airborne.

The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of not a majority of Americans. Proper PPE needs to be the standard of care in all medical settings as well as safe air ventilation of Merve 13 & 6 air exchanges per hour.

HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. This is a travesty. My husband was fired as a patient by his cardiologist for insisting that the tech preforming his four hour long treadmill test mask.

We can't protect ourselves. It's not even possible anymore. You can & must step up and protect patients in the care of medical professionals. We shouldn't have to ask medical professionals to wash their hands, to sanitize rooms and to wear masks. That is a part of their jobs.

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We can't protect ourselves. It's not even possible anymore. You can & must step up and protect patients in the care of medical professionals. We shouldn't have to ask medical professionals to wash their hands, to sanitize rooms and to wear masks. That is a part of their jobs. Do no harm.

I'm disappointed to see this committee is not recommending more stringent Covid precautions in healthcare settings. We are several years into this pandemic. We KNOW Covid is airborne and that more precautions can and should be taken to prevent people from catching Covid, particularly when there are higher concentrations of sick and vulnerable people in places like hospitals. My father is currently undergoing chemo and radiation. His immune system is very weak… and yet, even at Johns Hopkins, healthcare workers are not doing what they should to ensure their patients' health.

Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection. These layers should be required in healthcare settings. Schools and other places with densely populated areas indoors should be required to update their precautions. This would not only protect patients and students from Covid, but would keep people healthier in general.

Sincerely,
Sarah Duncan

N95 are appropriate protection for air or e pathogens. Anything less is negligent. We know better do do better. Masks should be at And are in healthcare. Infants can't mask. Dental, orthodontic, colonoscopy etc patients can't mask to protect themselves. Accessing healthcare should not require risk of contracting LongCovid.

Sara Cohen
Pierce County WA

Dear HICPAC,

I am writing as a concerned, high-risk citizen who currently does not feel safe accessing most healthcare. Hearing about your decision not to ensure the highest levels of protection against Covid-19, I am deeply disappointed, and I urge you to change your stance.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Sincerely,

Katrina Martin
Aurora, CO

Masks should be required in hospitals. It helps prevent disease transmission. Wearing masks should be exactly like washing hands. They both prevent spreading of communicable diseases.

Studies have shown that people catch deadly diseases like Covid inside hospitals. Masking protects patients and workers.
Up to 167,000 people caught Covid in hospital in second wave of pandemic – study
https://www.independent.co.uk/news/health/data-nhs-english-university-of-oxford-england-b2431909.html

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Hello,

I am writing again to demand that HICPAC recognize that COVID-19 spreads via aerosol transmission and that they correct their statements on the use of masking in healthcare settings. It is established science that N95 respirators and HEPA filters provide life saving infection control in a time when America needs it most.

I demand that the HICPAC committee implement the following to ensure the safety of the American public backed by thorough academic discourse and viewpoints:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
- Health care personnel and their representatives.
- Industrial hygienists, occupational health nurses, and safety professionals.
- Engineers, including those with expertise in ventilation design and operation
- Research scientists, including those with expertise in aerosols and respiratory protection.
- Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
- Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
- Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
- Open work group meetings to the public with virtual options and with ample time set aside for public comments.
- Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
- Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.

- Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
- Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
- Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
- Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
- Pre-symptomatic and pre-positive-test transmission are possible.
  Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
  All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
  Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
- The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
- Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
- Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
- Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
- Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.

- Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events)
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

It has been made aware that HICPAC is in violation of its charter, and as such, any recommendations that you propose should be considered illegal and subject to the highest scrutiny. You can be sure that the people and all concerned parties will be taking every available option to ensure that you are held accountable.
Thank you,
Michael Askren

To whom it concerns,

My name is Lauren DiVito, and I'm a resident of Chicago, Illinois. I am writing to echo the statement made by the independent organization "People's CDC" regarding infection control in healthcare settings.

Masks in healthcare absolutely should not be removed, as we are still in an ongoing pandemic. In addition, more infection prevention measures--such as enhanced air filtration and far-UVC air sanitation--should be introduced.

We have all the tools we need to stop airborne infections, and we need to be implementing them. In addition, a program to instate these measures in healthcare settings could create thousands of jobs.

On many fronts, it is imprudent not to take COVID-19 seriously.

I've included the People's CDC statement below:

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures

(including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (“air” and “touch”) – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thank you,
Lauren DiVito

Sarah Nehmer
Essexville, MI
No affiliation
Topic: Isolation Precautions Guidance/HICPAC/CDC transparency

Hello,
I am a wife and mother under 40 (for a couple more weeks), who cannot get the medical care that I need because I am high risk and medical facilities are not safe for me. I have been left to sit (the wheelchair required someone to be pulling a lever while pushing it to be able to move it, so it is not operable by the wheelchair user - this is the norm in the hospitals around here) next to people who exhibited clear symptoms of Covid, holding onto the pathetic surgical mask they were at the time required to "wear" by the hospital. People were literally coughing on me. I had

to leave without being seen because the risk was too great for me. I had to leave the ER because the risk of exposure to a known debilitating and deadly virus was more dangerous than not being seen for a medical emergency.

A similar situation occurred at the beginning of the pandemic when again the wheelchair I was in was just parked, and I was left stranded at a kiosk to check in for labs (the only lab open in about a 20 mile radius at that point due to a dam break that compounded an already overburdened and fragile medical system). After being left while people in line behind me complained about me being in the way for quite a while, a phlebotomist came out and moved me. Next to someone coughing over the surgical mask they wore under their chin. I was on chemo at the time. I had to call my husband in tears, and ask him to come get me (at that time no one was allowed with patients because of covid). We had to drive an hour away to get labs somewhere safe.

That's merely scratching the surface, but my health has only gotten worse since then, and its become less and less safe for me to seek and/or receive care.

I demand that HICPAC and the CDC use a fair process and sciece-based protections for healthcare workers AND patients. You must delay the vote until ample time has been given to the public to review the Isolation Precaution guidance updates.

HICPAC and the CDC must hold public meetings ahead of any votes, to hear from patients, healthcare workers, and experts outside of infection control, who have vital perspectives for the Isolation Precautions guidance updates.

The CDC and HICPAC must update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation, and fully recognize the science of aerosol transmission of infectious diseases.

The CDC and HICPAC must stop using a flawed review of N95 respirators to justify equating surgical masks, which offer inferior protection, with the same level of protection as an N95. I demand that the CDC and HICPAC stop using flawed "data" to justify loosening safety measures.

There can not be a "flexible approach" to safety. We have been shown so clearly that employers will always prioritize profits and convenience over employee health and safety. The CDC and HICPAC cannot bow to the whims of corporations at the expense of the health of the American people. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious disease.

I am also very concerned by the lack of acknowledging the importance and function of core control measures for infectious aerosols. I urge, nay, demand, that the CDC and HICPAC consider the large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols. We have known about this since BEFORE 2020 - I recently read an article about this very thing from 2018: http://www.bisnow.com/national/news/office/is-your-open-office-workplace-giving-you-the-flu-85085 .

HICPAC and the CDC must be transparent, must make science-based decisions, must act in good faith and use unbiased data, and must prioritize the health of human beings over corporate greed or public fatigue.

Thank you.
Sarah Nehmer

Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.

    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize

procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
  - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Reference guidance from CDC in January 2020
https://stacks.cdc.gov/view/cdc/84639/cdc_84639_DS1.pdf

Indi Zeleny

To whom it may concern,

I am a private citizen writing in regards to HICPAC's proposed guideline changes for medical facilities and staff as pertains to infectious disease control. As a chronically ill high risk person who cohabitates with an even more at risk person (an older parent with COPD and congestive heart failure and Crohn's disease,) and who lost his father earlier this year as a result of COVID-19 mitigations not being adhered to in his long term care facility, I am deeply concerned by what I feel are inadequacies in HICAP's proposed guideline changes.

The EPA (https://www.epa.gov/coronavirus/indoor-air-and-coronavirus-covid-19)and myriad reputable experts in aerosol dynamics acknowledge that infectious SARS-CoV-2 particles may linger for hours in aerosols in poorly ventilated indoor spaces, and that stringent mitigations such as respirators, ventilation, and filtration are critical to reducing infectious viral particles suspended in air. The failure to do any of these - including masking around him - are how my elderly father contracted COVID-19 earlier this year from his nursing home staff, after which he experienced a precipitous decline due to multiple organ and respiratory failure, followed by brief convalescence and a moment of hope, before then spontaneously dying as the result of an unspecified "cardiovascular event." This despite multiple vaccine doses, and the ostensibly "milder" circulating variants than earlier in the pandemic.

COVID-19 infection remains the third or fourth leading cause of death in America, depending upon how it's reckoned. Led only by cancer and cardiac arrest (with at least some fraction of those cardiac arrests doubtless being associated with COVID-19 as well, as research continues to show strong correlation between infection and cardiovascular and ischemic disease.)

People like myself, my elderly and high risk mother, and millions of other Americans cannot at present safely seek routine medical care, including dental care, without risking exposure to this pathogen, due to the same lack of stringent mitigations. Many also face financial, transportation, or other access barriers to vaccination and therapeutics, making trips to the doctor, crowded waiting rooms, etc. high risk events. There are at present no effective monoclonal antibodies for

immunocompromised patients anymore with regard to currently circulating variants either. Layer after layer of protection and "tools" seem to be being stripped away progressively.

As such, physicians, nurses, healthcare facility staff, all involved in delivery of care to patients, and policy makers such as yourselves, have a duty of care to engage in common sense and scientifically well founded infection control measures. We trust you all with our lives.

I implore HICPAC to reconsider the language and format of their new proposed guidelines to require indoor air filtration, well-fitted high quality respirator use, and ventilation in medical facilities and settings, in order to maximize the protection of vulnerable, high risk patients. As well as the retention of recommendations for isolation and airborne disease protocols.

"Learning to live with COVID-19" should include institutional and personal adaptations and changes that make everyone safer from airborne disease, particularly those seeking medical care in a vulnerable state. Not regression to the 2019 status quo, and certainly not regression backwards even beyond that from mitigations that are time tested and scientifically well founded.

Please consider the pleas and risks of patients like us (and those far more vulnerable than us, such as the immunocompromised) when crafting policy, we earnestly implore you.

Sincerely and respectfully,
Benjamin Joynes

Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:
Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including:
Health care personnel and their representatives.
Industrial hygienists, occupational health nurses, and safety professionals.
Engineers, including those with expertise in ventilation design and operation
Research scientists, including those with expertise in aerosols and respiratory protection.
Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
Patients, patient advocates, and disability justice groups.
Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:
Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.

Open work group meetings to the public with virtual options and with ample time set aside for public comments.
Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:
Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
Pre-symptomatic and pre-positive-test transmission are possible.
Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.

Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.
Reference guidance from CDC in January 2020
https://stacks.cdc.gov/view/cdc/84639/cdc_84639_DS1.pdf

Please consider the pleas of the public asking you to protect them. Covid is spread through the air. Clean air reduces its spread. Simple precautions like masking, opening windows and running air purifies and fans will protect us. Please make these strategies a part of your response to this pandemic.
Thank you
Cindy Thompson
Salina KS
Member of the public

Dear HICPAC,
I am writing to amplify the following message from the People's CDC re: Recommendations for CDC/HICPAC
Regards,
Laura Finch
--
Dr. Laura Finch (she/her)
Assistant Professor | Massachusetts Institute of Technology

Recommendations for HICPAC
Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
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- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
- Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
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    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
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COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions.
Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting

outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

My name is Leah, and I am so tired from my post-viral illness, bedbound and disabled, that most of the rest of my comment will be copy & pasted. Even though I have so much to say, I don't have the energy to write it because of my debilitating fatigue. Please. Stop letting patients and healthcare workers get post-viral illness like mine. Please. Protect those of us who are already sick and vulnerable from worsening or dying from COVID-19 infection acquired in hospitals and other healthcare settings. I am so tired, and I am avoiding in-person treatments and tests that could potentially help me because of the risk of being infected with COVID-19. Please protect us.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

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Thank you for upholding the standard to do no harm. If you need any more information for my comment to be accepted, please email back.

As a concerned citizen and COVID survivor with some long-COVID symptoms (and with close friends and community with worser suc symptoms), I'm writing to urge you to adopt the recommendations of the People's CDC to protect ordinary citizens, as well as those in risk groups, including the elderly and health-care workers.

The pandemic is not over, and our response should not be based on politics, politicized economics, denialism, wishful thinking, carelessness and callousness, or only-apparent lack of evidence due to quitting of testing and monitoring.

All the best in your endeavors to support and protect the health of the populous.

Sincerely,
Carl R. Castro

Hello,
My name is Tazmin Kaldhusdal and I am a US Citizen extremely concerned by the failure to protect people from COVID19. I would like to submit the following message as I agree with these statements and hope that HICPAC takes them into consideration:

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
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Thank you,
Tazmin Kaldhusdal

People have the right to be safe while seeking care in all medical settings. Instead people are being infected at their doctor's office, dentist and even while in the hospital. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of Americans. Proper PPE including N95 masks needs to be the standard of care in all medical settings as well as safe air ventilation of Merv 13 & 6 air

exchanges per hour. HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. This is a travesty. I'm immunocompromised and afraid to access needed medical care now that my doctors and dentists either don't mask or wear loose surgical masks. We can't protect ourselves. It's not even possible anymore. Your Guidelines Proposed will Disable & Kill.

Hi,
I am Zeke Pratchett, Portland, OR, Independent Clean Air Advocate.
Regarding this meeting:
https://www.federalregister.gov/documents/2023/10/10/2023-22327/healthcare-infection-control-practices-advisory-committee-hicpac

I still agree in full with the 900 experts who wrote to the CDC director in this letter:
https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Surgical masks are NOT RPE. The CDC's NIOSH has repeatedly said that they are not RPE. RPE is needed for airborne diseases, which the WHO indicates that Covid is - both short- and long-range.
https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

Here the CDC says that "SURGICAL MASKS ARE NOT RESPIRATORY PROTECTION"
https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

There should be universal respirator usage in hospitals. From the parking lot before you enter, to the parking lot when you leave.

Only continuous respiratory usage prevents transmission, as shown in the continuous arm of MacIntyre et al (2013):
https://pubmed.ncbi.nlm.nih.gov/23413265/

All the other RCTs has donning and doffing of N95s within 6 feet or less of the patients....which defeats the whole purpose of testing N95s against airborne diseases.
They should not be included in your reviews.
Thank you,

Zeke Pratchett

Dear HICPAC,

I don't have a lot of time to write a lengthy, eloquent letter.

I will only say this: you are derelict of duty if you continue to dawdle on creating strong, clear policies to guard against aerosol transmission of disease including Covid in healthcare settings.

Covid is airborne. It is inconceivable now that a healthcare worker would not wear gloves in patient care: we need to implement this kind of commonsense thinking about masking as well. This will protect healthcare workers and vulnerable patients, many of whom now weigh their risk

of foregoing or delaying care against their risk of nosocomial infection. This is simply unacceptable.

We can stop this deadly nonsense with sensible rules. You owe it to patients to institute masking in healthcare settings as a matter of course; you have the power to set policy and make it as routine as handwashing and gloves for infection control, neither of which would ever be allowed to come down to "personal choice". Do no harm is the first principle in a healthcare setting. You know this. Do your jobs.

Thank you.
Sincerely
Christina Dunbar-Hester, Ph.D.

My family and I, and all people, have the right to be safe while seeking care in all medical settings. Instead we are being infected at our doctor's office, dentist and even in the hospital. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of Americans. Proper PPE needs to be the standard of care in all medical settings as well as safe air ventilation of Merv 13 & 6 air exchanges per hour. HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. This is a travesty. You can & must step up and protect patients in the care of medical professionals.
Thank you,
R. Catania

Public comment submitted by:

Monica Allen, Member of Pan End It!
Eagan, MN

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To whom it may concern-

I write today with concern about HICPAC's newest draft for: Guideline to Prevent Transmission of Pathogens in Healthcare Settings.

CDC must reject HICPAC's draft and take material steps to gather and incorporate the expertise and perspectives of frontline nurses, other health care workers, patients, and public and occupational health experts outside infection control (e.g., industrial hygienists, respiratory protection experts, ventilation engineers, etc.).

Infection prevention must be the responsibility of the health care settings and employers, not the individual employees. Protections must include a multi-layered approach: proper PPE, ventilation and air quality, patient and visitor screening, and isolation of both symptomatic and asymptomatic individuals.

Scientific evidence on aerosol transmission of infectious diseases must be centered. The draft keeps talking about short vs far range transmission and the existing, disproven droplet-airborne paradigm.

Surgical masks are NOT respiratory protection—FDA, NIOSH, and OSHA are clear on this point, and yet CDC/HICPAC is proceeding to treat surgical masks as a default option for respiratory protection. N95 respirators must be required.

There is an on-going need to include symptom screening for COVID, influenza, and RSV: exposure history, travel history, risk factors for infection, etc.

Employers could implement changes for maintaining or reaching safe staffing ratios, especially bedside RN staffing, to prevent infection transmission, break relief for medical workers, and complying fully with OSHA's Respiratory Protection Program Standard.

I stand in support of NNU's call to the CDC to reject HICPAC's draft and to actively engage the input of frontline nurses, other health care workers, their unions, patients, and public health experts, in addition to infection preventionists, in the development of a new draft of the updated guidance. NNU urges CDC to hold public meetings, similar to the meetings held in 1992 during the development of the multidrug-resistant tuberculosis infection control guidelines for health care, as soon as possible and, based on this input, to significantly amend HICPAC's draft to better protect health care workers and patients.

My name is Jayda Jones and I have my Master's in Public Health in Epidemiology and am a member of the Massachusetts Coalition for Health Equity. Today, I am calling on the CDC to fully recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.

In my experience working at a major hospital in MA, it was alarming to witness the lack of protections in place to ensure the patients, visitors, and staff's health and safety. Even during the Public Health Emergency, I was not allowed to wear an n95 respirator during my shift. I was only allowed to wear an n95 if I am working with a patient suspected or confirmed positive of COVID-19. I was only allowed to wear the facility-issued surgical masks which are not as effective as n95 respirators in protecting against an airborne virus during an ongoing pandemic. With the removal of mask mandates and of admission, repeat admission, and serial admission testing for asymptomatic patients in healthcare facilities as of May 12th, 2023, not only are we unable to identify asymptomatic or presymptomatic cases among inpatients, but we are also unable to control transmission when most are unmasked as they are not required to anymore. For the healthcare workers who decide to continue masking, due to this hospital's restrictions of only allowing surgical masks, they are not even best protected against COVID. The lack of necessary precautions during an ongoing pandemic in a facility where several patients are at high risk of severe disability or death is completely unacceptable. Patients are locked out of safe and accessible health care and health care workers and patients are not protected against this virus. This is a major infection control issue, and we are already seeing the effects of this across several healthcare facilities in the nation including a COVID outbreak among patients and staff at Beth Israel Deaconess Medical Center in MA reported on June 24th.

Patients should not have to worry about becoming exposed or infected with a hospital-acquired infection. Several people on August 22nd at the HICPAC meeting gave a public comment stating their or a loved one's experience with being exposed and infected with COVID in a hospital setting or denied reasonable accommodations under the ADA, and therefore are locked out of safe and accessible healthcare due to the lack of protections that are in place to

control infectious disease transmission. On July 22nd, my 24 year old cousin died from pneumonia after being infected with COVID. Healthcare facilities are more than capable of altering these requirements; if they want to continue the representation of delivering the best care in a safe environment and to improve the health and wellbeing of patients, then their actions must reflect this. Implementing universal n95 masking and pre-admission/pre-procedure COVID-19 testing is crucial for infection control during an ongoing pandemic, in which hospitalizations are rising nationwide, and several institutions have reinstated universal masking, including Kaiser Permanente in CA as of August 23, 2023.

I urge you that when an issue is disproportionately impacting marginalized communities, which is the disabled community and people of color, to then listen to the issues from their perspectives and not from the perspectives that are claiming they are entering a safe healthcare environment or have the tools to ensure protections against the virus. The healthcare facility outbreaks and the countless stories of individuals struggling to access safe healthcare, especially individuals who are suffering from Long COVID, indicate otherwise. Understand the realities of marginalized communities: the end of the Public Health Emergency did not indicate an end to their continued high risk of severe disability or death. COVID continues to be a major threat as the WHO indicates that every 1 in 10 infections leads to Long COVID. The reality is COVID is a preventable infection and we can alter measures which promote public health. Listen to issues from disproportionately impacted communities, this way we can work from a point of prevention and control, rather than reaction at the cost of those most vulnerable. We demand safe and accessible health care, NOT COVID.

Jayda Jones, MPH

Dear committee,

Changing masking guidelines to make the Hospital Association happy is malpractice. The physics of the SARS COVID19 virus hasn’t changed and an N95 mask is needed to prevent healthcare workers from contracting it when working with patients.

Declaring Covid seasonal also does not alter the physics of the virus. Please do your jobs and protect the actual public. By the way, wastewater numbers show that covid is a problem year round.

KC Holeyfield MD
Palo Alto, CA

To whom it may concern,

I'm writing as an immunocompromised person whose life was destroyed by a Covid infection almost 4 years ago. I am now disabled and at serious risk of COVID-19 infection, after being reinfected in early 2022. Every day is hell with this disease and it affects millions of Americans. One of the most disturbing things since becoming chronically ill after my COVID-19 infection is that I'm now unable to safely access healthcare due to rampant Covid spread and no consistent airborne protections in place in healthcare settings. Instead of being able to trust that the CDC has the well being of patients like me at heart and is working to increase infection control in healthcare settings, I was dismayed to learn of the lack of transparency, lack of input from key stakeholder groups, and lack of concern for patient and employee health throughout the process

of updating HICPAC's infection control guidelines. It is shameful and violates the hippocratic oath many healthcare providers take.

I urge you to recognize aerosol transmission of Covid and other commonly circulating pathogens, to require respirators (n-95s, etc.) in healthcare settings regardless of vaccination status or known infection status, to acknowledge the far superior effectiveness of respirators over surgical masks (which have been proven over and over, like in this recent JAMA study https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811136), to require clean air tools such as HEPA filters and increased ventilation, to increase transparency in decision making, and to involve aerosol experts as well as the stakeholders most impacted by these guidelines, including healthcare workers and patients, particularly those from the disabled and chronic illness communities. On top of this, I urge you to consider the health of healthcare workers, many who have Long Covid and will be at risk of further adverse health outcomes if they are not protected by masks in their place of work.

Please put politics aside and respect patients, workers, and the health of all Americans.

Sincerely,
Miles Griffis

I urgently draw your attention to a crucial public comment submitted by Dr. Andrew Wang and Raj Chaklashiya, representing the People's CDC, which exposes significant shortcomings in the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) proposed COVID-19 guidelines. These oversights may have dire consequences on public health and safety.

Dr. Wang and Mr. Chaklashiya emphatically underline the following grave concerns:

- **Impact of COVID-19**: They starkly highlight the devastating and life-altering impact of COVID-19, including the widespread suffering caused by Long COVID, stressing that robust measures are imperative to safeguard everyone in healthcare settings.

- **Aerosol Transmission**: The comment insists that the deadly spread of SARS-CoV-2 through aerosols demands stringent layers of protection, such as N95 respirators, comprehensive ventilation, and rigorous air filtration.

- **Proposed Precautions**: The authors vehemently argue that HICPAC's current approach perilously permits healthcare employers too much latitude in creating infection control plans, potentially sacrificing safety for cost. They demand:
  - The establishment of an uncompromisingly high standard for infection control measures.
  - The formulation of an exhaustive exposure control plan assessing every level of exposure and mandating corresponding control measures.

- **Terminology and Categories**: The comment forcefully criticizes the new terms "air" and "touch" for transmission modes, asserting that they grossly underestimate the science of aerosol transmission and the critical role of inhalation in spreading this deadly virus.

- **Evidence Review Concerns**: The authors contend that the evidence review for N95 respirator and surgical mask effectiveness is woefully inadequate and insist on incorporating data from:
  - Scientific researchers and experts in respiratory protection.
  - Aerosol science and occupational health studies.

- **Control Measures**: The comment charges that the proposed guidelines recklessly neglect indispensable control measures such as ventilation, air filtration, and source control for infectious aerosols. They call for:
  - Explicit recommendations on ventilation and the use of airborne infection isolation rooms (AIIRs).
  - Thorough consideration of source control in the context of personal protection from inhalation.

Dr. Wang and Mr. Chaklashiya demand an immediate revision to the proposed guidelines, urging a more cautious and scientifically grounded approach that uncompromisingly prioritizes the lives, health, and safety of healthcare personnel and patients.

Please listen to the science,
Spencer Thayer

STOP ALLOWING US ALL TO DIE AND BECOME DISABLED BECAUSE IT'S MORE CONVENIENT!!!

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation

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To whom it may concern,

I am writing you to demand that HICPAC adopt the People's CDC's guidance for HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a**

multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:

- Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
- Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
- Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
- Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
  - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
  - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
  - Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
  - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more

accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
    - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Health care is the one thing I cannot avoid as a Long Hauler, infected by people who unmasked because public health officials and authorities lied to them and told them it was safe. Health care must be safe. The US can set standards that set an example and raise the bar around the world, instead of giving the rest of the world the go ahead to infect patients in health care settings. One of the few things that could ever get me to return to the US, and leave the UK with its NHS, is the adoption of stringent infection controls in health care settings in the US.

Regards,
Sophie Ciurlik Rittenbaum

Hello,

I'm writing as a concerned citizen who would like to see healthcare in the United States improve rather than get worse. Already, we are seeing alarming numbers of infections of *all kinds* -- COVID, candida, tuberculosis -- on the rise, and potentially spreading in healthcare settings.

I am following the leadership of National Nurses United and People's CDC in writing to you, and would like to echo their comments:

We need a fair and transparent process, as well as guidelines that reflect science and protect healthcare workers and patients.

https://peoplescdc.org/2023/11/01/peoples-cdc-public-comment-on-hicpac/
https://act.nnu.org/letter/tell-the-cdc-release-the-draft/

Thank you,
Rebecca

Current health guidelines are inadequate to protect patients and staff in healthcare settings. I urge CDC/HICPAC to revise and strengthen guidelines in healthcare settings to provide better protection from airborne diseases like COVID-19 for patients and healthcare workers.

All Americans, including the young, vaccinated, and otherwise healthy, are vulnerable to serious long-term health problems resulting from COVID-19 infection. They are especially at risk in medical facilities that are often crowded with sick people.

All healthcare settings should be required to use better, multilayered precautions to prevent the spread of airborne disease. These mandatory mitigation measures should include the use of high-quality respirators such as N95s for all staff, training on how to properly wear them, and better ventilation systems with HEPA filters throughout such facilities.

The health and safety of patients and staff are far more important than convenience. Do no harm.
Steve P.

Hi,

For your convenience, below my signature line is the text of my oral comment to HICPAC on November 2, 2023, regarding Standard Precautions against Transmission of Airborne Pathogens.

Sincerely,
Roselie A. Bright, Sc.D., Rockville, Maryland

Good afternoon. I'm Dr. Roselie A. Bright, a retired federal epidemiologist with a doctor of science degree in epidemiology. I submitted a comment for the August meeting that I still stand by. At the time, I did not have access to the materials from the June meeting. For today, I did not have access to today's meeting materials before the meeting.

1.The interpretation of policy related to using respirators vs surgical masks has been problematic.

a.COVID-19 has high transmissibility, serious and often permanent consequences, and no cure. The worst side effects of respirators vs surgical masks are minor. These two factors qualify respirator use as a Standard Precaution.

b.The whole idea of precaution is to take preventive action all the time, not just when one perceives present danger, and in the case of equipoise to make policies based on erring on the side of protecting patients.

2. The Standard Precautions need to be upgraded to include universal airborne transmission precautions, including universal (that is, patients, healthcare workers, and visitors) at-least-respirator-quality masks, air ventilation, and air cleaners (such as filters and upper room UV-C). Engineering is essential for infection control. Simultaneous use of all practices is necessary.

3. Everyone must be presumed COVID-19 infectious, because:

a. It is highly transmissible, including when people are asymptomatic or presymptomatic. [L SEP]

b. Even if one tests COVID-19 negative at the beginning of the workday, one can start emitting infectious-levels of the virus by the end of the workday.

c. Rapid tests have been negative even when the tested person is currently infectious.

d. Thus, everyone who seems healthy, as well as anyone who has symptoms, must be presumed to be infectious. This is why the HICPAC vote to recommend precautions only in the case of “suspected or confirmed infection in the patient” is inadequate.

4. Workers, patients, and visitors should always be supported to upgrade from mask precautions to respirators.

5. I object to allowing healthcare workers to forego precautions because of the mental health impact concerns. Your main concern should be infections.

6. The response to the current lack of COVID-19 disease surveillance should be to assume it is always present, rather than to assume it has disappeared. HICPAC should recommend frequent and comprehensive monitoring for COVID-19 among workers, patients, and visitors so that providers can learn lessons to stop spread.

7. Healthcare workers who test positive should stay isolated at home on paid sick leave. Routine staffing levels need to be designed to accommodate realistic levels of staff sickness to reflect the realities of the pandemic. “Presenteeism” needs to be discouraged.

8. You haven’t incorporated evidence-based public comments into your draft guidance. Please re-examine your resistance to the overwhelming majority of public comments such as mine.

Hello,
There is still a lot we don't know about the long-term consequences of a COVID-19 infection. While vaccines has reduced the mortality of the virus, there are studies coming our regularly indicating that infection, and repeat infection is not a sustainable model. Additionally, it would seem that the immunocompromised and elderly have become cannon fodder to this virus. The one place those most at risk should feel safe is in healthcare settings. Healthcare is necessary and vital, especially for the elderly and the immunocompromised. Those individuals should not have to make a choice between seeking care or avoiding a COVID infection.

The lack of transparency, lack of concern for the weakest among us, and lack of input from key stakeholders throughout the process of updating HICPAC's guidelines is unjustifiable. Please reconsider the potential of aerosol transmission, not just of COVID and other existing pathogens, but also future pathogens that could blind side us like COVID once did. Clean air not only protects patients, but it protects workers too. Healthcare cannot afford to have worker shortages, especially when another pandemic inevitably hits us.

Thanks for you consideration,
Jessica Mytrohovich
Marietta GA

CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) should correct their review on COVID infection control measures to reflect the science of aerosol transmission

through inhalation. The decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts.
Please consider doing the following:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
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- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
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- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
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    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
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        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).

- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Thank you,

Lila Guterman

I am a US citizen in California writing to object to new proposed HICPAC guidelines which do not require well-fitted masks in medical settings.

US citizens have the right to be safe while seeking care in all medical settings. Every day, people are being infected at their doctor's office, dentist, and during hospital stays. Covid, Flu & RSV are all examples of airborne viruses, the transmission of which has been scientifically proven to be reduced by masking. People who are immunocompromised, and those at high risk for disability or death due to complications from viral illnesses include millions of Americans.

Proper PPE needs to be the most basic standard of care in all medical settings, as well as safe air ventilation of MERV 13, with 6 air exchanges per hour. HICPAC has ignored scientific data by allowing medical professionals to eschew their medical ethics standards by putting personal convenience ahead of patient safety.

This is a travesty. Countless Americans are becoming disabled and dying every day from viral complications. This will have a terrible impact on the economy and standard of living over the next several decades in the US.

You must step up and protect patients in the care of medical professionals.

Signed,
Aubrey

Dear Sirs and Madams,

It is clear that SARS-CoV-2 (COVID) is propagated among people by airborne transmission in droplets AND aerosols. There is no longer any debate to be had about this. Any denial of aerosol transmission, at this point, amounts to incompetence if not outright malpractice.

All personnel employed in healthcare settings need to be required to wear an N95 or equivalent respirator when they are in those settings. We know that respirators are effective in interrupting aerosol transmission, we know that SARS-CoV-2 is transmitted through aerosols, we know that people an be asymptomatically infected with SARS-CoV-2 even if vaccinated, therefore, it is in the interest of the health and well being of patients, those accompanying them AND healthcare providers that ALL persons should be required to wear a respirator when on the premises of a healthcare setting.

Surgical masks are not sufficiently effective at preventing the aerosol spread of a vascular neurodegenerative virus such as SARS-CoV-2. We have known this since 2003 with SARS-CoV-1. There should be no debate about this.

In addition, healthcare facilities should employ all effective measures to clean the air in healthcare settings to include HEPA grade filtration, ventilation with outside air, and far UV illumination. Four years into this pandemic, given the volume of hospital/healthcare acquired infections, there should be no debate about this, as well.

As an entity, HICPAC needs to rehabilitate its image and make efforts to regain public trust. Towards this end, aerosol experts should be engaged to determine how best to achieve a safe environment for all who enter the doors of any healthcare facility. And, the outcomes of that engagement needs to be made public in real time to improve the transparency of this process.

Frankly, we the public are beyond tired of the gaslighting and the misinformation being propagated by many public health authorities. Engaging outside experts with specific skills in aerosols, atmosphere, and fluid dynamics and making their recommendations known in a time sensitive manner will encourage public trust and public participation, thereby, putting the "public" back in public health.

Respectfully,
Lori Mong Kryspin, MT,SM (ASCP)
Supervisor, The Ohio State University AIDS Clinical Trials Laboratory (Ret)
Co-Chair AACTG/IMPAACT Laboratory Technologist Committee (Ret)
Columbus, OH

Masks in Healthcare

As healthcare workers, patients, parents, and caregivers, we at the People's CDC urge public health officials and healthcare organizations, including hospitals, clinics, physician and dentist offices, nursing homes, and home health care services to require masking in all healthcare settings, and to provide masks (ideally N95 respirators) for everyone in those settings. The revised CDC guidance,1 which permits patients and staff in healthcare to stop masking when "levels of Community Transmission" are not "high," is dangerous, unethical and based on flawed data.

REMOVING MASKS IN HEALTHCARE IS DANGEROUS.

Clinics and hospitals are sites for COVID patient care, so even if transmission rates are low, they will remain among the most likely locations to encounter people infected with COVID, and also people who are vulnerable to severe disease or death from COVID. Contagion in healthcare settings is already a problem even in well-equipped US academic medical centers.2 Removing masks in healthcare puts both patients and healthcare workers at risk, which could place even more strain on the healthcare system amidst severe staffing shortages.

REMOVING MASKS IN HEALTHCARE IS UNETHICAL.

Failing to require masks in healthcare settings violates medical ethical principles.3 Patients come to clinics and hospitals to improve their health. Healthcare providers have an ethical responsibility to DO NO HARM and ensure that they do not expose patients to COVID. Children and babies who cannot or may not wear masks and people in clinical situations that do not permit mask-wearing (such as post operative units) need others to protect them by wearing masks. Vaccines alone are insufficient to prevent COVID-19 spread. Although vaccines lower the risk of hospitalization and death, vaccinated people can die from COVID-19,4 or develop Long COVID,5 which may affect as many as one in five people6 after COVID infection.

CDC POLICY TO REMOVE MASKS IN HEALTHCARE IS BASED ON FLAWED DATA.

The CDC's current policy relies on the Community Transmission7 map, which grossly

underestimates COVID-19 infection rates. Back in September 2021 the CDC estimated that only 1 in 4 COVID cases8 were reported. And in New York, for example, a spring 2022 study suggested that infections were underestimated by a factor of 30.9 This is because far fewer people are testing for COVID now that much required routine testing has ended, federal funding for COVID testing has diminished, and most home tests are not reported. Further, most low-wage workers don't have paid sick time,10 and therefore many are incentivized or compelled to go to work with COVID,11 or to avoid testing.12
In conclusion, we urge public health officials and healthcare providers to keep our communities safer from COVID-19, by requiring and providing high-quality masks for all. The healthcare system should be a place of healing, where the risk of acquiring infections is minimized. We urge you, as stewards of public health, to act in the best interests of the most vulnerable among us.

SINCERELY,
URIAH BUSSEY

The CDC's guidance for workplaces and businesses is insufficient to protect the public from SARS-CoV-2 and its sequelae, which is unfortunate. The best we can do is wear high-quality respirators and avoid long periods of time in crowds

But in the hospital, masking is not always possible. A patient may be unconscious, may be staying overnight, or may need their nose or throat checked. And they must therefore be protected, by requiring ASHRAE Standard 241-compliant ventilation and N95-equivalent masking of everyone sharing air with them.

As an immunocompromised person, I am able to avoid going into stores, restaurants, libraries, museums, arts venues, and, because I don't commit crimes and have so far been lucky in finding my clerks of court sympathetic when I have come up for jury duty, courtrooms. I will not, however, be able to avoid hospitals forever. Eventually, I will need medical treatment that I cannot put off. And the thought terrifies me. We know that patients catch illnesses in hospitals, especially SARS-CoV-2. So I do not understand why HICPAC would hesitate to enact protections for the most vulnerable patients.

Please, strengthen patient protections in healthcare settings. To do otherwise is to do irreparable harm to people like me and families like mine.

Here are a couple of related articles for your review:
Wilson ,C. "Concerns over catching covid-19 in hospital." New Sci. 2022 Jul 30;255(3397):19. doi: 10.1016/S0262-4079(22)01337-9. PMID: 35937961; PMCID: PMC9337914.

Van Beusekom, M. "Researchers estimate 1% or 2% of hospital patients in England caught COVID after admission." Center for Infectious Disease Research and Policy. 2023 Oct 19. https://www.cidrap.umn.edu/covid-19/researchers-estimate-1-or-2-hospital-patients-england-caught-covid-after-admission

Bansal S, Roy M, Chatterjee T, Roy AK. Deaths due to delayed presentation to the hospital from fear of contracting COVID-19 during lockdown period: a tertiary care center experience. J Community Hosp Intern Med Perspect. 2021 May 10;11(3):299-301. doi: 10.1080/20009666.2021.1918440. PMID: 34234897; PMCID: PMC8118468.

Coral Sheldon-Hess (they/them)

Dear HICPAC,

We need strong clear policies to guard against aerosol transmission of disease including Covid in healthcare settings.

With the evidence of studies it is clear masks work to help stop transmission of airborne diseases, and you owe it to patients and healthcare workers to protect them. This is not something that should be left to individual choice. Like the wearing of seatbelts, it needs to become the norm, we are talking about saving lives.

Thanks for your attention,
Teri Dobson
Port Angeles, WA

Please ensure that infection control guidelines for hospitals:

1. Recognize that many respiratory viruses, including but not limited to covid, are transmitted primarily as aerosols, and need to be addressed as such.

2. Recognize that covid is more highly transmissible than measles. Require containment procedures that are equivalent to or stronger than current procedures for measles (sealed, reduced pressure rooms, etc.)

3. Protect patients and healthcare workers from aerosolized dangers, just as we protect manufacturing workers.

4. Reiterate previously stated CDC policy, that surgical masks are not to be used for respiratory protection. Respiratory PPE must be n95 or equivalent respirators.

Thank you.

The public looks to healthcare to protect us and to be a role model as to what we should do. All healthcare workers should be masked to protect themselves and their patients. Bottom line. Make the decision that will save lives.

Sandy Wusterbarth-Brown

Dear HICPAC Committee,

As of now, it’s well known that over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) absolutely must correct their review on COVID infection control measures to reflect the real science of aerosol transmission through inhalation. This decision-making process absolutely must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts.

Your current committee oversees policies and protocols on the prevention of infectious diseases in healthcare settings yet includes none of the above mentioned representatives nor patient advocates, only business managers representing business and financial interests.

Additionally, my recommendations for CDC/HICPAC are:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.

- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.

- Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
  - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
  - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
  - Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
  - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.

    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
  - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Thank you,
Citizen

COVID-19 harms, disables, and kills people. Estimated millions of Americans also l are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The

review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

I am writing to encourage committee members to prioritize infectious disease control in healthcare settings by acknowledging the airborne transmission of disease (including but not limited to public health concerns like COVID-19, TB, and influenza) and mandating evidence-based practices to reduce transmission, including masking in high-quality respirators. We now have years of data suggesting that surgical masks are significantly less protective than N95s. Therefore, they are an unacceptable choice when caring for a population at high risk of severe disease, long-term disability, and death.

I would like to mention a case that has affected me, personally, and motivated me to advocate for universal masking: a patient who was admitted to the hospital due to a knee injury, which was resolved successfully with surgery. Tragically, he acquired COVID-19 from the surgeon, and consequently had a series of strokes. He never came home from the ICU: he was transferred to an adult care facility, where he is expected to remain permanently. Within days, he lost everything—and it was all preventable. There are, of course, many patients who suffered or died due to the negligence of hospital staff. If even one can be saved, it is the healthcare worker's responsibility to save them!

No one is more vulnerable than the hospitalized patient, who relies on their medical care team to protect them from disease, not sicken them further. They have no way of protecting themselves, since they must unmask while undergoing tests and treatments, so it is up to hospital staff—who take their cues from the CDC—to adopt effective preventative measures on their behalf.

Staff, too, will benefit from reduced spread. Universal respirator use will reduce their workload, as patients are healthier and thus able to be discharged sooner, and reduce staff shortages, as staff will require fewer sick days. This is common sense!

The preponderance of evidence that has emerged during this pandemic about aerosol transmission is a gift. Now we know that some viruses linger in the air like smoke, and we can stop them. With respirators, filtration, and ventilation, we have the tools to reduce the disease burden. We must apply what we've learned, and utilize them! We need universal masking with high-quality masks, fit-testing, respirators available at work, and air filtration and ventilation (according to standards set by the American Society of Heating, Refrigerating, and Air-Conditioning Engineers).

Thank you,

Michelle Mc Abee, MPH

I am writing to join my voice with the National Nurses United (NNU), People's CDC (links below), and thousands of experts in public health — calling on HICPAC to strengthen the guidance on infection control and fully recognize the aerosol transmission of SARS-CoV-2. The proposed updates weaken the guidance and do not adequately follow the current science on transmission. This will put more healthcare workers and patients at risk.

I am also urging more openness and transparency in your processes. You should be seeking input from frontline workers and other experts in respiratory health. Draft guidance should be published along with the scientific evidence well in advance, with an ample time for the public to make written comments.

NNU: https://www.nationalnursesunited.org/press/nnu-calls-out-cdc-hicpac
People's CDC: https://peoplescdc.org/2023/11/01/peoples-cdc-public-comment-on-hicpac/

Thank you,
Gregor Morrill

I'm mortified as I read peer reviewed scientific papers continuously warning of the dangers of Sars-Cov-2 to adults and children of all ages and previous health status, while you back down from proven, common-sense protections for health care workers and patients in the risky airborne ecosystem of health care facilities.

You understand that the disabled and medically vulnerable carry a higher risk that your previous director, Rochelle Walensky, expressed a morbid delight seemingly because it's only "them" suffering the consequences of an unmitigated mutating biohazard level 3 of 4 virus.

The CDC doesn't care about lives, rather politically and financially driven outcomes. The CDC is no longer a trusted public health entity. The medically vulnerable and disabled are now acceptable collateral damage. The public is unknowingly at risk.

My medically disabled young adult daughter and I struggle to attain safe health care. We ration and delay vital checkups that require close contact with improperly masked and unmasked health care's workers. We are put in a position to plead for access to safe health care with each provider. It's humiliating and frightening. We know of many who have been denied with cruel expressions of disdain, whereas we have experienced obfuscation, stonewalling, and denial of the Americans with Disabilities right to interactive engagement and other acts of disdain for our lives and physical well-being.

You understand Sars 2 is a vascular virus that is continuing to spinoff variants that continue to inflict serious harm and death en masse, not only to the disabled, but to everyone.

Yet you continue this farcical inbreeding of the CDC with political and financial interests. You neglectfully refuse to warn the American public of the dangers of infection, that these dangers increase exponentially with each infection and that we have and are still experiencing a mass death and mass disabling event. If you don't keep up with the profound litany of peer reviewed studies warning you of these facts, the onus should fall most directly on you morally and legally.

Proclaiming that surgical masks with gaping openings at sides and around the nose are comparable with N95 respirators that are meant to fit snugly on the face is a dangerous, deadly farce. You know this. The Sars-Cov-2 is an airborne pathogen. You know this. N95s are the gold standard protection against airborne viruses, and anything less is substandard and lethal, and advising otherwise is malpractice. How many deaths and destroyed lives will you be legally and morally responsible for?

Our medical facilities should be safe havens. You are determined they won't be. You know this. You know you are not following science. You know you are politically and financially beholden. You know your committee has purposely chosen to not include vital voices in air quality control, infection control experts, front line experienced medical professionals and the most vitally impacted. You have purposefully left these voices out of the room. Our voices mean nothing to you. This is an intentional farce. You know this.

Robin Saunders
Rio Rancho, NM
MS Counseling Psychology
Pandemic Equity Initiative
Covid Safe ADA Mutal Aid
Covid Safe New Mexico

Hello,
.I am writing to join my voice with the National Nurses United (NNU), People's CDC, and thousands of experts in public health — calling on HICPAC to strengthen the guidance on infection control and fully recognize the aerosol transmission of SARS-CoV-2. The proposed updates weaken the guidance and do not adequately follow the current science on transmission. This will put more healthcare workers and patients at risk.
I am also urging more openness and transparency in your processes. You should be seeking input from frontline workers and other experts in respiratory health. Draft guidance should be published along with the scientific evidence well in advance, with an ample time for the public to make written comments.
Thank you,
Julia Sullivan

Recommendations for HICPAC
PublishedNovember 1, 2023
Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:
Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including:

Health care personnel and their representatives.
Industrial hygienists, occupational health nurses, and safety professionals.
Engineers, including those with expertise in ventilation design and operation
Research scientists, including those with expertise in aerosols and respiratory protection.
Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
Patients, patient advocates, and disability justice groups.
Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:
Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
Open work group meetings to the public with virtual options and with ample time set aside for public comments.
Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:
Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
Pre-symptomatic and pre-positive-test transmission are possible.
Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.

Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

To do anything other than instating masking requirements in healthcare settings is malpractice. COVID is airborne. It's as common sense as wearing gloves.

Thank you,

Robert J. Grady

I am writing to implore you to move healthcare forward by requiring universally worn high quality KN95 or better masks.

We now know covid is airborne and that improved ventilation, and lessening of viral load can stop transmission. No one should get more sick when seeking healthcare. Leaving the choice up to individual doctors put the burden on patients to request (and often provide) high quality masks to medical workers. Still, not all medical workers are willing to mask, one recently told me "I don't need to do that, the CDC says we don't have to mask right now, and I'm not sick." He clearly demonstrated a lack of understanding about asymptomatic spread of covid, and a willingness to follow your lead, which would be helpful if you the CDC would indeed LEAD.

We do not need to repeat history of ignoring advancements simply because they change medical conventions, like was done when Ignaz Semmelweis invented hand washing. (https://en.wikipedia.org/wiki/Ignaz_Semmelweis)
Your work could move us forward, and medical providers will listen.

I am writing as a high risk individual who would like to see my child grow up. I suffered septic shock from pneumonia from the flu before the pandemic and have immune system issues and severe asthma as well. I take so many precautions in my own life, but it is outrageous that I continue to risk covid exposure when seeking necessary medical treatment.

I'm 81 years old. I've had covid and have a heart condition. My wife has had covid along with breast cancer.

I'm a lifelong democrat but you've lost me with this.

Nathan Goldhaber

Hello, my name is Jennifer Ritz Sullivan. I am disabled, chronically ill, and COVID bereaved.

I lost my 66-year-old disabled mom, Earla Dawn, to COVID. She was one of 77,000 people that we know of to die of COVID in December 2020 in the US alone.

My mom contracted the virus from a household member who did not wear a mask. Her death was preventable. My mom and the millions of others who have died from COVID have been treated as disposable and inconvenient statistics, as have all high-risk, disabled, and chronically ill people.

My husband works a high-exposure job and is frequently the only person masking with a respirator. We caught COVID for the first time this spring through my husband's job when cases were considered "relatively low."

Despite being up-to-date on vaccines and having access to Paxlovid and numerous over-the-counter medications, it is the sickest I have ever been, and I haven't fully recovered.

I am now further disabled by long COVID, which is debilitating and has no cure because one-way masking isn't enough to ensure safety from aerosol-transmissible viruses.

I didn't consent to COVID. Neither did my mother.

Although there are some medical needs I am currently able to put off until it is safer, I still require frequent office visits. My healthcare center dropped masking in May.

I remain at high risk for the same disease that killed my mom and further disabled me. My safety depends on others taking precautions, including masking in an n-95 or better.

I requested that my providers wear respirators when meeting with me, even offering to supply them, and I was told that staff only need to wear surgical masks if asked by a patient as they go by CDC guidelines.

Where is the support for my safety?

Surgical masks worn by a few providers in a large healthcare facility are insufficient to protect anyone from aerosol-transmissible diseases.

Every medical visit requires prompting, advocacy, and risk, which depletes me. With my masking request at the top of my file, I still have to state the request when I book my appointment, when I arrive for it, and when I meet the physician's assistant.

I've had providers become rude to me the second I ask them to mask, huffing, rolling their eyes, and one wearing a surgical mask under their nose the entire time as if they've never worn a mask before.

We need increased universal guidelines in healthcare settings for the safety of everyone.

No one should have to risk disability or death to receive medical care.

We must learn from the dead and disabled, and we must do better.

I agree with the People's CDC and the National Nurses United recommendations.

Jennifer Ritz Sullivan
Goshen, MA

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of

infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

The updated guidelines are inadequate and put health care personnel and patients like me at risk.

To Whom It Concerns. Ventilation, KN95 masks, and isolation of airborne contaminants are evidence based proper public health strategies crucial for population health. "Inhalation of aerosol particles is a critical pathway to contracting covid in indoor settings versus outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions." (Andrew Wang, PhD, MPH and Raj Chaklashiya).

I am a cancer center employee. Covid significantly impacted my previously very healthy life (I biked Ireland's Cork hills 8 hours a day for a week before contracting covid). Living with connective tissue disorders pre-covid was manageable and I was very healthy. After contracting covid in Sping 2020, my life was changed. I now live with chronic pain and have had serious injuries. My connective tissues disorder is worse.

Personally, I have significantly reduced indoor interactions and follow the layers (or Swiss cheese) approach when with anyone else. My hospital workplace has increased in-person meetings and tasks without providing proper masks, improving ventilation, or correctly instructing staff on safe in person interactions. In fact, my own oncologist director stated erroneously getting the covid vaccine prevents covid and long covid.

Research, decades professional public health career, and my personal experience align to show the crucial need to treat covid seriously or worsen my now exasperated disability.

Sincerely,

Sonja Darai, MPH, MA

Good Morning

I am writing to ask that you seriously take a look at the lack of infection control in healthcare facilities.

As an immune compromised high risk person I have not been able to receive healthcare, tests, procedures and office visits since the start of this pandemic. It's unsafe for myself and millions like me to risk entering a healthcare facility due to lack of infection control. That goes against all ADA requirements and guidelines.

Many I know have contracted covid and other infectious diseases while in a hospital, ER, Dr office, nursing home or just getting a general procedure such as a colonoscopy. Some have died just from attempting to receive basic medical care and this is unacceptable.

My Dear friend has been in a nursing home for 5 years and since mask mandates were dropped he's contracted COVID twice with the first time he almost lost his life.

How is this America?

The CDC needs to reevaluate clean air as well as isolated areas for those carrying contagious illnesses.

I personally am dying here because I can't get the treatments that would make my quality of life better.

I am begging you on behalf of myself and millions like me to protect us. Please note, surgical masks do not stop the spread or infecting of COVID 19.

It's hard enough we no longer have access to test kits and high quality masks and surviving on a fixed income we go without food and basic needs in order to purchase these protective products.

Please stop plating politics and focus on protecting us.

Thank you in advance for doing the humane work to protect ALL citizens.

Sincerely,

Janice M Cavanaugh
North Kingstown, RI

This is unbelievable. It's already bad enough that we're at high risk of healthcare induced infections, these guidelines cannot go through. Healthcare is to improve health not destroy it. We already know COVID is airborne and it's causing health issues that reduce the quality of life of those affected below what cancer does, but there will be more and more dangerous viruses also. We can't be doing eugenics and letting the old and vulnerable just die.

Dear people at the CDC -

I read with some shock and amazement that you are proposing to further weaken protection against airborne pathogens. As a person who has unfortunately been infected with COVID-19 several times, I *strongly* oppose this idea. To loosen restrictions in hospital and clinic environments while we are in a pandemic (no, it's not over, despite government wishes that it be so) seems the height of insanity. It forces me to question whether or not there is still any functioning interest in public health in your institution. If anything, hospitals and clinic staff should be wearing N95 masks at all times, while installing simple air cleaning devices in all public areas. Doing this would protect the public not only from COVID, but also from many other airborne illnesses.
To do the opposite leads me to suspect that you do not have Americans'
best interests at heart.

Sincerely,

Allen Kaatz

I am hereby stating my opinion as a concerned citizen Please implement policy to require universal masking and improved ventilation in healthcare. Healthcare, including dental cleanings, orthodontics, preventative screenings and even childhood vaccines are not safely accessible currently. Airborne pathogens require airborne protections. No one should have to risk infection and resulting organ damage to access healthcare.

I have never been vaccinated because of my sensitivity to inert ingredients in vaccines. I have been wearing masks in every indoor space since April of 2020. Originally I made my own 3 layer masks with an interfacing. When KN95s became readily available I switched to these. I realize as a senior who can easily limit my social interactions I am not representative of the average citizen. However, since Seniors are most vulnerable, I would hope my experience will be helpful to your evaluations.

Thank you for considering my input.

Donna Boxman

Dear people at HICPAC and the CDC -

I read with some shock and amazement that you are proposing to weaken protection against airborne pathogens. As a person who has unfortunately been infected with COVID-19 several times, I **strongly* *oppose this idea. To loosen restrictions in hospital and clinic environments while we are in a pandemic (no, it's not over, despite apparent wishes that it be so) seems the height of insanity. It leads me to question if there is any functioning interest in public health in your institution. If anything, hospital and clinic staff should be wearing N95 masks at all times, while installing simple air cleaning devices in all public areas.
Doing this would protect the public not only from COVID, but also from many other airborne illnesses such as flu etc. To do the opposite leads me to suspect that you do not have Americans' best interests at heart.

Sincerely,
Allen Kaatz
La Conner WA

Dear cdc,

I'm Judith Liebman, address: Pleasanton, CA, organization: none, member of public, topic: infection controls.

This is the time to be more transparent, more backed by peer reviewed literature, not close our eyes in favor of something easier. If you look at the many existing studies we see that aerosol transmission is a primary infection route of Covid, that universal n95 masks and increased ventilation definitely do reduce Covid transmission. We see that infections acquired in medical settings have even worse outcomes. The clear steps to take to uphold the hippocratic oath are to improve ventilation and require universal masking with high quality masks.

If you move in the opposite direction you are condemning more immuno compromised people to illness, long term issues, and death. If there is a simple and well known step to provide much better medical care to vulnerable populations, and we don't take it, we are practicing eugenics.

Sincerely,
Judy Liebman
Immunocompromised high risk person and Scientist and manager at one of our national laboratories... Until I get taken out with long illness.

People have the right to be safe while seeking care in all medical settings. Instead people are being infected at their doctor’s office, dentist and even while in the hospital. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of Americans. Proper PPE including N95 masks needs to be the standard of care in all medical settings as well as safe air ventilation of Merv 13 & 6 air exchanges per hour. HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. This is a travesty. I'm immunocompromised and afraid to access needed medical care now that my doctors and dentists either don't mask or wear loose surgical masks. We can’t protect ourselves. It’s not even possible anymore. Your Guidelines Proposed will Disable & Kill.

Lori Ross
Westerville, OH
No organizational affiliation

Hello HICPAC/CDC -

I am writing today to express substantial disappointment in the changes made to healthcare safety standards in recent times (and proposed changes) over the last few years. We need universal masking policies and an emphasis on high quality masks (N95s) in addition to facilities demonstrating that they are taking ventilation seriously in their facilities.

Local individuals and organizations will take the CDC lead, particularly when the CDC misinforms or misguides them. I cannot describe how infuriating it is to be told that nothing can be done, that there is little risk, etc. when I have to get a booster shot in a small, confined room with unmasked staff members and patients. We need science-based infection management, rather than sympathy for saving a few pennies for the financial institutions that run various healthcare clinics and hospitals.

Regards,
Michael Dittmer

To whom it may concern,
It is difficult to accept that in the midst of what continues to be the greatest public health crisis of (at least) a generation that the hicpac is considering slackening infection control measures. The science is settled; many pathogens including Sars-Cov-2 are airborne. Infection control must address that fact and require N95 respirators and universal masking in the standard for infection control in healthcare. Absent these standards dangerous pathogens will transmit in these facilities and anyone (healthcare worker or general public) within will be vulnerable to infection. Please reinstate the mask mandate in hospitals.
Cheryl Karsten
Eugene OR
Retired

I am hereby stating my opinion as a concerned citizen Please implement a policy to require universal masking and improved ventilation in healthcare. Healthcare, including dental cleanings, orthodontics, preventative screenings and even childhood vaccines are not safely accessible currently. Airborne pathogens require airborne protections. No one should have to risk infection and resulting organ damage to access healthcare.

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Thank you for considering my input.

Mark Boxman, CFP®
Boxman Insurance Group
Hazelwood NC

Hello,

I would like to provide a comment on the revised healthcare infection guidelines. Safety from coronavirus is a matter of protecting everyone, especially marginalized people.

Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times. Healthcare settings are where high-risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.
Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.
Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

CDC and HICPAC should make the process for updating guidelines fully open and transparent. Please prioritize the highest amount of caution as Covid continues to devastate communities.

Thank you for listening.

Alyssa Sileo
Madison, NJ
Morris County Resident

Greetings CDC HICPAC members,

I am writing as a concerned citizen and advocate for public health to address a critical matter regarding the current guidelines put forth by HICPAC in relation to the use of masks in healthcare settings during the ongoing SARS-CoV-2 pandemic.
I am deeply concerned about the recent proposition to declare surgical masks as equivalent to NIOSH N95 respirators and to limit their usage to specific circumstances. While I understand the desire to conserve resources and provide flexibility in mask usage, I strongly believe that the safety and well-being of both patients and healthcare workers must remain paramount.

Healthcare workers and their patients should not only feel safe in medical facilities, but actually BE as safe as possible. This is not currently the case, and will be even less so if the recent proposition to declare surgical masks as equivalent to NIOSH N95 respirators is approved.
The evidence surrounding the airborne transmission of SARS-CoV-2, particularly through aerosols, highlights the importance of high-quality respiratory protection for all individuals within healthcare settings. While I acknowledge that our healthcare professionals have shown immense resilience and dedication, it is essential to acknowledge that the risk of transmission is not solely limited to designated high-risk situations.
I kindly request that HICPAC considers the following points:
(1) Clear Communication: In these uncertain times, clear and unequivocal guidelines are crucial to ensuring consistency and compliance across all healthcare facilities. A clear communication emphasizing the importance of NIOSH N95 respirators in mitigating the spread of SARS-CoV-2 would significantly contribute to a safer healthcare environment.
(2) Comprehensive Protection: Healthcare workers are the backbone of our healthcare system, and their safety is synonymous with the safety of patients. Requiring all healthcare workers to wear NIOSH N95 respirators at all times while in healthcare settings would provide comprehensive protection against potential transmission, safeguarding both caregivers and those seeking medical care.
(3) Proactive Prevention: Implementing proactive measures is pivotal in preventing the inadvertent spread of the virus within healthcare facilities. By mandating NIOSH N95 respirators for all healthcare workers, HICPAC would play a crucial role in fortifying the defense against transmission and protecting those most vulnerable.
(4) I urge HICPAC to reconsider the current proposition and to take a stance that unequivocally prioritizes the safety of patients and healthcare workers alike. Together, we can ensure that our healthcare facilities remain sanctuaries of healing and care, unmarred by the threat of COVID-19 transmission.
Thank you for your time, dedication, and consideration. Your continued efforts are vital in guiding our nation toward a safer and healthier future.
Sincerely,
Jessica Reigelman
Buffalo, NY

No organizational affiliation

Do your job CDC! Shame on you for supporting unscientific, dangerous so called healthcare infection control practices that do next to nothing to prevent further infections. Shame on you for negligence in protecting people from COVID!

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Name: Carolyn Bick
Address: Gig Harbor, WA
Organisation: Unaffiliated
Topic: The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) proposed updated guidelines

Comment:
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

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Best regards,
Carolyn

See my comments below on the proposed HICPAC.
My name is Jeff Kidman, Milford, MA
I am a concerned citizen. I have a medically complex family, for one, my daughter had a heart defect and one functioning lung.
Any respiratory Disease is a threat for her.
However I believe that we are in general not protecting the lives and livelihood of even our most healthy citizens.
Please consider a much more conscientious set of guidelines.

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMXIyano4In0.LIIGuEGn75R9VH_zMnjWfwtS2lzX7bIX8DCROoILoE0) rather than infection control.

- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMXIyano4In0.LIIGuEGn75R9VH_zMnjWfwtS2lzX7bIX8DCROoILoE0) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMXIyano4In0.LIIGuEGn75R9VH_zMnjWfwtS2lzX7bIX8DCROoILoE0) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

CDC should reject HICPAC's draft; engage the input of frontline health care workers, patients, and public health experts in developing a new draft with public meetings.

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing transmission by air. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
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- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Sincerely,
Karla Barton (retired; no organizational affiliation)
Loveland OH

Evelyn Dial
Seattle, WA
No organizational affiliation
Commenting on HICPAC's revised healthcare infection control guidelines

Hello,

I'm writing to comment on HICPAC's proposed revisions to the guidelines for infection control in healthcare.

HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens and establish rigorous protocols to prevent airborne transmission in healthcare settings.

Medical facilities are places everyone must go, where high risk, disabled, and seniors must mingle with infected patients, visitors, and staff. Healthcare facilities and personnel should employ all precautionary strategies, including masking with high-quality masks (N95s or better), at all times to protect themselves and their patients. Surgical masks are not adequate protection

against airborne pathogens. Universal maskings in N95s or better should be the standard of care and masks should be provided free of cost to employees.

Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiM3Z1NXYifQ.fh8eDg3bZ8VaFdiHjNMRABEJHAmuflLk2wifzWGg5CI) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

As the nurses union is urging (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidancehttps:/www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance), CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

As a patient, I should not have to risk contracting a disabling disease at every medical or dental appointment. I should not have to perform a risk calculation every time I need to seek care for myself or my family. Healthcare settings should be the safest places in our communities.

The CDC's mandate is to control and prevent disease. As medical professionals, you have committed to 'do no harm.' There is still time to bring your actions into alignment with your stated values. Please do so.

Sincerely,
Evelyn Dial

Hi,

My name is Joseph Pincus and my address is Newton, MA. I am unaffiliated with any organization, I speak for myself. I am writing to ask you to rethink your new infection control guidelines. Not only has your process been unethical and unresponsive, you are ignoring the science around airborne transmission. This is unacceptable. If we cannot follow the science then we are going in the wrong direction that will lead to avoidable disease and death. SARS-COV-2 is airborne and our precautions need to reflect that. We also need layers of protection because no one intervention is perfect and this disease can spread both asymptomatically and pre-symptomatically. This means that waiting for people to test positive or display symptoms is too late to prevent transmission. We don't need to see our doctors smiles, we need doctors who are protected from airborne pathogens and who can protect us from them too. Just follow the science and stop trying to silence it like you are doing now.

We deserve better than we are getting from HICPAC right now.

Name: Daniel Hong
Woodside, NY

Org. Affiliation: None
Topic: CDC HICPAC Infection Control Changes

Comment:

I urge the CDC to start over the HICPAC Infection Control updates for hospitals and other health care facilities. Universal masking is necessary to make health care settings safer and more accessible for all. Much transmission is asymptomatic, so all precautions must be universally practiced at all times as long as COVID-19 is still considered a pandemic by the WHO (https://www.who.int/europe/emergencies/situations/covid-19). Surgical masks are not adequate to protect against COVID-19. N95 respirators or better should be the standard of care, and health care settings should be equipped with them. Health care employers must not prohibit patients or healthcare workers from using them. Thank you.

Be Well,

Dan Hong

Linda Chatters, PhD, Ann Arbor, MI. School of Public Health, University of Michigan
TOPICS: Transmission, Layers of Protection

Transmission
- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
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- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.

• Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
Layers of Protection
• Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.
• HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.
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• Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
• HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
• Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
• Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
• Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.
• If you'd like to comment on HICPAC process for updating guidelines:
• As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
• HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
• HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
• CDC and HICPAC should make the process for updating guidelines fully open and transparent.
• Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

As a former paramedic both in the pre-hospital and interfacility setting, I must confess that it is an embarrassment and a tragedy that the CDC, once touted as the premier public health service in the world, is aiming to lower infection-control standards in the healthcare setting. While many public health officials are wont to admit publicly the aerosol nature of SARS COV-2 to align themselves with political and cultural zeitgeist, in private many are aware that aerosols

are the primary transmission method of the virus. It almost seems inconceivable that the public has to convince the public health apparatus that such protections are necessary when so much quality information is freely available on the efficacy of masks, ventilation, and filtration of air against SARS COV2.

It is already well known that surgical masks are not effective enough to prevent the transmission of aerosols due to their lack of seal around the mouth and nasal passages of the wearer. Removing the N-95/respirator standard will lead to more nosocomial infections, more patient comorbidity, longer hospital stays, increased frequency of repeat hospitalizations, and higher healthcare worker turnover. The courts have ruled that hospitals and other healthcare facilities have the duty to reasonably protect patients from harm. Doing so otherwise sets up the facility to significant liability exposure through their negligence. Respirators are a reasonable means to prevent transmission of SARS COV-2 and other airborne pathogens. While also admittedly a more expensive modality to prevent aerosol transmission, increased ventilation and filtration of indoor spaces will also bolster infection control.Despite the higher cost, in light of the high rate of death and disability stemming from transmission, it can be argued that the placement of said systems in contrast to the eventual consequences meets the "reasonable" standard. It is very telling that experts in aerosols were not invited to provide expert testimony to the committee to put on record their professional recommendations for infection control.

Regardless of vaccination status, SARS COV-2 can still wreak significant damage to various organ systems that are cumulative in nature and even ultimately death. Vaccination does not provide immunity in the traditional sense where the vaccine prevents transmission. To add to that, the protection it does provide is fleeting, approximately 3 months, and may not always be formulated for the current dominant strain due to the highly mutative nature of SARS COV-2. Health officials repeating claims that vaccinated individuals are completely protected from death and disease is at best misguided and at worst evil in nature.

Moreover, the United States cannot afford to leave healthcare workers unprotected with many sidelined with "Long Covid" i.e. SARS COV-2 sequelae on top of the mass exodus of workers during the beginnings of the pandemic. Despite the intentional dearth of SARS COV-2 iatrogenic data collection, spread in hospitals is alive and well. Proceeding forward without a masking standard, will lead to the collapse of healthcare in the United States as the officials were not able to solve a nursing and physician shortage before the onset of the pandemic.

With rates of "Long Covid" conservatively estimated to be 20% per infection, the U.S. is seeing a mass disabling event as we move forward. All industries are suffering from shortages of workers. Officials among the HICPAC committee whom aim to lower standards in a boneheaded move to increase profits and smoothen operations will be immortalized for their part in the destruction of health in the United States. History will forever judge their pursuit to save a few dollars as what it is-- gross negligence.

Hello,

My name is Julia Patterson, Rutland VT, 05701. I am not affiliated with any organization.

I'm writing because I am extremely concerned about this committee's lack of addressing scientific evidence and guidelines regarding the transmission of SARS-CoV-2. It's vital that the new guides fully recognize aerosol transmission of SARS-CoV-2 and create strong protocols to prevent aerosolized transmission. The last several meetings have shown that public comment and opinion, as well as scientific and occupational opinion, widely supports the acknowledgment

and inclusion of airborne transmission and the usage of high-quality respirators, and does not downplay the risks of SARS-CoV-2. This committee has an obligation to protect public health and ensure a safe future for the public. It would be unconscionable not to include the strong guidelines regarding the transmission of SARS-CoV-2 and its airborne transmissible nature in the upcoming guidelines.

Sincerely,
Julia Patterson

I am over 65 and I have asthma. I have two grandbabies under five years old I want to live and have energy to watch the babies. I want to enrich their lives as a grandmother.
Please keep in 95 masks in healthcare settings so that when I go in for my health care, I don't contract Covid. Do you not loosen the infection control standards.
Thank you,
Cynthia, Nelson

To Whom It May Concern,

I am an immunocompromised patient who keeps postponing doctors and dentist visits, because of the risk of healthcare setting Covid-19 infection, due to a lack of proper masking and ventilation in medical facilities. On my last visit, I was verbally abused by an unmasked nurse who called upon her "rights by the CDC" and insisted on taking my temperature by mouth in an unventilated exam room. Therefore I'm asking you to do the following:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, **not** protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing **seeing "smiles"** (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiYmJmbHIifQ.MBRGMFrwej6Guu0CWkHT7gjh6wSG2u7u8yT8AsieGcs) rather than infection control.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields.

  TO CONCLUDE:
- It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired

conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

- HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
- The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but **fails to fully recognize the science on aerosol transmission** and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
- The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
- CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

In hope you'll act in a conscionable manner,

Sincerely,

Jelena Katic
Avon, CT

I am writing to urge you to make Universal Precautions the normative protocol in all health care settings, in order to control/prevent the transmission of SARS-CoV-2 and all other airborne-transmitted viruses. As a healthcare provider (Clinical & Developmental Psychologist working in healthcare settings), it has long been typica for me to use Universal Precautions in all healthcare facilities. Using the precautions -- requiring that they be practiced at all times by all staff, patients, and visitors in healthcare facilities -- protects all of us. With this in mind, please consider the following recommendation and information recommended by my profession and our medical colleagues. Please do this for yourself and for all of us. Thank you.

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Regarding specific layers of protection:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Regarding HICPAC process for updating guidelines:

- **As the nurses union is urging, (https://substack.com/redirect/88c55b43-78f5-4bd7-9b60-c67e4f6348b2?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Thank you for working to help make healthcare safer for everyone.
Dr. Theresa M. Schultz

To whom it may concern,

I have been made aware that the CDC has met to discuss efforts to fight against COVID-19 and failed to ensure the highest levels of protection. As someone who has friends who are immunocompromised and has an autoimmune disease myself, I disagree with this decision and find it dangerous. I have been made to feel like my life and their lives don't matter to the CDC and we are being left behind purely for "normalcy".

Universal PPE for healthcare workers and patients should be worn at all times to control aerosol transmitted virus spread. Without this accessibility you put people like myself and my friends at risk of long covid, further worsening of our conditions, and death. This is unacceptable and after everything we have learned since the beginning of this pandemic we should be moving forward with the tools that we know work not declaring they exist and expecting all threats to dissipate. I was diagnosed with Graves' disease in January 2022. I was in and out of the ER with a pulmonary embolism scare, SVT attacks, and sinus tachycardia and my TSH was undetectable. If I had gotten covid I could have been severely ill or could have died, but the mandate was still in place. I was able to experience that with far less fear or becoming more sick for seeking help, and it's really not too much to ask given what we know. I know masking helped keep me safe and alive so I could send this email today.

Fitted N95 respirator type masks clearly provided superior protection against the exposure to transmission of infections aerosols. HICPAC should emphasize procedures such as free availability and fit testing.

Facilities should implement better ventilation at minimum to the standards of The American Society of Heating, Refrigeration, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in healthcare settings.

Healthcare systems should encourage free vaccination and boosters as recommended or age appropriate ACIP schedules for all aerosol transmitted infections diseases for all healthcare personnel, patients, and visitors unless medically contraindicated.

Everyone should feel safe going to healthcare facilities. If we have the tools to combat COVID-19 why are you falling short on doing so? Why aren't you controlling a disease you have the tools for?

Sincerely,

Cyndal McCarthy-Dennison

I am writing to encourage you to create and enforce strong policies in healthcare settings to prevent the transmission of disease and infections, including those like COVID that are airborne. Gloves and masks should be a standard part of any health care worker's equipment when they are caring for or in the presence of patients. This should not be left to a worker's discretion, or be framed as optional in any way.

Patients are by definition vulnerable, health care workers have a duty of care and should be maximally protected whether they are in clinics, hospitals, pharmacies, or any other health care setting. Please create standards that meet a high standard, and that includes mandatory masking and gloves.

Thank you

Donna Lanclos
Charlotte NC

Dear HICPAC,

I don't have a lot of time to write a lengthy, eloquent letter. I will only say this: you are derelict of duty if you continue to dawdle on creating strong, clear policies to guard against aerosol transmission of disease including Covid in healthcare settings. Covid is airborne. It is inconceivable now that a healthcare worker would not wear gloves in patient care: we need to implement this kind of commonsense thinking about masking as well. This will protect healthcare workers and vulnerable patients, many of whom now weigh their risk of foregoing or delaying care against their risk of nosocomial infection. This is simply unacceptable.

We can stop this deadly nonsense with sensible rules. You owe it to patients to institute masking in healthcare settings as a matter of course; you have the power to set policy and make it as routine as handwashing and gloves for infection control, neither of which would ever be allowed to come down to "personal choice". Do no harm is the first principle in a healthcare setting. You know this. Do your jobs.

Blake Hihara (he/they)
Oakland, CA

Hola y Aloha.

By now, it is well known that the Covid virus is an airborne pathogen. Refusing to acknowledge this fact is killing people and promoting the spread of the virus.

While CDC personnel protect their children, sending them to (private) schools where they insist on masking, ventilation, etc., they continue to refuse to promote these proven methods of reducing Covid risk to the general public. What hypocrisy!

CDC, FDA, and other government agencies neglect to promote the simple, proven, methods of reducing Covid risk while promoting the use of "Big Pharma" vaccines that are almost useless is reducing the spread of an airborne Covid virus that mutates constantly.

Acknowledging that Covid is an airborne pathogen, promoting the use of masks, the use of simple Corsi-Rosenthal filters, adequate building ventilation (listen to the engineers!!) and other simple precautions should be a no-brainer. Yet the CDC and other government agencies have yet to inform the public in an adequate, proper, and forceful manner of these facts.

It's time to do so, loudly and clearly.

Thank you for your consideration.

Donald O. Cox, Ph.D., P.E.
Kamuela, HI

Dear HIPAC committee,

I am contacting you as a concerned citizen with a graduate level degree. That has worked at two recognized research universities.

I am a person that has what OSHA would deem as a disability or protected class due to health diagnoses by licensed medical professionals. What you, the CDC, would classify to have a potential adverse outcome to being infected by SARS COV2/Covid.

I belong to a online groups of tens-of-thousands of other immune compromised individuals who are also experiencing the same issues. We can not obtain healthcare safely without risking our lives. Every interaction for this group is like Russian roulette. We (immunocompromised individuals) have resorted to hiding in our homes. Spending additional money for grocery delivery and when absolutely necessary wearing a PAPR or a p100 to obtain healthcare or essential services.
We have been verbally harassed, physically assaulted (Actor Will Wheaton) by individuals for masking. One person's sanity (psychological) from a hospital admissions when requesting health care workers mask (a ADA accommodation) at a medical facility for a GI treatment.

Personally, I feel this is a direct violation of the ADA. The ADA protects people with disabilities in public accommodations. Examples of public accommodations include doctor's offices, public transportation, workplace, hotels, restaurants, etc. A person with a disability under the law is someone who has a physical or mental impairment that substantially limits one or more life activities. Life activities include learning, working, self care, performing manual tasks, walking, hearing and many more. A mask is very inexpensive and a reasonable accommodation for providers.

We implore you to please require masking in an N95 or better in healthcare settings. Or at a minimum offer immunocompromised hours with masking so immunocompromised people can acquire healthcare without risking their lives.

The lack of inaction by the medical community, public health officials and government agencies has cost many lives. I personally know of cancer patients and other immunocompromised that have died from hospital/healthcare acquired SARS COV2 infection. No to mention thousands of seniors.

At some point some litigious person will challenge this and there will be consequences for the way the disabled (by being immunocompromised or having an illness) have been treated. History will not reflect kindly on this time. Your inaction to protect the vulnerable says as a you and this country are fine with people dying. I am embarrassed and ashamed that the people that take a Hippocratic oath can't protect their own patients, this includes the individuals on the HIPAC committee that hold the tittle doctor.

Please reconsider your decision and bring back some form of masking in healthcare.

Sincerely,
Larissa Trygg
Concerned Immunocompromised Citizens
Green Cove Springs, FL

Hi,
I will keep this brief as a concerned retired healthcare provider in primary care and mother of a immunocompromised daughter.

Please listen to the experts in infectious disease, air quality, etc. and keep strong protections in healthcare settings. The data is stark and cannot be ignored as outlined by these experts.

I can attest to the fact that my daughter will do everything she can to avoid going into any healthcare setting but we all know that is an unrealistic reality for her in light of a diagnosis of Ankylosing Spondylitis. This leads to high levels of frustration, isolation, and feeling left behind and uncared for…a reality for so many.

We should not have to fight for our own personal protections while attending a simple office visit, or hospital admission but that is what's happening. Can you blame us for wanting to avoid an illness like SARS Cov-2, among others that could be life changing? Do any of you have disabled or immunocompromised family members who are belittled or made to feel lesser than for simple asking healthcare professionals to wear a N95 (not a useless surgical mask) to protect their health? Have you lost friends or family members to these infections or know any individuals who are now disabled post infection?

Sometimes it only seems to matter when it happens to us personally. Please hear us and do what you can to protect us all. We are relying on your empathy and leadership. Thank you for your attention.

Theresa Desilets APRN
Retired Adult Nurse Practitioner
Dartmouth-Hitchcock

As a person blessed to live over 60+ years and intending to live many, many more years I have been vigilant in my efforts to avoid contracting COVID-19 ~ not only to avoid being ill but also reducing the chance of suffering Long COVID. Furthermore, I reside with an equally high risk vulnerable individual.
I urge you to read my attached (one-page) statement and to give it your utmost thoughtful consideration.
Thank you.
T. Keenan

TO: CDC Healthcare Infection Control Practices Advisory Committee (HICPAC)
SUBJECT: HICPAC COVID-19 protocol
FROM : T. Keenan (private individual)
Whitehall, PA
DATE: November 5, 2023

As a person blessed to live over 60+ years and intending to live many, many more years I have been vigilant in my efforts to avoid contracting COVID-19 ~ not only to avoid being ill but also reducing the chance of suffering Long COVID. Furthermore, I reside with an equally high risk vulnerable individual.
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. In fact, I am very well acquainted with NUMEROUS individuals (various ages and gender) who are struggling with Long Covid and it is miserable to witness their struggle.
It is important that **everyone ~including and perhaps MOST importantly in healthcare settings ~ is protected from COVID-19 infections**. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. **Healthcare settings must employ layers of protection to ensure the highest quality of care. Layers of**

protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
It is imperative that there is a robust and full recognition of aerosol transmission of SARS-CoV-2 complete with the establishment of rigorous protocols for preventing "transmission by air" and **all precautions must be universally practiced at all times.**

Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. **Healthcare facilities and personnel should employ all precautionary strategies at all times.** The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially those at risk, and, therefore, all healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMWlkN2F6In0.bam-cwF7KXxXTSmR780556z5KB1WRuAJCp77oKLyZuQ) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
Finally, although vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases, **hospitals and healthcare systems should provide free vaccination and boosters for staff, and should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.**

Finally, **as the nurses union is urging, (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance) (the CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings**.

Thank you for working to help make healthcare safer for everyone.

Guidelines should protect the most vulnerable by protecting all and utilize the precautionary principle. Clean indoor air for infection control is just plain common sense. This should be a priority given the continuing spread and mutation of SARS-CoV-2 and the loss of life, productivity and disruption caused by other common airborne infections like RSV, influenza etc.

Airborne experts and others across relevant disciplines should be consulted at all stages of implementation and all available tools should be included in infection control measures, like ventilation, filtration, UVC technology, and PPE like N95s, elastomeric respirators or PAPRs. At-risk stakeholders (patients, HCWs) should be given a prominent seat at the table when making decisions about guidelines.

Clean air is a basic human right, as is safely accessing healthcare.

Diana Carpinone
Dover, NH

To whom it may concern,

My name is Grace Rountree and my address is Brattleboro VT. I am writing as a person with a disability who is deeply concerned about the HICPAC infection control changes.

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Much transmission is asymptomatic. This means that practicing and implementing universal precautions is key to preventing infection and protecting the rights and safety of patients and healthcare workers alike.

The science shows that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk, and the protocols must reflect this science.

Everyone deserves accessible access to healthcare services and settings. This is absolutely critical. Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” rather than infection control.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Hospital-acquired COVID has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID. It is essential that you do everything in your power to stop the preventable deaths and protect human rights and human life.

Sincerely,
Grace Rountree

To whom it may concern,

My name is Leo Weinberg and my address is Brattleboro VT. I am writing as someone who is extremely concerned about the HICPAC infection control changes.

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and set up meticulous protocols for preventing "transmission by air." Since a significant amount of transmission is asymptomatic, practicing and establishing universal precautions is very important to preventing infection and protecting the rights and safety of both patients and healthcare workers.

The science shows that each infection control measure works best when other infection control measures are also implemented in a multi-pronged approach to reducing transmission. These protocols must reflect this science.

Every person deserves truly accessible access to healthcare. Healthcare settings are where disabled, high risk, and seniors will mingle with infected individuals, therefore healthcare workers and officials should consistently implement all precautionary measures at all times.

The draft guidelines maximize healthcare employers' flexibility and do not protect healthcare workers and patients. The draft guidelines make it so that healthcare employers can make infection control decisions based on profit rather than public safety.

The HICPAC draft shifts responsibility onto individual workers, focusing almost entirely on what should be the last layer of protection—personal protective equipment—while failing to set adequate standards for ventilation, testing for patients and workers, and isolation.

Hospital acquired COVID has a 10% mortality rate, proving it to be deadlier than community-acquired COVID. It is absolutely imperative that you do everything in your power to stop preventable deaths and protect human life.

Sincerely,
Leo Weinberg

To the CDC: As a 70-year old person, frightened to go in to medical facilities, most especially hospitals, given these proposed weak protections measures for respiratory diseases, particularly COVID, I find it impossible to understand why the CDC would accept these ill-advised precautions. COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must

include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
Sincerely,

Susan Kellogg
Lakeway, TX

As senior citizens, my husband and I are used to being ignored, as became evident during the Covid-19 pandemic. But from what I understand, you are now drafting regulations that will put many people in jeopardy. Those who use healthcare facilities tend to be sick and vulnerable, which should be obvious. By loosening or eliminating infection controls, you are obviously not thinking of healthcare workers or patients. It appears instead that you are gratifying the desires of the healthcare industry, which is well known for putting profit ahead of the well being of those they serve.

Please reconsider your proposals. It would be better to scrap them and begin anew, with more input from those who will be affected by them. Consider just this line:

"During periods of higher levels of community respiratory virus transmission, facilities should consider implementing one of the tiers of source control…"

Do you know how inane that sounds? I certainly do. There are so many ways that makes no sense. I am terrified about what you are doing. And the period of time you will be setting for public input will span the holidays. It seems like this whole process is being pushed through with the hope of either not being noticed by the people chiefly affected or making sure they cannot dispute your proposed regulations. I don't understand the purpose you have for putting so many people's lives and health in danger.
Anita Gould

Bainbridge Island, WA
Private citizen

Dear HICPAC:

Regarding your review of infection control measures.

Help save lives and worker productivity (midterm and long term profits) by:

1. Please reflect the science of aerosol transmission through inhalation of SARS-CoV-2. It is aerosol-transmitted and can remain suspended in the air for up to 12.5 hours.

A. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

B. Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.

2. Please get input from health care workers (providers and other frontline workers such as cleaning crews), their unions, patients, patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel, union representatives, and occupational safety and health experts and occupational safety and health experts during your decision-making process.

Save lives, worker productivity (midterm and long term profits) and quality of life by implementing the above measures.

Thank you for your time and consideration.

Stay safe, healthy and sane,

Cathy Wong
Mountain View, CA
Representing self, no organization

It would be so helpful in preventing further health issues, including auto- immune disorders, heart issues for there to at minimum be a mask mandate in all hospital settings and medical offices.

Better air quality via far uv or hepa filtration in schools and other public arenas (courts, dmvs) cuts down on all airborne diseases / viruses making for a more equitable and healthier society.

Thank you

Marcy Freedman
Venice, CA

Written public comment:

Healthcare settings need masking mandates as well as other strict covid prevention policies as these are areas where vulnerable individuals must come to, so it is critical they are safe areas. People who are already suffering from other illnesses need to come to hospital and clinics for routine treatments.

It has been shown already that due to the covid pandemic and unsafe medical settings, people are having to choose between treatment of existing conditions and risking contracting COVID in unsafe hospital settings and staying home with no care. Many adverse secondary health effects are the result of people having to make this decisions.

At the end of the day, a hospital clinic or pharmacy should not be an addrional risk to the people who rely on them for their health.

It's embarrassing and disgraceful to see hospital coordinators and staff choosing to make these places unsafe, a blatant disrespect for the people you're supposed to be helping, despite their medical background.

Keep COVID restrictions in medical settings.

To whom it may concern:

I am writing to comment on your proposed draft for infection control. This topic is important to me as a family member of someone living with Long COVID and someone who is dedicated to protecting the most vulnerable in our communities.

First and foremost, I am saddened to hear that you've continued to neglect the voices of health care workers, their unions, patients, and a much broader array of public health/science experts.

We know by now (based on data, research, and the reports from a majority of public health/science experts) that COVID-19 infections have the potential to cause serious harm (physical and mental) and mortality. We also know COVID is spread via aerosol particles, with a higher risk in indoor settings. As such, healthcare settings must implement as many layers of protection as possible.

Please listen to the voices of experts from the People's CDC, who dedicate time to provide guidance and policy recommendations to governments and the public on COVID-19, disseminating evidence-based updates that are grounded in equity, public health principles, and the latest scientific literature.

One of the members of the People's CDC, Dr. Andrew Wang, has already submitted an extensive comment on this same matter, and I hope his is one of the voices that you center and elevate: https://peoplescdc.org/2023/11/01/peoples-cdc-public-comment-on-hicpac/

Thank you,

Mariana Harms
Mental Health Professional
Santa Barbara, CA

To whom it should concern:

One month ago today, my mother in law, Kayla Garelick, died of COVID, which she caught in a hospital in Oakland, CA. She was 69 years old and optimistic about the treatments she was receiving for her chronic illnesses. She did not need to die. Please demand high standards of infection control in healthcare settings so that people like Kayla do not continue to needlessly die at the hands of the US healthcare system.

I support the People's CDC's advocacy for multiple layers of protection such as the following:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiNHplNHMifQ.biGVNUy7A4pGcl1WSiR5p7USAiFr0x_bmWeXHykAj9I) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Sincerely,
Madeline Richer
Special Education Public School Teacher

Dear HICPAC,
I'm a retired biologist, and as a scientist I rely upon experts in the fields of epidemiology, immunology, virology, aerosol science and industrial hygiene for reliable information about SARS Cov2. For example, when Akiko Iwaski (HHMI Professor of Immunobilogy at Yale) mentions that she continues to use N95 respirators at alll indoor events with potential of crowding - I regard that as a reliable indicator of knowledgeable risk management. Thankfully

my physician and dentist also practice this attention to risk management by having by wearing N95 masks.

I write to object to the HICPAC Isolation Precautions Guideline draft proposal. These proposed guidelines will directly expose the most vulnerable people to SARS Cov-2. and indirectly increase it's transmission throughout communities. These proposed changes ignore the present reality that the physiological effects of SARS Cov2 infection are not well understood and that a significant fraction of infections have long-term consequences upon people's lives as well as the economy.

I am very concenred about how essential informaiton is sidelined. For example, it is well-established that SARS Cov2 is an airborne pathogen, yet there are no members of the HICPAC who have expertise in industrial hygiene or ventilation systems. This deficiency must be rectified before any Isolation Precautions Guideline can effectively address the reality of how SARS Cov2 is transmitted.

Another example of the problem of the lack of information with SARS Cov2 is understanding the level of "community transmission" in order to set a level of protection. Given the lack of widespread robust testing, such as wastewater testing, community transmission is measured through lagging indicators, such as hospitilizations. The level of protection is thus increased only after the infection has spread, and likely hitting hospitals first, resulting in a 10% mortality rate with Noocomial Covid.

Health care workers are at the front line of the Covid epidemic. Their health is essential for the system to effectively deal with the next wave of Covid. The Isolation Precautions Guideline should have clear instruction about how to effectively mitigate airbore transmission by proper masking with N95 respirators and adequate ventilation (ie. minimum indoor air quality stndards set by ASHRAE). Health care workers should also have mandatory free vaccinations and boosters, consistent testing regimes for SARS Cov2 and paid leave when infected. I fully agreee with the condemnation of the HICPAC proposal by the National Nurses Union for it's failure to adequately protect front line Health Care workers.

The degree to which Health Care Providers adhere to mitigation strategies to reduce SARS Cov2 should be transparent to patients. I don't want to go into a hospital or a doctor's office and discover that my risk of being infected with SARS Cov2 and acquiring Long Covid are much higher than I can accept.

I appreciate that the CDC has faced a tremendously challenging problem with SARS Cov2. However, the HICPAC has serious deficiency which work against the larger goals of CDC and the Isolation Precautions Guideline draft proposal should be sent back for more work and bring in expertise regarding ventilation and to develop a proposal that has buy in from representatives of health care workers, in particular the National Nurses Union.

Sincerely yours,

David Leaf, Ph.D.
Professor of Biology Emeritus
Western Washington University
Bellingham, WA

- **CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

Charleen Krueger BSEd RN
Ask. Listen. Learn. Change. Do.

Hello,
My name is LeAnn Brazeal, my address is Springfield, MO, and though I am a professor, I am speaking in my capacity as a private citizen.

I'm an immunocompromised person who helps care for two elderly and immunocompromised people. We have not had COVID, due in large part to us staying home. The only places we've been in the last 3.5 years are health care facilities, as we are trying to minimize the chances of serious illness and long-term damage to our health. We can't afford more health issues.

It's disappointing and frustrating to have our greatest risk of COVID be health care facilities. We all know COVID is airborne and often transmits asymptomatically - it's established science. We also know masks (well-fitting KN94 and N95) mitigate the spread substantially. Any infection control protocol needs to take these facts into account and require masking as part of a layered approach to mitigation. Minimum air quality standards (ASHRAE) and the use of negative-pressure rooms should also be included in mitigation protocols. Regular testing of HCWs and time off to recover from illness are also important to prevent the spread of this illness that can have serious and devastating consequences.

Health care facilities treat vulnerable and high-risk people every day, so there is no room for inconsistent application of protocols. And vaccines are not enough for us – we need the health care system to take other, science-based steps to prevent the spread of COVID.

I truly do understand that some health care workers would like more flexibility while at work. I understand that stronger protocols have some financial cost. But the whole point of health care is to treat and prevent illness. My family and I have made sacrifices that most people will never understand just to protect our health – we have enough to handle as it is.

We just ask that health care facilities do their best to keep us from getting COVID while we're there.

So I write today in support of the nurse's union's calls for the CDC to reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft," including holding public meetings.

Vulnerable people – and someday, if we're lucky, we'll all be elderly (and vulnerable) -- should not have to take their lives/health into their own hands just to receive the medical care they need.

Please help us.

Thank you,
LeAnn M. Brazeal, PhD

Comments submitted by:
Amy Tibbetts-Carlo
Walpole, MA
Private citizen

Re: HIPAC

Please create guidelines that create that safest possible environment for health care workers and patients. Effective, responsible infection control is possible. To choose not to do better when we know how to reduce transmission of air borne illnesses in health care settings is immoral.

- **The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."**
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- **Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.**
- **Nosocomial COVID has a 10 percent mortality rate – deadlier and more dangerous than community-acquired COVID.**
- **Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.**

Dear members of the CDC and HICPAC:

I'm writing as an individual and as a patient within the US healthcare system to express my concerns about the loosening of isolation and infection control in hospitals and medical centers. Rather than weakening these controls, the CDC should be encouraging science-based recommendations that healthcare providers reduce the spread of covid-19, as well as other airborne diseases, in healthcare settings by wearing N95 respirators. For instance, the evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

Transmission of airborne diseases could also be curbed in healthcare settings through increased air filtration and ventilation. Additionally, healthcare providers should be regularly testing for covid-19 and should isolate if they test positive.

Through the covid-19 pandemic, the scientific and medical communities have learned much about aerosol transmission of diseases such as covid-19 and the flu. Guidelines around isolation and infection control must take this data into account and should engage a wide range of experts, including: frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts. Furthermore, I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

Both patients and medical providers deserve guidelines that keep them safe from disease, and they deserve guidelines that recognize the critical role of inhalation. Unfortunately, the current version of the guidelines coming before HICPAC continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the covid-19 pandemic underlined the importance of strong protections for healthcare personnel and patients.

Protecting the health of both patients and providers through masking with N95 respirators, proper air filtration and ventilation, as well as isolation when sick is vital to protecting everyone, and especially vulnerable patients and providers. I have written previously about my grandmother when providing comment on the isolation and infection control guidelines. She has dementia, caught covid-19 after her medical facility lifted mask mandates for staff. She had previously avoided a covid-19 infection, and like many elderly individuals, after her covid-19 infection, her cognitive decline has become more severe and more apparent. Research demonstrates that she is not alone in suffering this way, as studies published in the Journal of Alzheimer's Disease Reports found that patients with dementia experienced rapidly progressive dementia following covid-19 infection. No one should have to choose between accessing necessary medical care and avoiding covid-19 infection that could exacerbate pre-existing health problems. Indoor air quality targets and source control measures prioritizing N95 respirators in healthcare settings would continue to protect those who are vulnerable to covid-19.

Thank you for your consideration of this message.

Sincerely,

Merrill Miller
Organizational affiliation: I am writing on my own behalf as an individual and patient
Silver Spring, MD

- I am appalled that HICPAC is proposing to water down infection control practices in health care settings. Upon doctor's advice, I am still trying to avoid a Covid infection, and

I am anxious about going to health care appointments where no one is masked. My most cogent concerns are:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMmN3bmwifQ.H_rmVbU6pMJnJBQzhzMFTmwMSJbmmfUPV17DyoNSyWE) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMmN3bmwifQ.H_rmVbU6pMJnJBQzhzMFTmwMSJbmmfUPV17DyoNSyWE) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Mary Moltmann, Ph.D.
Bull Valley IL

Hello CDC decision makers,

I am writing to you as the spouse of someone who has Long Covid and is generally immunocompromised. She has a mortal fear of going into health care situations (which she is forced to do but the very nature of her illnesses), where the people she is compelled to interact with are not wearing masks. As someone who regularly wears a mask in public areas (and especially areas where many different individuals are passing through during the course of a

day), I find it hard to believe these common sense procedures during a time where Covid levels rise and fall with little warning are not continued to be employed in healthcare settings.

Please read the statement at the link below which articulates my feelings better than perhaps I can.

https://peoplescdc.org/2023/11/01/peoples-cdc-public-comment-on-hicpac/

Sincerely,

Paul Narvaez

CDC pandemic standards as they are now are already inadequate, having caused untold death and disablement. Reducing them further, such as falsely equating N95 masks to surgical masks, and not making a stand for improved air quality in healthcare, will only further damage public health.

The CDC is supposed to be the gold standard and lead the world in controlling infectious diseases. It is supposed to be above political will. Please do not stoop to an even further disgraceful low to appease politicians and corporations. Please hold the line.

Do not pass the weakened standards of the current version of HICPAC.
Thank you,
Janelle Munns

Re: HICPAC Infection control changes

Jessi Presley-Grusin
They/them
(No organizational affiliation)
Portland OR

Hello,
My name is Jessi Presley-Grusin and I am very concerned about the changes to HICPAC infection control protocols that have been proposed.
As you well know, healthcare settings are where high risk, disabled, and elderly patients will share space with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

Your current draft guidelines maximize flexibility for healthcare employers, not protections for healthcare workers and patients, and this is extremely dangerous. They allow employers broad discretion to choose, implement, or restrict their own infection control plans, which will be based on profit considerations.

Healthcare administrators complain of the cost of protective measures to stop transmission, but in 2016 the US Department of Health and Human Services deemed an intervention cost-effective if it cost less than $9.6 million per life saved – and does not weigh that cost against profits, nor should CDC.

The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely

unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.

You can still do the right thing by delaying the vote. Incorporate our comments and base your recommendations on peer-reviewed evidence rather than vague and undefined “expert opinion” which conveniently overlaps with healthcare management priorities. Recognize aerosol transmission and recommend n95 respirators or better for healthcare workers accordingly, recommend upgraded standard ventilation and core control isolation protocols. Make universal masking the new standard of care year-round. Include occupational safety, healthcare union representatives and patient safety groups as voting members of HICPAC.

Sincerely,
Jessi Presley-Grusin

Hello,

My name is Jennifer Marer, and I’m a recent biology graduate from Case Western Reserve University.

I am resubmitting my previous comment for consideration after seeing HIPCAC’s proposal, knowing they have ignored both the outcry from public health officials as well as all evidence that shows the disastrous effects of relaxing regulations like they are proposing:

My parents are both healthcare workers; my mother is a primary care physician, and my father is an infectious disease specialist.

A family member was hospitalized last winter, likely from enterovirus that caused neuroinflammation. It became immediately clear to me — a sentiment that was reflected by my parents — that if my relative had a COVID infection during this time, they would likely not have survived.

After reading the proposed guidelines, or lack thereof, I am deeply concerned by the absence of prevention measures against airborne pathogens in hospitals —specifically the lack of N-95 quality mask enforcement, air filtration, and ventilation— which puts everyone at risk.

My relative was privileged. They have doctors in the family that are able to get them and all their family members Paxlovid and streamlined access to healthcare. It is horrendous to think that someone needs two family members that go through at least four years of medical school and four years of residency in order to barely survive under the circumstances that our healthcare system has created.

Today I want to emphasize air filtration and ventilation, specifically as it relates to future prevention. If the vast large body of evidence that respirators and proper air filtration are extremely effective for controlling worker exposure to aerosols isn’t enough, I’d like to provide another point: that as wildfires continue to rage across North America, forcing people indoors, everyone in those buildings — workers— medical professionals or not— and visitors —patients, relatives, or otherwise— will rely on this filtration.

It is unbelievable to me that with the obvious looming climate crises, housing crises, and continued healthcare crises over our heads, this lack of emphasis on prevention and preparation is not more of a concern.

As healthcare issues compound from all of these crises, healthcare collapses like those seen in the winters of this pandemic will only continue if left unaddressed.

Please enforce mandatory n-95-quality mask requirements and develop a thorough air filtration and ventilation plan for all hospitals. Please lift the onus off of patients advocating for themselves and enforce these obvious regulations for healthcare institutions.

Please do your job.

Signed,

Jennifer Marer
she/her pronouns

Hello,

I wish to submit a written comment regarding HICPAC's draft of revised healthcare infection control guidelines. My name is Rebecca Richardson, and I am writing both as someone with research interests in the medical humanities, disability studies, and the rhetoric of health and illness, as well as from my experience of needing robust infection control in healthcare settings.

I am deeply troubled by the way that the CDC and HICPAC have failed to adequately address infection control in healthcare facilities given what we have learned about COVID-19 and other airborne diseases. Everything we have learned about this new virus and how easily it spreads in the air should have immediately triggered new and permanent, standardized guidelines for preventing spread in healthcare settings. To leave such recommendations up to particular facilities' preferences – something to be "considered" – and dependent on perceptions of how much virus is spreading in a particular community is inadequate. It is also troubling, as it shows just how much the CDC and HICPAC are listening not to patients and the most vulnerable, but to those more concerned about the cost of PPE and HVAC upgrades than with saving lives.

Just as we eventually learned that we need to clean the water we drink and to wash our hands, it is past time that we learned we need to clean indoor air and employ layers of mitigations to prevent airborne transmission of pathogens. Our healthcare facilities should lead on this. They are one of the most essential of spaces to make safe and accessible – and they must center the most vulnerable. We know that patients come to facilities when they are vulnerable to infection, when they are incapacitated, when they can't advocate for themselves. We know that people with active infections are likely to be seeking medical services. And we know that healthcare workers have a poor track record when it comes to going to work while sick. Given studies on the high rate of mortality (around 10%) from COVID-19 infections caught in hospitals, the importance of this issue cannot be clearer.

The CDC and HICPAC need to incorporate the voices of key stakeholders in this process – listening to the most vulnerable, to those at high-risk of COVID-19. Those with expertise in aerosol transmission should also be consulted. It would also be useful to draw on the expertise of someone who studies the history of medicine. Such a person will, I'm sure, be able to share why history will not look kindly on this process if, instead of incorporating new knowledge about airborne transmission of deadly viruses like COVID-19, those in power kowtow to business interests and the illusion of "normalcy."

Those learning about the history of medicine are generally shocked and appalled by how long it's taken for science to become common sense -- how long John Snow fought to bring attention to the fact that cholera transmits via the water, how so many ignored and ridiculed Ignaz Philipp Semmelweis when he suggested that perhaps doctors should wash their hands between handling dead bodies in the morgue and then treating women in labor. Perhaps it can seem too easy and even unfair, to look back with what we know now and wonder why it took previous generations so long to act. But at this moment, we already know all that we need to know – and we actually have the tools to enact protections that will save lives. But we need those in these positions of power to act.

Sincerely,
Rebecca Richardson, PhD
Advanced Lecturer, Program in Writing and Rhetoric at Stanford University
Stanford, CA

I am a nurse with over 30 years in practice. I have always been involved in infection control measures wherever I have worked. My advocacy has always been on behalf of my patients, but now, retired and age 70, my concern is also for myself and my family.

Never in my nursing career has infection control been an individual responsibility. But the HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. How can we protect HCWs and our patients without clear, strong, and enforceable standards? Nosocomial Covid-19 has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired Covid. This fact alone argues for a high and multi-layered standard of protection in hospitals, where patients go to get well, not to be infected with Covid.

Universal masking with high-quality N95s is absolutely essential to protect our patients and staff. At the present time, HICPAC does not have members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members. Until HICPAC has these expert voices it should not be ruling on masking for airborne protection - I would never walk into a TB patient's room with a procedure mask, and with Covid endemic, no one should be relying on loose procedure masks for protection. Meetings were held in 1992 to help develop guidelines on control of multidrug-resistant TB - we must use this process again by actively engaging the input of frontline health care workers, patients, and public health experts in developing a new draft, including holding public meetings.

Transmission of SARS-CoV-2 is by inhalation of aerosols that can remain in the air for many hours. Transmission is from asymptomatic individuals in at least 40% of cases. These facts require that all precautions be universally practiced at all times.

I am profoundly sad to see hospitals abandoning their solemn duty to protect the patients in their care from nosocomial infection. Frankly, I never imagined I would see this day. The failure to require N95s and ventilation and air purification is tantamount to abandoning hand washing between patients.

CDC and HICPAC should make the process for updating guidelines fully open and transparent. Final guidelines should include an attachment that lists the public's comments and why each one was or was not adopted, with references to scientific evidence.

Signed:
Elizabeth Oram, RN, NP
New York, NY

I'm writing to urge you to reconsider the current draft guidelines for masking and other measures to mitigate transmission of COVID and other infectious diseases. The proposed guidelines are wholly inadequate to protect the public from contracting COVID or other viruses in healthcare settings.

As someone who lives with a medically fragile family member, I want to be sure that his doctors and other healthcare workers take every precaution to protect him and other patients. He masks when he attends medical appointments, but his doctors and staff do not. This is unacceptable. We should be able to rely on our healthcare providers to protect us and to model best practices at all times.

Sincerely,

Jill Adaman, Ph.D.
Broomall, PA

Kaitlin Sundling
Madison, WI

I am an MD-PhD physician-scientist and pathologist in Madison, Wisconsin. I'm a volunteer with the People's CDC and Wisconsin Community Health Action. I have no financial conflicts of interest to disclose.

I am writing in support of universal masking in all healthcare settings, with broad use of N95 or better respirators, appropriate ventilatory controls, and other effective methods to reduce the risk of aerosol transmission. Universal masking must be incorporated into CDC guidelines broadly across healthcare settings to protect patients and healthcare workers from transmission from asymptomatic and unrecognized infections that are commonplace in healthcare settings. I gave previous comments supporting universal masking in healthcare at the previous CDC HICPAC meetings in June and August of 2023 [1,2], as did hundreds of others including public health and healthcare professionals as well as patients and members of the public. Yet, the draft proposal continues to dodge the simple, obvious, and scientifically-supported conclusion: both patients and workers want masking in healthcare. You are leaders in this field who can improve the standard of infection control, and you must do so to stop further preventable death and disability in the ongoing COVID pandemic.

In healthcare settings, airborne infectious disease transmission from either patients or healthcare workers who may have unrecognized or asymptomatic infections is unfortunately not a rare event. Healthcare-acquired infections are a preventable cause of death and disability, and following an appropriate patient-centered approach, there is no acceptable level of healthcare-acquired infections. The only reasonable goal is to reduce the rates of these infections as low as possible through effective measures. Aerosol transmitted infectious

diseases are no exception. In a recent study of patients hospitalized with COVID in the US, 4% of those COVID cases were hospital onset (first positive test after day 7 of hospitalization) [3]. As we have learned from HIV and the development of bloodborne pathogen standards, we cannot rely only on case identification via symptoms, testing, or identification of particular risk groups. Such an approach perpetuates stigma and puts both patients and healthcare workers at risk. Universal masking is the straightforward solution.

With respect to transmission-based precautions, in the draft proposal, groupings of "Routine," "Special" and "Extended Air Precautions" are made using a pseudoscientific explanation that airborne pathogens spread shorter or longer distances on the basis of pathogen factors. There is no demonstrated biophysical mechanism to support such claims–it is a *de facto* perpetuation of droplet dogma that will cause unnecessary death and disability, as loose-fitting surgical masks provide inadequate protection for the wearer against aerosol transmission. Only the Extended Air Precautions incorporate both N95 respirators as well as ventilation controls appropriate to aerosol transmission. An appropriate, science-based proposal would include N95 or better respirators, ventilation controls, and additional multilayered approaches for all airborne pathogens.

Many pathogens, including COVID, can cause a broad spectrum of disease with both short- and long-term consequences. The consequences of infection are unpredictable and depend importantly on medical conditions that may not be recognized prior to exposure. Medical conditions that cause an increased risk of severe COVID are common in the general population, with about 75% of the US population having high risk conditions for severe COVID infection [4].

It is well past time to incorporate universal masking as a new addition to standard precautions. Universal masking, with broad use of N95 or better respirators, is a precautionary approach that would be a significant improvement for infection control, simplifying the logistics of how and when to mask, and aligning our healthcare precautions with well-established science.

References

1. Sundling KE. June 2023 HICPAC public comment. https://precaution.substack.com/p/public-comment-to-cdc-infection-control
2. Sundling KE. August 2023 HICPAC public comment. https://precaution.substack.com/p/cdc-hicpac-infection-control-committee
3. Hatfield KM, Baggs J, Maillis A, et al. Assessment of Hospital-Onset SARS-CoV-2 Infection Rates and Testing Practices in the US, 2020-2022. JAMA Netw Open. 2023;6(8):e2329441. doi:10.1001/jamanetworkopen.2023.29441
4. Ajufo E, Rao S, Navar AM, Pandey A, Ayers CR, Khera A. U.S. population at increased risk of severe illness from COVID-19. Am J Prev Cardiol. 2021;6:100156. doi:10.1016/j.ajpc.2021.100156

To whom it may concern:

Please prioritize the health of patients and healthcare workers in hospitals and nursing homes by requiring well-fitting masks in all spaces, including N95s or similar in areas of especially high risk.

Please also require facilities to implement the minimum air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

Sincerely,
A concerned citizen
Dana J. King
Topeka, KS

I am writing to strongly advocate for maintaining the highest infection control standards for health care. Patients and caregivers must be given the best equipment to protect them from unnecessary biological hazards. The virus that causes COVID is airborne. Surgical masks are not adequate to protect people from a BSL-3 agent. Adequate protective equipment must be used. Please do not weaken the standards that keep people safe.

Beth Garaas Isley
MT, SM, CLS (ASCP)
Clinical Microbiologist

Dear CDC Members
My name is Jan Nespor, Columbus, OH. I write as an individual urging you to reject HICPAC's draft infection control guidelines and revise them in toto with input from health care workers, their unions, patients, and a much broader array of public health/science experts. SARS-2/COVID is an infectious aerosol-spread virus and there is a large body of evidence showing that N95 respirators and high-quality ventilation and air filtration systems are needed to limit its spread. The proposed guidelines do not provide adequate guidance on respirators and there are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

I have a severely immunosuppressed friends (e.g., one with a heart transplant). Your proposed guidelines put them at risk. The aim should be maximum protection, not backdoor eugenics. Again, I urge you to reject the proposed guidelines and attend to the science.
Sincerely,
Jan Nespor, PhD

Dear HICPAC/CDC,

In late April this year I saw my doctor for a yearly Wellness visit and he ordered the usual tests for blood work and preventative screenings.

Two weeks later President Biden declared the pandemic emergency over which led almost all hospitals and health care providers to 1) drop masking mandates and 2) drop COVID-19 screening tests. As someone the CDC designates as high risk for COVID-19 that leaves me in the precarious position of having to weigh which is the greater risk: catching COVID-19 at a blood lab (for example) because lab workers (and patients!) are not masking OR rolling the dice and hope that the potential problems that might show up in a blood test (for example) will hold off for a while.

Since the May 11 change I have spent hours calling around for new doctors still willing to mask. I have not yet gotten any of my diagnostic and preventative testing done. I am vaccinated but also understand that the COVID vaccination status has no bearing on the transmission of this particular **AEROSOL-TRANSMITTED** virus.

Thus at present, the best personal mitigations relevant to infectious disease that prevent **aerosol transmission** are **N95** masks. Surgical masks have been proven over and over to fail at this job due to their obvious leakage issue--one has only to witness the state of our hospitals and health care systems and the health of their workers right now to understand the extent of this failure.

I am now concerned that the CDC will profoundly weaken its Infection Control guidance by ignoring **AEROSOL TRANSMISSION** placing health workers and patients at risk of short- and long-term harm and even death from infectious diseases.

Universal **N95** masking is a simple measure to reduce the risk of infectious disease transmission. HICPAC should codify universal masking in health care facilities across the board and require the use of required **N95** respirators, not loose-fitting, leaky surgical masks.

If healthcare workers continue to refuse to wear **N95s** and/or downgrade to surgical masks (with your 'permission') many more workers and patients will develop COVID-19--as we are seeing in real time. Please protect your family and your community and mine and vote AGAINST watering down infection control protections, particularly for **aerosol transmission** and multidrug-resistant organisms.

HICPAC needs to drag itself into the 21st century and drop the 'droplet theory'. We need **MORE** mitigations in health care, not less—not only for this virus but for the viral and bacterial pandemics coming down the pike. We need **N95s** and CO2 monitors and HEPA filters in hospitals and health care facilities and doctors' offices. It's essential and crucial that HICPAC get aerosol experts, ventilation experts, and engineers involved.

Thank you for your attention to this critical matter.

~ Martina Ortega
Dorchester, MA

Herriman Utah
I am not representing an organization, but am just a future patient and concerned husband and father.
The HICPAC committee has illustrated perfectly how they have narrowly focused on what they believe is needed for the businesses of the hospitals that they represent, and have disgregarded and sidelined the voices of patients, nurses, occupational safety professionals, physicists and the public. The new guidelines represent a regression in the quality and standard of care, and I find it unacceptable.
To reiterate; forcefully: the new guidelines are bad, and will result in even more death, disability, and economic harm than the previous, inadequate guidelines.
For example, Tuberculosis is a micro-aerosol BSL-3 pathogen just like SARS-COV-2, and it's agreed that N95's are needed for Tuberculosis, but not for SARS2, because it's "endemic?" It's endemic because we never treated it like the micro-aerosol it is. Additionally, we are preemptively giving up on the next pandemic before we even finished giving up on the ongoing one. Tuberculosis generally has a much better patient outlook and even has better therapeutics, and we treat it differently in the new guidelines?
Before they stopped reporting the percentage of patients getting infected with SARS-COV-2 AT THE HOSPITAL in New York, the number was roughly 76%, and climbing by the week.
https://x.com/youarelobbylud/status/1638769169809244160?s=61&t=-97mzZssCWI75SF8legWkw

HICPAC instead of PREVENTING infectious disease in healthcare is giving it a new footfold, and by making nosocomial infection the new “standard of care”. It will become a 100% certainty that any patient who enters a hospital will get a nosocomial infection of SARS2, and this puts Influenza, TB, Step, and many other diseases that are resurgent on the nosocomial menu as well.
The previous guidelines were inadequate to prevent nearly 100% spread of micro-aerosol infectious disease spread IN HOSPITALS because we’ve failed to treat it like the micro-aerosol that it is. We don’t clean the air, and we don’t require N95’s or better at all times from our health care workers. It’s the only infectious disease in the top 5 causes of deaths in the US, and HICPAC’s recommendations guarantee it will keep climbing the top killer rankings.
I’m sickened by the dereliction of duty. And if anyone you know is ever going to go to the hospital for anything if these guidelines go into effect hold, then your friends and relatives will be sickened too—by SARS2.

Best regards,

- Jonathan Huff

I’m just a concerned citizen and prospective patient. I do not represent any organization.
Thank you for the opportunity to provide feedback related to Infectious Control Practices. As the SARS-COV-2 pandemic has unfolded, I have been forced to become very familiar with the state of the art of aerosol transmission and how to illness. My wife is one of the vulnerable people that we are supposed to protect from the virus, and I have been utterly disappointed by the CDC guidance around the airborne (think smoke, not droplets) transmission of SARS2, which transmits just like SARS1 via particles that remain in the air long after the infectious person has left.
Every single healthcare encounter from vaccinations and dental work to outpatient or inpatient care all now create a huge risk to the health of my wife that she may contract SARS-COV-2, and if not die, at least have her chronic condition significantly worsen. It is unacceptable that masking to prevent airborne transmission has nearly universally left hospitals and clinics.
This is a great opportunity for HICPAC to step up and protect the patients and healthcare workers the committee was formed to protect.
I cannot comment on the actual draft guidance, because the CDC/HICPAC has not made this available. It is damning that I must comment based on what are best termed “leaks” or “rumors” about what is proposed.
Again thank you, and I wanted to make sure to emphasize these 6 points for this meeting and future meetings:

1. HICPAC’s process to develop updates has purposely excluded essential input from frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.
2. HICPAC/CDC MUST increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. HICPAC’s process has been closed to public access or engagement. For example, there are no copies of the draft guidance under review. It’s impossible to have real public feedback, review, and engagement when it’s impossible to access what we are giving feedback about until the day of the meeting. The deliberations and their conclusions during the meeting seem designed to make it impossible to engage with in good faith. Given that this affects the safety of healthcare workers, and the vulnerable people under their care this process needs to actually be open and involved. The current process seems designed to exclude

feedback and constructive criticism instead of to provide space for it. This is in stark contrast to other federal advisory committees. It's hard not to conclude that this structure is designed to prevent the very process that advisory committees are organized to encourage and create.

3. The Work Group on the Isolation Precautions Guidance wants to use a "flexible" approach that only requires minimal protections and lets health care employers decide how to prevent infections. During the COVID-19 pandemic this approach allowed health care employers to skimp or withhold adequate protection for health care workers and patients, based on cost. I urge HICPAC and the CDC to keep an approach in the updated guidance that is clear and specific about the needed precautions to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the exposure level, choose suitable control measures (including PPE) for each job, task, and location, and write an exposure control plan following the hierarchy of controls. "Flexibility" especially regarding individual situations has been shown many times to mean that the least allowed protection is used, which is inadequate to protect healthcare workers, or vulnerable patients placed in their care from acquiring infectious diseases in clinic and hospital settings. Just as we use Biosafety Levels with different pathogens to control for all necessary safety precautions, we should use a hierarchical approach to safety where there is no question as to what is the correct and adequate protection for a given infection disease situation.
4. The Work Group on the Isolation Precautions Guidance wants to change the terms for infectious disease transmission to "air" and "touch" - but they ignore the science on aerosol transmission and how people inhale aerosolized pathogens. The new draft categories of "air" and "touch" are wrong for many health care-related infections. The CDC/HICPAC calls it "air" transmission, but they don't admit that inhalation is important and they still recommend surgical/medical masks, which don't protect people from breathing in infectious aerosols. They also need to update the list of diseases that are now known to spread through aerosol transmission/inhalation, not just airborne or droplet routes. The Work Group's suggestions would make health care workers less safe, even though the Covid-19 pandemic showed how much they need strong protection.
5. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. For a detailed explanation of how some of these studies are deeply flawed in both math and prior assumptions, see https://www.researchsquare.com/article/rs-3486610/v1 . The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.
6. The CDC/HICPAC does not recognize the role and value of basic measures to prevent the spread of infectious aerosols. They have ignored the strong evidence that respirators, ventilation and air filtration are effective in protecting workers from inhaling infectious aerosols. They do not give any advice on ventilation. They also limit the use of special rooms (AIIRs) or other methods to isolate patients who may emit infectious aerosols. Moreover, they do not consider how to reduce the source of infectious aerosols as a way to protect workers from breathing them in.

Best regards,

- Jonathan Huff, Herriman Utah

Hello
I am a severely immunocompromised senior widow,
in self quarantine since March 2020 since I want to
stay alive and the world has forgotten that
Covid still exists .
Please consider Americans like me.

I endorse all the below:
CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.

    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.

        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
    - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated

Thank you'
Welles Grey Bay
Marshall, VA

Greetings HICPAC,

The CDC must reject your changes to infection control standards, which will decrease the amount of protection and precaution that healthcare settings must have in place to prevent the spread of infectious disease.

This issue is important to me because my grandfather is immunocompromised and has lung disease, among other health issues. Due to this, he must frequently go to doctors for medical procedures and other essential care. By changing infection control guidelines for healthcare settings to reduce the amount of protection required, the CDC will enable hospitals to shirk their duty to protect every patient from infectious disease.

In healthcare settings, high-risk patients like my grandfather and many other seniors and disabled people are in contact with infected patients, and asymptomatic carriers of disease. In order to prevent the spread of disease to the most vulnerable, healthcare facilities and personal should employ all precautionary strategies at all times.

My grandfather should not have to risk catching COVID or other airborne infectious diseases in order to access the healthcare he needs to survive.

The cost of such measures may be large, but it is worth it to protect the lives of all patients and employees in healthcare settings. In 2016, the US Dept. of Health and Human Services deemed an intervention cost-effective if it cost less than 9.6 million dollars per life saved. The common sense safety measures such as universal masking in healthcare that should be implemented will cost much less than this, and save countless lives. Thus I implore you to reject the HICPAC guideline changes and implement more layers of protection in healthcare settings to protect the right of every patient and employee to a long, healthy life.

Thank you for your consideration and have a lovely evening,

Athen Schaper
High School Student

Greetings. I wanted to submit a public comment regarding the HICPAC proposed infection control changes.

First, I will state how shocked and disappointed I was when the decision was made not to require universal masking in healthcare settings anymore, as it seems like a common sense requirement even without a pandemic. COVID-19 and other airborne viruses/diseases are still

spreading rapidly, with the public largely unaware due to the unavailability of data and of course the invisible spread from people with few to no symptoms.

Please require universal masking in healthcare settings, at the very least. I am not personally immunocompromised, but I find it a very small thing to wear a mask to protect others who could potentially have serious complications if they were to contract COVID-19. These people should not have to fear going to the doctor and put off getting needed medical attention. Masks obviously work best when they are worn by everybody.

Secondly, I am asking the CDC to increase the availability of free tests and data regarding COVID-19 to the general public. It is quite upsetting to see that the agency that is supposed to be about public health seems to have caved into political and economic pressures. Since most people are using home tests now, please make them more available to the public at no cost (many are dismissing symptoms as "just a cold" and exposing others because they don't have access to tests) and require that results are reported for public health data purposes. There are creative ways to get the public to do an easy scan of results with their phones to do this - the ihealth app is the best one I've seen, but you could make them even quicker and easier and could even add raffle incentives for scanning the results. Also, I am asking that wastewater data be required by every county in the US, and the results to be available to the public.

The general attitude now seems to be "every man for himself," yet we are not even able to make decisions for our own personal best interest with no data. I personally wear a mask any time I am indoors because of this, yet if there were reliable and available data I may not feel the need to do this when transmission levels are lower. But, the purpose of public health is to protect everybody. Elderly and immunocompromised people shouldn't be forced to live their lives in isolation because our public health agencies are not standing up for their right to be protected in indoor/crowded settings.

Thank you,

Caitlin McAuliffe Lector
Fort Lauderdale, FL
No organizational affiliation - just a concerned US citizen

Dear CDC,

I am writing again to urge you to reconsider loosening infectious disease guidelines in healthcare. I am deeply concerned about the lack of consideration of aerosol spread of COVID-19 and the denial of the importance of respirators, isolation, and proper ventilation for patient and healthcare worker safety. I am also extremely concerned about the lack of space for public input and input from frontline healthcare professionals and scientists. Loosening these guidelines is not in the best interest of healthcare workers or patients, and I believe it to be short-sighted from an economic and public health standpoint. Healthcare workers deserve the best possible PPE. Higher risk and immunocompromised people deserve to be able to access healthcare safely. Patients with highly infectious diseases deserve to not be exposed to other highly infectious diseases while in recovery.

Please prioritize patient and worker safety in healthcare settings and reconsider.

Thank you,

Ruby Cromer

Dear HICPAC,

In order for your revised infectious control guidelines to truly ensure safe and healthy lives for all persons amid the ongoing threat of the COVID-19 pandemic, you must include the following provisions:

- Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.
- HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.
- Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.
- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" than infection control.

Thank you for lending me your time by reading this. Please have a nice rest of your day.

-Anja Schaper
High School Student

I am a physician with years of experience in medical oncology and internal medicine. I am concerned that the current draft proposal does not recommend masking in health care settings using N95 masks which are much safer in preventing airborne diseases than surgical masks or no masks. Changes in practice often come slowly in medicine but with HIV we moved pretty quickly to improve needle and blood precautions. Eventually we moved to expanded testing and then to starting treatment immediately. It is time for CDC to recommend more urgent interventions for airborne disease now. COVID 19 is still circulating and mutating and has real health consequences for patients. Good masking policies can improve the transmission rates and are especially important in hospitals where there are sick patients and visitors with unknown risks and diseases. In the outpatient setting patients need to be able to avoid new problems by having staff wear N95 masks. Staff in all areas need to be protected as well. Eventually

improved ventilation and other systemic methods need to be implemented but cost and time limit some of these interventions in many places. Masking can be implemented now and hospitals should be evaluated for this intervention by such groups as the Joint Commission and OSHA. . Hopefully ventilation, filtration and other systemic interventions will improve air quality and will lead to improved health care throughout the system Multiple strategies are needed to make health care setting safer and the CDC needs to provide leadership and education on the question of airborne diseases.
Thank you
Linda D. Green MD (Maryland license)
Mount Rainier, Maryland

To whom it may concern,

My name is Kat Naphas and I am located in Westminster, California. I am unaffiliated with any organization and am messaging you on my own behalf. I am writing to urge you to take the necessary actions to ensure safer medical settings for staff and patients alike.

We need to bring back mask mandates and improve filtration to make sure that healthcare workers and their patients are as safe as possible. It is extremely inappropriate to lessen safety measures in the midst of an ongoing pandemic and upcoming flu season when transmission is going to result in many people experiencing a loss in quality of life, getting weaker immune systems, and becoming more prone to die with future infections and health complications. We already know that covid affects every part of the body and that initial infections do not reflect the catastrophic harm done to people's brains, hearts, lungs, etc.

Please do the right thing and act with the urgency necessary to protect workers, families, and communities. Without your organization's guidance, many other organizations will default to doing the bare minimum and viruses will continue to debilitate and kill thousands of people in this country alone. We are in this together and need to act accordingly.

Thank you for your time,
Kat

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect

health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Sincerely,
Uriah Bussey

Dear Members of HICPAC:
I am a physician , with some expertise in infection control. The proposed Isolation Precautions Guidelines are inexplicably weak and dangerous in the midst of an uncontrolled pandemic. I urge you to reject the current draft, and start over, as detailed by the National Nurses United.
COVID-19 infections in both the Acute phase and the Post Acute Sequelae continue to injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. Every infection that is not prevented triggers a cascade of increased illness, and weakens the healthcare workforce. The current situation has been called unsustainable.
On a personal basis, the high risk of healthcare acquired COVID has discouraged both me and my immunosuppressed daughter from accessing healthcare. The proposed guidelines will make the situation even worse.

SARS-CoV-2 is undeniably airborne. That must be emphasized in the guidelines. It follows that guidelines must include layers of protection including high quality respirators such as N95s and elastomerics, ventilation, and air filtration which have been demonstrated to protect individuals from a COVID19-infection.
As over 50% of COVID-19 transmission occurs before people develop symptoms, and show no established seasonality, policies must also be established that promote UNIVERSAL masking of healthcare workers, patients and visitors in healthcare settings until such time as safe, breathable air can be guaranteed. The report by Most et al documented a remarkable increase in healthcare associated respiratory infections when masking was decreased from universal to patient contacts only. At a minimum, facilities should now implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
HICPACs lack of proper attention to aerosol transmission and the attendant requirement for engineering controls underscores the need for HICPAC to broaden its membership, transparency and processes to include frontline workers, patients, public health experts and fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection.
The lack of care for healthcare providers themselves, with its attendant disability from Long COVID, burnout from staff shortages is leading to a crisis in healthcare. According to the president of the AMA, the physician shortage is an "urgent crisis". With lack of autonomy and concerns for patient safety cited as two of the biggest factors. Citing concerns about burnout and how clinician shortages will affect them, an astonishing 1 in 4 U.S. med students report that they are considering quitting medical school , while 58% of medical students (student doctors) and nursing students plan on going into careers in healthcare that do not involve treating patients.
I ask that you provide the best recommendations that employ a multi-layer approach to protect patients, healthcare workers and their communities for the ravages of acute and long COVID19, as well as drug resistant pathogens like MRSA and Candida auris.

Sincerely,

Cynthia Mahoney MD
Danville, CA

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1. Americans continue to catch and die of COVID-19 infections.
2. Millions of Americans currently suffer from Long COVID and many more will become disabled or die without implementing better mitigations.
3. SARS-CoV-2 is spread via inhalation of aerosol particles and all indoor settings are higher risk compared to outdoor settings. Not masking and/or surgical masks do not offer optimal infection control against an airborne virus.
4. To ensure the highest quality of care and to prevent healthcare acquired conditions, healthcare settings must employ layers of protection such as high-quality N95 respirators, ventilation and air filtration, all of which have demonstrated to protect individuals from a COVID-19 infection.
5. Every hospital and healthcare facility should be fundamentally safe spaces where patients can access care and healthcare workers can go to work and not worry about acquiring a work or healthcare-acquired COVID-19 infection.
6. It's as fundamental as the oath physicians promise to uphold, "First Do No Harm."

Respectfully Submitted,
Pamela MacKay, Retired Registered Nurse, Healthcare Former Risk Manager

Beverly, MA

To Whom It May Concern,
There are several things that need consideration in your latest document.
1. COVID is airborne and requires and N95 or better to stop spread. Surgicals are NOT for aerosols.
2. Asymptomatic people spread COVID, so just requiring masks when there is high spread is ridiculous.
3. Everyone requires access to healthcare. I have caught multiple times at healthcare because staff was not propery masked in n95 over nose. We are years into pandemic and this should be taken seriously. I got organ damage from this carelessness, just as The VA study shows after multiple infections . One way masking is NOT enough.
4. Long COVID risk continues as you get more infections. My husband got long covid after our third infection. My son and I got after 1st infection and my young son stopped walking.

Please learn from our mistakes. "The distinction between droplet and airborne transmission has enormous consequences. To combat droplets, a leading precaution is to wash hands frequently with soap and water. To fight infectious aerosols, the air itself is the enemy. In hospitals, that means expensive isolation wards and N95 masks for all medical staff." from Wired in 2021, **"The 60-Year-Old Scientific Screwup That Helped Covid Kill"**
You continue on ignoring science. Please correct it as I wont last many more infections. Im tired and irritated I cant access healthcare anymore, send kids to school, leave my house, etc because clean air is not addressed and Im at 5 infections that have given me long term damage. THIS IS NOT SUSTAINABLE. I want my life back and for us to follow BASIC SCIENCE. Far UVC, ASHRAE air standards, N95, sensors to detect covid before entry (already exist) should be standard at schools and hospitals. How many have to die or become disabled before you will listen?

Sincerely, an expendable citizen, because you repeatedly forced infection upon me without my consent in healthcare and have ruined my life and any sort of normalcy, holidays, etc,
Angela Bartholomaus
Issaquah, WA
Official Title and Organization: Expendable Long COVID Citizen to the CDC

Please reject HICPAC's draft and actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft including holding public meetings. COVID is the result of an airborne virus that should be mitigated through strict air quality control regulations in all health care worker and patient settings as well as the general workplace and all other indoor settings (such as supermarkets and gyms). Further, health care workers should be required to wear N95 respirators when interacting with patients. Thank you for your attention to this important matter.

Sincerely,
William Colella
Los Angeles, CA

To Whom It May Concern,

People have the right to be safe while seeking health care in all medical settings. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if

contracting Covid, or other airborne illnesses, comprise a great number of, if not a majority of, Americans. Proper PPE needs to be the standard of care in ALL medical settings as well as safe air ventilation of Merve 13 & 6 air exchanges per hour. Without these appropriate and necessary actions, people are being infected at their doctor's office, dentist's office, other outpatient providers' offices, and while in the ER and inpatient at the hospital.

HICPAC needs to promote these safety measures as standard of care. Receiving health care should not be a risky action and instead care should be provided so that the most vulnerable among us are accounted for and cared for. **Please take action to protect both patients and health care providers by requiring proper PPE, air filtration and ventilation in healthcare settings.**

Thank you for your attention to this urgent and important matter.

Shoshanna Press, MD
Seattle, Washington

Good evening,

I'm writing to encourage the creation and promulgation of clear policies related to the necessity of masking in health care and hospital settings. In 2007-2008, I was employed as a technician at Georgetown Hospital. One of the things emphasized over and over in my training was the risk of hospital-acquired infections. We were told about the separate and combined risks of antibiotic resistant bacteria and on the overall increased infection risk of patients who were in the hospital for conditions that might lower their immune response (various illnesses/autoimmune conditions), getting treatments that lowered their immune response (e.g. chemo), had healing wounds, or were simply more fragile due to their age (old and young).

During that year, I went through a ton of lotion outside work, trying to fight the dryness of so much hand washing and sanitizing, but it was also extraordinarily clear that it was the right thing to do.

A significant amount of COVID transmission is airborne. Newspaper articles and reports also report that many of the transmissions that happened after the state of emergency was ended in May (until the recent spike) happened in hospital settings in particular.

I also have friends with autoimmune conditions who are in their 30s like me and worried about getting the medical treatment that they'll need to live anything like a normal lifespan. I have older friends in church with combined health conditions which make them more vulernable. It deeply saddens me that while they can mask, the people treating them for conditions which make them more vulnerable to things like COVID do not also mask and thus increase their risk of transmissions. Their care isn't optional.

I hope that their medical providers are truly well-intentioned and would mask, especially if it could be handled financially like gloves and soap and other things that contribute to patient safety are. It also baffles me that people would take steps to avoid MRSA and the like while not taking steps to keep patients safe from COVID -- or the flu or RSA. Please take patient safety seriously. Getting care is stressful enough in this country, you can at least make it less risky.

Sincerely,
Ruth Tillman

Ruth Tillman
State College, PA
Unaffiliated

Public comment for
HICPAC Infection Control Changes

From:
Barbara Nesin
Unaffiliated with any organization

I am a senior with pending medical procedures that I don't feel safe doing in hospitals and medical facilities that are not following safe COVID/SARS-CoV-2 prevention precautions.

I expect medical services to be provided in a safe environment, not one that further endangers my health, putting me at risk for unnecessary complications or even death. "Do no harm" is a most important tenet of the medical profession that demands the implementation of sound safety measures to protect patients as well as medical personnel.

I am urging the immediate and complete implementation of protocols that PRIORITIZE patient and personnel safety by optimally addressing the following standards and concerns:

- Guidelines that fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiN2ltbzEifQ.5rsH_Qi1KHDtO6yA8zVluE_sQMNB5qcjhXE9yCZhidk) rather than infection control. THIS IS UNACCEPTABLE!
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiN2ltbzEifQ.5rsH_Qi1KHDtO6yA8zVluE_sQMNB5qcjhXE9yCZhidk) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data. UNTIL TESTING IS ACCESSIBLE TO ALL, THIS CRITERIA IS INVALID.

- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the LAST layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Sincerely,
Barbara Nesin
Atlanta GA
(Unaffiliated)

Dear HICPAC,

We need transparent and comprehensive airborne infection control by November 6th.

I understand you are on the verge of weakening airborne infection control. As more and more of my friends get Covid this season and resort to Test2Treat to get Paxlovid, I urge you to instead increase airborne infection controls.

I am asking that HICPAC:

- Involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.
- Make the process for updating the guidelines fully open and transparent.
- Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.
- Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

Thank you,
Tiff Chang
San Francisco, California

As a healthcare provider, I urge, I demand HICPAC to substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines. Make the process for updating the guidelines fully open and transparent. FULLY recognize aerosol transmission of SARS-COV-2 and establish rigorous protocols for preventing “transmission by air” and asymptomatic spread. Require healthcare facilities to employ precautionary strategies at all times. Weakening infectious disease guidelines will only push more nurses out of working the bedside and worsen the conditions for people requiring care who are high risk, elderly, and disabled. Weakening infectious disease guidelines would be a failure to the American people. Safety over profit should always be the priority

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It is becoming increasingly clear that CDC/HICPAC care not a whit for the health and safety of the public.

The proposed guidelines must fully **recognize aerosol transmission of SARS-CoV-2** and establish rigorous protocols for preventing "transmission by air." Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. **Universal masking** protocol must be put back in place, most especially so in healthcare settings to prevent the spread of infection where people are their most vulnerable. Much covid transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

I feel I must remind you that CDC stands for **THE CENTER FOR DISEASE CONTROL AND PREVENTION**. And yet you have proven time and again that you are failures at your jobs. You abandon high risk, disabled people to die. You abandon nondisabled people to deal with their inevitable disablement on their own. Shame on you.

Todd Dansworth
Austin, TX

Hello,

I am writing to urge the CDC to:
Seek input from patients, healthcare workers & scientific researchers—using Federal Register Public Notice Process +Town Hall Meeting + virtual options
Be transparent
Recommend Airborne Precautions: Respirators Usage
Set min. IAQ set by ASHRAE 241

thank you,
Ellen Mueller

To whom it may concern,

I am a citizen of the United States and I am extremely concerned over the lack of care and support HICPAC and the CDC in general is giving surrounding the currently on-going COVID-19 pandemic that is ravaging through the United States and the rest of the world.

HICPAC's newly proposed policy to lower healthcare infection control standard is going to kill thousands. What we need now, in this time of rapidly evolving COVID-19 strains and increasing infections, is to strengthen infection control standards and take precaution against this virus that will show no mercy, as it has been doing for the past three years. HICPAC needs to actually do what it was made for and create useful, necessary policies and protocols that will recognize COVID-19 for the airborne, potentially fatal, vicious virus that it is and make a plan for how to limit this virus to the point where people aren't constantly dying or becoming disabled from such high levels of infections.
In making these decisions, HICPAC must involve healthcare unions, experts in ventilation and occupational safety, and the public to ensure that what is put forward is actually helpful, unlike the policies and protocols that we've had to put up with for the past three years of this pandemic. The process for updating the guidelines must be fully open and transparent, to

prevent another happening of how the CDC has acted the past years that we've struggled to survive with COVID-19 destroying our communities. High risk areas should especially be focused on, including schools and healthcare setting. The most vulnerable people, such as children, the elderly, disabled people, and people of color, must be accounted for, as they will bear the brunt of what is to come with COVID-19 continuing to decimate our population.

People are dying. People have died. People will continue to die if HICPAC doesn't update their policies to reflect the current disaster that is still happening with COVID-19 continuing to grow and spread. We need transparent, comprehensive airborne infection control immediately.

Sincerely,
a concerned, scared citizen

Dear HICPAC,
Please strengthen air filtration and mask wearing guidelines to protect health care workers and patients in all health care settings.
Covid will be with us for a long time to come. Preventive measures are simple, cost-effective and non-invasive. Covid is the opposite.
We are watching for compassionate and transparent guidelines and counting on you to protect our health.
Sincerely,
Carol Poliak

Re: HICPAC's Revision of CDC's 2007 Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings – 11/5/2023
Instead of appropriately revising 2007 infection control guidelines to reflect new information on COVID, HICPAC has eviscerated existing protections, to render these guidelines virtually useless in protecting workers, patients & the public health at large, solely to cater to corporate greed. This will result in massive unnecessary death, disability & suffering, particularly for the sick & vulnerable, whom it is the sole mission of healthcare to heal & protect. Denying COVID-susceptible patients personal safety lays waste to basic medical ethics (do no harm) & denies the disabled (e.g. COVID Longhaulers, immunocompromised) access to healthcare, in violation of federal law.
HICPAC/CDC has betrayed its mission & the public trust in numerous ways, including by:
Pointedly ignoring asymptomatic transmission of COVID, despite objections, & contrary to scientific fact.
Weakening guidance wording upon every turn, to remove all obligation to prevent airborne disease transmission, even specifically requiring that infectious patients be allow to wander the halls, transmitting infection, & to prohibit the use of gloves in some instances.
Ignoring the aerosol transmission of COVID & other airborne pathogens, in contradiction to CDC's own 5/7/2021 "Scientific Brief: SARS-CoV2 Transmission" document. Recommending the use of surgical masks, when they offer no protection against aerosols. Inadequate use of source control, effective masking (N-95 or better) & eye protection.
Removing requirements to contain infection using negative pressure rooms, isolation rooms, proper ventilation/MERV-13 HEPA filtration using 6 air exchanges/hr.
Ignoring a deluge of expert criticism, including my own prior arguments & objections. This includes criticism that its board does not include ANY applicable experts in the fields of aerosol science, industrial hygiene, UV & HEPA filtration, ventilation engineering, respiratory protection & occupational health/safety, which are necessary to make knowledge/science-based decisions.

Limiting the comment period to 3 days & 1 page, so complainants cannot possibly detail all of the deliberate gross blunders/fallacies underpinning this document, much less prove their scientific baselessness.
This willful negligence will only serve to breed increasingly transmissible variants which evade existing protections & treatments. Any one of these could become highly virulent, & could have disastrous public health & economic consequences.
Laura Lauck Cole
B.S. Pharm, UNC; RPh (NC Lic. # 11794)
M.E.M. Biohazard Science, Duke University
Chapel Hill, NC

To Whom It May Concern:

I am writing to you as a person that is immunocomprised with disabilities and whose doctors have predicted that if I contract COVID-19 I would likely die. My parents are seniors that are also immunocomprised and over the course of the pandemic we have successfully avoided contracting COVID-19. We've done so through some of the initial recommendations that were put in place in 2020. We wear N95 masks in public, including outdoors when other people are in the vicinity. We also have installed air purifiers in our homes and upgraded our filters in HVAC systems. We do not dine inside restaurants.

I work in a community that has experienced five significant waves of COVID-19 since 2020, resulting in many deaths. We have followed the same measures as above at my workplace and we still require masking for everyone. I have had 15 close exposures since 2020 from people who tested positive for COVID-19 within 24 hours of being near me, in an enclosed space, and not once have I tested positive.

I have traveled to and from DC, twice this year during COVID-19 spikes. Both times I traveled via crowded Amtrak and crowded DC Metro rail and buses. I even participated in two days of intensive tennis training indoors in close proximity with unmasked people who later tested positive, but I did not.

I implore you to include proven recommendations that have kept me and my family alive—masking with N95 masks and ventilation measures DO WORK. It's critical that these be recommended for all businesses, government buildings and especially schools and in other public spaces. The individuals most harmed by COVID-19 have been the elderly, like my parents, front-line and low wage workers, and individuals with disabilities like myself.

Please do the right thing to keep us alive. We are depending on you.

Breanne Armbrust

I am a former public school teacher, who at 26 became one of the over 4 million Americans completely disabled out of the ability to work by Long COVID. Before my mild acute case of COVID — which I caught from an asymptomatic carrier, which comprise 1/3 of COVID cases and 60% of transmission (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/277470) — I was a fully healthy 26-year-old with no pre-existing conditions, who exercised frequently and walked almost everywhere where I was living in Boston. However, about a month after my acute infection ended, I started developing severe neurological and gastrointestinal problems

that are common with Post-Acute COVID Syndrome, such as chronic migraine, occipital neuralgia, post-exertional malaise, vision problems, and severe nausea/vomiting.

SARS-CoV-2 is spread via inhalation of aerosol particles, traveling well over 6 feet and lingering in the air for hours (both facts cited by the EPA at https://www.epa.gov/coronavirus/indoor-air-and-coronavirus-covid-19) with an especially higher risk in indoor settings.

Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Vaccination, while effective at reducing the severity of disease, does very little to reduce transmission of the virus. Layers of protection, including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

The HICPAC must look to scientific facts to guide their recommendations, not financial interests. The way that COVID spreads, ways to prevent it, and its effects on the body even after a “mild” acute case are now well-documented by peer-reviewed research.

More specifically, HICPAC must:
1. Substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.
2. Make the process for updating the guidelines fully open and transparent.
3. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.
4. Ensure healthcare facilities employ precautionary strategies at all times, including mask mandates and air ventilation, as such settings are where high risk, disabled, and elderly people have no choice but to share air with infected patients and staff.

Max Guttman
Rockville, MD

The CDC seems to have forgotten that it is **THE CENTER FOR DISEASE CONTROL AND PREVENTION,** for this new draft of infection control protocols completely leaves healthcare workers and consumers (i.e. the entire population) to the wolves of continued mass disablement and death. **COVID-19** is transmitted via **AEROSOLS**, and this transmission is often **ASYMPTOMATIC. UNIVERSAL MASKING PROTOCOLS** as well as requirements and standards for updated air ventilation are essential to keep the public safe. This is especially true in healthcare settings. People go to these settings to receive care, not to get sick and risk Long COVID. Many people in my life, as well as myself, decline to get routine, preventative, and necessary medical treatments because the transmission of COVID-19 remains unmitigated in any meaningful way. **One way masking is not enough.**

Shame upon HICPAC/CDC and all your ancestors for putting profits before the people you were supposed to serve.

Dinh Tam
Houston, TX

I hear the CDC is considering guidelines that weaken infection control in healthcare settings. I already avoid the doctor as much as possible because I know it’s not safe and nobody is doing anything to make it better so please don’t make this situation worse. I’m like so many folks in a

hospital or clinic—more vulnerable to severe outcomes from infectious disease—and I beg you to help me out and make this world accessible for me and those like me.

If there is solid evidence that infection control can be lessened, so be it. However, it seems this is not a prevention-centered process and that political and/or financial considerations are being foregrounded.

The ways decisions are being made is infuriating and frustrating and I just really do not understand…except the cynic in me definitely does understand. I have zero trust in the federal public health system after its Covid response. Please get back on track and act according to good evidence and preventing illness before it happens.

Thank you,
Jennifer Woody Collins

Nov. 5, 2023

Dear CDC Healthcare Infection Control Practices Advisory Committee,

We are representing ourselves as concerned individuals. We are writing to most strongly urge the CDC to require universal masking in healthcare as well as broad use of N95 or better respirators, appropriate ventilatory controls, and other effective methods to reduce the risk of aerosol transmission. We must learn from and improve infection control based on what we have learned during the COVID pandemic. All patients and healthcare providers deserve protections.

Over the past few years several beloved elders we know have needed hospital care. We are immensely grateful for the care they received but with weakened controls we now have extra worries when someone needs care that they will contract COVID or another serious respiratory illness during their stay. The risk of doing so can be reduced with infection controls.

Healthcare settings are places where vulnerable people are in contact with people who could be infectious. We must do all that we can to protect members of our community.

Thank you for your consideration.

Best wishes,
Susan Nossal and Steve Burns
Madison, WI

Hello,
I am reaching out because I have urgent concerns about the decisions this committee is making. It is our duty to protect one another and value human lives, as well as quality of life, over profit margins. Especially in healthcare settings!

I believe in protecting people's autonomy, particularly people's right to basic community safety when they navigate necessary public infrastructure like hospitals. This is only possible through maintaining safe and sane collective public health practices.

I do not consent to *avoidable* contagious disease becoming the norm when I am trying to seek medical care, and strongly advise you to do your part in preventing the mass disabling of the American people through long covid. This is not like a common cold, experts have been warning us since 2020. My entire workplace shuts down multiple times per year due to the unchecked spread of covid. I have multiple friends and family ages 18-70 who are now severely disabled due to long covid, even thought they chose to wear a mask and get vaccinated themselves. Elderly patients as well as children are especially vulnerable in these environments, and their lives are valuable too.
We have to prevent community spread of major disease in our healthcare systems, it is the lowest bar in a developed nation in 2023.

I demand that the following recommendations be taken for the well-being of our nation:

HICPAC must substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.
Make the process for updating the guidelines fully open and transparent.
Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.
Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

This is not complicated, it is simple science and safety. We should listen to epidemiologists and healthcare experts, as well as abide by the wishes of healthcare workers to ensure safe working conditions that protect our providers and ultimately all patients.

As a Biologist and concerned citizen I urge you to put the greater good over lack of true care driven by corruption and profit.

Thank you,
Mary Aquiningoc

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing as an advocate for patient safety to strongly recommend improving ventilation and requiring the use of N95 masks in all healthcare settings. These critical steps are essential to combat the aerosol spread of diseases, reduce hospital-acquired infections, and ultimately save lives.

Patients in healthcare settings are already vulnerable due to illness or injury, and the risk of acquiring additional infections can be life-threatening. People should go to the doctor to get well, not to get sick. I only go to the doctors when absolutely necessary. I avoid going to the dentist. When family members need surgery I can’t even take the time to worry about the actual procedure, all my concern is focused on them not contracting COVID while at the hospital. It’s on me to ask doctors to wear a mask or wear a mask correctly. That should not be my job. What happened to ‘first do no harm’? People should not have to worry that seeking care will get them sick. COVID is airborne, many cases are asymptomatic, and people are often contagious and don’t know it.

There are many places immunocompromised and high-risk people can avoid going (though they shouldn’t have to) but medical facilities are not one of them. Healthcare settings need improved ventilation and air quality standards and universal mask mandates with N95s for all providers

and patients. The updated guidance for safety standards needs to be strengthened, not weakened. It is shameful, harmful and ableist how medical facilities have handled COVID. Stop allowing a deadly and disabling virus to spread unchecked.

Thank you for your time,

Molly Bryck

Dear HICPAC,

I am an immunocompromised community member with dynamic disabilities and chronic illnesses. I am very high risk to severe COVID outcomes. My life is worthy. I deserve safe access to medical care, as do my high risk loved ones. We demand more airborne protections in medical care, not less. We demand high quality mask mandates for workers and patients alike and medical grade HEPA air filters. We shouldn't have to fear being further disabled or killed by COVID or other airborne viruses for seeking medical care and we deserve a transparent decision making process to get there. One-way masking is insufficient to protect those of us most at risk.

Urgently,

Melanie Saeck, PhD

Topic: HICPAC Draft Guidelines

I am very concerned about the proposed healthcare infection control guidelines by HICPAC. I work with people that are immune compromised for many reasons (cancer, autoimmune conditions, etc) and many are getting sick with Covid19, RSV, strep when they go to see their doctor or get necessary treatments. Please make stronger guidelines to protect patients and healthcare workers by recommending the following:

· Universal masking to make healthcare settings safer for all, and more accessible to people especially at risk.
· HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.
· Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.
· All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
· Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
· Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMW1zNW4ifQ.PpszvKPun3R8GrvDIiSPKHcTRkuISPIB2G3TbceqZto) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

· HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
· Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
· Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
· Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Thank you for your attention to this very important matter.

Margaret Lockwood
Chicago, IL
Individual, no organizational affiliation

Hello,
My name is Isabella Perdomo and I am a constituent of Los Angeles and a student. It is of great importance to me, both as a concerned citizen and an immunocompromised person, that decisions made that will impact our healthcare system be backed in scientific evidence rather than private interests. We know now, after having seen the impact of COVID-19 on our nation and hospitals, that we were extremely underprepared to face the spread of the disease with regards to ventilation, disinfection and PPE. With the current draft approved by HICPAC, we will continue to be underprepared for both future pandemics and outbreaks and for ongoing COVID-19 concerns. The science is very clear: improved ventilation and masks in healthcare settings prevent the transmission of various diseases and protect all of us, from healthcare workers to immunocompromised patients, to YOU reading this right now. The science is also becoming more clear on the lingering negative impacts of illnesses like COVID-19 and SARS that can affect those who've been infected for years down the line, and the more we can avoid these long-term complications, the better for the health of all of us. A layered approach to disease control measures is our best bet going forward, which includes masks for healthcare workers, air ventilation and filtration requirements, and disinfection measures – practices that are not uncommon outside of the US. Health care workers also should be required to be vaccinated, and tested regularly to best care for their patients. As the nurses union is urging, CDC should reject HICPAC's draft and work with experts to develop improved guidelines backed by empirical evidence. HICPAC cannot develop appropriate guidance now, as it has no members who are experts in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection.
Frankly, I could go on and on about why it is important to follow the science to prevent more tragedy, but you as the reader work for the CDC and I would hope that you know these things already. Despite peer pressure from the most uninformed and from supporters of anti-intellectualism in our society, I hope you and your peers will do the right thing to protect children, people with disabilities, the elderly, healthcare workers, and all of us who deserve to live full and healthy lives. Thank you for your time and consideration.
Sincerely,
Isabella B. Perdomo

I am writing in several roles:

- as the leader of a local health equity group that is working hard to address the disparities caused by COVID and the disparities that make COVID worse for people of color, the poor, disabled people, and rural populations
- as the leader of a support group for people who continue to mitigate against infection because they want to protect their health and the health of their community
- as a scholar of inequity
- as an educational coach who assists others in remote and emergency teaching

I am writing to share my grave concern that you are choosing to increase risk for already-vulnerable people by lowering the standards for safety in medical settings.

Clients deserve to be as safe as possible when seeing medical help. The science is very clear that we can lower the risk of passing an aerosol-born virus to others by wearing a well-fitting respirator at all times (not intermittently), cleaning the air, testing and staying home until no longer contagious, and getting vaccinated.

Instead, few HCWers currently wear masks. The power imbalance between client and provider makes asking difficult, and clients rightfully fear that providers who are not masking even after seeing patients masked lack empathy and may even choose to be retributive. Given the high stakes of healthcare, clients cannot afford to correct a HCW who is not masking. HCWs may still refuse, or if they comply with the request, they typically wear a far-less-effective surgical mask. The consequence is that healthcare acquired infection rates are high, and they grow higher when community spread is higher. This is unacceptable: people deserve to seek medical treatment in a space that is safer than a bar or a bus station, but COVID mitigations in healthcare settings are no better than the ones they face there. Nearly half of HCWs who have COVID still report to work. As clients, we actually have no ability to protect ourselves from them without your help.

Every client deserves to know that, in every setting, HCWs are preserving their health. But there is an additional reason why you must recognize that the large majority of COVID spread is via aerosols (and stop implying that it is through fomite transmission, which is what continued suggestion to wash hands does) and immediately implement policies to radically reduce nosocomial spread:

Because science tells us that we can radically reduce the spread of this virus.

And if you don't allow us to use science to save lives, *then people will stop believing that science can save lives*.

Already, our public health leaders' failures have undermined people's faith in vaccines--including for their pets.

Science needs a win, not just to help us out of the COVID disaster that we face, but so that we can address the other public health crises that have contributed to the shortening and sickening of American lives.

If you can't convince people with college and graduate degrees in healthcare to wear a respirator to prevent them from spreading an aerosol-born virus that has killed more than 1.1 million Americans--including their colleagues at an especially high rate--then you are ceding your ability to solve any problems at all and, worse, you are allowing the further development of a culture that denigrates science and a society that chooses a "you do you" approach to public health.

We all deserve better.

Dr. Barrett-Fox

To Whom It May Concern,

I am writing to document my public comment for the Healthcare Infection Control Practices Advisory Committee (HICPAC). All members of this committee have a crucial role in shaping the effects that COVID-19 has on the American population at large. You all have the ability to set the record straight about what precautionary measures help prevent the transmission of COVID-19, and ensure that those steps are taken. It is crucial that you all fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed “transmission by air” category.

In addition to this, for the safety of all, it is vital that your committee ensures that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE). Similarly, it is necessary to communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk. Health care personnel should be kept up to date with aerosol infection transmission information and fit testing, to make sure they are able to protect themselves, and their patients. Lastly, it is necessary to reinstate health care mask mandates, in order to keep workers and patients alike safe when receiving or giving care.

Please utilize the HICPAC committee for the greater good of all American people. You all have the power to protect a countless number of lives.

Grayson Breen MSW, LSW, PEL:SSW

Hello,

I am a constituent who lives in Oregon. The spread of SARS-CoV-2 has deeply impacted my life and community, and I'm writing in to support the People's CDC recommendations for HICPAC, which are as follows:

- Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including: Health care personnel and their representatives, industrial hygienists, occupational health nurses, and safety professionals, engineers, including those with expertise in ventilation design and operation, research scientists, including those with expertise in aerosols and respiratory protection, experts in respiratory protection, including scientists from NIOSH’s National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA), patients, patient advocates, and disability justice groups.

- Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency: Use the Federal Register public notice process to announce the meetings,

agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments. Open work group meetings to the public with virtual options and with ample time set aside for public comments. Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

- Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available. Fully recognize aerosol transmission through inhalation of
SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air"
category. Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk. Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel. Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.

- Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2. Much transmission is asymptomatic.
Therefore, all precautions must be universally practiced at all times.
Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies. Pre-symptomatic and pre-positive-test transmission are possible. Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures. All people should be presumed infectious because they might be, and should take all precautions against spreading the virus. Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work. SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state: The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles,
tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols. Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make

masking prohibitive, and infants. Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes. Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings. Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).

- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

I hope that the CDC will finally adopt the necessary precautions to protect the public during the ongoing SARS-CoV-2 pandemic.
-
DeForest Rolnick-Wihtol
Eugene, Oregon

Greetings,

We are still in the midst of a pandemic and universal masking should be required in healthcare settings to make them safer for the vulnerable populations they serve. N-95 respirators should be the standard of care. All healthcare workers should be regularly tested for COVID-19 and RDV during peak season. Workers who are infectious must be supported with paid leave and allowed to stay home until symptoms improve and testing is negative. Hospitals and healthcare systems should provide free vaccines and boosters for all patients and employees. Hospitals and healthcare systems should require staff to be up to date on vaccinations for aerosol-transmitted infectious diseases. Facilities should implement indoor air quality standards as set by ASHRAE. The lives of countless more people will be on your hands if the guidelines are changed.

Sincerely,

Nathaniel Lenington
Shaker Heights, OH

Topic: Public comment on draft of the revised healthcare control guidelines
Name: Susan Greene
Address: Napa, CA
Organizational Affiliation: Retired from Pacific Arthritis Center

I am an immunocompromised senior with a number of chronic illnesses. I literally have to choose between lifesaving medical care and exposure to covid. I have now lost access to all of my doctors because I will not risk my health in order to obtain unsafe "health" care. Health care facilities have become high risk places for me and many like me.

I urge the CDC to reject HICPAC's draft and start over, actively seeking input from health care workers, patients, and a much broader array of public health/science experts. HICPAC must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel and occupational safety and health experts.

I urge you to create concise control guidelines that recognize transmission characteristics of SARS-CoV-2. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times. Healthcare settings are where high risk, disabled and seniors mingle with infected patients, visitors and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies. Pre-symptomatic and pre-positive-test transmission are possible. All people should be presumed infectious because they might be, and should take all precautions against spreading the virus. Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work. SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state: The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles." Healthcare organizations should strengthen respiratory protection, PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols. Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks.

- **Is is time to consider HEALTH when making health care policies and directives!**

Comment on HICPAC Infection Control Changes
Rebecca Weisgerber, Bismarck ND

I am a concerned citizen, and member of the People's CDC.

My partner is currently preparing for complicated spinal surgery.

In addition to the usual worries about the risks of the surgery, we're having to pack our own reusable half-face silicone respirators, air purifiers for the hospital and hotel rooms, and N95 masks to hand out to those we come in contact with. We wouldn't have these extra burdens if the country's medical systems were carrying out their fundamental duties of infection control. Frankly, it's reminding me of third-world countries where the patient doesn't get nursing care unless a family member provides it. Why should we have to literally put on armor to enter the place that is supposed to provide healing?

We know how to prevent infection!

- SARS-CoV-2 is a level 3 biohazard, just like tuberculosis – and we have TB hospitals achieving a 0% staff infection rate. Use their tools!
- ASHRAE – the people who ARE indoor air-quality – have published minimum air quality standards, and methods of achieving them. Use this info!

- Peer-reviewed and proven aerosol scientists have been begging to participate in this recommendation process. Let them fill the empty spots in HICPAC!
- My colleague Nathanael Nerode has put together a document geared towards individual clinician's offices. He provided it as part of his verbal comments to this body. If you do your job and provide EFFECTIVE methods of infection control, frontline workers can get back to their jobs of providing healthcare.

Proper infection control is cost effective!

- Reusable silicone half-face respirators can be purchased for less than $30 per person, and last years. They're quite comfortable for long-term use; I've used them in 16-hour stints when my aunt was hospitalized this fall.
- Even if you're only concerned about the acute phase of the infection, our health-care systems are already strained from the increased demand from the pandemic so far. Short-term absences from the initial respiratory infection further stress the remaining staff, and are so easily avoidable.
- Every week new studies come out about viral persistence in different organ systems. We're disabling our population, adding to demand; and we're disabling our health care providers, reducing supply. We need to properly apply infection prevention if we want there to continue to be a health care system at all.

We can't afford to keep focusing on short-term concerns, when simple and cheap actions right now can make such an impact on the long term. Please revise your recommendations to include layers of protection – ventilation to minimum indoor air quality standards, required universal masking with quality masks, molecular testing and proper reporting of cases. The public WANTS public HEALTH.

I don't want to fear getting covid at the doctors office, because of lax protocols. We have tools and the knowledge to lower this risk. We need strong protections for health care personnel and patients. This includes, but is not limited to, masks (n-95/kn-95), better air filtration, and a strong plan in place for contact tracing if an outbreak occurs.

thank you,
a concerned citizen,
Christi Petrucelli
Kettle Falls, WA

Dear HICPAC,

Please tighten and enforce higher standards for stopping the spread of COVID infection, particularly in the healthcare setting. The use of masks should be as routine and required as gloves and handwashing, both for healthcare providers and for patients.

Please do not delay in setting clear policies to mitigate against the aerosol transmission of COVID.
Thank you.
Jackie Thai
SSF, CA

Hello,

My name is Sophie LaRoche of 818 Main St. Apt.1 in Ashby, Massachusetts, and of behalf of the People's CDC I come forth with concerns regarding the proposed changes in the draft guidelines for the CDC. I am concerned that the "Enhanced Barrier Precautions" lacks protection against airborne/aerosolized viruses such as SARS-Cov-2, where patients and nurses/doctors/caretakers can be asymptomatic.
"Enhanced Barrier Face Coverings" are not intended to be in health care settings, why are they mentioned in the guidelines?
In the "Guidance for Manufacturers on Enhanced Barrier Face Coverings (BFCs Which Build Upon the ASTM International (ASTM) Standard", the CDC informs:
"It's important to note that no BFCs, even enhanced BFCs, can replace NIOSH Approved® respirators within a workplace respiratory protection program." If these Enhanced Barrier Face Coverings cannot be replaced by NIOSH approved respirators, they should NOT be used in healthcare settings, and should be taken out of these guidelines and be replaced with NIOSH approved respirators. Healthcare staff need and deserve to be protected in the workplace and patients deserve to be protected when they need to receive healthcare to live. High quality NIOSH approved respirators save lives, and should replaced by the "Enhanced Barrier Face Coverings".

Thank you,
Sophie LaRoche

To whom it may concern,

I urge you to revise the current draft proposal and base revisions on Care and Facts > Wishful Thinking. The well-being of US citizens will determine the direction of our country and that of the world. Our healthcare facilities and personnel should employ all precautionary strategies at all times. These controls became universally employed precautions for good reason.

I know from the death of my father that C-diff, which he caught in a hospital during cancer treatment, interrupted the course of his cancer treatment and destroyed his quality of life. At least I could believe the hospitals were doing everything they could to prevent this.

I can't imagine that unnecessary infections, disabilities, deaths and misery are your goal: the changes you are discussing are irrational and represent a danger and detriment to all inside and outside the hospitals. This draft goes against what American medicine and values underscore: we as a country are resourceful, open-minded and grow more advanced medical care all the time.

- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, failing to set strong standards for crucial tools such as ventilation, testing of patients and staff, and isolation.
- Letting infections run rampant is not acceptable.

Thank you very much for your consideration.
Sincerely,
Nina Miller, PhD,
clinical psychologist, practice in Manhattan,
affiliated via email and Twitter with the people's CDC
NY, NY

I am so deeply saddened by the vote by HICPAC to weaken the health and safety of everyone needing healthcare and those that provide the health care during this ongoing Covid pandemic. I have a young niece, in her mid 20s, that has long covid from the beginning of the pandemic. She gets worse every time she contracts covid and now going to any healthcare appointment she is unprotected and likely to contract covid and get worse. Covid transmits with a high level of asymptomatic cases. Surgical masks don't protect anyone. I shouldn't have to worry about a life altering infection when I get routine care.

The guidelines must fully recognize aerosolize transmission and establish protocols for preventing transmission by air. Because of asymptomatic infection, all precautions must be universally practiced at all times.

Healthcare settings and personnel should employ all precautionary strategies at all times. Nosocomial Covid has a 10 % mortality rate than community-acquired covid. Allowing covid to run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation and isolation.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. Surgical masks are not adequate. Healthcare personnel should be tested regularly for Covid, and flu and RSV during those seasons, but covid is every season.

I'm very disappointed that HICPAC seems to be in the pockets of big business and pharmaceutical and not using science or working for the people.

Georgia Rosenblum
Asheville, NC

Name: Chikara Saito
Address: Seattle, WA
Organizational Affiliation: A concerned U.S. citizen
Topic: Comment on the recent HICPAC draft of revised infection control guidelines

The miracle of modern medicine is predicated on effective infection control. HICPAC's recent draft of revised infection control guidelines undermine these gains in healthcare settings and compromises care standards.

HICPAC's draft guidelines ignore the well-established evidence that nosocomial infections are one of the main vectors for COVID infections. The guidelines fail to adequately address transmission by air and the prevalence of asymptomatic COVID transmission. Nosocomial COVID has a 10% mortality rate. This is dire. The guideline's failure to recommend effective layered protections — strong ventilation standards, widespread testing, universal masking with N95 respirators among others —compromises care standards, reduces healthcare accessibility, and endangers healthcare workers.

The proposed guidelines and recommendations are indexed to a deeply flawed indicator. Given the lack of meaningful transmission data from testing to tracking and reporting, a pathogen's community transmission — especially for COVID — becomes a largely unusable benchmark. Indexing recommendations to a largely untracked indicator that requires significant conjecture and that includes a pathogen with a 10% mortality rate actively harms patient and worker health and safety.

The lenient guidance on source control in the guidelines prioritizes profits over patients and workers. The guidelines focus on the last protective layer (namely, personal protective equipment) and precious little on directing employers to implement effective environmental and social layers from paid sick leave to minimum indoor air quality standards. These guidelines place much of the infection control responsibility on individual workers who have less resources and power than their employers.

HICPAC failed to include material stakeholders and subject matter experts in drafting these guidelines. In the publicly released documents, the discussions did not include necessary stakeholders from industrial hygienists to respiratory protection expert, aerosol scientists and engineers to disability justice and patient advocates. Broader stakeholder participation can correct the dangerous lacunae of the draft guidelines.

I strongly urge the CDC to reject HICPAC's fundamentally flawed draft proposal that undermines modern medicine and start again to promote patient and worker health and safety.

Hello,
My name is Lisa McCorkell, and I am a co-founder of the Patient-Led Research Collaborative, located at 23564 Calabasas Rd STE 201, Calabasas, CA 91302. Patient-Led Research Collaborative is a group of people with Long COVID and other conditions onset by infections that conduct research on these conditions. As such, preventing transmission of viruses is of utmost importance to us, as we know that viruses can lead to long-term consequences, including organ damage, dysautonomia, ME/CFS, strokes, and more.
I write in opposition to the draft infection control guidelines. The draft guidelines do not adequately protect healthcare workers or the public from infection, which not only puts them at risk for acute infection, which for many people, particularly already high-risk populations, can be deadly or result in lowering of health baselines, but also puts them at risk for long-term sequelae. For example, according to the CDC, about 20% of people who get COVID develop Long COVID.
The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields.
To improve the guidelines, I urge the following:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Precautions must be universally practiced at all times, and across all employers, to protect the most vulnerable, because much transmission is asymptomatic, and because we do not have accurate tracking of pathogens.
- Guidelines must require universal masking of N95 respirators or better in order to make healthcare settings safer for all, and more accessible to people especially at risk.
- Guidelines must require all healthcare personnel to be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

- Guidelines must require personnel who are infectious to be provided with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Guidelines must require that facilities implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiejVxaHIifQ.tpALn8uU310MUWXjDQvKCRlQ-YINvU8mo7fj6XJ_Fuo) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- Guidelines must require hospitals and healthcare systems to provide free vaccination and boosters for staff, patients, and visitors.
- Guidelines must require hospitals and healthcare systems to require staff be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

I urge CDC to reject HICPAC's draft, and as National Nurses United is urging, to "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings.
Sincerely,
Lisa McCorkell

To the Healthcare Infection Control Practices Advisory Committee:

COVID-19 infections injure, harm, and can lead to the death of Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which offer some protection against droplets but do NOT provide

respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and absolutely needs to incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on such a severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are, bafflingly, no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

-Laura Cornwall

Please take measures to protect patients who can't avoid healthcare settings.

COVID-19 infections injure, harm, and cause mortality among Americans. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings.

Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

K Sweeney

Bend, Oregon

Madeleine Saito
Seattle WA
No organizational affiliation

To whom it may concern:

I live with a loved one who is high-risk for death if they were to contract Covid. Every day, I live in fear of having to spend time in medical settings where my family members will be exposed to COVID, and likely die. For one simple reason: because of dangerously inadequate Covid precautions in medical spaces.

It is an unspeakable tragedy that healthcare settings are not safe for the people who need them.

Please: Do your duty to do no harm, and keep people safe and alive.

Please don't lie to people. We know transmission is often asymptomatic, so precautions should be upheld at all times.

Universal masking with respirators is the bare minimum for healthcare settings. Lest they become "death"care settings for even more people.

This draft puts massive burden for protection on individual workers, who are already overburdened and at enormous risk.

Please have courage and do the right thing. I know many of you got in this field to do good and help people. Please, do the right thing.

Respectfully,
Madeleine Saito

Name: David Graper
Address: Albany NY
Org Affiliation: No affiliation, private citizen

Dear CDC:
I'm writing to tell you *not* to move forward with proposed changes in HICPAC.

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air." Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk, so universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

Please put implementation of recommendations on hold and restart the process, bringing in the ppinions of actual on-the-ground experts like the Nurses Union.

Thank you.

On the subject of HICPAC Infection Control Changes, from Julia Boscov-Ellen (10 Timothys Green Ct, Pikesville MD, 21208):

It's clear that Covid-19 isn't going anywhere anytime soon. But "learning to live with Covid" shouldn't mean accepting unmitigated spread and the easily preventable deaths and disabilities that come with it. As an immunocompromised person, I have a right to access necessary healthcare in medical settings without risking death or further long-term illness from a preventable disease. Vulnerable people shouldn't have to weigh whether the risks of a medical emergency are greater or less than the risk of covid exposure at a hospital. It's unacceptable that hundreds of thousands—if not millions—of people are already put in this position. You have the ability to adopt measures that would ultimately save so many lives.

It starts with acknowledging that transmission is airborne and establishing rigorous protocols for prevention and layers of protection. These protocols must be universal; the majority of cases are transmitted either asymptomatically or before symptoms present, so adopting protective measures only in cases where someone is symptomatic would not help nearly enough people. Both financially and emotionally, the cost of additional protections such as improved air filtration/ventilation, regular testing, isolation, and masking (with n95s at least, surgical masks are *not* adequate) are nothing compared to the toll of so many lives lost or permanently altered by Long Covid. Saving both lives *and* money should be an easy decision, and yet left to their own devices an alarming number of hospitals and healthcare settings have chosen to cause lasting harm by abandoning protections. Basing protections on "community transmission" is deeply flawed when most tools we have for monitoring transmission (as well as mitigating it) have already been stripped away.

We were told the emergency was over as we had the tools to handle the pandemic. What tools are left? Testing is less accurate and harder to access, and less frequently reported; people are no longer granted sufficient sick days and come back to work contagious (or can't take off to begin with); vaccines have limited efficacy against infection or Long Covid and fewer and fewer people are adequately boosted; the majority of places have abandoned masking. Meanwhile the disease itself has not become significantly more mild, but has become *much* more infectious than in 2020. Additionally, personal efforts to avoid infection (such as masking) are nowhere near as effective when left to the individual. This is especially true in healthcare settings where people may *have* to unmask, but is always true because one-way masking is significantly less effective when the infectious person is unmasked. "You do you" doesn't work when you can take all the preventative measures available to you as an individual and still get sick. It is fundamentally eugenicist to leave vulnerable people on their own like this, and is additionally a disservice to the healthcare workers who are more and more likely to experience lasting health problems the more infections they get.

The current process for HICPAC guidelines is deeply inadequate and does not include enough input from either experts or those most directly affected. At present HICPAC isn't adequately equipped to develop appropriate guidance, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members. The nurses union has urged the CDC to reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB). The current approach seems designed to shut out the voices of healthcare workers, experts, and the general public, and greater communication and transparency is needed. Whatever is decided, final guidelines should include an attachment that

lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Thanks for your time.

Dear HICPAC members,

It is beyond time that we strengthen airborne infection control measures in healthcare settings. Universal masking -- with respirators that will protect staff and patients from airborne pathogens -- is the only way forward, and I fully support the nurses union in their demands that the CDC reject HICPAC's draft and "actively engage the input of frontline healthcare workers, patients, and public health experts in developing a new draft" including holding public meetings. Current recommendations have been made without aerosol scientists, indoor air quality engineers, and PPE experts, and that needs to change. Please prioritize patient and staff safety and consider strengthening -- not loosening -- infection control guidelines at a time when COVID is still spreading, killing, and disabling people en masse.

Stefanie Schulyk
Columbus, OH

Name: Lisa Boscov-Ellen
Address: Pikesville, MD
Organizational Affiliation: N/A
Topic: HICPAC Infection Control Changes

COVID-19 infections injure, disable, and kill Americans every day. Millions of people in this country already have Long COVID. People must be able to access healthcare without risking infection and the severe consequences that can entail. Protections including respirators (such as n95s) and air filtration have proven effective in reducing transmission. Universal masking with high-quality respirators in healthcare settings is essential to make it safe and accessible for all, especially those at higher risk. Surgical masks are not adequate. Healthcare personnel should be tested regularly for COVID-19 and workers must be able to remain home until they have recovered and are consistently testing negative. In order to control infectious aerosols, healthcare facilities must implement minimum indoor air quality standards set by ASHRAE. Healthcare systems and hospitals should require staff to remain up-to-date on vaccinations and should provide them for free. As an immunocompromised person, I have been forced to delay and avoid important medical appointments. Vulnerable people and healthcare workers deserve better. Every life matters and we must not accept preventable transmission and harm.

From: Amy Boscov
Baltimore, MD
affiliation: NA
topic: HICPAC infection control changes

It's clear that Covid-19 isn't going anywhere anytime soon. But "learning to live with Covid" shouldn't mean accepting unmitigated spread and the easily preventable deaths and disabilities that come with it. As an immunocompromised person, I have a right to access necessary healthcare in medical settings without risking death or further longterm illness from a preventable disease. Vulnerable people shouldn't have to weigh whether the risks of a medical emergency are greater or less than the risk of covid exposure at a hospital. It's unacceptable

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It starts with acknowledging that transmission is airborne and establishing rigorous protocols for prevention and layers of protection. These protocols must be universal; the majority of cases are transmitted either asymptomatically or before symptoms present, so adopting protective measures only in cases where someone is symptomatic would not help nearly enough people. Both financially and emotionally, the cost of additional protections such as improved air filtration/ventilation, testing, isolation, and masking are nothing compared to the toll of so many lives lost or permanently altered by Long Covid. Saving both lives and money should be an easy decision, and yet left to their own devices an alarming number of hospitals and healthcare settings have chosen to cause lasting harm by abandoning protections. Basing protections on "community transmission" is deeply flawed when most tools we have for monitoring transmission (as well as mitigating it) have already been stripped away.

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The current process for HICPAC guidelines is deeply inadequate and does not include enough input from either experts or those most directly affected. At present HICPAC isn't adequately equipped to develop appropriate guidance, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members. The nurses union has urged the CDC to reject HICPAC's draft and "actively engage the input of frontline health care

workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB). The current approach seems designed to shut out the voices of healthcare workers, experts, and the general public, and greater communication and transparency is needed. Whatever is decided, final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
COVID-19 infections injure, disable, and kill Americans every day. Millions of people in this country already have Long COVID. People must be able to access healthcare without risking infection and the severe consequences that can entail. Protections including respirators (such as n95s) and air filtration have proven effective in reducing transmission. Universal masking with high-quality respirators in healthcare settings is essential to make it safe and accessible for all, especially those at higher risk. Surgical masks are not adequate. Healthcare personnel should be tested regularly for COVID-19 and workers must be able to remain home until they have recovered and are consistently testing negative. In order to control infectious aerosols, healthcare facilities must implement minimum indoor air quality standards set by ASHRAE. Healthcare systems and hospitals should require staff to remain up-to-date on vaccinations and should provide them for free. As an immunocompromised person, I have been forced to delay and avoid important medical appointments. Vulnerable people and healthcare workers deserve better. Every life matters and we must not accept preventable transmission and harm.

Amy Boscov

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submitter's name: Lillian Komarow
address: Alexandria VA
topic being addressed: guidelines for prevention measures for airborne pathogens in healthcare settings

Hello, my name is Lillian Komarow, and I am writing in support of stringent and logical guidelines to protect patients from airborne pathogens (particularly Sars-Cov-2) in healthcare settings. The adoption of effective prevention measures would have important implications for the health of patients and healthcare workers. There is no room to compromise on safety, any more than laxity in providing any medical care is tolerated.
I also feel strongly that guidelines should be based on the precautionary principle, which emphasizes the need for policy makers to prioritize risk reduction. Unlike individual decision-making, policy decisions have wide-ranging impacts on society. People look to their doctors to guide their own decision-making, therefore I believe greater emphasis should be placed on minimizing risk for many people, who may themselves have various hidden vulnerabilities. I have personally watched a loved one lose sight of the importance of precautionary measures to avoid Sars-Cov-2 because their doctor dropped precautions. Even though this loved one is high risk for covid, after seeing that her doctor was no longer protecting her, she stopped protecting herself.
Additinally, development of infection control guidelines should include experts across disciplines studying airborne transmission, as well as those who are most at risk, including patients and healthcare workers and their representative organizations. These guidelines should fully adopt established science of airborne transmission and its prevention. This includes using effective masking including N95 respirators, elastomeric respirators, and PAPRs. There is no justification for adopting non-airborne precautions for airborne pathogens, and overemphasized non-airborne precautions will only serve to further confuse patients who have likely already recieved confusing public health messaging when trying to educate and protect themselves. Therefore, guidelines should include comprehensive measures including ventilation and HEPA air

purification, masking, testing, and minimizing unnecessary sharing of air of those who might be infected with those who are susceptible. Such guidelines will protect all patients, especially the most vulnerable. Those who are the most vulnerable are likely to already be spending much of their time in healthcare settings and should not be at further risk of disease because they do. Further, nobody of any level of vulnerability should have to worry that seeking out healthcare will make them more sick. I myself have delayed certain doctors visits when unable to find practices that will take precautions to protect me from Sars-Cov-2. I know many people who have delayed appointments or lost their trust in the healthcare system for similar reasons, and it is vital that this issue not be exacerbated, so that all people can confidently seek healthcare and leave healthier than they came in, not sicker.
If the CDC doesn't speak for those at risk and doesn't consider their opinions in the policy making process, I worry that it will lose credibility among many populations and have long-lasting impacts on the health of US residents. Therefore, I urge HICPAC to consider use of high-quality respirators and HEPA filters as essential parts of it's guidelines regarding airborne pathogens, in addition to listening to the opinions of airborne transmission experts across disciplines.
Thank you for your time,
Lillian Komarow

Dear HICPAC,

My name is Elizabeth Suffern. I live in Olympia, WA and I am not affiliated with any organization. I am writing to address the proposed Infection Control Guideline changes.

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMWs5dHoifQ.nTXaZ-ztD3lnUgpTE84M-cWCzAAwV8LB_o_M70io4Mk) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMWs5dHoifQ.nTXaZ-ztD3lnUgpTE84M-cWCzAAwV8LB_o_M70io4Mk) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.

- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMWs5dHoifQ.nTXaZ-ztD3lnUgpTE84M-cWCzAAwV8LB_o_M70io4Mk) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.
- **As the nurses union is urging,** (https://substack.com/redirect/88c55b43-78f5-4bd7-9b60-c67e4f6348b2?j=eyJ1IjoiMWs5dHoifQ.nTXaZ-ztD3lnUgpTE84M-cWCzAAwV8LB_o_M70io4Mk) **CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Sincerely,
Elizabeth Suffern

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed

these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Kerri N. Johnson, PhD

It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

Here is four demands:

- HICPAC must substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.
- Make the process for updating the guidelines fully open and transparent.
- Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.
- Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

Madelynn Amalfitano
Los Angeles, CA

I'm writing to advocate for safe and accessible healthcare for vulnerable immunocompromised patients.

The United States' current healthcare safety policies are leading to preventable death and disability in immunocompromised populations. Influenza, RSV are seasonal. COVID-19 is not. The Centers for Disease Control and Prevention's (CDC) provisional SARS-CoV-2 death data has maintained a level of COVID-19 deaths above 450 per week. A rate which is currently rising.(1) Although cases are currently not tracked by the CDC, healthcare systems utilizing Epic medical record software have seen weekly cases rise from 17,360 in mid-June of 2023 to 58,283 in mid-August.(2). While many of these acute infections are mild in the general population, they aren't for immunocompromised individuals. So additional steps need to be implemented to assure the safety of immunocompromised individuals in the healthcare setting.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them. All healthcare

personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative. And hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.

Likewise, facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiZGF1aTgifQ.jm81iCNmnvuaWsoKMmDK2IbZUIKJ3X9rn0BK-a3JFXk) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

As a severely immunocompromised patient, I've often avoided getting necessary tests and procedures done because of the lack of masking and infection control in healthcare settings. I've had to advocate for myself -- often without success -- with hospitals and doctors for basic protections, such as use of N95s. This often makes scheduling even basic but necessary check ups difficult.

This is unacceptable. People have the right to be safe when seeking care in all medical settings. You can and must step up to protect patients, especially the most vulnerable.

Sincerely,
Madelynn Amalfitano
Save Lives - Wear a Mask!

Dear Centers for Disease Control and Prevention,

I am writing in regard to the recent proposal of loosening the HIPAC standards, against which I wish to express my profound concern. While I understand the immense strain our healthcare system currently faces, lessening infection prevention control could place both patients and healthcare workers at significantly increased risk of exposure to respiratory illnesses.

Illnesses such as COVID-19, RSV, and influenza pose alarming threats and demand dedicated prevention strategies. We live in times when even the slightest negligence could cause irrevocable losses.

Firstly, the implementation of universal masking must be reinforced. This inexpensive, yet effective method has the potential to significantly reduce the risk of transmission for many airborne diseases, including COVID-19. In this spirit, we need a shift in gear addressing the usage of masks: N95 masks should be preferred over surgical masks to ensure higher levels of protection for healthcare workers in specific, owing to their proven efficacy in filtering airborne particles.

Also, regular testing for underlying respiratory illnesses should be integral to the standards, both among patients and healthcare professionals. Such proactive identifying and isolating of cases is a cornerstone in controlling the spread.

Lastly, the importance of maintaining optimal air quality in healthcare facilities cannot be understated. Ensuring adequate ventilation and air cleaning strategies are incorporated into building design and maintenance significantly reduces airborne transmission.

I urge you to reconsider these looming changes and prioritize the safety and well-being of our patients and dedicated healthcare providers. The proposed HIPAC changes need adequate revisions to incorporate these proven preventive tactics against deadly respiratory illnesses.

Yours sincerely,

Antonio Lassandro
People's CDC Member (https://peoplescdc.org/)
Nashville TN

Dear HICPAC Members and Staff,

I applaud the section of your draft guidelines that recommend N95 (or better) masks in some cases, e.g. for emerging pathogens. I have worked as a researcher for many year with clinical samples from patients and animals with idiopathic disease and unknown virological content. In these settings, my fellow researchers and I recognize that aerosol control is essential. We know this without any randomized trial that would expose randomly selected co-workers to novel viruses. I am sure that if you were working with an unidentified aerosolized virus, you would take precautions to ensure the safety of yourself, co-workers and ultimately your community. You would not cut corners, ignoring the solid aerosol science that our Personal Protective Equipment and laboratory equipment incorporates.

I am appalled that your recommendations, as applied to SARS-CoV2 aerosol controls, will fail to reduce SARS-CoV2 infection in healthcare settings. Available COVID vaccines to not effectively stop transmission of SARS-CoV2, are not utilized by large segments of the US population, and may not maintain their current efficacy given the rapid mutation of the virus and the proven fact that SARS-CoV2 persists and evolves in some patients for up to 18 months.

Similarly, the fact that there are pharmaceutical treatments available for acute-phase COVID, is not a reasonable basis to abandon sound infection control for this aerosol-transmitted virus. The CDC acknowledges that 19% of infected people have Long-COVID. Over the long haul, Long-COVID is likely to be a more significant burden on individuals and society as a whole than acute-phase COVID. There are no pharmaceutical treatments available for Long-COVID. It has been clear for years that each SARS-CoV2 infection carries a risk of Long-COVID. This risk is not mitigated by prior infection, vaccination or acute-phase treatment. Hence it is the duty of the healthcare community and HICPAC to reduce SARS-CoV2 transmission.

You obviously know that airborne transmission of pathogens is reduced with proper use of N95 masks. This is clear in your "extended air precautions" guidance. Therefore your guidance as it applies to SARS-CoV2, is clearly insufficient, and dare I say: negligent. If your draft guidance is approved without a strong recommendation for universal N95 use in healthcare settings it will result in a long-term burden to the healthcare system and the health and wellness of Americans.

Thank you for your attention,
Kael Fischer, PhD.
Department of Pathology, University of Utah - School of Medicine (retired)
Salt Lake City, UT

Hello,

I am a chronically ill & disabled US citizen imploring you to do your jobs and protect all Americans against COVID-19 and other infectious air-borne diseases by adopting The People's CDC's recommendations. The early pandemic taught us that masking, ventilation/air filtration, testing, vaccination, and adapting to new scientific evidence of disease characteristics and spread are effective measures we can take to avoid mass disablement and death. You already have the blood of tens of thousands of Americans on your hands, please don't let any more bodies pile up under your watch.

Rose Beverly
Seattle, WA

To Whom It May Concern,

I am a young American in her 20s who is suffering greatly from Long COVID, and I am heartbroken to see careless COVID policies being proposed, and in health care of all places. The place I'm supposed to go to seek help and feel safe. On a personal note, I am reluctant to pursue medical care for certain things due to the lack of policy around actual safety precautions for COVID. **We must implement long-term sustainable COVID safety protocols for current patients, and for future generations to come**. Long COVID will continue to destroy lives, and in turn, ruin the economy. **It took me almost 2 years to be able to work a job again...and that is after acquiring thousands in medical debt for newly researched experimental treatments. COVID** totally changed the course of my life and we must prevent it from wreaking havoc on more people. We have the data backing on **how** to be safe, so please, protect us, our healthcare workers, and yourselves.

The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen. Still, for COVID in particular, those levels are largely unknown because **there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.** Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. **N95 respirators or better should be the standard of care**, and healthcare employers must not prohibit workers or patients from using them.

Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative. All staff needs to be regularly tested during peak seasons. Please do not ignore that COVID can be asymptomatic! Many transmissions come from asymptomatic cases, and are exactly why we need to focus on significant HEPA air filtration, universal masking, and consistent testing.

HICPAC cannot develop appropriate guidance now, as it has no members experts in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection.

Please, do the right thing and do not take what HICPAC has proposed as adequate care for millions of people. **We need you to do the right thing now more than ever. Our future counts on it.**

Sincerely,
Katie Drackert
Austin, TX

Comment submitted on behalf of People's CDC

I stand behind the People's CDC recommendations:

Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

Recommendations:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols,

including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit

testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Members of HICPAC,
As someone who is still taking COVID seriously and significantly limiting my life in order to protect both myself and my community, I am outraged and appalled by your actions. We are still in an airborne pandemic. We must take the knowledge that we have learned from these past few years as well as what we already knew before the pandemic and continue to apply it to all healthcare settings. Over 500k lives lost, and you are wanting us to go backwards.
When any of us go to the hospital, we are at our most vulnerable. I have been putting off medical care since the mask mandates were dropped. Now thinking about the changes you are about to make has me even more concerned for my health and access to healthcare, as well as that of my loved ones and community. I don't want to be scared of getting sicker by going to the hospital – Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID. Mask mandates must be reinstated, and surgical masks are not enough.
The guidelines must fully recognize aerosol transmission and establish rigorous protocols for preventing "transmission by air." The science shoes that a layered approach is most effective. So much of transmission is asymptomatic, so all precautions must be universally practiced at all times. All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative. Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
Every measure that was used at earlier stages in the pandemic should still be used. We are not out of the woods. Long COVID is a major threat that the CDC needs to take seriously.
HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely. This is highly unethical.
So, too, is the process by which you are making these decisions. It is appalling and deeply concerning that you have no members who are experts in occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. How can you make an informed decision without them?

Please make any draft guidelines available for the public for extended review before submission to the CDC. Final guidelines should include an attachment with all of the public's comments, why each was or was not adopted, and with references to scientific evidence.
Please listen to the nurses union and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
The public's health is in your hands.

Thank you for your time and consideration,
Mercedes Klein
Olympia, WA
Concerned citizen, no affiliations

To Whom It May Concern,

My name is Shanahan Europa and I am submitting a written comment in response to the recent CDC HICPAC meeting, and the failure to ensure the highest level of protections against COVID-19.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for

health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Sincerely,
Shanahan Europa

...after testing positive for covid in her nursing home in mid-October. At the time she tested positive, masks were optional in the facility for staff as well as visitors. This, alongside the facility's decision to delay making the new booster available until later in November, put her life at risk, and she, and we, lost. For this reason and many others, I am writing to express my opposition to the new guidelines for standard of care vis-a-vis airborne diseases in medical and healthcare settings.

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMmYzYnkifQ.5V_8N0FSYAPO_d0sC8skhzwV3aMhDP_za6k2W-EdZEo) that have been set by The American Society of Heating, Refrigerating, and

Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Please don't make these changes! More people like my mother, who has not been dead even a week, will suffer, become disabled, and die as a result of the proposed changes.

Sincerely,
Catherine Kemp
Private citizen
Yonkers, New York

Dear CDC,

I am a concerned citizen of California (USA) who wishes to make a comment on the HICPAC Infection Control Changes. I feel similarly to the nurses union that the CDC should reject HICPAC's draft and hold public meetings in order to develop guidelines which will be most effective.

I am very concerned about healthcare settings, where high risk, disabled, and senior citizens will have to interact with infected patients, other visitors, and staff. I feel it is imperative that health and safety protocols such as universal masking are insisted upon. It is also essential that healthcare employers allow their employees and other staff to wear N95 respirators if they wish to be fully safe. Surgical masks are not adequate to protect against airborne pathogens. It is also extremely important for healthcare personnel to be tested for Covid-19, RSV, and Flu regularly during peak season to avoid transmitting such infections to patients. Hospitals and healthcare offices should also provide free vaccinations and boosters for patients and staff. There should also be a standard set for healthy ventilation standards that are in alignment with the data released regarding aerosol-transmitted infectious diseases. As the carer for a senior citizen who has congenital heart failure I have experienced a wide variety of health and safety protocols in different California healthcare centers and doctors offices. I am frankly appalled that there is no standard set of ventilation precautions, mask-wearing, and disinfection across all healthcare settings in our country.

Please prioritize the safety and wellbeing of patients and healthcare workers over smiles.

Sincerely yours,
Melody
Petaluma, CA

Hello!

My name is Flannery and I am writing to express concerns about infection control policies and urge you to keep protections in place particularly in healthcare settings. Hospitals and doctor's

offices are places where vulnerable, elderly, and/or immunocompromised people interact with those who are working there constantly exposed to illness and those who are sick. Going to the ER and seeing doctors and nurses without masks on around patients they were rapid testing, and then removing my mask near these same patients is not acceptable. The CDC needs to do what they can to reduce the spread of covid and one of the most important places is within the medical system.

As citizens, we also need transparency in the HICPAC's decision making process. A variety of scientists, researchers and medical professionals should be included in the process.

Best,
Flannery French

Dear CDC's HICPAC,

My mother who is in heart failure was just diagnosed with myocarditis from a recent COVID infection. I want her to get all of the treatment she needs, but I am terrified for her to go to the hospital because another COVID infection or complication could easily be fatal. My brother and sister-in-law who act as her caretakers both work in hospital settings and have endured multiple COVID infections, including the one that was spread to my mother. I try to map my own visits to healthcare settings to correlate with times when wastewater seems to be low in my area and then wear an N99 respirator that I have to decline multiple routine exams in order to keep on and lower my risk of contracting a deadly and disabling virus.

The reason that this is all so frustrating is because this level of viral spread, of risk calculation, of disability, and death is completely avoidable. The CDC's HICPAC must use all of the research and technology that we already have — isolation protocol, mandate of fit-tested universal N95 or better respirators, far UV technology, HEPA ventilation, pre-hospital covid screening, and rapid molecular testing — to protect all of us from nosocomial infection.

It is my deepest demand that the below can be instated, and soon, so that my mother can seek treatment :

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare

facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
    - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.

    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.

Thank you for your time,
Nia

Dear HICPAC,

I am writing as both a professional that helps design clinical trials suited for patients in industry and as a person living with type 1 diabetes. I ask that you strengthen infection protocol rather than the proposal to allow standards to be decided by hospitals, which unfortunately do not have the patient's interest in mind.

It is already very difficult to have to constantly ask for doctors to wear a mask because I live with a 97-year old elder and personally am at risk for COVID, which has been proven to be aerosol in transmission, frequently spread pre and asymptomatically.

The following research shows not only short-range but likely long-range aerosol transmission, which would make a case for hospitals and medical facilities to properly mask and filter throughout their facilities not just based on the request of the immunocompromised patient.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10372516/

The following research shows the impact of pre and asymptomatic transmission, meaning, staff that aren't testing have no way to reassure a patient that they are not positive with COVID and infectious.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10118396/

My request is that you are clear and transparent in your policies for infectious disease protocols and allow public comment as the public is who ultimately has to face the consequences of your decisions at scale.

You also need to recognize the transmission of COVID, via aerosols, this is not conjecture but a fact that must for any rigorous organization be taken seriously.

With Concern,
Justus W. Harris
Medidata - Patient Insights Board Member

I am writing in support of National Nurses United's condemnation of the inadequate public review period and weak, unsafe recommendations for infection control guidelines drafted by HICPAC.

I am also writing in support of universal masking in all healthcare settings, with broad use of N95, or better, respirators, and better ventilation and air filtration methods, to reduce the risk of aerosol transmission.

The secrecy surrounding this closed committee is disturbing and profoundly undemocratic. Safety measures are planned to be sacrificed for the benefit of big money shareholders. Putting infection control risk, responsibility and liability on the backs of healthcare workers, instead of the institutions they work for, is beneath contempt.

The current draft guidelines would make it even more dangerous for people at medical risk, such as myself, to get the care we need. Many of us already postpone medical appoints due to lack of precautions; we face life threatening choices.

CDC should reject HICPAC's draft until a wider spectrum of experts including scientists, industrial hygienists, physicians, nurses and technicians have provided a much more detailed review over a much longer time period. The world is watching; many other nations look to CDC for guidance. Have we become a third world country?

Derek Blackwell, Seattle

Respirators should be required by hospital personnel where patients have viruses and where personnel work amongst each other.
I am a school teacher at ASMS in Alabama and wear a respirator every day. Kids are getting sick A LOT more often. Viruses are only going to be on the rise in the future because kid's respiratory systems have been getting killed in recent years.

Karen Palazzini
Alabama School of Math and Science

My name is Deborah Santor and I am a retired Physician Assistant. I worked at Johns Hopkins for over 20 years. I took pride in how hospitals and staff went to great lengths to do everything possible to DO NO HARM to patients. This is no longer the case. It has become apparent that hospitals no longer care whether or not they spread covid to their patients. They have dropped universal masking, they no longer test asymptomatic patients admitted to the hospital for covid, and the CDC no long requires them to report Covid Hospital Acquired Infections.

As a patient, I have no idea of what my Covid Risk is if I am admitted to a hospital because there is no reporting on C 19 HAI's and with the dropping of universal masking in hospitals, I have no protection against acquiring Covid in a hospital setting. I live in fear of being admitted to a hospital. The irony is that the hospital is now the one place I am unable to protect myself against Covid.

Hospitals are in the business to provide safe care to medically ill patients. Patients who are at their mercy, and can no longer protect themselves because they are ill and vulnerable. What hospitals and HICPAC are doing is morally unethical and medically negligent.

HICPAC's revisions of the recommendations and narrative need to be made public. The slides with the accepted changes to the draft recommendations are public but the changes to the narrative have not been made public.

Covid 19 is an aerosol disease. Up to 60% of Covid infections are asymptomatic. There is no reliable way to ascertain the prevalence of Covid in the community since case count and wastewater data is now incomplete. The recommendation to base mask usage on community prevalence data is a joke. This community prevalence data is in a shambles. The idea that a healthcare worker can ascertain their own risk when up to 60% of covid infections are asymptomatic is also a joke.

The only solution in a situation like this is to bring back universal masking in medical facilities. The committee needs include people who know how to deal with aerosol transmission of infectious diseases. It is clear that this committee does not know how to do this given the recommendations they have promulgated and they need to have experts in aerosol transmission, masking, ventilation, and HVAC engineering on this committee.

Given that the guidelines address transmission of infectious agents. their responsibility does include ventilation which is integral to the spread of infectious agent. It is not plausible that ventilation is outside their scope as they tried to claim.

Thank You,

Deborah Santor

Name: Christie Ritten
Glenview, IL
Topic: Comment on HICPAC Guidelines

Hello,

I write to urge HICPAC to make more stringent recommendations to prevent aerosol transmissible diseases in healthcare settings. We need to protect our healthcare workers and

patients as much as possible. I support the People's CDC statement here: https://peoplescdc.org/2023/11/01/peoples-cdc-public-comment-on-hicpac/

Recently I was hospitalized and put on a blood thinner. I was told to try not to get covid, because the blood thinner and Paxlovid do not mix. I had to ask several healthcare workers to wear a mask, because masking was not protocol. I should not have to request that healthcare workers defend my health; it should be standard procedure.

Moreover, protections should correctly correspond to the health threat; e.g. well-fitted N95 masks and air filtration for infectious aerosols. While a surgical mask is better than nothing, it is not the appropriate protection against covid transmission.

Please follow the science, and do your duty to protect public health.

Thank you for reading.

Regards,
Christie Ritten

HICPAC:

I'm fortunate enough to have somewhat recovered from long covid. It's "mild" in that I've returned to many of my day-to-day activities, but I still suffer from crashes that can take me out for days/weeks at a time. And despite being able to do far more than during the first phase of long covid, I don't feel great most of the time. As you can imagine, avoiding a backslide is my top priority. I take a number of precautions to avoid getting covid again, but ironically healthcare environments are some of the highest risk places for me due to poor infection control.

During my healthcare journey, I've faced numerous barriers just trying to keep myself safe. Offices have resisted my requests that the staff masks for my appointments, unmasked providers have told me covid is "no big deal" while describing their own long covid symptoms, and waiting rooms are full of sick patients.

I'm writing to ask HICPAC to update its infection control measures to account for airborne aerosol transmission. Healthcare unions, patient representatives, and ventilation & occupational safety experts must be heavily involved in the all guidelines. Input must be sought from these groups and the public during the drafting process. It's crucial that the process be fully transparent and open to the public.

When creating these guidelines, it's critical to recognize that vulnerable people are part of the general population. I don't wear a bell. People don't get an alert when I'm walking down a hallway that I'm at high risk of infection. Therefore, precautions must be taken at all times. This is especially important with covid, since asymptomatic spread is a large part of transmission.

Since covid is transmitted via aerosols, facilities must implement the ASHRAE minimum air quality standards. Universal masking must be required, and fitted N95s that fit a variety of face shapes must be provided. Providers shouldn't be wearing surgical masks, which do not offer superior protection against aerosol transmission. In addition, since outdoor transmission is possible, any guidelines about crowded spaces must include outdoor healthcare spaces.

Nobody should have to weigh up the risk of infection against necessary medical care. But unless HICPAC makes the above changes, that's exactly what will happen.

Thanks

Lynn Chealander
New York

Date: November 6, 2023

To: HICPAC

From: Ann Bristow, Ph.D., retired Health Psychologist, Frostburg State University, Frostburg, MD

Re: recommendations for airborne pathogen precautions

HICPAC's recommendations are not sufficiently informed by the available science on airborne transmission of viruses, of particular relevance to COVID-19. Notably, this advisory board does not have one aerosol scientist, though the public and healthcare professionals have requested this addition.

The public trust in the CDC is enormously eroded by failures to place public health science and care for people, especially those receiving services from medical facilities, above corporate interests. This is reflected in board membership (e.g., hospital corporation representatives vs. aerosol scientists) and the incredible deaf hear that HICPAC has turned to public input and prior public testimony.

These failures of HICPAC mean that the most vulnerable among us have suffered and died and will continue to do so. This is such a stark example of caring more about the corporate bottom line than the well being of the people for whom it is your mission to serve.

You still have a chance to make a course correction. This would take listening to the overwhelming and informed input from researchers, healthcare providers and patients — particularly those who are immunocompromised and deciding NOT to seek healthcare services because they feel unsafe. If you fail to act on the best available science and to protect the most vulnerable among us, then your actions can best be viewed as cruel and sociopathic.

Good morning,

We are on week 3 of a respiratory illness we contracted as a family from taking my daughter to her 12-month pediatrics exam. We, her parents, masked but my daughter is too young to safely do so. That means we have to trust everyone around us to not have something that can spread to her through the air.

Please tell me how we can take her to her exams without risking COVID if the staff and other patients don't mask. I genuinely want know. People don't think about everyone when they change rules around. In New York we cannot get the smallest children vaccinated anywhere but at a pediatrics office. That means we have to risk getting her infected to get her vaccinated?

Please let me know.

Sincerely,
Lauren Ashcraft

To whom it may concern…and it should seriously concern all of you as it does all of the people whose lives will be endangered if this proposed revision is allowed to go through as currently written, It is mind blowing that you would even consider weakening protective standards when you have seen the horrific results of such carelessness during the pandemic. Both my husband and I had all the vaccinations and boosters, but , as stated, the vax do not prevent Covid…they can keep one out of the hospital and reduce the severity. We contracted Covid from unmasked carriers due to a relaxing of the mask advisement and now have to deal with long Covid. To throw aside all caution and common sense and all warning from those actually involved in healthcare is to cast the entire population back to early 2020 before much was Known about the spread of Covid. The only reason you would even propose such a ludicrous change must be profit over people. Please do the right thing ,the ethical, the humane thing and reject this draft and start over with input from a much broader array of public health and science experts.
Sincerely, Julia Kneeland, senior citizen
Decatur, GA

Hello HICPAC and CDC,

Over 900 occupational safety, aerosols science, public health, and medical experts have written to new CDC Director Mandy K. Cohen, MD, MPH, informing her that CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and their decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts. HICPAC is a CDC committee that oversees policies and protocols on the prevention of infectious diseases in healthcare settings.

People's CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**

- Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
- Open work group meetings to the public with virtual options and with ample time set aside for public comments.
- Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
  - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
  - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
  - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
  - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
  - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
  - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
  - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
  - Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.

- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Dear Members of the HICPAC Committee,

My name is Heather Sue Rosen. I am a medical sociologist and disabled person working with the World Health Network. My research has focused extensively on how people perceive health risks and their behavior to mitigate said risks. I write as a fellow expert to express my concerns over the committee's repeated disregard for adequate infection prevention and control practices regarding COVID-19 and other diseases transmitted via infectious aerosols.

As an expert who has frequently been ignored by expert medical providers when it comes to my own safety in healthcare, and given this happened long before COVID-19, I once again urge HICPAC to acknowledge the need to consult experts in other sciences, particularly aerosol science and social science, regarding the draft guidelines for standard precautions for preventing the transmission of airborne disease in healthcare settings.

I will begin with an anecdote that hopefully gives a clear picture of the situation this committee has cemented into reality for most Americans by voting to pass the drafted infection prevention

and control guidance, guidance which has been repeatedly criticized by scientists qualified to make judgements about air quality (engineers, aerosol scientists, physicists) and behavior (sociologists, historians).

Prior to COVID-19, I navigated rural healthcare. I want to explain some of those challenges, as they are now challenges faced by patients at even the most renowned hospitals in the United States. When I lived in Athens-Clarke county, our hospitals served 17 counties in Northeast Georgia. 17. This was in 2018, two years prior to the emergence of COVID-19. At least one of the two hospitals was on diversion pretty much all of the time. Often, both were on diversion. The closest alternative options were in Atlanta and Augusta, 1.5 hours either direction on a good day. The EDs were always over capacity. Cots in the hallways, the works. We used to joke about avoiding the ED because the wait time was so long that you better hope you didn't have an actual emergency…because the risk of them not treating in time was real, and that wasn't even with the risk of needing to be transferred to Atlanta or Augusta for more specialized care. This is the situation for most Americans since COVID-19 arrived, and especially since the dropping of mask mandates in healthcare settings.

Americans are avoiding healthcare because it is no longer safe. They are avoiding healthcare because, related to this lack of safety, there is a massive workforce shortage. The quality of care has gone down. Nurses and physicians are overworked; many are also underpaid. Wait times are impractical and only getting longer as more people inevitably seek care—I say inevitably because, when people become chronically ill, they can only do so much to avoid healthcare. The unmitigated spread of COVID-19 has led to an influx of chronically ill people, including those with recognized Long COVID, but also those with long term health complications not recognized as being related to COVID-19 infection such as clotting disorders and cardiac events.

Now, I offer an explanation on behavior that is grounded in my research expertise and not based on assumptions about authority. It is important to understand that people are generally risk-aversive; when people know there is a risk, they try to avoid it, particularly if they are aware of how to avoid it. It is baffling to me that medical doctors believe the public will panic when informed of risk. There is no evidence that this is the case, so why do the members of this committee assume panic over willingness to protect oneself? My hunch is that it has to do with a lot of underlying bias—bias about patients, and an inflated ego brought by socialization into a culture which idolizes western medical knowledge. Unfortunately, as much as many doctors would like to think that "the only real doctors are ones who have caught a baby" (i.e. people with an MD), or put another way, that the medical knowledge learned in medical school is superior to all other medical knowledge including lived experience, this is simply untrue. In fact, it is increasingly apparent that medical training favors the social standing of MD's in society over all else—why else would the MD's on this committee be so opposed to working with other experts? Social standing of this committee has nothing to do with the science of COVID-19, and based on the public's reaction to the committee's laisse-faire attitude towards COVID-19 precautions, I would argue that a committee concerned with their social status should take note that they have received a lot of criticism suggesting that people do not hold them in high regard over these decisions.

The members of the HICPAC committee spent two days last week nitpicking over language choices like "may" versus "will/can expect" instead of discussing the very real threat of contracting COVID-19 in healthcare settings should these guidelines become *the* guidelines. This is not behavior many, including myself, consider worthy of respect. Upholding the oath to protect patients is worthy of respect.

I will end with two final questions for the committee. First, **why are the members of the HICPAC committee so opposed to acknowledging the ongoing need to mitigate infectious aerosols in all circumstances and all healthcare settings while COVID-19 remains a threat**? Second, **why are the members of the HICPAC committee using the possibility of non-compliance by healthcare workers as an excuse to endorse guidelines endangering patients rather than addressing the non-compliance of healthcare workers as a violation of patients' right to safety**?

If the members of the HICPAC committee are unable to cope with the reality of COVID-19, that is understandable, but it is not an excuse for the committee to recommend the CDC bury its head in the sand and pretend patients are safe when they are, in actuality, at risk of death, new disability, and exacerbation of existing disability. Additionally, it is unscientific for HICPAC members to assume that the public's perception of COVID-19 mitigation aligns with their own desire to erase it from their memories—in fact, the science suggests that many if not most of the public does not agree with this desire. If you are unwilling to listen to the science, listen to the public comments from the last meeting, from this meeting, and all over social media. The public wants safety. Give them safety, or please, give up your spot on this committee to someone in aerosol or social science who can and will do what is needed to protect the public.

Warm Regards,
Heather Sue Rosen

Name: Aviera Mitchell
Philadelphia, PA
Organization Affiliation: Socialist Alternative
Topic: Healthcare Guidance
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission

for healthcare-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1Ijoia21leCJ9.xazLiEfiZKXlK_Fmnasqj90CUj7WFHKYUuP_OCx0D1U) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1Ijoia21leCJ9.xazLiEfiZKXlK_Fmnasqj90CUj7WFHKYUuP_OCx0D1U) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.

- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

If you'd like to comment on specific layers of protection:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1Ijoia21leCJ9.xazLiEfiZKXlK_Fmnasqj90CUj7WFHKYUuP_OCx0D1U) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

If you'd like to comment on HICPAC process for updating guidelines:

- **As the nurses union is urging, (https://substack.com/redirect/88c55b43-78f5-4bd7-9b60-c67e4f6348b2?j=eyJ1Ijoia21leCJ9.xazLiEfiZKXlK_Fmnasqj90CUj7WFHKYUuP_OCx0D1U) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a**

new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Hi,

I am a person living with Osteogenesis Imperfecta which has actually been determined to be a collagen disease affecting every bodily system. As such, I and others with Osteogenesis Imperfecta, are at high risk from infectious diseases such as COVID and RSV.

I just had to take my ex-husband to the ER because he became so ill. The waiting room was filled with incredibly sick people and almost no staff were masked and less than half of the patients. He was diagnosed with RSV and although I was wearing an N95, I am now getting sick. One way masking isn't enough and it feels as though you're throwing people with underlying conditions to the wolves.

The CDC needs to delay a vote until they have given the public ample opportunity to review the draft proposal. It's also critical that you hold hearings open to the public. Finally, please follow the science on infectious diseases and update the list of diseases currently classified as having aerosol transmission.

The CDC is failing the very public you serve at every turn. People are needlessly dying and becoming disabled because of things like promoting hand washing over masking for diseases with aerosol transmission.

Please do your job and protect everyone in this country by allowing public comment on the draft, holding public hearings and following the science on infectious disease transmission.

Thank you so so much for reading and for your time.

Sincerely,
Tracy Mulroy (unaffiliated)
Bethesda, MD

LaRae Paguio
Mpls, mn

Dealing with cancer in a setting where no one is masked is really really hard. If nothing else can be done, please have healthcare professionals wear masks. What is the use of months of chemotherapy just to be infected by healthcare workers. Thank you

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Good morning,

My name is Maryann Patterson and I have been a Registered Nurse for 32 years. For 30 of those years I have worked in Emergency Medicine which is the front door of the healthcare system. Therefore I have some concerns about any changes that lessen protection for health care workers and patients. When people seek care via an Emergency Department staff do not have the luxury of knowing a patient's recent status regarding COVID or other respiratory illness. Not to mention that many patients seeking care for non respiratory illnesses test positive for COVID, influenza or RSV. Personally I have worn a mask continuously since the onset of the COVID pandemic even though hospitals no longer require masks. My husband who is a paramedic and Emergency Department Technician have been vaccinated and received all boosters for COVID even though the boosters were neither required or provided by our employers. In addition to protecting ourselves by continuing to mask there is a concern for those patients who are immunosuppressed, disabled or otherwise at a higher risk of complications from respiratory infections. Therefore I believe that masking requirements should remain in healthcare settings and ongoing COVID vaccines and boosters should be required and provided by healthcare organizations.

Thank you
Maryann Patterson RN
Washington, PA

Ben Begleiter
Baltimore, Maryland

A. Regarding the Draft 2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings [1]:
a. For types of pathogen transmission, please add "exhalations" to line 326.
b. Replace "mask" with "respirator", which are much more effective [2, 3], throughout.
c. Lines 414-418: patients should wear respirators whenever they are not in their rooms.
d. Page 14: All patients who test positive for an airborne pathogen should wear respirators, if possible, within their rooms, especially if they share the room.
e. Visitors must be included in the guidelines; they should constantly wear respirators and be frequently tested for airborne pathogens.
f. Facility engineering is directly in the purview of these guidelines, contrary to the attempt by HICPAC to ignore them. HICPAC should at least specify the desired standard, for example, no more than "x" viable pathogens per cubic foot of air. There are studies that specify infective dose for a variety of pathogens [4, 5]; expert opinion should be sought on the best ones to use.

B. Regarding some of the HICPAC member discussions during the November meeting:
a. Healthcare workers should always have the option to substitute an employer-supplied well-fitted respirator wherever the guidelines call for a mask.
b. To follow the safety principle of using "layers" of protection [6], all precautions (testing, paid sick leave, respirators, eye protection, ventilation, filtration, and air cleaning) should be used regardless of the vaccination status of the individuals. None of the precautions are 100% effective on their own.

C. This past summer, a friend had to take their partner to a top teaching hospital for an arterial dissection with pseudoaneurysm. The partner caught COVID-19 in the hospital, where many staff were unmasked– including ICU staff. My friend subsequently caught COVID-19 while caring for their partner. After the partner was discharged, they both had to go home to work on the partner's recovery from the arterial event, as well as from both having COVID-19. This

arterial event left their partner at high risk of stroke, and they are rightly concerned that COVID-19 will make them even more vulnerable to stroke [7]. Meanwhile, my friend is disabled with Long Covid, and has yet to recover to their previous baseline after this reinfection.

D. I am concerned that on the morning of Nov. 3rd, there was an announcement that the staff revising the draft guidelines didn't consider the comments by the public. Many of them are experts in the fields directly relevant to the isolation guidelines that were being discussed and modified. Your patient liaison's comments were also ignored. FACA requires CDC and HICPAC to seriously and transparently engage and consider expert input [8].

E. Written comments should not have page limits. We cannot have a fair scientific discussion of the merits and problems with specific infection control policies if CDC and HICPAC don't share their full discussions along with the scientific bases for what they say and write, and if the external experts and public are not allowed to share their full expertise along with the scientific bases for what they comment.

References:
1. https://www.cdc.gov/hicpac/pdf/DRAFT-2024-Guideline-to-Prevent-Transmission-of-Pathogens-2023-10-23-508.pdf.
2. https://doi.org/10.1021/acs.chas.1c00016.
3. Respiratory Protection. OSHA. https://www.osha.gov/respiratory-protection/general. Accessed Oct 31, 2023.
4. DOI: 10.1007/s12560-011-9056-7.
5. DOI: 10.1016/j.gsf.2021.101285.
6. DOI: 10.1136/bmj.320.7237.768.
7. DOI: 10.1038/s41586-021-03553-9.
8. https://www.gsa.gov/system/files/FACAFinalRule_R2E-cNZ_0Z5RDZ-i34K-pR.pdf.

James Nehmer
Essexville, MI

First I would like to thank you for the opportunity to make a public comment on this important matter, I am a Husband and caregiver to a Strong disabled woman. I have seen this woman need to make a decision on her health (she should never need to), what is worse the symptoms from her illness or the possible exposure to any number of illness by going to the ER. When we have needed to go to the ER during the pandemic a number of times and we needed to leave because the so called Mask requirement we not being followed or the mask requirements were not being enforced. We have seen people waiting in the ER put their mask under your chin because you needed to talk on the phone to a friend to let them know they may have exposed them to Covid but you wouldn't know until the test results were back in a few days. Every time her health is gets worse this is what we need to think about and we should not need to worry about catching something at a place where we should be getting healthcare. This is not how health care should be in the Richest country in the world. We should demand our heath care providers do better, they are providing health care to our most vulnerable and they need to ensure they are doing everything they can to make it safe when people are in their care. I would demand a Fair and process and science-based protections for healthcare workers and patients.

I would express the NEED to delay the vote until CDC/HICPAC has given the Public opportunity to review the draft Isolation Precautions guidance updates. I urge the CDC/HICPAC to hold Public hearings ahead of any vote to hear from Health care professionals, patients and experts

outside of the Infection Control. The CDC/HICPAC need to recognize the Science of aerosol transmission of infection diseases and update the list of Infection Diseases currently classified as transmitted by airborne or droplet route to those that can be transmitted via aerosol transmission/inhalation.

I would like to urge you to acknowledge the need for precautions against these airborne Infection Diseases such as wearing quality N95 or better face coverings, and air ventilation to protect both health care workers and the most vulnerable among us who are trying to receive health care. I would like you to acknowledge the Flaws in the Mask study you are relying upon to make the decisions and I urge you to conduct a proper study using University and public health experts.

The CDC/HICPAC has failed to acknowledge let alone require core control measures for infection aerosols at all health care facilities. We need to hold our health care system accountable for the health of everyone they encounter. Health care facilities need to worry about the health of their workers and patient instead of their profits. I would stress the Need to require health care facilities to have air ventilation and filtration to control the exposure to infectious aerosols. I would urge you to Set Standard for the use of airborne infection isolation rooms, (AIIRs) or other approaches to isolation when use of AIIRs is not possible.
James Nehmer

Dear HICPAC
On behalf of myself, family, friends, and co-workers I submit that this committee should:
Recognize fully the threat of aerosol transmission of Covid -19 and other pathogens.
Recommend the use of N-95 masks in health care settings as an effective way to protect patients and workers.
Recognize that the major benefit of reducing the spread of Covid -19 and other pathogens through mask use, far outweighs the minor inconvenience of wearing an N-95 mask.
Recognize and prioritize increased ventilation in creating a health environment for patients and health care workers.
Andrew Milanese
Stonington, Connecticut

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must

include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Tessa Baldwin
Shelton, Wa.

Guidelines Proposed will Disable & Kill People have the right to be safe while seeking care in all medical settings. Instead people are being infected at their doctor's office, dentist and I'm even while in the hospital. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of, if not a majority of, Americans. Proper PPE needs to be the standard of care in all medical settings as well as safe air ventilation of Merve 13 & 6 air exchanges per hour. HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. This is a travesty. I was fired as a patient by my cardiologist for insisting that the tech preforming his four hour long treadmill test mask. I have no pericardial sac around my heart to protect me from viral attacks. I needed the test because Covid got me in March & my heart hasn't been ok since. I reported this to DOJ (dismissed) and the state medical board (dismissed). We can't protect ourselves. It's not even possible anymore. You can & must step up and protect patients in the care of medical professionals.

To HICPAC and whomever needs to be addressed:

As a live in caregiver to my 83 year old mother who is at high risk for COVID, I write this comment to seek protection for anyone who enters a medical setting that they are protected at the highest safeguards from not only catching COVID, but any airborne virus in a medical setting.

These are the issues that must be addressed:

1) Universal masking is necessary to make healthcare settings safer for all and more accessible to people at risk

2) HICPAC's named "Enhanced Barrier Precautions" would radically weeken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida autism or MRSA interact with other vulnerable patients without restriction and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely

3) Surgical masks are not adequate to protect against airborne pathogens including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

4) All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season

5) Personnel who are infectious must be supported with paid leave or where appropriate, remote work and allowed to stay homer until symptoms improve and testing is negative

6) Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings

7) Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases

8) Hospitals and healthcare systems should provide free vaccinatiok and boosters for staff, patients and visitors

9) Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Thank you for listening, acting and making these urgent changes.

Remember this effects everyone which is YOU and your loved ones!

Sincerely,

Jennifer R McZier
Live in Family Caregiver
Washington, DC

Hello,
Please record my comment below for the Public Comment Nov 6 on HICPAC Infection Control Changes

Name: Ashton Nichols
Address: Albuquerque, NM
Organization Affiliation: Disability Advocate and Concerned Citizen
Topic: COVID SAFETY POLICY: Nov 6 on HICPAC Infection Control Changes

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
- Healthcare settings are where high-risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement, or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://www.ktnv.com/news/coronavirus/after-3-years-mask-mandate-lifted-at-sunrise-health-hospitals-in-las-vegas) rather than infection control.
- Healthcare providers complain about the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance.pdf) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
- Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.
- HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.

- Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce the use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are severe airborne infections.
- Vaccines reduce BUT DO NOT STOP the transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccinations and boosters for staff, patients, and visitors. Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.
- As the nurses union is urging, (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the conferences held in 1992 to help develop guidelines on the control of multidrug-resistant TB).
- HICPAC cannot develop appropriate guidance now, as it has no members experts in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3 but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each was or was not adopted, with references to scientific evidence.

Thank you and have a great day.

- Ashton Nichols

We know the White House has it.

Why is this not implemented in every public indoor bdlg such as hospitals & all healthcare facilities, schools, offices, nursing homes & senior communities, banks, supermarkets, planes, subways, trains, ubers/ taxis, theaters etc.?

Why is the Center for Disease Control & Health & Human Services taking away masks in health care and not acknowledging covid is airborne?

Why are you committing crimes against humanity of the general population of the people of the United States to be victimized by the depopulation agenda??? Why are you allowing covid to rip

through communities which if it doesn't kill is a mass disabling event causing Long Covid to millions of formerly healthy people.

I am emailing today to beg you to do your job.

Healthcare settings are, by definition, filled with vulnerable populations, from the elderly to the immunocompromised, not to mention healthcare workers. If you make these places less safe, more people will die. It is that simple. They will die by coming in for care and getting infected, OR they will die from staying home out of a very reasonable fear of infection. This blood is on your hands if you loosen infection control requirements.

Covid doesn't care that it's been 4 years. Covid doesn't care that hospitals want to make more money. Ignoring reality will not keep people safe. Ignoring the people you're endangering will not make your institution less guilty.

Please, please, PLEASE be transparent in your design of safety protocols. Please work directly with health care worker unions and experts on ventilation and other mitigation tactics. Please do not give up on us.

I'm begging you.
Jam

I'm writing because I saw this post by the Peoples CDC on Instagram

I have long COVID. Please don't leave other disabled people behind.

11/6/23
To Whom it May Concern,

Private Individual – No Affiliation
Topic: HICPAC's Draft of Enhanced Barrier Precautions for Health Care Settings

My name is Mary Gutierrez and I'm writing to you to express my grave concern re: the CDC's HICPAC draft of Enhanced Barrier Precautions for health care settings. From the beginning of the pandemic, the CDC has minimized and misinformed the public about the full risks of COVID and the full extent of mitigations needed to return to normal. The results of your actions have been devastating for the public and their health. CDC's prioritization of the interests of corporations/economy over the interests of public health has led to increased mortality, decreased life expectancy, increased sickness, and disability. Ironically, this will eventually negatively impact the economic/corporate interests you've been prioritizing. Your actions have been short sighted and will have negative long-term consequences. This is your opportunity to make REAL change.

First and foremost - you must have guidelines that fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing transmission by AIR. Protocols must account for the science showing that layers of infection control are needed to reduce transmission. Universal masking is necessary to make healthcare settings safer for ALL and more accessible to people especially at high risk. You must warn the public that most transmission is asymptomatic (60%) which requires all precautions for COVID to be universally practiced always. Healthcare settings need to be accessible for all patients in all areas of these

settings. Precautions for COVID should be employed by all personnel and visitors. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will (are) disable countless workers in healthcare as well as other professions (particularly schools & children). Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all health care setting (and indoor public setting). Millions of Americans already suffer from Long COVID, and it's only been 3+ years. Who will be able to do these highly specialized jobs in the future?

My husband is severely immunocompromised, and we have been forced to isolate, shelter in place and retire early to keep him healthy/safe. He does not have safe access to healthcare or any public indoor space. My family and I are NOT collateral damage and should not be sentenced to "fall to the wayside" and die because you refuse prioritize public health. Please do the right thing!

Sincerely,
Mary Gutierrez
Farmingdale, NJ

Respirators should be required by hospital personnel where patients have viruses and where personnel work amongst each other.
I'm a school teacher and wear a respirator every day - kids are getting sick A LOT more often. Viruses are only going to be on the rise in the future because kid's respiratory systems have been getting killed in recent years.

To Whom it May Concern,

I am writing to urge the CDC to adopt stringent infection control policies and procedures that address the most vulnerable individuals in our society. We go to the hospital and other healthcare facilities to feel better, not worse.

Sincerely,
Valerie L. Shebroe, Ph.D.
Psychologist
Haslett, MI

Dear HICPAC,

My name is Mark Dixon, and I am a resident of Pittsburgh, PA. I do not have an organizational affiliation related to healthcare and COVID. I am writing as a concerned citizen of the United States.

Nosocomial COVID-19 has a 10 percent mortality rate. Therefore we must change our approach to this virus, particularly in healthcare settings where our most vulnerable community members visit.

Please, please increase the required COVID protections in all healthcare settings. At a minimum, you must recognize aerosol transmission of SARS-CoV-2 and establish rigorous,

multi-layered protocols for preventing transmission by air. Furthermore, because significant COVID transmission is asymptomatic, all precautions must be universally practiced at all times.

My wife and I have been extremely COVID cautious since the beginning of the pandemic, in-part because she has a rare blood clotting condition that we understand to increase the risk of unwanted health outcomes should she be infected with COVID-19. We are both deeply concerned about the risks of long COVID as well. We have changed our dentist once for improved COVID safety but even the new dentist office does not require all staff to mask. Now I can't find one that requires masking throughout their office to protect patients who can't wear masks during their visit (nobody can wear a mask during dental procedures).

I am also personally well-read on air quality issues and believe that we are on the cusp of regarding clean air like we do clean water. We do not drink puddle water or drink out of the general public's cups. This is how germs are spread, and decades ago we collectively implemented massive standardized infrastructure to provide healthy, safe potable water across the country. Similarly, and especially now with COVID-19 pervasive around the world, we must treat public air as a public health hazard and filter/ventilate/monitor it accordingly. You have an opportunity to move this country over to the right side of history by addressing indoor air quality where it counts most, in medical settings. This will reduce the societal impact of COVID on our most vulnerable populations while preparing ourselves to better handle inevitable and potentially much more immediately deadly pandemics in the future.

Thank you for your consideration.
Mark Dixon

I think that this church's statement says it best and if a church can take this caring, sacrificial stance all the more healthcare should be following the science and protecting it's workers, the vulnerable and the community.

Covid Precautions
We are glad you are here to join us for worship. Your safety and the safety of the Christ Church community is paramount.

Masks Are Required: We have a large supply of N95 masks for you to have if you need or want one.

Air Movement and Filtration: We have upgraded our HVAC system to provide significantly increased air circulation. Additionally we have added HEPA-level filtration as well as UV scrubbers that sanitize the air in the sanctuary.

Testing for Preacher: The only person who will remove their mask during the service will be the preacher. The sermon is the portion of the service where there is no written and visual corollary. So, it is important for people to be able to hear the preacher clearly and lip reading is essential for many. It is our policy that because of this, the preacher will take a rapid antigen test the morning of the service to ensure they are not infected with Covid for the safety of everyone.

Why are we still masking?
Because Covid is the third-leading cause of death in the United States, and it is preventable. Most of us will never meet the people who die when we spread Covid unknowingly in public, but that does not mean we should not care about them.

Because people in this community are immunocompromised. Masking is an accessibility issue for people whose immune systems are compromised or vulnerable: people with cancer, people with transplants, people with autoimmune diseases, pregnant people, the elderly, and babies who are not old enough to be vaccinated. We do not believe only the able-bodied should be able to attend worship safely.

Because we are a sacrificial tradition. Jesus died on the cross for the liberation and salvation of all, and asked us to lay down our lives for our friends. If an hour or two of mild discomfort allows all people to participate, and prevents the death of the most vulnerable in our society, then we cheerfully and wholeheartedly invite that discomfort.

Hi,
My name is Michelle Eastridge and I am an immunocompromised mom of 3 high risk children. If there is anything the pandemic has shown us, it is that the American healthcare system is very broken. At this point in the pandemic, patients should not still be fearing for their lives receiving the healthcare that they need. High risk patients unfortunately have diseases, symptoms, secondary issues that require in office visits.

Since the healthcare masking mandate ended, I learned that healthcare offices do not have well or sick rooms. So a covid patient can be in a room and 20 minutes later a high risk patient can enter and be asked to remove their mask. We all know this is an airborne virus, which is known to remain in the air for hours. Especially without improved ventilation. Why is this even up for debate and why have you allowed politics to interfere with people's right to safe healthcare?

This is unacceptable. We are going into year 4 of this virus and have made very little improvements to the system. The fact you are even debating weakening healthcare infection prevention is appalling and a disservice to all Americans. Especially the children. There have been so many studies showing the long term damage to organs due to Covid, and everyone is so eager to get back to normal they aren't thinking about what multiple infections will do to the kids. Preventing healthcare spread is extremely important and should be a top priority.

Thank you for your time,

Michelle Eastridge
Huntersville, NC

I am submitting a public comment regarding the CDC/HICPAC regulations:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.

- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare

facility and must be supported with paid leave, or if appropriate, remote work.

- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
  - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
  - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
  - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
  - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
  - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
  - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Reference guidance from CDC in January 2020
https://stacks.cdc.gov/view/cdc/84639/cdc_84639_DS1.pdf
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Laura Markstein

To whom it may concern,
I'm a constituent from Chicago writing to urge the following:
1) You must substantively involve healthcare unions, experts in ventilation and occupational safety, and the general public in drafting your guidelines.
2) You must make the process for updating these guidelines fully open and transparent.
3) It is vitally necessary that you fully recognize covid spread by aerosol transmission, and establish rigorous protocols for preventing transmission by air and asymptomatic spread. I'm sure you are aware that infections can have severe and lasting consequences, so prevention is the most vital tool we have!

4) Require precautionary strategies at all times in healthcare settings where high risk, disabled, and senior patients mingle with infected patients and staff.

Thank you for your consideration. I am reminded of the simple (but effective) public messaging infographics we saw in 2020, with layers of cheese where each open hole might be caught by another slice with different holes. There are a lot fewer "layers of cheese" these days, even though we know much more and have many more tools at our disposal. Please use your platform to be a useful tool instead of following trend of providing the least protections we can get away with.

Sincerely,
Elisabeth Del Toro
Chicago, IL

Hi, my name is Liana Fixell, I live at Yonkers, NY, and I am submitting this comment as an individual. Here are my thoughts on the CDC's infection control guidelines:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**

Thank you,
Liana Fixell

I am very concerned about the proposed guidelines concerning airborne transmission of disease. Respirator masks are proven to have the best protection. Clean air is another and all I see is the downplaying of facing the reality of airborne spread especially in medical settings. So far I have been lucky and have not been infected but it's because I use a respirator masks in all settings where there are other people whom I know nothing about their level of precautions. The fact that I cannot find safe healthcare and have been told to leave because I asked for an ADA accommodation of wearing an N95 while treating me, is willful negligence. A higher standard recommendation is needed to address these vulnerabilities for patients, staff and the general public.
The additional fact that HICPAC is in violation of its own charter and government guidelines for public access to information looks like a horrendous cover up. This too needs to be addressed just as acknowledging strongly airborne transmission of diseases.
https://whn.global/hhs-complaint-on-hicpac/
There are a number of issues we face to move forward in the face of the pandemic. Lessons have been learned and need to be acknowledged. The public as well as healthcare workers need strong messaging and guidance that is clear and straight forward.
Please DO NO HARM!
Sincerely,
Holley Madden

Augusta, GA

Good morning,

I am writing as a concerned citizen and recent NYU Journalism graduate with immunocompromised relatives with cancer, and relatives that work in healthcare. I am deeply alarmed by this week's CDC decision regarding new infection control guidelines. It will be nothing short of life changing for those who work in or frequent a healthcare facility, like my family members who are caregivers, medical workers, and patients themselves.

After all, healthcare settings are where high risk, disabled, and elders interact with infected patients and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times. Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk, but also to protect their workforce and avoid staff shortages.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers who should be protected by their workplace, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. For this reason, HICPAC should be substantively involving healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines, and then make the process for updating the guidelines fully open and transparent.

It is imperative to publicly recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. The CDC is giving approval for the use of surgical face masks to prevent the spread of airborne pathogens such as seasonal influenza and coronaviruses. Surgical masks are NOT designed to stop airborne infections.

With enhanced Barrier Precautions the CDC is allowing those with Candida auris to freely wander around a facility and at the same time the CDC is warning of dangerous outbreaks of Candida auris. The CDC is also not routinely recommending the use of negative pressure rooms for MERS, SARS-1 or, SARS-CoV-2. There is also lack of provisions for air quality standards, such as ASHRAE Standard 241 for the "Control of Infectious Aerosols," and a lack of provisions for screening of these pathogens.

Nosocomial COVID has a 10% mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID. Relaxing these guidelines that had remained unchanged for year will come at the cost of thousands of lives.

Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID. The US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved [see, for example, pages 20 and 22 of the PDF file https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance.pdf] – and does not weigh that cost against profits.

I beg you to reject the draft and reconsider the new guidelines before their high cost of economic loss, invaluable human life, and further collapse or strain on the healthcare system. You can still and MUST prevent and control disease.

Sincerely,
Daniela Bologna
Providence, RI

Speaker: Dhruv Raturi, Iowa State University

Comment:
Having a spouse that works at the bedside gives me so much pride. Their work is demanding and long, yet the "expert opinion" that CDC sought wants workers like my spouse to take on the personal responsibility of preventing infection by weakening other layers of protection such as testing, ventilation and isolation?

Having a spouse that works at the bedside should not mean accepting a high exposure to infection for me and my family. Having a spouse that becomes infected through their hospital should not mean that they failed in their personal responsibility, especially since their employer is not required to shoulder any responsibility. It makes me so disappointed to hear that "expert opinion" was used as a lazy substitute for the direct consultation of healthcare workers and their unions.

It is clear to me from the content of this draft - along with the lack of transparency of the process (who are these experts?), that the trust that people place in the CDC is misplaced. It is no surprise that more and more people like myself and my family are turning to the People's CDC to advocate for their health. Please listen to the national nurses union and start over so that this time you may keep the process transparent and inclusive.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please send this link to HICPAC members:

https://www.cbsnews.com/news/indoor-air-quality-healthy-buildings-60-minutes-transcript/

Thank you,
Ann Bristow, Ph.D.
Emerita Professor, Frostburg State University
Frostburg, MD

Dear Members of HCPAC Committee,

I am 69 years old and while fortunately in good health, have done my very best to stay well during the pandemic. However, there are some routine medical procedures I need to take care of yet - I have hesitated. I have four friends my age or older who contracted COVID-19 during hospital visits or stays. One of those now has Long Covid. This is unacceptable.

You have plenty of research at your fingertips to know the damage that this virus does to the body. Why are you loosening standards? Why is this suddenly something that you feel the need to "fix?" Is it the money? Infection control saves money and misery.

I have worked in healthcare before and know well the protocols that one takes to keep staff and patients well. Loosening these restrictions will not serve us well. How can we throw caution to the wind so hospitals can save money, but the consumer may pay with their money or life? This makes absolutely no sense what-so-ever. I occasionally read about research into how to prevent hospital acquired infections. We know that masking can prevent airborne disease. The steps that healthcare workers take to keep themselves and the patients they care for are generally routine: handwashing, counting the instruments, wiping down surfaces, etc. Why do we want to leave mask wearing to chance? Who loves to wear a mask? I don't but it is abundantly clear to me that when I wear my mask around my grandchildren I have fewer respiratory infections. If I do not wear it, I get sick. You all know this.

How is it that we care so little about people seeking healthcare? How is it that we care so little for our healthcare employees? Show some courage here and do the right thing.

Martha Shockey
Clarkston, GA

November 3, 2023

Dear members of CDC/HICPAC,

As a patient who frequently accesses the US healthcare system, I join other commenters from the November 2-3, 2023, meeting in requesting that universal N95 or elastomeric masking in healthcare become standard in the same way that disposable gloves did due to HIV/AIDS, and as handwashing did generations earlier.

I am immunocompromised and immunosuppressed due to lupus and medications for it. Therefore, I am at high risk of severe COVID-19, of long COVID, and of an autoimmune flare caused by any infection. I am also a cancer survivor at high risk of recurrence. Additionally, I am caregiver to elderly parents, one of whom is clinically extremely vulnerable and not eligible for Paxlovid due to drug interactions.

My family has often been refused N95 masking by our healthcare providers, despite our prior written request for reasonable accommodation per the ADA. We have even been yelled at repeatedly by healthcare workers in medical offices for our request that they mask. This happened even when I devoted a dozen hours prior to one appointment to requesting and obtaining approval for that accommodation. Repeatedly we have been told by healthcare workers, “The CDC says we don’t have to mask, and you can’t make us.” This has happened to us in specialties primarily or exclusively treating high-risk patients: gerontology, rheumatology, cardiology, mammography, and oncology.

As a result of this lack of mitigation against airborne pathogens and healthcare refusal of any kind of mask at all, even as a disability accommodation, doctor-patient relationships of decades are crumbling and I have been forced to cancel scheduled cancer imaging because I do not consent to unmasked care during an airborne pandemic. Even if the imaging were done and found cancer, no oncology center in my community is willing to protect patients from airborne pathogens.

Seven hospitals are within a 15-minute drive from my home; not one is willing to grant patients like me safe and accessible care. It feels like vulnerable patients are shipwrecked sailors, surrounded by water yet dying of thirst.

With very few exceptions, my providers have made it clear that they will not accommodate mask requests without clear, definitive direction from a higher authority like CDC/HICPAC. In the absence of such, providers in my area have defaulted to preference- rather than risk-assessment.

Self-advocacy is exhausting, time-consuming, traumatic, and increasingly futile, but what alternative do vulnerable patients have? Almost weekly we face risk calculations: which poses the greater risk, getting this unsafe care or risking the consequences of forgoing it?

COVID continues to surge in waves several times a year. Tuberculosis and measles are breaking out nationwide. Though 59% of COVID transmission is asymptomatic, medical providers and patients no longer screen to find these cases. In addition to the high proportion of asymptomatic spread, workers face internal and external pressure to work when they are symptomatically ill. Multiple sources have documented the 10-20% frequency of post-acute sequelae of COVID, removing millions (and counting) of newly disabled persons from the labor force.

This rate of disability and destruction of lives is not sustainable. Implementing clear, simple, universal N95 mask standards is a small step that would yield large benefits beyond the threat of COVID. A 2023 study found “immediate, substantial, and sustained increase in healthcare-associated respiratory viral infections” as indoor mask mandates relaxed from universal to intermittent. In contrast, the tuberculosis center for the state of Texas has had no healthcare-acquired TB cases since they instated elastomeric respirator requirements for staff decades ago.

Airborne pathogens pose a grave present and future threat. The tools are available to protect healthcare workers and patients. Please, HICPAC members, put the tools into practice for public health and welfare.

Thank you for your time,
Christina Moore
Plano, Texas

Greetings,

My name is Alex Fay, my address is Seattle, WA and I have no organizational affiliation. I am writing to ask that HICPAC's policies regarding infection control in healthcare settings recognize the aerosol transmission of COVID 19 and establish strong and rigorous protocols to prevent transmission to patients and healthcare staff. These protocols should be universally practiced, as many COVID 19 cases are transmitted asymptomatically, and should take a layered approach as to be most affective.

As a registered nurse who has worked in a facility with layered precautions, including universal masking, air filtration, and routine testing, I have been able to keep myself and my patients safe from COVID 19 and other respiratory illnesses while at work. This policy needs to keep both patients and healthcare workers safe by requiring healthcare facilities to employ precautions at

all times. Healthcare employers should not be given broad discretion to choose when or how to implement precautions, and instead should have strict and strong guidelines of how to prevent hospital-acquired infections of COVID and other respiratory illnesses. By upholding strong precautions, we will reduce the burden of COVID on both patients and healthcare workers, reduce comorbidities and health conditions caused by COVID 19, and ease the workforce strain as less workers will be exposed to potentially debilitating viruses.

We need strong infection control precautions that are applied universally, required for healthcare facilities to maintain, and that are based in science, not economic benefit.

Thank you,
Alex Fay, BSN, RN

I am submitting this comment in the hopes you will follow the science and NOT loosen infection control guidelines in healthcare facilities. If an infectious disease is airborne, as many are, why wouldn't the CDC recommend basic measures to reduce transmission?

I always ask my healthcare providers to mask, but sometimes they aren't willing. It's such a simple thing to do to require they mask, and it can save lives!

Please!
Anita Schuneman
Lafayette CO

Good day -

I support the position of the People's CDC and urge HICPAC to adopt guidelines that promote safety for the most vulnerable.

HICPAC must substantively involve
healthcare unions, experts in ventilation
and occupational safety and the public
in drafting guidelines.

Make the process for updating the
guidelines fully open and transparent.

Fully recognize aerosol transmission of
SARS-CoV-2 and establish rigorous
protocols for preventing "transmission
by air" and asymptomatic spread.

Healthcare settings are where high risk.
disabled, and seniors mingle with
infected patients and staff. So,
healthcare facilities should employ
precautionary strategies at all times.

Thank you.
Jennifer Barkan

Albany, NY

Lauren Reinbold
Lebanon PA
People's CDC

It is disheartening to say the least that masking in medical facilities and government facilities hasn't been continued, especially seeing as even the CDC acknowledges how dangerous covid still is to people with pre existing medical conditions (which realistically is a vast majority of the population). As an immune compromised person who has gotten Crohn's from long covid and almost watched my husband die from a post covid brain bleed it is frankly impossible to safely navigate the medical systems that we rely upon to stay alive and relatively healthy. Even if I can wear a respirator and eye protection to protect myself, I am still risking my and my husband's life getting seen for eye care, dental care, or anything involving the mouth and nose. I have also been harassed and targeted in medical facilities simply because I wear a mask, not normalizing masking in medical facilities and government offices has significantly increased the harassment and assaults on masking individuals so not only do we need to protect ourselves on a microbial level, we must also be prepared to physically defend ourselves. So many of us with chronic illnesses are putting off medical care because it doesn't seem severe enough to risk getting covid from medical facilities, and we are painfully aware of how many people are getting medical facility acquired covid watching many of our friends need urgent medical care and getting covid ontop of whatever they were facing. We also know an ounce of prevention is worth a pound of cure, so why are we making preventative medicine so difficult? This isn't logical, this isn't moral, this isn't right. We need to do a much better job of protecting people otherwise we are putting significant and avoidable strain on our health system and individuals. There is a breaking point to this all and do we really want to threshold test that while there is still a pandemic going on? The answer should be no. The answer should be to protect people and give people with medical issues the equality they deserve and make it possible for them to participate in life. So many of us are homebound when there is an option to protect us, but that option isn't being selected. Pray tell me why? Why don't we deserve safe health care? To be able to go to the post office/dmv/social security office? Realistically we deserve to go shopping for clothing and food but that feels like an exorbitant ask considering the basic basics aren't available to us. Yes life isn't fair, but this is just flat out cruel, illogical, and immoral.

Hello Committee,
Please see below for comment regarding HICPAC's latest decision which will ultimately weaken airborne infection control and cause harm to all, but especially vulnerable people.

First off, healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times. Especially infection control, in the realm of SARS-CoV-2, where asymptomatic spread cannot be overlooked. It is your responsibility.

In addition, Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans and counting suffer from Long COVID.

Furthermore, Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare

employers must not prohibit workers or patients from using them.

Most importantly, personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Lastly, HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

Thank you for your time.

Abigail Solomon
Austin, TX
Not affiliated with any organization

I worked in Health Care for over 30 years and am very concerned this committee is failing to look at the true science, not the junk science that looks for ways to reduce the costs of caring for patients and nursing home residents infected with any of a long list of very contagious airborne pathogens. Putting the financial health of hospitals and other healthcare institutions before the health of patients is very misguided and morally wrong. This says institutions matter more than a human life.

- **The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."**

Living with someone who is immunocompromised I have had to take extra precautions to not bring an infections into our home which very likely will become a lethal infection for her. Going into a hospital or healthcare setting has become a very stressful event. While we protect ourselves, real protection is eliminating the airborne pathogens, which means universal masking in healthcare. We have a right to receive healthcare in a safe environment. These are just some of what these guidelines need to address to create that safe environment and "do no harm".

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- **All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.**
- **Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.**

HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members. Only when this committee engages these experts in the development of these standards can we have an environment safe for even our most vulnerable patients.

Thank you for your attention to this serious matter.
Mike Conley

Fenton, MO
Private concerned citizen

Hello,

I hope this message finds you well. I am writing to strongly urge the Centers for Disease Control (CDC) to implement stronger protections in healthcare settings. I have a child with compromised immunity and we have had such a difficult time finding medical care for him that is safe.

The CDC has always followed the science and the spread of aerosol transmission of infectious diseases can be limited with required use of masks and air purifying systems. The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

Thank you for your time.

Sincerely,
Claire Reinhardt

To ensure the safety of individuals seeking medical care, we must make the most of available resources, including vaccines and mask-wearing. The well-being of healthcare settings is paramount, and public health measures like masks and vaccines should transcend divisions. Clear and consistent messaging is crucial for regaining public trust.
Just as clean water has brought about transformative changes, clean air can have a similarly positive impact. In the meantime, let's prioritize purification, mask-wearing, and UV treatments. Think about the lives saved through improved hand hygiene and reduced surgical infections due to mask usage. These measures have proven to be effective; let's not undermine their significance.
In the annals of history, plagues and diseases once unleashed relentless devastation, unopposed and unchecked. Now, armed with the knowledge and tools to defend against them, our nonchalance towards these life-saving measures seems nothing short of absurd and indefensible.

Amber
Michigan

Hello,

I am writing to add my voice to the wiser comments of many others calling for mandated Covid-19 safety measures in medical facilities. As a person with a lousy immune system thanks to some chronic issues, not only is it difficult to find practitioners who can treat me safely (e.g.

finding a PT who was willing to mask was a huge project) but I also experience active discouragement of mask wearing when I am at appointments for everything from dermatology to gynecology.

We should be much farther along in the science of covid transmission affecting actual practices. I'm so tired to see places advertising their cleaning schedule when we know that the air is much more dangerous than surfaces. In addition to my own concerns, I am also worried for the clients I see at work who are suffering the effects of long covid. I don't even work in the medical industry, but I see a lot of damage from the politicization of basic infection prevention.

Please be more cautious and stop ignoring disabled people,
Lisa Clark
East Providence RI

I am writing to express my concern over the lessening of infection controls in health care settings as written in the current draft of the *2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings*.

SARS-CoV2 (COVID19), like many viruses, is spread through the air, as acknowledged in the public recently here. It can spread through the air in distances farther than six feet (see here) and can linger in the air. Considering the SARS-CoV2 (COVID-19) pandemic is still occurring and individuals who are positive with the virus can exhale large amounts of it, it is imperative that stronger ventilation and air quality standards are in place in medical and health care settings.

Additionally, the use of PPE, such as N95 face masks, can prevent health care workers - as well as patients - from contracting the virus themselves and spreading it to their communities. Quality fit-tested respirators, like N95s, are an effective means of preventing the spread of viruses as expressed here by the American Medical Association.

It is imperative that these strong standards are put in place. Not only because many SARS-CoV2 (COVID-19) cases are asymptomatic and can still be spread, but also because by having strong standards in place from the start, you are ensuring that these proactive measures will contribute to safer, healthier environments for everyone in these medical settings - both medical staff and patients alike - and will hopefully ensure that if other unfamiliar viruses come about in the future, these strong measures will lead to less cases, less harm, and less casualties.

As past studies have found here, masking works to prevent the spread of the flu, But also as seen recently (link to the study here) with one strain of the flu potentially being eradicated due in part to our initial societal SARS-CoV2 (COVID-19) mitigation efforts, such as mask wearing.

With all of this in mind, please pause your initial intent of finalizing the draft and provide more time for the public and health care workers and patients to read the documents and provide their thoughts and recommendations.

Thank you for your time in this matter.

Brittany Bilodeau
Leominster, MA

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
I urge HICPAC and the CDC to establish an approach in the updated guidance explicitly about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.
- Emily Cavazos

Mary Vogel
Bedford, TX
A concerned citizen, no affiliation

Your recommendations for SARS-CoV2 aerosol controls are woefully inadequate. I would even go so far as to say negligent.

Surely you know that well-fitting N95 masks reduce airborne transmission of pathogens.

A strong recommendation for universal use of N95 masks in healthcare settings is required. Patients and hospital staff need to be protected.

I am writing to strongly advocate for the reinstatement of universal face-masking in health care settings, to protect patients, health care staff, and visitors alike.

COVID is airborne and asymptomatic in 40% of cases. Therefore, anyone (staff or patient) can potentially transmit the infection. Not wearing face masks in health care settings will inevitably lead to increased COVID transmission in patients and health care workers. Furthermore, COVID in staff will only worsen the health care workforce crisis.

An editorial in the prestigious Annals of Internal Medicine highlights that universal masking, along with other personal protective measures, significantly reduces the risk of health care personnel acquiring COVID-19 from occupational exposures. By employing these measures, health care facilities can safeguard their employees from contracting the virus in their workplace.

Also, health care personnel often come to work while ill, even with symptoms that could indicate a potential COVID-19 infection. With the unavailability of free home COVID tests, staff members experiencing mild cold-like symptoms or allergies may be less likely to be tested. I recall times before the pandemic when I and other health care staff continued to see work despite having respiratory illnesses.

An editorial by the executive medical director of Infection Prevention and Control at the University of Chicago reminds us that hospitals and clinics are places where the sick are in close contact with the vulnerable. Adopting a universal masking strategy is a harm reduction approach that protects everyone, much like hand washing, glove usage and room disinfection, which are well-accepted infection control practices.

Terminating infection control measures, particularly in health care facilities, puts individuals with physical and mental disabilities who require frequent medical care at even greater risk. The Americans with Disabilities Act safeguards the rights of disabled people, as well as those who live with or care for them. According to the CDC, age is the most significant risk factor for severe COVID-19 outcomes. The risk of death is 60 times higher in the 65-74 age group compared to the 18-29 age group, 140 times higher in the 75-84 age group, and a staggering 340 times higher in those aged 85 years and above. Medical units within hospitals typically care for these higher risk age groups.

It is very important to know that people of all ages can develop debilitating long COVID-19 symptoms, even after being vaccinated. Studies show that the risk of getting long COVID-19 is approximately 10% after the first infection, with a higher risk following subsequent infections. It has been clearly shown that this virus can affect multiple body systems, including the lungs, heart, liver, kidneys and intestines, and even cause abnormal functioning of brain cells.

Given that the primary focus of health care facilities is the health and safety of patients and employees, it is imperative to apply the precautionary principle and honor the Hippocratic oath, which compels physicians to “do no harm.” As such, health care facilities must reinstate universal masking as a safety measure to protect everyone, especially our more vulnerable older population.

Finally, universal precautions including masking will offer protection against future pandemics, the likelihood of which is increasing due to climate change.

David B. Alpern, M.D.

Board Certified, Internal Medicine
Emeritus staff, Cooley Dickinson Hospital, Northampton, MA
Florence, MA

My name is Heather Detwiler and I live at Sherman Oaks, CA. I am affiliated with actioncareequity.org.

It is extremely disappointing that HICPAC doesn't care about actually protecting people's lives. Implementing and maintaining aerosol protections in healthcare settings is extremely important in this ongoing airborne pandemic. SARS-2 (COVID-19), like many other infectious diseases, is aerosolized and moves much like smoke. The use of respirators, such as N95s, has been proven time and time again to be effective in protecting against aerosol transmission.

People should not be getting a biosafety level three pathogen from their doctor. It is not fair to patients to be getting treated at the hospital or doctor's office for one thing and leave with a deadly and disabling virus, but that's what is happening! It is unfair to the most vulnerable among us, such as the immunocompromised, the elderly, and babies. According to the CDC, the US infant mortality rate had the largest increase in two decades recently. Is wearing a respirator too much trouble to protect them? Doctors are supposed to "do no harm." Hospital systems are strained across the country and healthcare workers are dwindling. Mask mandates in healthcare settings would help alleviate all of that.

When it is said that we have the tools to fight COVID-19, that is incorrect. The vaccines wane faster than we can get boosters, and the cost of Paxlovid is going up over $1000, plus neither Paxlovid nor the vaccines do anything for preventing long Covid. Babies cannot get vaccinated, wear masks or take Paxlovid! The real tools aren't being used: respirators, ventilation and filtration.

It's crucial for the HICPAC committee to recognize and acknowledge the reality of aerosol transmission of SARS-2, and ensure that healthcare workers wear respirators, and wear them correctly, irrespective of vaccine status. 60% of SARS-2 infections are asymptomatic, which makes it impossible to know one is spreading a deadly disease.

Numerous studies have shown that respirators are far more effective than surgical masks in preventing the spread of aerosol-based diseases. Clean air tools like HEPA filters should also be an integral part of healthcare settings to enhance air quality and minimize the risk of infection. Education for healthcare workers on the science of aerosol transmission and the importance of wearing respirators correctly, covering both the mouth and nose, is essential.

Respirator requirements are necessary, because of asymptomatic infections, the decrease in testing, and the unwillingness of most people to do the right thing, unless they are made to. When I called 13 different orthodontist offices for my daughter, most of them said "we don't have to wear masks anymore." That was when Los Angeles, where we reside, was going through a surge in cases. I had to risk my vulnerable daughter getting a BSL-3 virus to have her braces adjusted!

Involving aerosol experts is essential to making informed choices regarding aerosol protections, and that's not just OSHA's job; it's yours too. It's not just about COVID-19; various viral, fungal, and bacterial illnesses are transmitted through aerosols, and TB cases are on the rise. When a person goes to the ER with symptoms, the cause is not known right away, and if they have something like TB or Covid, they are putting everyone at risk in that hospital by not being

masked and the healthcare workers not being masked. By the time they find out they have TB it's too late!

The safety of both patients and healthcare workers should be a top priority! Healthcare settings must implement respirators, air filtration, and other technologies to reduce the spread of aerosol pathogens. The well-being of individuals should not be compromised for corporate interests! Protect patient and healthcare workers and prioritize health and safety over financial considerations! Protect the babies!!

Dear HICPAC/CDC,

As a retired physician, I urge you to improve the infection control standards within health care facilities with regard to aerosolized pathogens.

This is an urgent matter with regard both to patient and occupational safety. Especially given the significant prevalence of asymptomatic viral shedding (either prior to symptom onset or for the duration) , the risk to debilitated patients that comes from lack of adequate ventilation mitigation strategies is shocking and short sited. After the last several years of the COVID pandemic, this should be self evident and its costs in human and fiscal terms are clear.

Please up the standards for masks and for improved ventilation at health care facilities.

Yours respectfully,
Liz Vandermark, MD
Cambridge, MA

FROM:
Carolyn Davis
C-IAYT + Journalist
NYC
11/6/2023

TO: CDC Healthcare Infection Control Practices Advisory Committee

I am writing as a concerned citizen, yoga therapist (C-IAYT), journalist and caregiver to express my deep reservations about the proposed updates to the Isolation Precautions guidance by the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC). The changes being considered, as presented in June 2023, have the potential to weaken existing CDC guidance, thereby increasing the risk to both healthcare workers and patients from various infections.

I strongly urge you to prioritize a fair and transparent process, underpinned by sound scientific principles, to safeguard the health and well-being of healthcare workers and patients. To this end, I would like to emphasize the following critical points:

Public Input: The CDC/HICPAC should delay any vote on these proposed updates until the public has had ample opportunity to review the draft Isolation Precaution guidance changes. Transparency and public engagement are essential in making informed decisions that affect the healthcare sector.
Public Meetings: Prior to any vote, the CDC/HICPAC should hold public meetings to gather

input from a diverse range of stakeholders, including healthcare workers, patients, and experts from outside the field of infection control. These perspectives are invaluable for crafting effective guidance.
Aerosol Transmission: It is crucial that the CDC/HICPAC fully recognizes the science of aerosol transmission of infectious diseases. The list of infectious diseases currently classified as transmitted via airborne or droplet routes should be updated to include those that can be transmitted through aerosol transmission/inhalation.
Flawed Evidence Review: The evidence review on the effectiveness of N95 respirators and surgical masks must be reevaluated with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The previous review appeared to prioritize certain data while omitting other applicable data and studies, undermining its credibility.
Flexible Approach: The proposed "flexible" approach that grants broad discretion to healthcare employers in creating infection control plans must be reconsidered. This approach can inadvertently prioritize cost considerations over the safety and protection of healthcare workers and patients.
Core Control Measures: The CDC/HICPAC should acknowledge the critical role of core control measures for infectious aerosols. Evidence regarding the effectiveness of respirators and the importance of ventilation and air filtration in controlling worker exposure to infectious aerosols should be included. Furthermore, source control, limiting outward emissions of infectious aerosols, should be integrated into the guidance.
In conclusion, I implore the CDC/HICPAC to prioritize the safety and well-being of healthcare workers and patients. These proposed changes have far-reaching implications, and a careful, evidence-based approach is essential. By ensuring a fair, science-driven process, we can maintain high standards of infection control in healthcare settings.

Thank you for your attention to this critical matter. I look forward to your commitment to protecting the health and safety of healthcare workers and patients. Remember: FIRST, DO NO HARM.

Sincerely,
Carolyn Davis

Proper PPE needs to be the standard of care in all medical settings. We also need safe air ventilation of Merv 13 & 6 air exchanges per hour. People have the right to be safe while seeking care in all medical settings. Instead people are being infected at their doctor’s office, dentist and even while in the hospital. Covid, Flu & RSV are airborne. The immunocompromised & those at high risk for disability or death if contracting Covid comprise a great number of, if not a majority of, Americans. HICPAC has ignored science, data and opted to allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. We can’t protect ourselves. It’s not even possible anymore. You can & must step up and protect patients in the care of medical professionals. For the immunocompromised the status quo is unacceptable, and weakening current regulations will result in a direct threat to their safety and wellbeing and does not maintain accessible features for safe and adequate access to a facility as required by the Americans with Disabilities Act.

Jennifer Kinzler
Aledo, TX
Protect Their Future

Hello,

I am writing in my capacity as an American citizen who is concerned about public health for all patients, healthcare professionals, and their families. I believe that the CDC needs a transparent, comprehensive airborne infection control policy.

I know that over 900 occupational safety, aerosols science, public health, and medical experts have already written to the CDC and to director Dr. Mandy Cohen urging the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) to correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation. **HICPAC's decision-making process must include patient advocates, infectious disease transmission scientists, aerosols scientists, union representatives, occupational safety and health experts, and healthcare personnel, from medical providers to cleaning crews.**

I request that HICPAC make the process for updating the guidelines fully open and transparent, as HICPAC is chartered under the Federal Advisory Committee Act; full recognize aerosol transmission of SARS-CoV-2; establish rigorous protocols for preventing "transmission by air" and asymptomatic spread; and advise healthcare facilities to employ precautionary strategies for high-risk, disabled, and elderly people at all times.

It is crucial that the CDC and HICPAC's understanding and assessment of key scientific evidence is up-to-date with the most current knowledge, and **I urge HICPAC to seek input from a multidisciplinary set of scientific researchers and key stakeholders, and to then make those written reviews publicly available.**

Thank you so much for your time.

Best,
Amelia Merrill

Name: Gregg Rice
Address: Bothell WA
Subject: Proposed HICPAC Infection Control Changes

I am writing as a private citizen to object to HICPAC's proposed changes to their Infection Control protocols. The notion that universal masking in healthcare facilities is *NOT* required is shortsighted, craven, and ultimately serves only the interests of the covid deniers, normalizers, and the get-back-to-work-save-the-economy business owners at the expense of employees and their health. I strongly endorse the attached comment on these proposed changes from the People's CDC:

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People’s CDC, submitted to the CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.

COVID-19 infections injure, harm, and cause mortality among Americans.
Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to

ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a
COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and
"touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens.
There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air"
transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting

outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Alexandra MacWade
Brooklyn, NY
Individual / member of the public

To Whom It May Concern:

I'm writing to strongly urge HICPAC to recommend universal masking in all healthcare settings to make medical care more accessible to all, particularly for people who are already at high risk.

Furthermore, the HICPAC guidelines must recognize aerosol transmission of covid and establish rigorous protocols for preventing its transmission. The guidelines need to recognize the work done by aerosol engineers and scientists that shows each infection control measure is most effective when other infection control measures are also implemented, in a layered approach to reducing transmission risk.

Because so much transmission is asymptomatic, these airborne precautions must be practiced at all times.

Thank you for taking the time to consider my comments.

Best,
Alexandra MacWade

Dear CDC/HICPAC,
I am a member of the public who is currently unable to get healthcare I need because I cannot afford to get COVID while in the hospital. If the CDC allows healthcare employers to have a “flexible” approach to implementing precautions and does not adequately recognize aerosol transmission of infectious diseases, patients and staff will be left even more vulnerable. If I have the abdominal surgery my doctor is recommending, I should not have to worry about getting COVID or *any* aerosol-transmitted infections (colds, flu, TB, etc.) that are easily prevented with two-way respirator use (n95 or greater) and good ventilation practices (as in ASHRAE Standard 241). Surgical masks are not sufficient for this use – please refer to experts in aerosol science, occupational health, and respiratory protection on this topic.
We know that anyone can become seriously ill, die, or develop Long-Covid damage with a COVID infection – it is rolling the dice each time. We also know that viruses other than COVID can also have negative long-term health effects (e.g. Epstein-Barr’s link with MS) – which is why healthcare institutions and workers must do the utmost to stop passing viruses around: wearing respirators, regular testing to catch pre-symptomatic and asymptomatic illness, and not allowing people to work sick.
To get needed healthcare, I should not have to risk further disabling family members who already have health issues or acquiring new health problems of my own. The science is actually clear that two-way masking with respirators – n95s or better – plus adequate ventilation and air-cleaning, would actually keep BOTH healthcare workers AND patients exponentially safer and healthier. In situations where the patient cannot mask, it is even more essential that healthcare workers be wearing effective respirators *continuously*, and that institutions be fully committed to preventing infection -- cleaning air just like we must clean hands, sanitize

surfaces, etc. There are plenty of cost-effective, well-fitting, and comfortable respirators for institutions and healthcare workers to select from. There are just no excuses for willfully spreading viruses at this point, particularly in healthcare settings.
Why would we ever want to *reduce* infection control in healthcare settings? Healthcare workers are vital and should be protected adequately at work. Surgical masks are insufficient to protect anyone from airborne illnesses like influenza, COVID-19, measles, TB, and other aerosolized pathogens. We must clean the air, use ALL the infection-preventing technology we have -- including source-control/respirators of n95 or better -- and make sure that people who need healthcare are not made worse in the process of getting that care.
Sincerely,
Karin Lightstone
Gainesville, FL

I would like to ask that all the words "Recommendations" be changed to "Requirements"

CMS states that Hospitals and Critical Access Hospitals must follow National Standards for Infection Control and Prevention. The CDC Standards are the "National Standards" and unless the wording gets changed, then our Administration does not feel that we have to follow these guidelines and just look at them as "recommendations" which is causes extreme hardship especially during a pandemic when the single infection preventionist in a critical access hospital is trying to enforce the guidelines and does not have any further backing because the STATE does not have any Infection prevention regulations other than to state "Follow the National Standards"

Please help us by changing your wording, it will help THOUSANDS of Infection Preventionist across the United States that are dealing with this same situation.

I speak for those who have voiced their frustration on the APIC Connect, Heart of America APIC google group, and ASHRM Exchange.

The second item that I would like to bring to your attention is that our staff failed to wear their surgical facemasks appropriately during the Covid-19 outbreak and we did not have one documented Covid-19 transmission from a staff member to a patient or vice versa.
I do not recommend that during a covid outbreak that N-95's are required for all staff at all times. Surgical facemasks are sufficient.
We have a LTC and 25 bed CAH plus a 4 bed OB and Nursery, surgical unit and 4 bed ICU. The surgical masks were sufficient to protect the staff from transmission during Covid. They did use N-95's when taking care of an acutely ill Covid patient while in that room, and then returned to a surgical mask upon exiting the Covid positive patient's room,

Thank you for taking the time to read my suggestions for the new isolation updates.

Sincerely,
Christine

November 3, 2023

Healthcare Infection Control Practices Advisory Committee (HICPAC)
Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases

Centers for Disease Control and Prevention
1600 Clifton Road NE Mailstop H16–3
Atlanta, Georgia 30329

Comments regarding HICPAC's draft updates to *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* Submitted to: hicpac@cdc.gov

Washington State Labor & Industries appreciates HICPAC's effort to update the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. We hope that the new HICPAC/CDC guidelines will include clear recommendations to protect workers and patients. Washington State Labor & Industries and Washington State Department of Health have some concerns with content of the guidelines as well as the current process HICPAC is using to develop this guideline based on what is publicly available. Our comments are based on the work group presentation at the June 2023 HICPAC meeting made available on YouTube, recent meeting minutes, and the first draft posted to the HICPAC page on November 2, 2023. We urge HICPAC and CDC to take time to engage with a broad range of experts before finalizing their draft for formal public comment.

Concerns:

1. The HICPAC subcommittee working to update the guidelines is composed predominately of infectious disease physicians from large academic medical centers leading to draft guideline with a relatively narrow perspective. Notably absent are representatives from occupational health and safety, industrial hygiene, other types of healthcare settings, and healthcare worker advocacy. We have learned through the COVID-19 pandemic the importance of involving professionals from a variety of disciplines in developing infection control guidelines. A multidisciplinary approach with greater diversity of experience, expertise, and interest would help to identify blind spots and gaps in the guidelines, and ensure equitable protections across healthcare worker roles and healthcare settings.

2. HICPAC noted that their guidelines are intended to be the minimum to protect patients and healthcare personnel. While we understand the CDC does not adopt occupational health standards, HICPAC/CDC recommendations and guidelines are often enforced by regulatory and accrediting agencies, such as state licensing agencies, CMS, The Joint Commission, and DNV. There currently is no national occupational health standard to protect workers from aerosol/airborne transmissible diseases, however, Cal/OSHA has rules in place to protect workers (including healthcare workers) from exposure to aerosol transmissible diseases and rules specifically protecting against COVID-19. Washington State Labor & Industries is working on rules to protect workers from exposure to infectious diseases.

3. While HICPAC/CDC guidelines are "just guidelines", they are used not only to develop facility level policy, but are also enforced by a number of regulatory and accrediting entities. HICPAC/CDC must acknowledge the weight of their guidelines and ensure a multi-disciplinary, open, and transparent process in guideline development.

4. HICPAC goals do not include measures of success. There is very limited public reporting of infectious disease exposure and incidence in healthcare workers. There is reporting of some healthcare-associated infections, though primarily device-associated, procedure-associated, and select multi-drug resistant organisms through CDC's National Healthcare Safety Network. There is no public reporting of healthcare-associated respiratory infections. HICPAC does not state desired outcomes or how those outcomes will be assessed.

5. Entities with regulatory influence should consider the health and safety of all affected populations, including workers. The healthcare workforce is diverse in age, job duties, as well as underlying health conditions.

6. We encourage HICPAC to consider all aspects and impacts of infectious disease exposure. For example, many infectious diseases have long-term health effects beyond acute infection, some of which can be disabling. Severity of disease and risk of long-term effects are highly dependent on host factors that may or may not be known to the individual. About 27% of health care workers diagnosed with COVID-19 developed long-COVID with multiple infections being associated with the development of long-COVID and multiple vaccinations being protective.1 Despite this, over 40% of healthcare workers indicated that they are unwilling to receive future COVID-19 boosters.2 The fact remains that the majority of working age adults in the U.S. have at least one medical condition that puts them at higher risk of severe COVID-19 with proportions increasing with age and 100% of adults over the age of 50 having at least one medical condition that puts them at higher risk of severe COVID-19.3 These conditions likely also relate to a higher risk of severe illness from other infectious diseases. While we currently enjoy high levels of protection against COVID-19, that may not always be the case and repeated infections, even if mild, place healthcare workers at risk.

7. HICPAC should consider the implications of infectious healthcare workers for public health. Healthcare is the biggest and one of the fastest growing industries in the U.S. with over 22 million workers representing 14% of all U.S. workers according to the U.S. Census.4 Given this and the increased risk of infectious disease exposure inherent to their job duties, even if they experience mild disease, infectious healthcare workers increase the risk of outbreaks outside of the workplace.

8. HICPAC presented only evidence with an outcome of healthcare worker illness and excluded evidence indicating that respirators are better protection than masks against exposure to aerosol/airborne particles, including those particles that are potentially infectious. HICPAC notes that the studies included in their review have problematic methods and considerable limitations, including lack of validation of PPE adherence or proper use of PPE, or consideration for exposures outside of the workplace when healthcare workers are not likely to wear PPE. HICPAC should broaden its review to include evidence that has fewer methodologic concerns and limitations.

9. Well-fitting facemasks are intended to protect against fluid splash and spray and to provide source control. They are **not** considered respiratory protection. NIOSH conducts a comprehensive program for the testing and certification of respirators that is used throughout the United States and in many other countries. Although

NIOSH has recognized a level of “barrier protection” as defined by ASTM, in “workplace performance” and “workplace performance plus” categories, NIOSH has clearly stated that these devices are **not** certified as respirators.

10. Contrary to HICPAC’s presentation, the risk of exposure to a healthcare worker caring for a patient with a specific infectious disease during the pandemic phase vs. endemic phase is the same, and therefore, the same PPE should be worn regardless of the community transmission when caring for a patient with the known or suspected infection. Decisions regarding PPE and source control according to standard precautions may bedriven by the likelihood that a person is infected (and undiagnosed), which would be associated with community transmission and we are pleased to see this called out in HICPACs recommendations for standard precautions.

11. HICPAC identified several challenges with healthcare worker use of respirators and masks, however, they should consider innovative respiratory protection devices that could overcome these challenges, such as elastomeric masks, PAPRs/CAPRs, and clear respirators. While challenges to implementation and adherence must be considered, challenges with implementation and adherence should not be used as a reason to not protect workers. Challenges must be addressed and strategies to overcome them developed at the national and facility level.

12. In providing substantial flexibility to healthcare facilities and workers, HICPAC should consider that individual level risk assessments rely on healthcare workers to assess based clinical knowledge of the patient. While clinical staff generally have ready access to this type of information, non-clinical staff do not and therefore are at higher risk, which disproportionately impacts low wage workers and has the potential to lead to inequitable access to PPE. This has long been a weakness in the standard precautions model and HICPAC has the opportunity to address it in their updated guidelines. Clear and direct guidelines on when respiratory protection and other PPE healthcare workers should wear will not only be easier to implement as it does not rely as heavily on individual decision-making, but also provides protection that is more equitable across the spectrum of healthcare settings and roles.

Recommendations:
Washington State Labor & Industries and Washington State Department of Health recommend HICPAC:

- Invite input from occupational health experts, industrial hygiene experts, healthcare worker unions and advocacy groups, and representatives from varied healthcare settings and roles.
- Broaden the scope of evidentiary review to include laboratory studies and studies with exposure as an outcome.
- Consider all impacts of exposure, including post-infection sequelae, the proportion of healthcare workers at risk of severe disease, and impacts on greater public health when developing respiratory protection recommendations.
- Consider respiratory protection beyond N95s (such as elastomeric masks, PAPRs/CAPRs, and innovative models of NIOSH approved N95s) when reviewing evidence, assessing challenges, and developing guidelines.

- Develop clear guidelines, regardless of individual susceptibility to severe disease, that ensure equitable application across the spectrum of healthcare workers and settings.
- Publicly state desired outcomes and measures of success for the draft guidelines. If desired outcomes and measures of success include decreased patient and healthcare worker infections and post-infection sequelae, a standardized mechanism must be developed to facilitate the reporting and public access to those measures.

Washington State Labor & Industries and Washington State Department of Health recognize the difficulty in making these updates given the complexity of infectious disease transmission, healthcare system operations, evaluating PPE effectiveness, and human factors. Which is even more reason HICPAC should take the time needed to gain a broader spectrum of perspectives and evidence. We would be happy to discuss any of these concerns and recommendations with members of HICPAC or CDC staff.

Thank you for your time and consideration.

Sincerely,

Craig Blackwood
Assistant Director Division of Occupational Safety and Health
Washington State Department of Labor & Industries

Tao Kwan-Gett, MD, MPH
Chief Science Officer
Washington State Department of Health

Cc:
Ryan Allen, DOSH Standards, Technical, & Laboratory Services Program Manager
Cari Anderson, DOSH Deputy Assistant Director
Stella Daniels, MPH, BSN, RN, COHN-S, Healthcare-Associated Infections Occupational Health Team Supervisor
Kat Gregersen, MPH, CIH, DOSH Industrial Hygiene Technical Manager
Larissa Lewis, MPH, RN, CIC, FAPIC, DOSH Occupational Nurse Consultant
Elaina Mills, RN, MSN, CNL, CIC, Healthcare-Associated Infections Education and Guidance Development Program Manager
Sara Podczervinski, MPH, RN, CIC, FAPIC, Healthcare-Associated Infections and Antimicrobial Resistance Section Manager
Nicholas Reul, MD, MPH, FACOEM, DOSH Medical Officer
John Stebbins, CSP, CIH, DOSH Industrial Hygiene Technical Specialist

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2 Gu F, Lin H, Chen Z, Ambler G, Chen X, Chen X, Xia P, Liu N, Du H. Future COVID-19 Booster Vaccine Refusal in Healthcare Workers after a Massive Breakthrough Infection Wave, a Nationwide Survey-Based Study. Vaccines. 2023; 11(5):987. https://doi.org/10.3390/vaccines11050987
3 Ajufo E, Rao S, Navar AM, Pandey A, Ayers CR, Khera A. U.S. population at increased risk of severe illness from COVID-19 [published correction appears in Am J Prev Cardiol. 2021 Jun;6:100195]. Am J Prev Cardiol. 2021;6:100156. doi:10.1016/j.ajpc.2021.100156

4 Laughlin L, Anderson A, Martinez A, Gayfield A. Who Are Our Health Care Workers? United States Census Bureau. www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html. Published April 5, 2021. Accessed August 3, 2023.

Dear HICPAC members,
Please find attached written comments and a public petition concerning HICPAC's recent critical decision regarding CDC's isolation precautions.

These comments are submitted by Project N95, a 501(c)(3) organization. Our mission is to increase access to life-saving respiratory protection for those who need it most.

The accompanying petition includes 350 signatures from concerned health care workers and patients who are urging more transparency and deliberation around this decision.

Thank you,
Kimberly Paulk

Attachment:

Project N95 shared the following petition with our community to urge CDC to consider other perspectives in the critical decision regarding CDC's isolation precautions by the Healthcare Infection Control Practices Advisory Committee (HICPAC).
In response, 350 community members and representatives from ten organizations signed on in support of the petition. The petition and signatories are below.

Petition
At Project N95, our mission is to increase access to life-saving respiratory protection for those who need it most. Every single day we help vulnerable people who spend far more time in hospitals and at doctors' offices than they would wish.
Patients should not risk getting sick while getting medical care and healthcare workers should be protected from aerosol transmissible diseases at work.
Please join us in signing this petition to let CDC/HICPAC know that want transparency, science-based guidelines, and safety for all:
1) We urge the CDC and HICPAC to release the draft with ample time for public review ahead of any vote.
2) Everyone benefits when policy changes are made transparently and collaboratively. We urge CDC/HICPAC to delay any vote on updated guidance until public meetings are held on the draft guidelines.
3) We urge CDC/HICPAC to include more stakeholders -- aerosol experts, respiratory protection, occupational hygienists and healthcare worker representatives -- in its guideline formation.
4) We urge CDC/HICPAC to acknowledge the aerosol nature of respiratory diseases and the need for adequate precautions to prevent the inhalation of aerosols.
5) We urge CDC/HICPAC to make a policy that prioritizes healthcare workers and the most vulnerable patients. The health and safety of high-risk groups cannot be compromised in the interest of returning to "normal." The guidelines should reflect a commitment to "leaving no one behind" -- no patients, workers or communities should bear an unequal share of risk.
Everyone benefits when public health policies prioritize protecting the most vulnerable.

Summary of Signatures*

350 names representing individuals and the following organizations:
● Project N95
● McGill University
● Covid Safe Colorado
● Montreal University
● St. Louis Queer+ Support Helpline
● American Association of People with Disabilities
● Maskbloc Sunset SF
● Woodner Tenants' Union
● Feed The People DC
● Hollingsworth & Vose
● Sunrise DC

*Individual signatures are not included in this meeting summary.

The health of our people is key to the health of our economy and our nation. Please do everything to ensure healthcare is accessible and safe as possible for everyone. This includes:

1. Fully recognizing that SARS-Cov-2 IS AIRBORNE, and ensure that the guidelines fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."

2. Implement a layered approach to infection control, including vaccines, universal N95 masking, ventilation, filtration, and more.

3. Acknowledge that a significant amount of transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

Thank you,
Susan Asato
United States Citizen and Registered Voter
Aliso Viejo, CA

To the CDC:

I personally know multiple people who have been SEVERELY disabled in corrections settings due to inadequate healthcare and prevention against the COVID-19 virus. As in, partially blind, wheelchair-bound, permanently reduced lung capacity. The settings you take in ALL healthcare settings must extend to prisons, with oversight and with a mechanism for fielding complaints from patients in those facilities. Additionally, I urge you to incorporate the following measures:

- Involve healthcare unions and experts in ventilation and occupational safety in all policy and decision-making processes.
- Make the process for updating policy/guidelines completely transparent.
- EMPHASIZE the aerosol transmission of the COVID virus and take steps to prevent transmission by air! What are you waiting for?
- Take measures to protect immunocomp, disabled and elderly patients in healthcare settings, especially in congregate areas.

Regards,

Tyler Morse

Hello my name is Jonathan Goldner, I am 45 years old and live at Bronx, NY.

Prior to the covid-19 pandemic I was in reasonably good health. I saw my dentist every six months, saw my primary care physician for well visits, and got my routine vaccinations such as influenza on time / as available. I went to work and saw movies and dined out in restaurantes. I lived a fairly "normal" typical life.

The current covid situation has made many of those previously innocuous normal activities incredibly risky. One-way masking is not sufficient to protect the wearer if they are in close proximity to a highly infectious covid patient -- symptomatic or otherwise. Because of this I have not been able to seek certain types of preventative care.

In close contact situations such as health care, it is paramount that providers be required to wear quality masks and provide reasonable accommodations to those who request them (air filtration, access, waiting time, etc). A person should be able to go to a health care provider with a high degree of confidence that their health will improve as a product of their visit. Letting airborne diseases, particularly but not exclusively covid, run rampant because of relatively minor inconveniences like masking or air filtration does not make any sense.

Sick people cannot work. Sick people do not contribute to the economy, other than needing more health care.

Encouraging health care settings to take little or no precaution is backward, derelict and downright irresponsible.

Thank you for your consideration on this matter,
-jtg

My name is Meghan Krausch, and I am a concerned citizen (no organizational affiliation). I am extremely distressed to see what HICPAC is recommending. These recommendations do not follow science, and they do not center the health and needs of either patients or workers in healthcare settings. Any new guidelines MUST fully recognize that SARS-CoV-2 is transmitted via aerosol and must establish appropriate protocols. This includes but is not limited to the use of tight-fitting masks for all involved via universal masking policies. Contrary to popular talking points about the flu and how "it happens every year", the lesson we need to draw is that we should have been doing this in healthcare well prior to the COVID pandemic, not that no protection is OK. Furthermore, it is clearly demonstrated that multiple layers of protection are much more effective in concert than a pick-one model. These layers include vaccination, air quality filtration, masking, and testing. This means that healthcare personnel should be tested regularly for COVID-19 as well as RSV and flu, and that they MUST be supported with ample paid leave in order to actually avoid spreading disease to patients. I am writing today because I am concerned for my own safety and for the safety of my loved ones should these revised guidelines be adopted. I do not want the hospital to become an unnecessarily dangerous and risky place. Thank you.

Hello,

My name is Keely Mizell of New Orleans, Louisiana. I am writing to you to comment on HICPAC's disastrous policy draft that would contribute to the continued disabling and killing of healthcare workers, patients, and members of the general public across the country. I care about this because my mother has long COVID and cannot afford to get reinfected.

I'd like to discuss the insufficient recommendations to require surgical masks in healthcare facilities instead of N95-quality masks. Specifically, the N95 review is flawed and currently contains the following errors:

· The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks.

· The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

Additionally, while CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols.

We need N95-quality masks for maximum protection in healthcare facilities. While evidence is still being collected, many healthcare officials as well as various English-speaking studies and recommendations (that were then compared in reviews, which were then compared in further independent investigations) find that N95s provide higher protections than surgical masks for SARS-CoV-2 transmission (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10509348/, https://pubmed.ncbi.nlm.nih.gov/33360295/ , https://pubmed.ncbi.nlm.nih.gov/37200654/, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705692/, https://royalsociety.org/-/media/policy/projects/impact-non-pharmaceutical-interventions-on-covid-19-transmission/covid-19-examining-the-effectiveness-of-non-pharmaceutical-interventions-executive-summary.pdf).

The proposed approach provides insufficient, minimal regulations against the spread of SARS-CoV-2. It would allow healthcare employers to avoid providing necessary protections for healthcare personnel and patients and to place cost considerations above people's lives. I urge HICPAC and the CDC to rectify the above problems explicitly in future proposed updates to protect healthcare workers and patients from infectious diseases and prevent further killing and disabling of the general public.

Signed,
Keely Mizell

Hello,

My name is Ruby Levine, I live at Minneapolis, MN, USA, and I have no relevant organizational affiliation. I am writing to comment on HICPAC's changes to the Infection Control standards.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect

individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

To Whom It May Concern,

I am writing to submit a public comment regarding the proposed infection control changes. As an immunocompromised person in this ongoing pandemic, I have been avoiding health care settings and forgoing care I desperately need for fear of infecting myself and/or my elderly parents who I am caring for. Sadly, I don't think I am alone on this front.

If your goal is, in fact, to help people like me get the care they need, you need to make these spaces safe and accessible for us and for everyone, by requiring masking (with N95-level masks), ventilation, and testing. We know that this disease spreads via aerosol transmission, and that we have the tools to combat its spread. Rather than put the onus on patients like me to beg for accomodations (which, in my experience, are usually not granted anyway) you need to be protecting your patients, staff, and visitors accordingly. We have already seen outbreaks in hospitals and how destructive they are; I ask that you learn the lessons from these terrible events and incorporate them into your plans for the future.

Véronique Hyland
New York, NY

Dear Healthcare Infection Control Practices Advisory Committee (HICPAC),

This is Meridith Richmond. My address is Saint Paul, MN. I do not have an organizational affiliation, I am an interested individual. The topic I am emailing you about is the proposed changes to the infection control standards.

I am emailing you asking you to not abandon your responsibility to the public and delegate it to employers to choose what level of infection control to take. This is a clear situation for the authority of the federal government and the CDC to come into play in order to protect people's lives, both provider and patient. I am already delaying healthcare because of the decline of masking in healthcare situations. Going to the doctor or going to work should not increase your chances of acquiring a highly transmissional respiratory virus! Especially when we know there are affordable and effective precautions we can take (N95 masks!)
This is what I would like to see:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those

levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

I would also like to note that we need layers of protection:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Lastly, in terms of this process, I'd like to say:

- **As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Thank you for your time,
Meridith Richmond

Dear CDC/HICPAC,
I am writing to express my profound disappointment and concern regarding the recent decision by the CDC to relax infection control measures in hospitals. This decision is not only misguided but also extremely dangerous, and it disregards the safety and well-being of both healthcare workers and patients.

The CDC has been a trusted source of guidance during the ongoing pandemic, and its abrupt shift in policy raises serious questions about the motivations behind such a reckless move. Weakening infection controls in hospitals goes against the very principles of public health and patient safety, and it threatens to undermine the progress we have made in the fight against infectious diseases.

Healthcare workers on the front lines have been risking their lives day in and day out to provide care to those in need. We owe it to them to ensure the highest levels of protection and support. Relaxing infection control measures not only puts their health at risk but also compromises the safety of patients, many of whom are vulnerable to infections.

It is essential that the CDC reconsider and reverse this decision immediately. The consequences of this reckless action will be dire, leading to an increase in hospital-acquired infections and a heightened risk of disease transmission within our communities. We cannot afford to take such a gamble with public health.

I implore you to reinstate and reinforce the infection control measures in hospitals and provide clear, science-based guidelines that prioritize the safety and well-being of healthcare workers and patients. The health and lives of countless individuals are at stake, and it is imperative that we do everything in our power to protect them.

Sincerely,

Dana Whitfield

My name is Sidelia Reyna
Williamsburg, OH
I have no organizational affiliation except as a patient
I would like to address the topic of the healthcare infection control guidelines

As a patient who requires healthcare, I implore you to do all you can to protect patients from health-care acquired airborne infection. I am writing to urge you to enact guidelines that fully recognize the aerosol transmission of SARS-COV-2 and establish rigorous protocols to prevent "transmission by air" in all healthcare settings.

Please do not continue to force patients to face potential exposure to a deadly pathogen in order to access necessary healthcare.

How can I trust the knowledge, expertise, or ethics of healthcare workers who are putting my health at risk by not wearing appropriate PPE while they care for me? I cannot. Please require health care providers and staff to wear an N95 or better respirator at all times in patient areas. Please invest in the infrastructure needed to improve indoor air quality in health care settings. Improve ventilation through the use of dilution with fresh air and also through the use of technologies such as HEPA filtration and Far-UVC light to kill airborne viruses.

SARS-COV-2 is a dangerous airborne pathogen and we need our partners in healthcare to protect us from airborne transmission. Thank you.

Hello,

My name is Giuseppe C. Cavaleri. I served as a frontline public health worker mitigating the spread of HIV and HCV in various organizations before the pandemic and continue to serve supporting roles for the last 17 years. Today I speak as a member of the public.

The Center for Disease Control Healthcare Infection Control Practices Advisory Committee (HICPAC) has an opportunity to update guidance based on new information that has come to light since Charles V. Chapin's book Sources and Modes of Infection was first published in 1910; You can read more about that in Dr. Jose L. Jimenez, Dr. Kimberly A. Prather, Dr. Trish Greenhalgh, et al in 2021's peer reviewed paper: "What were the historical reasons for the resistance to recognizing airborne transmission during the COVID-19 pandemic?" [1]

In lieu of broader mitigation methods an evolution proof physical barrier is necessary to stop the spread of COVID-19 causing SARS-CoV-2. Surgical masks are insufficient for purpose. Vaccine benefits are enhanced by better masks. This is why I urge HICPAC to update their language to require the use of fit-tested / seal-tested N95 respirators in healthcare settings. 'Reinvention of the wheel' isn't necessary. In 2009 the US Department of Labor produced a 5-and-a-half-minute video that covers the differences. Titled simply: "The Difference Between Respirators and Surgical Masks." Circulate the link to the official USDOL page. [2]

I want to believe the members who sit on HICPAC's Work Group on Isolation Precautions Guidance wish to serve life in all their recommendations. Four years into the COVID-19 pandemic it's clear that -for now- there is no sense of administrative urgency to retrofit outdated ventilation systems, or add them where absent. Human ingenuity luckily persists beyond the lives that enacted it. Towards that end I want to highlight a list of successful efforts made towards broad public health solutions that continue to be successful.

Between 1850 and 1860, Chicago was raised 14ft out of swampland to prevent hygiene related health issues including but not limited to cholera. The 1854 cholera epidemic led to death in 1-in-20 cases. Surely in the wake of this tragedy it galvanized city planners and workers to action. Using 6000 jackscrews to lift only one of those acres (a mere 35,000 tons) between Lake, Clark, and LaSalle Streets felt like little effort to avoid future calamities. [3]

The once ubiquitous 150+ year old radiator whose size grew at the turn of the 20th century specifically to combat tuberculosis, rhinovirus, and yes influenza through allowing fully open windows during a New York winter to air out various pathogens. [4]

In 1927 the Vancouver Orpheum Theatre was built in the wake of the 1919 Flu Pandemic to be pandemic proof through ventilation that remains in operation today. During a visit in 2022, a friend sat among 1700 other people not counting performers. Provisioned with an Aranet 4 took CO2 readings which put modern ventilation to shame. Never below 450 and never above 600 ppm. [5]

During the 1980s, to combat the spread of HIV; hospitals and clinics implemented what would become known as universal precautions to prevent the spread of blood borne pathogens. Part of these measures included the standardization of gloves in healthcare settings where potential for contact with blood and other bodily fluids is probable. Before then it wasn't standard beyond operating rooms and similar. In 37 years (between 1981 and 2018) 700,000 people died of HIV in the United States. [6] That number would have been larger without the implementation of universal precautions outlined in 1987's Recommendations for Prevention of HIV Transmission in Health-Care Settings. [7]

So in the wake of nearly 1.2 million deaths attributed to COVID-19 in 4 years and countless more impacted by Long COVID (which has zero meaningful treatments); now more than ever we need truly universal precautions which account for aerosolized transmission of pathogens.

With notoriously airborne tuberculosis now on a worldwide rise for the first time in twenty years (10 million cases observed in 2018 vs. 10.6 million observed in 2021), and 1-in-3 cases is treatment resistant TB it's sure to reverse an outstanding declining mortality trend observed between 2005 and 2019. Mortality rates fell 42% between 2000 and 2018. All figures according to the 2019 & 2022 Global Tuberculosis Report published by the World Health Organization. [8][9]

With, as of September 2023, 1700+ variants designated Omicron now identified and logged during the last two years [10] I recognize that figure has likely grown since then. It will continue to grow long into the future if we don't break the chain of transmission. Chapin continues to be right about that. [11]

Because viruses mutate inside people. People are where the mutations happen. You get fewer mutations if fewer people have viruses inside them. You get more mutations when more people get viruses inside them. Because mutations happen when viruses are inside people.

Because all variants are inherently immune invasive because there is no meaningful cross-variant immunity. People can be infected with multiple variants at one time, again because there is no meaningful cross-variant immunity.

We have the tools. So let's use them. Let's start—with wearing a well-fitting n95 respirator. Getting an updated vaccine. And protecting our communities through broad àpublicß health measures that strengthen individual-oriented prevention strategies.

[1] https://doi.org/10.1111/ina.13070
[2] https://www.youtube.com/watch?v=ovSLAuY8ib8
[3] https://www.enjoyillinois.com/illinois-200/raising-chicago/
[4] https://www.smwc.edu/the-radiator-and-the-pandemic-blog-feb-21/
[5] https://web.archive.org/web/20220905181648/https://twitter.com/moss_sphagnum/status/1537686147660271616

[6] https://www.oar.nih.gov/about/directors-corner/letters-director-new-plan-end-hiv-epidemic-united-states#:~:text=More%20than%20700%2C000%20people%20in,new%20infections%20are%20diagnosed%20annually.
[7] https://www.cdc.gov/mmwr/preview/mmwrhtml/00000039.htm
[8] https://archive.ph/cdLtw
[9] https://web.archive.org/web/20231106153934/https://cdn.who.int/media/docs/default-source/hq-tuberculosis/global-tuberculosis-report-2022/global-tb-report-2022-factsheet.pdf?sfvrsn=88f8d76_8&download=true
[10] https://twitter.com/RajlabN/status/1700361822119850431?s=20
[11] https://twitter.com/jmcrookston/status/1301635464139624450?s=20

Kind Regards,
Giuseppe C. Cavaleri
Oakland, CA

November 6, 2023
To: HICPAC, CDC
Re: HICPAC's Proposed Infection Control Guidelines

Dear HICPAC:

My name is Rev. Anne Dunlap, I am a United Church of Christ minister, and I have spent the last week caring for my spouse who has Covid. We still mask indoors everywhere, and still my spouse got infected.

In our city we know of 2 churches who in the last month have had to cancel services due to Covid outbreaks, and a 3rd that has 10% of its members, including its pastor, out sick with or exposed to Covid.

Clearly Covid is not going away.

I am appalled to learn that HICPAC is considering lowering infection control guidelines in health care settings, opening the door to employers to make decisions based on what prioritizes profits, not public health. The impact of lowering infection control guidelines will mean more death, more disability. And for whose benefit?

I won't list all the reasons why science shows reducing infection control protocols is a terrible decision, first because scientists are telling you so I don't need to repeat them, and second because ***you already know what the right thing to do is***. You know what the best infection control is, you know what the science shows, and you know what the impact will be of letting Covid and other infectious diseases run rampant.

As a faith leader, I know what choices make for good, thriving, healthy communities. Those choices include protecting people's health, assuring people's bodies have all the care and protection they need, and **not** creating conditions where some get to benefit from people's suffering. ***What will you choose?***

We lost a brother-in-law to Covid, and nearly lost 2 others. We know many friends who have been permanently disabled by Long Covid. I am praying my spouse is not one of those.

I urge you to do the right thing: do all you can to prevent more deaths, more disability, more suffering, by creating strong, science-backed infection control protocols that protect patients, health care workers, and all their loved ones, in all healthcare settings.

Sincerely,

Rev. Anne Dunlap
Buffalo, NY
United Church of Christ
Showing Up for Racial Justice

Covid has been downplayed by the CDC since 2020. It is an airborne and highly communicable virus that has long term consequences. The public health emergency, including messaging has been downplayed by the government of the US to the detriment of hundreds of thousands of Americans, who now believe it is not airborne, not widespread, and not serious.
Hope Pennestri CRNP

To whom it may concern,

This message concerns the inadequate nature of the proposed update to HICPAC Infection Control.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans.

The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations.

As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance **explicit** about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols.

The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Sincerely,
Nila Narain

Russell & Aries Dial
Seattle, WA
No organizational affiliation
Commenting on HICPAC's revised healthcare infection control guidelines

Hello,

We are writing to comment on HICPAC's proposed revisions to the guidelines for infection control in healthcare.

HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens and establish rigorous protocols to prevent airborne transmission in healthcare settings.

Medical facilities are places everyone must go, where high-risk, disabled, and seniors mingle with infected patients, visitors, and staff. Healthcare facilities and personnel should employ all precautionary strategies, including masking with high-quality masks (N95s or better), at all times to protect themselves and their patients. Surgical masks are not adequate protection against airborne pathogens. Universal maskings in N95s or better should be the standard of care, and masks should be provided free of cost to employees.

Facilities should implement minimum indoor air quality standards set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft," including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on the control of multidrug-resistant TB).

HICPAC cannot develop appropriate guidance now, as it has no member experts in crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

As patients, we should not risk contracting a disabling disease at every medical or dental appointment. We should not have to perform a risk calculation whenever we seek care. Healthcare settings should be the safest places in our communities.

The CDC's mandate is to control and prevent disease. As medical professionals, you have committed to 'do no harm.' There's still time to align your actions with what you said. Please do so.

Sincerely,
Russell & Aries Dial

Topic: HICPAC recommendations to CDC
Name: Jonathan Soper
Silver Spring, MD
Organizational affiliation: None

I am extremely concerned and disappointed by the most recent HICPAC draft recommendations. To give employers, and especially healthcare employers, discretion over what safety measures to implement and when would be a complete abandonment of CDC's most basic mission. It is essentially telling everyone to "figure it out" for themselves, which is among the worst, most nonsensical and counterproductive messaging possible.

Every credible study done on the subject is clear that layered protection at all times is the only safe and effective prevention measure, and it seems as though HICPAC is explicitly ignoring the science when the most they recommend is to "**consider** implementing **one** of the tiers of source control". If these were serious recommendations intended to serve the purpose of the CDC, the recommendation would be to "implement all tiers of source control", but instead they seem to be intended to serve the purpose of employers.

These recommendations are in fact so out of line with the available science that the CDC should reject the draft entirely and start over, seeking input from health care workers, their unions, patients, and a much broader array of public health/science experts.

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to: HIPAC committee at CDC
from: K. Heatherington, a concerned citizen who badly wants to not get exposed to deadly pathogens while in life-saving medical care, and who is deeply concerned that your new reccomendations will create exactly that scenario for thousands of people

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.
- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."

- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- **Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.**
- **Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.**

Nora Heaphy
Winooski, VT, University of Vermont, Dept. of Plant Biology

I am a PhD student, studying how trees adapt to climate change. I am also immunocompromised and have Long Covid. Since the end of mask mandates in healthcare settings, accessing care has become exponentially more challenging to me. To get the care I need to do my work and continue with my life, as we all want to be doing, I have no choice but to enter rooms filled with people, many of whom have respiratory symptoms and all of whom are not wearing masks. I should not have to risk my health to get healthcare. I do not understand how this could possibly be in question. I also know personally clinicians who have been required to return to in-person patient interactions while still testing positive, which is horrific. I must now always wonder whether my own care team would tell me if they were sick, whether they would stay home, or whether they would just wear a baggy surgical mask and come in anyway, breaching my trust in them irreparably.

All the research on aerosol transmission and the long-term health impacts of Covid infections is clear: well-fitting respirator masks (KF94, KN95, and N95+) are key to preventing transmission, in addition to ventilation and filtration. Wearing a mask for most people is so, so incredibly easy.

And it could save someone's life. You know that if the current draft goes into effect with language about "suggesting" that employers "consider" implementing certain precautions, most hospitals will not choose to implement them.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Masks in public places NOW!!! Hepa filters and Ventilation NOW !! No public health messaging or guidelines—UNCONSCIONABLE!!!

Good afternoon,

I'm Emme McManus and I'm located in Durham, NC. I'm writing to say that the CDC's guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air. Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. A very significant amount of **transmission is asymptomatic- with many studies citing it accounts for 40% of cases. Therefore, all precautions must be universally practiced at all times.** Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**

The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles"rather than infection control. Healthcare providers have complained of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved and does not weigh that cost against profits, nor should CDC.

The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data. The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely. Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious must be supported with paid leave, or where

appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative. Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections. Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases. Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors. Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB). **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC. CDC and HICPAC should make the process for updating guidelines fully open and transparent. Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
Emme McManus

Kristen Alexander
Madison, AL

I am a concerned citizen.

Topic: Respirators in Health Care

I am begging you to please consider the impact of ignoring that COVID is airborne. Not requiring hospitals and health clinics to use respirators and not asking them to clean the air sets every patient up for a devastating outcome. No one should leave a medical facility with a SARS infection. It is preventable.

If you want to reduce the requirements on face coverings to something that does not adequately stop forward transmission (like unscientifically approving surgical masks over respirators), clean air standards should first be met in every place where health care is conducted. Anything else is harmful and destructive to our society.

We have been told that we should just ask our caregivers to wear a mask for our care, but it doesn't work that way. They play games and make excuses and do nothing to protect the public from COVID, because the industry does not require them to. It feels like the challenges Semmelweis faced to get people to wash their hands all over again. We know better, we must do better, lives are at stake.

Please stop the uncontrollable spread of this preventable disease.

Thank you,
Kristen Alexander

I am writing to ask you to require at least N95/KN95 respirators for all healthcare workers and patients and visitors, anytime they are inside the building. In areas where it is necessary to unmask, such as bathrooms and eating areas, the employer or building management should be required to provide ventilation and filtration at minimum 80 CFM clean air per occupant.

Evidence has shown that surgical masks, while an improvement over bare faces, are not nearly as effective as N95 respirators. Rates of transmission for flu, covid, RSV, and colds all went down dramatically in environments where everyone consistently wore respirators. And for inpatient hospital stays or skilled nursing facilities, it is not possible to keep everyone in respirators during meals and bathing. Therefore it will be necessary to provide ventilation and filtration along with N95-respirator requirements.

Sincerely,
Amelia Ayer
Cambridge, MA

Ella Elman
Redmond, WA

November 6, 2023

Dear Healthcare Infection Control Practices Advisory Committee,

I submit these comments regarding the draft guidelines submitted by your Work Group on the Isolation Precautions Guidance with a heavy heart, knowing that you have no interest in reading my comments or consideration for what I have to say. Nor do you care about what numerous experts in infectious control and aerosol transmission have told you during comment periods during your meetings. You also do not care about healthcare workers, nurses, doctors or patients in hospital or clinical settings, because they and National Nurses United have sent in many comments letting you know that your draft guidelines are completely inadequate to protect anyone from infectious diseases. Yet you persist in voting to finalize these guidelines anyway, because all you care about is saving some money for hospital administrators who don't want to pay for N95s and air ventilation for their already understaffed staff.

I had the pleasure this weekend of reading an article in Forbes about your "fine work" on this committee: https://www.forbes.com/sites/judystone/2023/11/01/a-storm-is-gathering-around-a-cdc-committee/. You do not have a single member of the committee who is an expert in infectious disease, respiratory science, air filtration or industrial hygiene. Yet, you somehow get the job of making recommendations in these fields that will affect every single person in this country. It's quite unbelievable.

Let me once again reiterate some of the things you have already heard thousands of times:

- Infectious diseases are transmitted by breathing. The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Infection control must include a layered approach that includes N95 or better respirators, HEPA filters and other air filtration methods (such as having windows that

open), rapid molecular testing for patients and health care workers and most importantly, isolation of infected patients. This should include implementing minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. These measures should apply to all healthcare settings, including nursing homes. Healthcare employers do not get to set their own infectious control plans based on how they are feeling that morning.

- Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times. Healthcare settings are where high risk, immunocompromised and elderly people will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times. Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Your draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. The recommendation that surgical masks are just as effective as N-95 respirators is completely false and based on bad science, and you know it.

The fact is that these guidelines are completely inadequate and put healthcare workers and patients at risk in an already risky setting. Today, I think twice before going to the hospital but these new guidelines would make me unlikely to visit unless my life was in danger. These guidelines need to be scrapped entirely, a proper committee with scientific expertise needs to be assembled and this whole corrupt and disgusting behind-closed-doors process needs to start over in the light of day, with participation from the public and all documentation available on-line well before each meeting.
This is truly a new low for the CDC, which is saying a lot.
Your truly,
Ella Elman
A living, breathing person who is trying to avoid COVID and other infectious diseases so she can keep her health and marbles for as long as possible

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From:
Mona Kanin
North Egremont, Ma

Public Citizen/Health Consumer

To Whom It May Concern,
Though the medical establishment was reticent to accept Covid was, without question, airborne, it seems that HICPAC is even more hesitant to acknowledgment viral transmission.. May we diagnose cognitive dissonance on HIPAC part? Should we diagnosis hesitation to admit that we are interdependent in this context rather than independent, that a public health point of view is necessary?

As I’m sure you'll see in public comments, many of us understand that Covid is preventable if we have the will to prevent it. We are horrified that HICPAC is considering loosening measures that mitigate transmission in healthcare environments. At what point did it become acceptable that any of us might get sicker when we visit care providers? Why are you refusing the responsibility you have for nosocomial infections? We’ve noted that only hospital

administrations sit on the panel— this is inappropriate and inexcusable. Since when has profit been more important than health?

We know the facts: Covid is airborne. The endemic is as dangerous as the pandemic. If we don't mitigate transmission chains, more variants of concern will likely develop. We know Covid is a vascular disease that may change T cells. We know that many, even if not diagnosed with Long Covid (for which there is no solution) will suffer sequelae that affect our long-term longevity, heart health, gut health, brain health. And hey, in the Covid context, those of us who are informed know we don't have to worry about fomites—though in the context of other diseases, fomites are a concern, and hospitals are doing a woefully poor job at basic cleaning.

Any of us armed with this knowledge understand that healthcare settings must subscribe to layers of protection to prevent nosocomial infections: Well-fitting respirators, ventilation + filtration, and improved data collection and dissemination.

(By the way, I carry my Aranet C02 reader to all appointments. My dentist has changed his approach, influenced by me. And yes, I understand there's no direct correlation between C02 and viral contamination—a moment of *mansplaining* I heard from a physician.)

There's no science behind the approach HICPAC's Work Group on the Isolation Precautions Guidance proposes. It will lead to minimal protections and allows healthcare employers who are often not well-informed an undefined broad discretion to create their infection control plans. Of course, this puts not only patients but also healthcare providers at risk.

(*The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also essential to update the list of infectious diseases currently classified as transmitted by airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for healthcare personnel even though the Covid-19 pandemic underlined the importance of strong protections for healthcare personnel and patients.)*

I hope you've read the latest JAMA survey on the efficacy of masks. We know the early Cochran study (which Cochran walked back) was deeply flawed and influenced by the Brownstone Institute—which is against all government regulations. At the moment, HICPAC has failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-healthcare workplaces. It is unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

Is it not the CDC's responsibility to establish a high standard for infection control measures?

I urge HICPAC and the CDC to establish an approach in the updated guidance that explains the precautions needed to protect healthcare workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure and select

appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

Sincerely,
Mona Kanin

HICPAC's draft guidance weakens airborne infection control and will result in continual increase of patient and staff infection, disability and deaths.

Many pathogens are airborne in aerosols, not only droplets, including Tuberculosis, SARS Cov 2, Measles, RSV and others that are circulating
in communities and health care centers. The way to protect patients
and staff is to acknowledge the need for protection from airborne pathogens including the use of N95 or P100 respirators - loose fitting medical/surgical masks that often have lower filtration are not sufficient.

We urge the CDC to listen to Peck:
Seek input from patients, healthcare workers & scientific researchers—using Federal Register Public Notice Process +Town Hall Meeting + virtual options Be transparent Recommend Airborne Precautions: Respirators Usage Set min. IAQ set by ASHRAE 241 The #MaskTogetherAmerica community strongly opposes reducing protection of patients and staff in all healthcare settings because #COVIDIsNotOver and #COVIDIsAirBorne. Air precautions are not a matter of opinions, they're a life and death necessity for high-risk #immunocompromised patients who are vulnerable to nosocomial infection. The standard should be raised, not lowered, after COVID has already taken over a million lives and disabled countless Americans with #LongCovid in our country. #millionsmissing

Danielle Peck, Patient from #Michigan, made several suggestions as a public comment in response to the weakened CDC infection control
guidance proposed by CDC HICPAC on Nov. 2, 2023. "Despite my efforts
to mask… I contracted COVID-19 at a doctor's office while seeking postpartum care. I often wonder how many other pregnant patients and their unborn babies who are at significantly higher risk of severe outcomes from COVID were also infected that day."

National Nurses United, @nationalnurses —the largest union of RN in the US, with ~225K members nationwide, affiliates with @calnurses @minurses @nynurses condemns @cdcgov committee #HICPAC for voting to finalize draft "Isolation Precautions Guideline" for #healthcare settings without a proper public review process or seeking input from frontline health care workers, patients —and most importantly, failing to make strong recommendations on essential measures, including ventilation, patient screening & isolation Isolation Precautions Guideline, which directs infection control practices for health care facilities, has not been updated in 16 years. This critical guidance will be referenced by US employers, gov't agencies & health agencies around the world NNU President Zenei Triunfo-Cortez said: "HICPAC's draft is permissive and weak and seeks not just to maintain existing practice — which has been shown to be inadequately protective — but even rolls back the use of some important measures, such as airborne infection isolation rooms. This draft guidance will only further degrade the already dangerous working conditions…and further contribute to high rates of moral distress, which will only serve to drive more nurses away from the bedside and further deepen the staffing crisis in health care.
During the C19 pandemic, nurses saw too many patients and colleagues become infected, get sick, and even die because of inadequate infection prevention. Too many continue to

experience the impacts of #longCovid…we need a multiple measures approach that combines ventilation, PPE including respiratory protection any time we are exposed to an aerosol transmissible disease like COVID screening and isolation, exposure notification, and other measures."

National Nurses United (NNU) condemns today's unanimous vote by the Healthcare Infection Control Practices Advisory Committee (HICPAC) of the Centers for Disease Control and Prevention (CDC) to finalize a draft of infection control guidelines before giving the public ample time to review the draft or before seeking input from health care workers and patients whose health and safety will be directly impacted by this guidance.

The draft Isolation Precautions Guideline, which was only released to the public yesterday, Nov. 2, is an extremely influential document that directs infection control practices for health care facilities in the United States. This guidance, which has not been updated in 16 years, will be referenced by U.S. employers and government agencies across the country and also by health agencies around the world.

Despite the critical importance of this infection control guidance, the CDC/HICPAC is only accepting written public comment on the draft until 11:59 p.m. on Monday, Nov. 6, giving the public a mere five days to review the 24-page document and 162 pages of supporting documentation and provide feedback.

HICPAC's draft guidance is aimed at frontline nurses and other health care workers, rather than health care employers, inappropriately shifting responsibility and risk to individual workers to protect corporate profits. The focus of HICPAC's draft is almost exclusively on personal protective equipment, and it fails to make strong recommendations on other essential measures, such as ventilation and patient screening and isolation.

"HICPAC's draft is permissive and weak and seeks not just to maintain existing practice — which has been shown to be inadequately protective — but even rolls back the use of some important measures, such as airborne infection isolation rooms," said NNU President Zenei Triunfo-Cortez, RN. "This draft guidance will only further degrade the already dangerous working conditions of nurses and other health care workers and further contribute to high rates of moral distress, which will only serve to drive more nurses away from the bedside and further deepen the staffing crisis in health care."

During the oral public comment section of the CDC/HICPAC meeting yesterday, Triunfo-Cortez urged the committee members to delay their vote until they have incorporated input from nurses, other health care workers, their unions, patients, and other public health experts. "HICPAC is missing the perspective of frontline nurses, other health care workers, our unions," said Triunfo-Cortez. "As nurses, we carry out many essential pieces of infection prevention. We have insights and expertise that are essential to crafting protective guidance.

"During the Covid pandemic, nurses saw too many patients and colleagues become infected, get sick, and even die because of inadequate infection prevention. Too many continue to experience the impacts of long Covid. And now, extensive research has documented what nurses have advocated for since the beginning of the Covid pandemic — we need a multiple measures approach that combines ventilation, PPE including respiratory protection any time we are exposed to an aerosol transmissible disease like Covid, screening and isolation, exposure notification, and other measures," Triunfo-Cortez added.

NNU urges the CDC to reject HICPAC's draft and to actively engage the input of frontline nurses, other health care workers, their unions, patients, and public health experts, in addition to infection preventionists, in the development of a new draft of the updated guidance. NNU urges CDC to hold public meetings, similar to the meetings held in 1992 during the development of the multidrug-resistant tuberculosis infection control guidelines for health care, as soon as possible and, based on this input, to significantly amend HICPAC's draft to better protect health care workers and patients.

In July, NNU sent a letter to the CDC asking to meet to discuss the union's concerns about the guidance. In August, NNU delivered a petition signed by nearly 11,000 individuals and organizations urging the CDC to fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens and to strengthen the agency's Isolation Precautions guidance. In September, nearly 2,000 experts in public health, infectious disease, and industrial hygiene and concerned individuals sent a follow-up letter to CDC Director Mandy Cohen urging the CDC "to involve key experts and all stakeholders in the development process" and hold public meetings. Yesterday, NNU called out the CDC/HICPAC planning to vote on the infection control guidance before public review and comment.

Nov 6, 2023

Worksafe is writing to express serious concerns regarding the HICPAC infection control guidance. We have reviewed and we share the concerns expressed by National Nurses United, including:

- **HICPAC's draft is oriented to frontline personnel, not employers—even though infection prevention programs are the employer's responsibility—and is written in a manner that maximizes "flexibility" for employers, not protections for health care workers and patients, thus shifting the risk and burden onto individual health care workers to protect corporate profits.**
- **HICPAC's draft fails to fully comprehend the scientific evidence on aerosol transmission of infectious diseases, remains overly focused on short vs far range transmission, and maintains the existing, disproven droplet-airborne paradigm.** HICPAC maintained the June 2023 proposals for Transmission-Based Precautions to Prevent Transmission through the Air:
- **HICPAC's draft inappropriately treats surgical masks as respiratory protection and PPE for health care workers exposed to infectious diseases transmitted through the air and treats surgical masks as a default level of protection, reserving N95s/other respirators for only specific "special" circumstances.** Surgical masks are NOT respiratory protection.
- **HICPAC's draft fails to address the importance of safe staffing,** especially bedside RN staffing, to infection prevention.
- **HICPAC's draft is focused on symptom screening and does not fully account for the risk of asymptomatic and presymptomatic transmission with multiple infectious diseases** (e.g., Covid- 19/SARS-CoV-2, influenza, and RSV).
- **HICPAC's draft marks recommendations as either "Standard Practice" or "Expert Opinion," but that is not the distinction that matters.** Standard practice on droplet is wrong—that's been proven. HICPAC needs to look at the evidence—all the evidence from the variety of disciplines with expertise on the matter, not just randomized control trials or clinical studies.
- **HICPAC's approach to assessing scientific evidence is overly focused on "real world" studies and fails to account for the current failures of employers to protect**

health care workers. HICPAC's draft seeks to protect corporate profits at the expense of worker and patient safety.

Thank you for your attention to this matter.

--

Stephen Knight
Executive Director - He / him / his
Worksafe: Safety, Health, & Justice for Workers
Oakland, CA

Hello,

I am writing to submit a comment concerning HICPAC's draft of revised healthcare infection control guidelines. I am deeply concerned that the current draft revisions ignore science and will cause significant -- and wholly preventable -- harm to hospital staff, patients, visitors, and their households. I am the mother of two beautiful children, one of whom is disabled, non-verbal, and high-risk for severe illness and death from covid. All of us are -- just as all of you are -- also at risk of suffering from long covid due to covid infection(s). **We are actively using all the "tools" available to us to avoid infection as best we can, and I am disheartened to see that HICPAC's draft guidelines are not doing the same.**

SARS-CoV-2 is a highly-contagious airborne pathogen. **The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."**

Infection prevention/control protocols must also account for the science showing that **each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.**

Healthcare settings are where high risk and disabled people like my son, seniors, infants, pregnant people, and immunocompromised people will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**

Also, much transmission is asymptomatic. Therefore, **all precautions must be universally practiced at all times.**

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation. Widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID. It does not need to be this way, and it should not be this way.

When walking into a medical building to seek care for my children, I should not have to worry about whether one or more of us is going to walk out with a covid infection. My relatives who work in hospitals should not need to worry about whether they are going to bring covid home to their children after ending their shift.

As the nurses union is urging, **CDC should reject HICPAC's draft and "actively engage the**

input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings.

Signed,

Sheela Shankar
Berkeley, CA
Affiliation: Self, Concerned Community Member and Parent of a Disabled, High-Risk Young Child
Topic: Grave concerns over HICPAC's draft of revised healthcare infection control guidelines.

Dear HICPAC,
Comment by Kelsey Simpkins, M.A., submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients. The CDC ultimately should establish a high standard for infection control measures, that fully recognizes aerosol transmission of SARS-CoV-2 and establishes rigorous protocols for preventing "transmission by air."

Kelsey Simpkins
Professional air quality science communicator

Broomfield CO

Dear HICPAC Members and Staff,
Public Comment – HICPAC guidance on SARS-CoV2 infection control in heath care settings
I am a concerned citizen.
Thank you for the section of your draft guidelines that recommend N95 (or better) masks in some cases, e.g. for emerging pathogens. I am sure that if you were working with an unidentified aerosolized virus, you would take precautions to ensure the safety of yourself, your loved ones, co-workers and ultimately your community. You would spare no expense and cut no corners and not ignore solid aerosol science.
I am shocked and appalled that your recommendations, as applied to SARS-CoV2 aerosol controls, will fail to reduce SARS-CoV2 infection in healthcare settings. Available COVID vaccines to not effectively stop transmission of SARS-CoV2, are not utilized by large segments of the US population, and have proven not maintain their current efficacy given the rapid mutation of the virus and the proven fact that SARS-CoV2 persists and evolves in some patients for up to 18 months.
Similarly, the fact that there are pharmaceutical treatments available for acute-phase COVID, is not a reasonable basis to abandon sound infection control for this aerosol-transmitted virus. The CDC acknowledges that 19% of infected people have Long-COVID. Over the long haul, Long-COVID is likely to be a more significant burden on individuals and society as a whole than acute-phase COVID. There are no pharmaceutical treatments available for Long-COVID. It has been clear for years that each SARS-CoV2 infection carries a risk of Long-COVID. This risk is not mitigated by prior infection, vaccination or acute-phase treatment. Hence it is the duty of the healthcare community and HICPAC to reduce SARS-CoV2 transmission.
You obviously know that airborne transmission of pathogens is reduced with proper use of N95 or better masks. This is clear in your “extended air precautions” guidance. Therefore your guidance as it applies to SARS-CoV2, is clearly insufficient, and dare I say: negligent and possibly criminal. If your draft guidance is approved without a strong recommendation for universal N95 use in healthcare settings it will result in a long-term burden to the healthcare system and the health and wellness of Americans and the future of our country and should be a source of great shame for you personally and everyone at the CDC.
You know better. Do better.
Kyle Jackson
Indianapolis, Indiana

Hal Enerson
Port Angeles, WA

Affiliation: Director, NOLS - Retired (commenting as individual)

Comment:

CDC should reject HICPAC’s draft and actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft, including holding public meetings

Further, HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing transmission by air.

Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

Finally, CDC and HICPAC should make the process for updating guidelines fully open and transparent.

Thank you for considering my comments.

Hello!

- Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

I no longer feel safe going to any of my medical appointments. I get anxiety and have postponed many of them. I skipped my annual gym appointment when they dropped masking. I do not know if I will ever go back.

Surgical masks do not provide sufficient protection. N95 should be the masks for all.

All should be tested for Covid, RSV and flu routinely.

Personnel who are positive should be allowed paid leave or afford remote work if applicable.

Facilities should provide minimum air quality standards as those stated by the ASHRAE.

Covid is both airborne and much transmission is asymptomatic, so all precautions should be practiced universally at all times.

Itzel Kibler
Avon, CT
Concerned citizen, no organization

I am a 77-year-old woman with more reasons every year to need to see a healthcare provider in person while at the same time becoming more vulnerable. I'm not a professional in the healthcare field nor do I belong to any organizations. I'm simply one of many who find it unfathomable that the CDC would consider lowering infection control standards, thus endangering healthcare staff and patients.

I do everything I can to protect myself, my family, and others around me, including wearing a KN95 mask to all indoor settings, especially healthcare settings. I am completely up-to-date on all my vaccinations, I keep my home well ventilated and have air purifiers in all its rooms. But when I or a family member go to a healthcare setting, we're surrounded by people who are not wearing masks. And if and when we might need to be hospitalized we will be completely at the mercy of current hospital safety standards. That these standards, in a setting full of vulnerable people (hospital staff at all levels and patients who are already compromised), would be worse than what I practice in my own home is mind-boggling to me.

I have access to all manner of statistics and studies, but you are surely hearing about these from many with more expertise than I. I am simply one person making an impassioned plea to you to prioritize the health and safety of healthcare staff and patients over company profits.

Sincerely,
Lili Byers
San Francisco, CA
no organizational affiliation

To Whom It May Concern,

As someone who has seen the debilitating effects of Long COVID on my family and colleagues, affecting their productivity and health, I am deeply concerned about the proposed changes in the CDC's infection control standards discussed by HICPAC.

****Key Concerns:****
1. ****Aerosol Transmission:**** The guidelines must unequivocally recognize aerosol transmission of SARS-CoV-2 and enforce rigorous airborne transmission prevention protocols.

2. ****Layered Infection Control:**** Current proposals seem to dilute the effectiveness of layered infection control measures, essential for robust protection.

3. ****Universal Precautions:**** Given asymptomatic transmission, constant and universal precautions in healthcare settings are vital.

4. ****Employer Discretion vs. Public Health**:** The draft prioritizes employer discretion in implementing infection controls, which could conflict with public health interests.

5. ****Cost vs. Public Health**:** The high cost of protective measures like N95 masks and ventilation cannot overshadow their necessity for saving lives and preventing long-term health issues like Long COVID.

6. ****Community Transmission Reliance**:** Relying on 'community transmission' levels is ineffective due to current insufficient testing and data reporting.

7. ****PPE and Ventilation Emphasis**:** The draft overly focuses on PPE, neglecting other crucial elements like ventilation and testing.

8. ****Nosocomial COVID Risks**:** Higher mortality rates from hospital-acquired COVID-19 demand stricter, not relaxed, infection control measures.

9. **Economic Impact**:** Ignoring the spread of COVID-19 in healthcare settings overlooks the broader economic impact, particularly concerning Long COVID.

Process Concerns:**
- The swift movement of these guidelines through the review process, especially during the holiday season, raises concerns about comprehensive public and expert engagement.
- HICPAC's lack of diverse representation in crucial fields like aerosol science and patient advocacy is troubling and could affect the credibility of the guidelines.

Conclusion:**
I urge the CDC and HICPAC to thoroughly reconsider these guidelines, keeping in mind the lessons from the pandemic and prioritizing the health and safety of healthcare workers, patients, and the community. As a data scientist, my analysis of public health data has underscored the profound impacts of these decisions on public health outcomes and workforce productivity. It is crucial that these guidelines reflect the best practices informed by science and data.

Thank you for considering these critical points, Sincerely,
Eric Sherlock
Chicago, IL

To the HICPAC Members and their Staff:

It is evident that Covid is still a huge issue. As much as everyone would love it if the disease were behind us, wishful thinking is not science or reality. Healthcare experts must not give in to a lowering of standards. N95 mask requirements and air filtration with UV light along with thorough sanitation is known to be successful in infection control and good health outcomes. Proper discipline should be modeled by the healthcare community. This will be good for the economy and America's culture as a whole.

Thank you,

Rachel Whitmore, concerned citizen of America.
Enumclaw, WA

Hello,

I'm writing to comment on **HICPAC's drafted revisions to CDC guidance on infection control** and to urge HICPAC to recommend stronger protections in its guidelines. I feel disheartened that the proposed revisions provide an opportunity for loose interpretation and lack of attention to scientifically-proven infection control measures that help protect patients and providers alike. As a key component to these guidelines, HICPAC should be recognizing that COVID-19 is an airborne virus spread by aerosols, and implementing infection control measures based on this fact--respirators, air filtration, and ventilation are key in stopping the spread of this disease. Isolation and surgical masks are not enough to address the ease with which COVID-19 is spread. Indeed, these lax guidelines feel like an attempt to give unsafe behavior a pass for the purposes of cost-saving and ease for employers. But it is not cheap to be sick and disabled. From a provider perspective, it is not easy to run a healthcare system which seeks to treat and support patients experiencing Long COVID and its disabling effects. The HICPAC must take a long-term view and understand the impacts and implications of these proposed guidelines.

As a patient, I feel frustrated at the fact that every time I go to seek healthcare I am simultaneously putting my health at risk--by doctors, dentists, and fellow patients. Universal N95 masking, air filtration systems, and COVID testing and isolation practices (including paid sick leave) should be standard in healthcare settings. To advocate for less does healthcare workers and patients a huge disservice and puts their health at risk. Please revise your proposed guidelines to include stronger language and protocols around infection prevention in healthcare settings.

Sincerely,
Katharine Pong
San Francisco, CA
no organizational affiliation; concerned citizen and healthcare patient

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- **As the nurses union is urging, (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

--
Kristin Dodds
Pronouns She/Her

Joyce Green, Citizen of the United States, Robinson, TX
Voicing public comment on behalf of myself and the People's CDC

Covid-19 infections are continuing to harm and injure Americans. This can happen through the disease infectious period as well as suffering from long Covid after the initial Covid infection is over.
I have received every vaccination and update available. Still, I was infected at my dentist's office this spring and unknowingly brought the infection home to my husband with underlying conditions. While we both took Paxlovid, unfortunately my husband got rebound Covid within a few days of testing negative. Further, while I have been quite healthy and not on any long-term prescription drugs, I suffered at Transient Ischemic Attack this fall with no conclusion as to what the cause was and no family history of this type of health issue. My father was 95 before he suffered from an ischemic stroke. The question remains as to whether my body threw a

blood clot as a result of my earlier infection with Covid. I am now required to take two long-term prescriptions to hopefully avoid a TIA in the future.

All medical facilities, hospitals, clinics, dental offices, optometrists must be required to maintain a high state of infection controls to better control the spreading of Covid and other diseases which spread through simply speaking, laughing, etc. UVI lights, air purifiers, at least KN95 masks and other such methods must be instituted and/or continued for all medical facilities and personnel.

It is not fair for me, or any patient, to be afraid to get my teeth cleaned because of possible Covid-infected aerosols left in the room from the previous patient or the medical personnel employed.

HIPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach and it is not in the public's best interests to permit less cautious protections! Please do what is right for the American People and protect our health.

Sincerely,
Joyce E Green

To the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I write to express my strong reservations about the recent revisions in the CDC's guidance on infection control, which appear to prioritize flexibility for healthcare employers at the expense of healthcare workers and patients. These revisions fail to fully acknowledge the aerosol transmission of SARS-CoV-2 and overlook the importance of comprehensive, layered infection control measures to mitigate transmission risk. I believe that the proposed guidelines must be reassessed for the following reasons:

Recognition of Aerosol Transmission: The guidelines should explicitly recognize the aerosol transmission of SARS-CoV-2 and establish rigorous protocols to prevent "transmission by air." Failing to acknowledge
this mode of transmission may undermine efforts to control the spread of the virus in healthcare settings.
Layered Approach: Scientific evidence shows that infection control measures are most effective when implemented in a layered approach. This approach acknowledges that no single measure can provide complete protection and that a combination of strategies is necessary to reduce transmission risk.
Universal Precautions: Given the prevalence of asymptomatic transmission, it is essential that all precautions are universally practiced at all times in healthcare settings. This includes the use of PPE, hand hygiene, physical distancing, and proper ventilation to reduce the risk of infection.
High-Risk Environment: Healthcare settings are where high-risk individuals; seniors and the disabled, come into contact with infected patients, visitors, and staff. It is imperative that healthcare facilities and personnel employ all available precautionary strategies consistently to protect vulnerable populations.
Profit Considerations: The proposed guidelines seem to grant employers broad discretion in implementing infection control plans, which may be influenced by profit considerations or other factors unrelated to patient and worker safety. Protecting the health of healthcare workers and patients should take precedence over economic concerns.
Community Transmission: The current guidelines link the level of protection to the level of "community transmission." However, for COVID-19, community transmission levels are often

unknown due to limited testing, wastewater monitoring, and tracking and reporting of cases. This approach may result in insufficient protection during periods of high transmission.
Shifted Responsibility: The draft guidelines appear to place significant responsibility and risk on individual workers, with a heavy focus on personal protective equipment as the last layer of protection. Strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation are essential and should not be neglected.
Nosocomial COVID: Nosocomial COVID, transmitted in hospitals, has a significantly higher mortality rate than community-acquired COVID. Neglecting robust infection control measures in healthcare settings not only endangers patients and healthcare workers but can also lead to a higher mortality rate.
Long-Term Costs: Allowing COVID-19 infections to spread unchecked can have long-term costs that far exceed the expenses of providing N95s, fit testing, rapid molecular testing, ventilation, and isolation. The consequences of widespread infections and long-term health issues like Long COVID are immeasurable.
Sincerely,
Emily Damelio, Ben Carlson-Berne Scholarship Fund Coordinator
Cincinnati, OH

Public Comment by Colline Emmanuelle, an individual citizen, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for

health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please protect everyone by updating guidelines.

Sincerely,
Colline

Dear HICPAC Members and Staff,
Public Comment – HICPAC guidance on SARS-CoV2 infection control in health care settings re masking guidance
I support the section of your draft guidelines that recommend N95 (or better) masks in some cases, e.g. for emerging pathogens.
I do not support your recommendations, as applied to SARS-CoV2 aerosol controls. Available COVID vaccines do not effectively stop transmission of SARS-CoV2, are not utilized by large segments of the US population, and may not maintain their current efficacy given the rapid viral mutation. Optimum ventilation is still not widely available. There are reputable studies such as the Bangladesh study that show N95 use is at least 35% effective.
The CDC acknowledges that over 10% of infected people develop Long-COVID. Over the long haul, Long-COVID may be a more significant burden on individuals and society as a whole than acute-phase COVID. There are no pharmaceutical treatments available for Long-COVID. It is the duty of the healthcare community and HICPAC to reduce SARS-CoV2 transmission.
Airborne transmission of pathogens is reduced with proper use of N95 masks. This is clear in your “extended air precautions” guidance. If your draft guidance is approved without a strong recommendation for UNIVERSAL N95 use in healthcare settings, it will result in a long-term burden to the healthcare system and the health and wellness of Americans.
As a health care consumer, I am delaying some non-emergency health care due to concerns about the lack of N95 masking in health care facilities.
Thank you for your attention,
Barbara Reyes
Woodside Ca

My name is Brianna Pickett, I live in Rochester, MN and I'm writing about the HICPAC protocols regarding the loosening of infection control and prevention. This in unsubstantiated in this ongoing COVID pandemic and could harm countless invaluable medical professionals and the patients they care for. As the spouse of a medical professional, who still masks in an N95, to prevent illness for himself and our family, I am awed that you would consider loosening protocols for safety in the midst of a pandemic. This can only benefit hospitals budgets, and do nothing to care for actual human lives. Repeatedly being infected with SARS-COV-2 damages the immune system and is known to be oncogenic, detrimental to the vascular system, and aids in the development of autoimmune diseases, alzheimer's, diabetes, and more.

Please do the right thing: do not loosen infection control, please make the process for updating these guidelines transparent and public, please recognizes SARS-COV-2 as an airborne pathogen spread both asymptomatically and symptomatically, and please do your part to keep the most vulnerable in our society at the top of your mind as you make any changes.

We do not know if the next pandemic will be even worse than what we're seeing now with COVID. I beg of you for the sake of my husband, our vulnerable young children, and all of America. Please do the right thing and strengthen infection control standards and be transparent about it as you do!

Sincerely,
Brianna Pickett

The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” rather than infection control.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

As the nurses union is urging, CDC should reject HICPAC’s draft and “actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft” including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

Caitlin Olson
Reston, VA

Hello,

I am writing to request that you take ALL scientific evidence regarding communicable diseases into account as you make your recommendations. The science overwhelmingly shows that Covid-19 is an airborne disease and that masking — specifically universal masking – and high-quality air filtration prevent the spread of this disease that is continuing to cause both acute and long-term problems, even in healthy people. Long Covid develops in approximately 25% of people who get Covid, plus there’s increased risk of death in the year after an infection, cardiovascular problems like strokes and heart attacks, dozens of neurological problems like Parkinson’s disease and dementia and dysautonomia, autoimmune diseases, cancer, and more.

The people who are being affected most by Covid at this point are the most vulnerable — people like me and my parents and stepparents — who are also the ones who need the most in-person medical care. It's clear how to protect everyone, namely masking and air filtration, so it is unethical to put vulnerable people in danger when they are simply receiving their necessary healthcare, especially when there are such simple solutions. Simply going into a medical center without mandatory masking causes stress and fear for those of us who are already in precarious bodies and acutely aware of the potential consequences of even a single Covid infection; the stress alone can be enough to exacerbate symptoms.

In addition, research shows that it's possible that the risk of Long Covid and other problems increases with frequency of infection — at best, people are still exposed to the risks every time the virus invades their bodies. Regardless of prior infection or vaccination status, millions of people have and are still coming down with Long Covid, and, due to their exposure levels, frontline healthcare workers are at a higher risk of infection and therefore potentially Long Covid. By not protecting our medical professionals and people who support them, you're risking having major staff outages and even possibly the collapse of medical systems that would coincide with more people needing care due to Covid's acute and long-term consequences. That's true for everywhere, but especially in rural communities that are already struggling with far too few medical care options.

Ignoring Covid's airborne spread means putting lives, medical centers, families, schools, careers, businesses, and the economy at great risk both now and down the line. Again, masking and good air quality are obvious, science-backed answers that will help not only with Covid but with all respiratory/airborne diseases and will protect both patients and staff. To not require medical centers to mask and ensure good air quality is as ridiculous as allowing smoking in medical centers again and saying, "It's okay because it will only affect patients with asthma and COPD." No, not masking and not ensuring good air quality affects everyone both in direct and indirect ways.

You are a medical body. I urge you to follow the science, to follow the oath of "first do no harm," and to act ethically to do everything possible to protect not only the most vulnerable, whose lives matter and who deserve to be protected, but to protect everyone and all the systems both directly and indirectly involved.

Sincerely,
Katie Baron

November 6, 2023
Dear HICPAC/CDC members,

I am writing to express concern over infection control recommendations made at the November 2023 HICPAC meeting, and to encourage adoption of appropriate healthcare system standards for infection control that include universal N95/P100 respirator use.

I am a former social psychologist who worked in health risk reduction. I am also an immunocompromised health care consumer, made medically vulnerable by mixed connective tissue disease, cardiovascular and kidney disease, and both asthma and COPD. I am a heart attack survivor with 31% lung capacity, yet every time I seek medical care, convincing health care workers to protect my health by wearing an N95 becomes a major ordeal. More than once, I have had to leave a medical appointment without having obtained care because staff would

not don an N95, despite having supplies readily available. I have had to leave screenings to check for malignancy recurrence. I have had to leave a hospital ED to seek care at another hospital during a medical crisis, because health care workers would not mask even for just the few minutes they were in my presence. On every occasion, the reason provided was that the CDC does not require N95 use, and that the system's infection control chair has advised against N95 use on that basis.

Healthcare system representatives have repeatedly told me that, because N95s are costly, their use is discouraged among staff even during interactions with high risk patients such as myself. They say this will not change until/unless the CDC provides a clear recommendation for N95 use. But this issue is one that should be viewed in terms of the impact to human lives rather than to the short-term financial cost of PPE. Since the spring of 2020, it is likely that hundreds of thousands of Americans have been infected with SARS-CoV-2 and other airborne viruses while seeking health care, and that tens of thousands have died from those nosocomial infections.

Covid and other airborne infections remain a significant risk in health care settings. Implementing a standard of care that includes universal N95 use would do much to mitigate these threats to patients' lives and health; to the ability of healthcare systems to maintain the health of their workforce; and to the well-being of our nation. Improved PPE uptake by healthcare systems would also allow domestic PPE production to become economically sustainable, preventing anticipated shortages during future public health emergencies that are expected due in significant part to the present limited demand resulting from HICPAC/CDC recommendations.

Please put human lives before short-term economic agendas and corporate healthcare system profits; measures that decrease patient safety in order to curb costs are not sustainable in the long term for either human health or the economy – an economy in which I have been a productive participant, but on the altar of which I do not wish to sacrifice my literal life.

Sincerely,
Jessica Offir, Ph.D.
Coventry, CT

Good evening,

My name is Maggie Harding and I am writing as a follower of the People's CDC to urge HICPAC to draft, revise and implement policies and protocols that actually prevent infectious diseases and enhance policies that already exist. Any lowering or relaxing of healthcare infection control standards is dangerous and appalling, especially now that we live in a world where Covid exists and persists and the potential spread of disease due to climate change that will only increase.

I, as a civilian who could at any time become a patient, deserve to go to a hospital/clinic/etc. and be healed - not have my health and my life put in further danger. The doctors and nurses that treat me deserve those same protections as well. We need to keep ourselves and each other safe, especially in places like these where high risk, disabled, and elderly people and patients interact with infected patients and staff. Our health and our lives are non-negotiable and safety policies NEED to reflect that.

I urge you to achieve the highest standards for infectious diseases, airborne or otherwise, by looking and listening to science. In the case of SARS-CoV-2, we know it is transmissible via aerosol droplets and prevention protocols should reflect that as well as its asymptomatic

spread. In addition, HICPAC must involve and center the voices of healthcare unions, ventilation experts, occupational safety experts as well as the public when crafting these guidelines and the entire process must be fully transparent.

Respectfully,

Maggie Harding
Finksburg, MD
Member/Follower of People's CDC

Please err on the side of caution.

Safety in healthcare is important to all of us.

Sincerely,
Lee Ann Bryant

Dear Healthcare Infection Control Practices Advisory Committee

I'm writing today to ask you to listen to the science and the experts on air quality, transmission of covid-19, and stakeholders like myself who are concerned about our country's overall response to the ongoing pandemic. Although there is plenty that could have been handled better, you still have a chance to improve— literally improve life outcomes for many people. People that have Long Covid that must still visit hospitals frequently for the rest of their lives need to be safe from further infection. There are people who are disabled, there are people who are immunocompromised, the very very young, the very very old and every able-bodied person that risks disability when our medical spaces are not safe. I cannot state clearly enough that respect for people’s lives in containing and managing this virus is at the forefront of this demand.

I am not only writing from my position as chair of the Disability Caucus of the Iowa Democratic Party but as a person who is currently sick with Covid. My entire family is sick, and we believe that we contracted it at the Iowa City VA Medical Center where coughing people were in the building unmasked. Not only that, no practitioners of medicine appeared to be masked to protect the health of their patients. My husband, who has serious heart health issues was there for a Cardiology appointment. It remains to be seen whether his heart and vascular system will be affected by Long Covid which impacts many of the body's critical systems and affects disability status for otherwise abled people. The evidence of this is compounding.
It is your duty to protect the health of our citizens and the future health of every citizen.
You must step up and protect patients in the care of medical professionals. Proper PPE needs to be the standard of care in all medical settings as well as safe air ventilation of Merv 13 with 6 air exchanges per hour. Please fill the board with the right makeup of experts. Please do not ignore science, data and allow medical professionals to violate their ethics standards by putting their own convenience ahead of patient safety. It is one of the last places to expect safety from further infection and appropriate and humanitarian treatment people of all ages who are at risk of death and disability.
Respectfully,
Julie Russell-Steuart
Chair, Disability Caucus of the Iowa Democratic Party

Hello,

I am writing to urge that COVID continues to be seen as a significant threat to people's health. COVID must be recognized as an aerosol transmitted virus that is a significant hazard to people's health. There are many ways of mitigating spread that cannot be abandoned, ignored, or unused to bolster shareholder profits.

Masks save lives and people in healthcare settings must be required, not requested, to mask as ability permits. Air filtration reduces airborne transmission and all buildings should be retrofitted with well circulated, filtered air, with filters that can remove COVID from the air. High quality air filtration can reduce transmission even as the public is propagandized into believing that COVID is over. N95's, hand sanitizer, and rapid tests must be widely distributed free of charge. Hospitals must provide free vaccines and boosters to staff, patients and visitors.

COVID is not over until we implement zero COVID policies and people will continue to be disabled and killed by COVID until we do.

Thank you for receiving my feedback,

Cole Swenson

Date: 11/6/2023 1:15PM PST
To: CDC Healthcare Infection Control Practices Advisory Committee (HICPAC)
Subject: Implement effective Aerosol Transmissible Disease infection hazard controls for health care worker and patient safety

HICPAC should create concise control guidelines that recognize transmission characteristics of SARS-CoV-2. The Work Group on the Isolation Precautions Guidance must fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens.
There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for health care-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and have continued to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols.
- Much transmission is asymptomatic. Therefore, effective infection source control using high-filtration masks that are fit-to-purpose must be universally practiced at all times to control aerosol transmissible diseases.

- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all feasible infection control strategies for aerosol transmissible diseases.
- Pre-symptomatic and pre-positive-test transmission are possible and should not be dismissed or ignored.

CDC's own scientific briefs and research findings have demonstrated that masks are effective at reducing risk of SARS-COV2 infection, and that SARS-COV2 infection presents serious risks of adverse medical outcomes across the population of all people who enter medical facilities.

"SARS-CoV-2 infection is transmitted predominantly by inhalation of respiratory droplets generated when people cough, sneeze, sing, talk, or breathe. CDC recommends community use of masks to prevent transmission of SARS-CoV-2. Masks are primarily intended to reduce the emission of virus-laden droplets by the wearer ("source control"), which is especially

relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others (estimated to account for more than 50% of SARS-CoV-2 transmissions).1, 2 Masks also help reduce inhalation of these droplets by the wearer ("filtration for wearer protection"). The community benefit of masking for SARS-CoV-2 control is due to the combination of these two effects (source control and filtration for wearer protection); individual prevention benefit increases with increasing numbers of people using masks consistently and correctly." **Source: Centers for Disease Control and Prevention, Scientific Brief: Community Use of Masks to Control the Spread of SARS-CoV-2, Updated Dec. 2021, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html**
"Experimental and epidemiologic data support community masking to reduce the spread of SARS-CoV-2, including alpha and delta variants, among adults and children. The prevention benefit of masking is derived from the combination of source control and wearer protection. The relationship between source control and wearer protection is likely complementary and possibly synergistic, so that individual benefit increases with increasing community mask use. Mask use has been found to be safe and is not associated with clinically significant impacts on respiration." **Source: Centers for Disease Control and Prevention, Scientific Brief: Community Use of Masks to Control the Spread of SARS-CoV-2, Updated Dec. 2021, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html**

"A combination of HEPA air cleaners and universal masking reduced exposure by up to 90%... Portable HEPA air cleaners can reduce exposure to simulated SARS-CoV-2 aerosols in indoor environments, especially when combined with universal masking." **Source: CDC Morbidity and Mortality Weekly Report, Efficacy of Portable Air Cleaners and Masking for Reducing Indoor Exposure to Simulated Exhaled SARS-CoV-2 Aerosols, July 9, 2021 / 70(27);972–976, https://www.cdc.gov/mmwr/volumes/70/wr/mm7027e1.htm**

"Consistent use of a face mask or respirator in indoor public settings was associated with lower odds of a positive SARS-CoV-2 test result. Use of respirators with higher filtration capacity was associated with the most protection, compared with no mask use... In addition to being up to date with recommended COVID-19 vaccinations, consistently wearing a comfortable, well-fitting face mask or respirator in indoor public settings protects against acquisition of SARS-CoV-2 infection; a respirator offers the best protection." **Source: CDC Morbidity and Mortality Weekly Report, Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection, Feb 11, 2022 / 71(6);212–216, https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm**

It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.

The Work Group's proposals should not ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

Thank you for taking my comment.

Aaron Harris
Graduate Student
University of California, Davis

November 6, 2023
Dear CDC/HICPAC Committee:

I am an Occupational and Environmental Medicine Physician who has been practicing in both the public health and clinical arena for over 25 years. I have virtually attended the past 3 HICPAC committee meetings (June, August, and November 2023) with the specific interest in HICPAC's recommendation to CDC for updates to the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. The former and current Deputy Chief for Health for the Division of Occupational Health & Safety (Cal/OSHA) provided oral comments at these meetings. I worked at Cal/OSHA and the California Department of Public Health (CDPH) during the time California promulgated the first in the Nation regulation that specified protections for healthcare workers exposed to aerosol transmitted infectious agents. This regulation was ground-breaking in its scope and established the necessary engineering, administrative, personal protective, training, and other measures required to protect this workforce. California was fortunate to have this regulation as a roadmap when SARS-CoV-2 emerged in 2020. Despite this regulation, California's workforce and vulnerable communities experienced unprecedented morbidity and mortality related to COVID-19. This was in part due to shortages in required personal protective equipment (PPE) and confusing messaging, including from the CDC, about how this virus spreads and recommended protections. Fortunately our Aerosol Transmissible Diseases (ATD) regulation, CCR Title 8 Section 5199 (5199), calls for specific protections for novel viruses, so we had a strong foundation for how best to protect against this novel viral agent, but CDC recommendations carry tremendous weight and should align and be defensible.

The draft proposal passed by HICPAC on November 3rd does not support the requirements embedded in CA's ATD standard. This is concerning. Cal/OSHA went through a lengthy process when promulgating this regulation, incorporating input from multiple experts and stakeholders from all sides of this issue to ensure that appropriate provisions were included. This process took years to complete, and it was entirely transparent with respect to participant inclusion, availability and documentation of drafts and revisions, statement of reasons, including justifications for specified requirements. The best product comes out of such transparent efforts because it encourages questions, discussion and justification. This has not been observed with HICPAC's process. I am sincerely perplexed and deeply concerned that HICPAC has refused to acknowledge the process and other specific concerns raised by stakeholders and experts, including industrial hygienists, aerosol scientists, state and federal public health officials and advocates, healthcare workers, patients and families advocating for vulnerable family members.

As a Medical Director for Employee Health at a major healthcare facility in Northern California I engaged regularly with the Infection Control committee. We did not always see the issues eye-to-eye, because we actually came from different training, backgrounds and perspectives. But, this yielded a robust discussion, sharing of information, and ultimately a more defensible outcome. I strongly believe HICPAC is making a critical error to shut down input and ignore feedback. The feedback HICPAC has received, including the over 600 pages of public

comments from one meeting alone, has merit and value. Ignoring it sends a message of disregard for healthcare workers, vulnerable patients and communities. Healthcare workers have been described as heroes–those who constantly risk their own lifes and wellbeing to ensure the safety and wellbeing of others. Interested parties have shown up at your meetings to make oral comments and have submitted written comments. The comment period is not designed to be a Q&A, but the committee has not shown the decency or respect to acknowledge the concerns raised, by making or even discussing requested edits to the draft document or its process. This committee obviously cares about the quality of its product. It spends hours wordsmithing during its public meetings, but the questioned content does not get the same intense scrutiny or attention. I am frankly embarrassed for HICPAC for holding the vote and moving a flawed document on to the next stage of this process. No legitimate committee that serves the public's health should conduct its business in this fashion.

Sincerely,
Janice Prudhomme, DO, MPH
Retired Annuitant, Cal/OSHA Medical Unit
Former Public Health Medical Officer, Occupational Health Branch and Environmental Health Investigations Branch, California Department of Public Health (CDPH)
Former Assistant Deputy Director, Center for Healthy Communities, CDPH

To Whom It May Concern,

I respectfully ask that you allow for additional patient feedback and implement more precautions be taken on behalf of sick Americans seeking medical help during the time of COVID. Please include my comments in public record for the recent meeting.

On 9/22 my father was recovering from surgery at a top Chicago skilled nursing facility and contracted COVID as did a number of other patients. At both Northwestern Memorial Hospital and the skilled nursing facility, staff, doctors (including the surgeon) and nurses were not wearing masks around him - despite community spike. They were aware that he was on immunnosupressants and yet they did not protect him. During the height of COVID, he was hospitalized 20 times and never contracted COVID because staff and doctors were wearing masks. And when the masks came off, he got infected.

Because he had a compromised immune system, he was struggling to clear the infection. We brought him home for hospice in mid October for a few days, only to learn that nursing agencies would not send nurses as long as he was testing positive. As a result, he could not die at home as he wished because we couldn't get help in caring for him. After a few days at home he was sent back to the skilled nursing facility to die without his family nearby.

I can't tell you how painful it is for me to not have been at my father's side as he was dying. He devotedly stood by my side all through my life and because I'm immunnocompromised and a facility did not protect him, I could not be by his for his final days. The last time I looked into his eyes, he looked terrified. He died alone on 10/21 still testing positive for COVID.

I ask that you prioritize providing safe access to medical care for those who are vulnerable. I'm exhausted by the lack of support and the challenges thrown at me by the medical community as I navigate my own disease and the passing of my dear father. Additionally,I know many of us

who are most vulnerable have come to avoid seeking much needed medical attention as a result of current policies and recommendations.

Thank you for your consideration.

Kirstin Osgood

Dear HICPAC Members and Staff,
Public Comment – HICPAC guidance on SARS-CoV2 infection control in health care settings re masking guidance

I support the section of your draft guidelines that recommend N95 (or better) masks in some cases, e.g. for emerging pathogens.

I do not support your recommendations, as applied to SARS-CoV2 aerosol controls. Available As a health care professional, I hope you will consider my input regarding COVID protection in health care settings. I am in support of UNIVERSAL N95 use in all health care settings. COVID vaccines do not effectively stop transmission of SARS-CoV2, are not utilized by large segments of the US population, and may not maintain their current efficacy given the rapid viral mutation. Optimum ventilation is still not widely available. There are reputable studies such as the Bangladesh study that show N95 use is at least 35% effective.

The CDC acknowledges that over 10% of infected people develop Long-COVID. Over the long haul, Long-COVID may be a more significant burden on individuals and society as a whole than acute-phase COVID. There are no pharmaceutical treatments available for Long-COVID. It is the duty of the healthcare community and HICPAC to reduce SARS-CoV2 transmission.

Airborne transmission of pathogens is reduced with proper use of N95 masks. This is clear in your “extended air precautions” guidance. If your draft guidance is approved without a strong recommendation for UNIVERSAL N95 use in healthcare settings, it will result in a long-term burden to the healthcare system and the health and wellness of Americans.

This is an easy way to control a serious, even deadly disease. Please do it!

Thank you for your attention,
Susan Miller, M.A., CCC-SLP
Sonoma, CA

To Whom It May Concern,

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Dear HIPAC Members and staff,

I would like to submit a public comment concerning your COVID health care infection control guidance. COVID is classified as a type 3 biohazard, and the protocol for dealing with such a

hazard is to wear protective equipment, including a respirator; the use of respirators should be encouraged to reduce the spread of COVID.

Respirators are cheaper than N95 masks because they are reusable. A tuberculosis hospital in Texas has successfully followed this approach.

Sincerely,
Edward Qubain, concerned citizen
Lexington, VA

Hello,

My name is Samantha King-Shaw and I am writing to urge that the CDC/HICPAC continues to understand that COVID remains a significant threat to public health and the wellbeing of people in the U.S., and that these organizations *continue to act as such*. COVID is transmitted by air, and the new guidelines must include protocols for preventing transmission by air. Further, because much COVID transmission is asymptomatic, rigorous protection and precaution needs to be practiced at all times, especially in health care settings where vulnerable populations are seeking care. Practices to stop the spread of COVID must not be abandoned or ignored to increase shareholder profits.

Universal masking is necessary to make healthcare settings safer for everyone, especially immunocompromised and otherwise disabled people who are particularly vulnerable to COVID. Surgical masks do not provide adequate protection against COVID, so N95 respirators must be the universal standard for healthcare workers, to protect both themselves and their patients.

COVID is a public health issue, and should not be left up to individual workers' or workplace decisions. Masks, high quality air filtration, testing, and reliable infection rate data are all crucial to reducing COVID transmission, and therefore reducing COVID-related death and disablement. Additionally, resources including rapid tests, adequate masks, hand sanitizer, and vaccines/boosters must be made free and widely available.

Just because the state of emergency has been repealed by the government does not mean that the pandemic is over. COVID remains a significant cause of death among US Americans, and the long-lasting effects of Long Covid as a disability have yet to be truly felt and understood. COVID is not over! It is your responsibility to protect the health and wellbeing of the American public.

Thank you for receiving my feedback.
Samantha King-Shaw

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i’m emailing to urge the CDC to have N95 respirators as the standard in all healthcare settings. enough of the senseless deaths, be human and protect the patients, and the workers.

November 6, 2023

CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC)
MS – H16-3, 1600 Clifton Road Atlanta, GA 30329-4027
hicpac@cdc.gov

Re: November 3, 2023, Vote to Accept Draft Revisions to the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

The American Association of Occupational Health Nurses (AAOHN) would like to take this opportunity to comment on the draft revisions to the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings that were approved at the November 3rd meeting. We are concerned that this process was not conducted in a transparent manner (with the draft only being provided on the day of the meeting). It is also concerning that none of the public comments and requested revisions provided to you by aerosol scientists and occupational health experts were considered in this final draft.

The new category of "air" transmission, as written, fails to recognize the critical role of inhalation in health care worker exposure and work-related illness. The use of surgical/medical masks will not provide respiratory protection against the inhalation of infectious aerosols, and the FDA, NIOSH, and OSHA have been clear and consistent on this point. Only properly fitted respirators (like N95s and Elastomeric) or PAPRs can be considered PPE for the prevention of aerosol transmission.

We reiterate that the Work Group's proposals will ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and their patients. Health care workers are already leaving the profession from the strains of working through the pandemic with inadequate PPE, while also experiencing higher rates of pandemic-related illness and death. Reducing the workplace protections for health care workers at a time when we should be proactively preparing for the next pandemic will only further contribute to the health care worker crisis.

As experts in the field of occupational health nursing, we would welcome an opportunity to partner with your committee in the future to advance and protect the health and safety of the health care workforce, and the patients they serve.

Yolanda Lang
Yolanda Lang, PhD, MSN, CRNP, COHN, FAAOHN
AAOHN President

Dear HICPAC Members and Staff,

Public Comment – HICPAC guidance on SARS-CoV2 infection control in heath care settings

I am happy that the draft guidelines include recommending N95 or better masks in at least some cases. However, I am deeply upset that the recommendations on the whole, when applied to SARS-CoV2 aerosol controls, will do nothing to reduce SARS-CoV2 infection in healthcare settings. That a fatally flawed document was used as a basis for this decision is disturbing to me (Cochrane), as is the lack of any HICPAC staff having expertise or basis in aerosol science. Additionally there have been a number of troubling departures from the stated rules for transparency and process which must be clearly addressed if HICPAC and all organizations associated with it intend to retain credibility with the public.

Further, using pharmaceutical treatments which are only bale to reduce severity of symptoms, and/or increase survival rates for those hospitalized for SARS-CoV2 is a fundamentally incorrect way to approach infection control in any setting. The treatments do not, and can not stop transmission, and this includes all currently available vaccines. It is also worth considering that vaccine uptake is extremely low, with no indication it will improve any time soon; and the available pharmaceuticals have limited availability in our healthcare setup. It also bears

consideration the rate that SARS-CoV2 is mutating to evade the shots and other treatments, as well as any adjustments individual immune systems may have made.

I also think that Long-COVID has not been taken any where close to as seriously as it should be. Currently the CDC says that 19% of people infected with COVID develop Long-COVID. As infections continue completely uncontrolled, this will catch up with more and more people, leading to catastrophic effects for those individuals and our society at large. Currently there are no treatments for Long-COVID, and while some percentage of people naturally recover, many more continue to be affected or even deteriorate. The only way to protect people at this time, from a potentially calamitous number of people being disabled with Long-COVID, is to use aerosol science to reduce the aerosol load of SARS-CoV2 in healthcare settings; and really in all settings. As healthcare professionals, it is a moral imperative to take aggressive steps to ensure the cleanest air possible in all healthcare settings.

You have shown that you know that airborne transmission of pathogens is reduced with proper use of N95 masks. This is clear in your “extended air precautions” guidance. Therefore your guidance as it applies to SARS-CoV2, is clearly insufficient, and dare I say: negligent. If your draft guidance is approved without a strong recommendation for universal N95 use in healthcare settings it will result in a long-term burden to the healthcare system and the health and wellness of all Americans.

Thank you for your attention,
Jon McConnell, Concerned Citizen
Milwaukee, WI

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (“air” and “touch”) – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of “air” and “touch” as modes of transmission

for healthcare-related infections. While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thank you,
Bonnie VanKeersbilck
Michigan

Hello -

The revised guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”

Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.

Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement

or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” rather than infection control.

Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.

The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.

Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Regarding specific layers of protection:

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

HICPAC’s deceptively-named “Enhanced Barrier Precautions” scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.

Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.

Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.

Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.

Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Regards,
Joseph Boyle

The CDC should be fired at this point for failing to do their job. The rest of us would have been...

To HICPAC:

SARS-CoV2 is a Level III Biohazard spread via aerosols, and is largely spread by infected individuals who are asymptomatic.

There is no dispute about this fact, which has been well understood for years.

There is also no dispute re. the long term general organ damage and immune system disregulation caused by the pathogen, even in asymptomatic cases.

There is also no dispute that the immunocompromised, who typically make up an overwhelming proportion of individuals who must attempt to access health care in hospitals, clinics, doctors offices, etc., are particularly at risk to SARS-CoV2.

There is also no dispute that the risk of SARS-CoV2 can be significantly mitigated in health care settings by the enforcement of strict rules to implement N95 respirators, (NOT surgical masks that do nothing to arrest the spread of aerosol- borne pathogens), HEPA filtration, and near and far UVC light.

In view of these facts, since your organization seems poised to remove all protections for patients and staff in health care settings one can only conclude that the members of HICPAC are either serving an agenda completely, or are incompetent.

Should you fail to recommend the proper mitigations against this pathogen, the consequent fact that immunocompromised patients, and indeed any patient, will be forced to choose between accessing vital health care and protecting themselves and their loved ones from SARS, thanks to your malfeasance, will go down in history as one of the greatest practical and ethical failures in the history of medicine.

Sincerely,

William Wright
Concerned Citizen

Los Angeles, CA

Dear Healthcare Infection Control Practices Advisory Committee,

I am writing to comment on the HICPAC Infection Control Changes. The proposed updated guidelines are inadequate and must be reconsidered. Protocols must account for the science of SARS-CoV-2 infection control: given the aerosol transmission of the virus, rigorous protocols must be instituted for preventing “transmission by air.” The science also demonstrates that infection control measures are most effective with layered with other infection control measures. This is the most effective way to reduce transmission risk. Additionally, because so much transmission is asymptomatic, all precautions need to be universally practiced at all times.

Because healthcare settings are places where senior, high risk, and disabled individuals mingle with infected patients, staff, and visitors, healthcare facilities should use precautionary strategies at all times. As someone who is high risk, it is very important to me that healthcare facilities employ layers of precautionary measures at all times. If healthcare visits mean increasing my risk of exposure, I may choose to forgo care, especially during times of peak viral transmission.

I’d like to make two final points: First: The draft guidelines focus on maximizing flexibility for healthcare employers—not protections for healthcare workers and patients. As a result, they give employers the broad discretion to choose, implement, or restrict their own infection control plans, which may be based on things other than than infection control—that is, other than the health of patients, staff, and visitors—such as profit considerations or on prioritizing seeing “smiles” rather. This is unacceptable. Second: The draft fails to set strong standards for crucial tools such as ventilation, testing of patients and staff, and isolation. Instead, it inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection—personal protective equipment.

Thank you for your consideration,

Colleen Lanier-Christensen, MPH
Harvard University
Cambridge MA

Please listen to National Nurses United and reject these changes. Healthcare settings are where high risk, disabled, and seniors mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times. **Vaccines reduce but don't stop transmission of aerosol-transmitted infectious diseases!**

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
Letting COVID-19 infections run rampant *will* be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

Thank you,

Megan Groves
Chicago, IL

Comments on Healthcare Infection Control Practices Advisory Committee (HICPAC) to revise the CDC's "Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings".

When I was younger, I worked as an inpatient unit clerk at a hospital that offered professional staff then new Hepatitis B vaccine. Clerks weren't offered it. We were told we had no exposures. The decision was so flawed that it got clerks discussing collective action, organizing. Facing the prospect of us unionizing, admin allowed clerks to get vaccinated. They only did it when NOT protecting us from hospital-acquired infection might hurt their bottom line. During the fight to get my hospital to provide HBV preventative measures for all employees, I wasn't aware of boards and committees like the current CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC). If I'd known, I'd have written to them then as I am now. But now, the fight is bigger. Now, it's HICPAC making it harder to control ALL infections in ALL healthcare settings. Now, I'm writing as a medically complex, disabled person. As someone who has post-infectious complications from an influenza infection ten years ago. I'm writing as someone who doesn't want to get sicker or die for healthcare executives' bottom line, who thinks that no one should have to worry that we'll get sick, or sicker, or die for trying to get or give care.

The CDC must reject HICPAC's proposed Isolation Precautions Guideline draft. Redo it with a transparent process involving those most impacted by these decisions and least able to afford the risks healthcare execs would impose on us. Do it with science driving the recommendations, rather than as recommendations crafted to further financial goals of healthcare executives. The next draft guidelines must be developed using the Federal Register for public notice and comments. They must be created using virtual and hybrid "town hall" style meetings with reasonable opportunities for input from all stakeholders including: healthcare staff and their representatives; engineers with expertise in ventilation design and operation; research scientists with expertise in aerosols and respiratory protection; scientists from NIOSH's National Personal Protective Technology Laboratory and the Occupational Safety and Health Administration; as well as patients, independent patient advocates, and disability justice groups.

The new draft must address disease transmission in healthcare. It must recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category. It must include guidance that the use of multiple control measures have been shown to effectively

prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).

It must: communicate that each infection control measure is most effective when other infection control measures are also used in a layered transmission reduction approach; implement mandatory continuing education with updated aerosol transmission information and fit testing for all healthcare staff; and recommend development and dissemination of education about updated aerosol infection transmission information for all patients and visitors in the form of accessible multi-lingual videos, digital materials, and pamphlets.

I'm writing messier than I want, pressed for time. This is how HICPAC wanted it - hoping those of us most affected, most at risk, would be too busy to write. Well, I'm writing. Mess, pain, starving, and all. Others will too. Hopefully many will write this better, but this is personal for me, and so you're getting this messy personal message which is: Do better, Stop putting my life at risk, stop forcing us to pay for healthcare executives' egos and profits with our lives, don't make policies that make hospitals make us sick.

Laura Sabadini
Weymouth, MA
No affiliation, just a sick person.

I am writing out of concern of the blatant disregard of science and human life in the CDC's Healthcare Infection Control Practices Advisory Committee (HIPAC) latest proposal to revise CDC guidance on infection control standards for hospitals, nursing homes, and all US healthcare settings.

I spent last winter and spring trying to keep my dying mother from dying from COVID, which would have been a more terrible death than she had already been dealt. I spent so much of my time with her in the hospital and in the nursing home requesting that the nurses who came into her room put on a mask so that they would not transmit COVID. The CDC has already failed in its messaging to the public, and the average person—including a healthcare worker—is oblivious to the facts that COVID is airborne, asymptomatic transmission happens all the time, and that none of the vaccines available thus far fully keep one from getting COVID, transmitting COVID, getting Long COVID, or dying from COVID.

On two occasions last spring, the nursing home in which my mom resided had a COVID outbreak bad enough that they requested that visitors stay away. During this time, I was notified that the nurses TURNED OFF the air purifier in my mother's room because they didn't want it spreading germs. This level of ignorance and your lack of leadership is why COVID is still rampant in nursing homes and other healthcare settings where high risk, disabled, and seniors are becoming infected from other patients, visitors, and staff at a rate that is simply immoral.

Healthcare facilities and personnel should always employ the best, known precautionary strategies at all times. We have learned that nosocomial COVID (transmitted in hospitals) has a 10% mortality rate—more deadly than community-acquired COVID; therefore, suggesting anything less is murderous.

I am glad that my mother passed away when she did because I could not bear another month of fighting with nurses to put on an appropriate mask, over their nose, so that they wouldn't get my mom sick, me sick, or my kids sick—not to mention anyone else in the facility. What has our

healthcare system come to when the patients on their deathbeds and their visitors are forced to advocate for safe and effective healthcare precautions?!

Finally, I urge the CDC to simply reject HIPAC's draft, for this committee and process has not included the input of frontline healthcare workers, public health experts, occupational health and safety experts, aerosol scientists, industrial hygienists, clean air engineers, nor the public. This process for updating guidelines needs to include these voices and be fully open and transparent.

Sincerely,
Holly Jean Richard
Beresford, SD
Citizen, no organizational affiliation

Hello,

My name is Emily and I am disabled and immunocompromised, which places me at high-risk for Covid. My husband is also high-risk, although even if he wasn't, we would want to avoid Covid at all costs, as it is a mass disabling event. Due to my disabilities, my husband comes with me to my many doctors appointments and treatment sessions.
The proposed drafts are very dangerous to all, and especially disabled people and immunocompromised folks. If these guidelines are decided upon without changes, Covid will continue to spread through medical centers, HCWs will continue to get sick and spread to patients, and HCWs, who have some of the highest rates of Long-Covid, will continue to leave the profession. If I have to choose between receiving care and possibly getting exposed to Covid or staying home and putting off care, even if it means I suffer longer, I will put off care and stay home.

Covid is airborne and deadly and should be treated as such. Please institute universal masking- it improves health outcomes for all and creates an accessible health care setting for high-risk patients like myself.

Sincerely,
Emily Richey-Stavrand
Lexington Park, MD
No organizational affiliation

Good evening,

My name is Melanie Gleason, and I am submitting a public comment to deeply and strongly disagree with the 11/3 HICPAC decision to approve draft proposals to revise CDC guidance in numerous ways that would undermine long-standing infection control standards for hospitals, nursing homes, and all US healthcare settings.

I have lifelong chronic asthma, and continue to be at higher risk for acquiring further disability from an acute/long COVID-19 infection during this ongoing pandemic—a disabling and deadly virus that is airborne. Visiting healthcare facilities that do not employ universal masking, is violating my human right (as well as immeasurable others) to access safer health care—as the mortality rate of dying from COVID at hospitals is at a staggering 10%—higher than community-acquired COVID infections.

Universal masking at hospitals, nursing homes, and all US healthcare settings are essential to make healthcare settings safer for *all* of us during the ongoing COVID-19 pandemic—and particularly those of us who are at higher risk. Surgical masks are not adequate to protect against airborne pathogens, including COVID-19—and the science clearly illustrates that. N95 respirators or better need to be the updated medical standard of care, and healthcare employers must not prohibit workers or patients from using them. In my opinion, prohibiting workers or patients from using them is medical negligence, as present and emergent data and science continue to demonstrate the disabling and deadly effects of acquiring an acute/long COVID infection, especially after multiple infections.

Furthermore, all healthcare personnel should be regularly tested for COVID-19, RSV, and flu regularly, especially during peak season—to help mitigate transmission when it is among the highest. Additionally, personnel who are infected need access to paid leave, and are allowed to stay home until symptoms improve, and testing is negative.

Hospitals also need to ensure both personnel and the broader population has consistent access to current COVID vaccines/boosters. Furthermore, vaccines are a necessary part of the overall mitigation strategy—it is also one out of a number of mitigating components. It has been demonstrated that current vaccines reduce but critically do *not* stop transmission of aerosol-transmitted infections diseases—so the above re: masking needs to be implemented as the standard of care to meet the ongoing moment in these precarious, further disabling, and deadly times, as additional pandemics continue to descend.

Finally, health care facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. Negative pressure rooms are also still essential for these serious airborne infections.

This is an ongoing public health issue that affects every single one of us in this country, and it is the responsibility and duty of HICPAC not to look away from this and weaken infection control standards. In this ongoing era, where dangerous airborne pathogens continue to be widely circulated, healthcare facilities cannot stand idly by—and in this case, further enable mass disability and death. Your agency has a powerful and direct influence on the collective well-being and public health of this country—these standards will be determinative in the life or death of millions.

Sincerely,
Melanie Gleason, Esq.
Public Interest Attorney
Lowell, MA

Dear HICPAC,

I am writing as a concerned individual and member of the Transplant Recipient and Immunocompromised Patient Advocacy Group (TRAIPAG) with regard to CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) which is in the process of proposing updates to the 2007 Isolation Precautions guidance. These proposals as presented in June 2023 would weaken existing CDC guidance and put health care workers and patients at increased risk of a wide range of infections.

As an immunocompromised solid organ transplant recipient, I am concerned for myself and other vulnerable folks, as these policy updates assuredly will lead to hospital/medical care setting infections leading to pushing vulnerable folks 'by the wayside' through weakening infection control practices.

Instead, I strongly recommend the infection control practices be *strengthened* to prevent medical setting infections in vulnerable patients such as the immunocompromised, the elderly, and the very young instead of the current approach of weakening them.

In addition, I'm concerned that the CDC/HICPAC follow a fair process and science-based protections for healthcare workers and patients in a pandemic by a BSL3 level airborne pathogen, SARS2! This is essential for patient centered care and for preventing unnecessary infections!!

Specifically:
• CDC/HICPAC needs to delay the vote until they have given the public ample opportunity to review the draft Isolation Precaution guidance updates.

• CDC/HICPAC must hold public meetings—ahead of any vote—to hear from health care workers, patients, and experts outside of infection control, who have essential perspectives for updating the Isolation Precautions guidance.

• CDC/HICPAC must fully recognize the science on aerosol transmission of infectious diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. Aerosol scientists/engineers should be included as subject matter experts in the transport of infectious aerosols in indoor settings.

• There is a big difference between N95 respirator and 'loose' blue surgical mask protections, and the evidence review on N95 respirator and surgical mask effectiveness was flawed. It must be redone with input from scientific researchers and experts in respiratory protection, aerosol science & engineering, and occupational health. The draft evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is unconscionable that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased and flawed review.

• HICPAC’s Work Group on the Isolation Precautions Guidance has proposed adopting a more “flexible” approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations.

I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

• CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation in the poorly written draft. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please include aerosol scientists/engineers and other subject matter experts who prioritize the health and safety of staff and patients from infection in indoor medical venues and redo the draft with a patient safety focused approach to prevent unmitigated infection thru aerosol spread in medical settings.

Thank-you in advance for your time and consideration to this important safety topic and feedback.
Best Regards,
-Donna Jean Kaiser
North Reading, MA

Hello,

I am writing to express my strong opinion that the CDC rejects these guidelines to better protect public health. This matter is important to me, as someone who is at higher risk for infection and complication from covid and other viral diseases.

Science shows that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.

Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Thank you for considering these concerns.

Best,
Augustin Kendall
Minneapolis, MN

Dear Sirs and Madams,

1. It is clear that SARS-CoV-2 (COVID) is propagated among people by airborne transmission in droplets AND aerosols. There is no longer any uncertainty about this.
2. All personnel employed in healthcare settings need to be required to wear an N95 or equivalent respirator when they are in those settings. We know that respirators are effective in interrupting aerosol transmission, we know that SARS-CoV-2 is transmitted through aerosols, we know that people an be asymptomatically infected with SARS-CoV-2 even if vaccinated, therefore, it is in the interest of the health and well being of patients, those accompanying them AND healthcare providers that ALL persons should be required to wear a respirator when on the premises of a healthcare setting.
3. Surgical masks are not sufficiently effective at preventing the aerosol spread of a vascular damaging neurodegenerative virus such as SARS-CoV-2. We have known this since 2003 with SARS-CoV-1.
4. In addition, healthcare facilities should employ all effective measures to clean the air in healthcare settings to include HEPA grade filtration, ventilation with outside air, and far UV illumination. Four years into this pandemic, we have learned about the prevalence of hospital/healthcare acquired infections.
5. As an entity, HICPAC has a particular responsibility to the public. Towards this end, aerosol experts should be engaged to determine how best to achieve a safe environment for all who enter the doors of any healthcare facility. And, the outcomes of that engagement needs to be made public in real time to improve the transparency of this process.

Respectfully,
Mary Kay Woodward
Affiliation: Concerned Member of the Public
Fort Collins, CO

Name: Clarice Rheault
Minneapolis, MN
Organization: Not affiliated with any organization
Topic: Proposed updated hospital guidelines

I am writing to implore the HICPAC to do the right thing for science, public health, and humanity. Several people in my life have had their health and lives debilitated after getting infected with COVID and I find it sickening that hospitals are allowed to negligently infect patients in their care with this life-ruining virus (and other preventable viruses) rather than standing by the oath all healthcare professionals take to do no harm. I agree wholeheartedly with the following statement from the People's CDC:

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is

spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Topic: Responding to and protesting the new Isolation Precautions Guideline document
Name: Annalisa Schaefer
Trumbull, CT
Organization: The WHN

I'm writing again to object to the latest HICPAC draft. As a high risk patient and a mother of young children I am frightened by the direction HICPAC seems to be going. The new attitude inappropriately shifts responsibility and risk to individual workers, who are already overworked and suffering burnout. These guidelines focus almost exclusively on what should be the last layer of protection, PPE, while refusing to set strong standards for other crucial systems of protection such as ventilation, air filtration, testing of patients and staff, and isolation. What would be so onerous about recommending cleaner indoor air in facilities where the vulnerable gather to seek medical help?

As a patient I can't see this latest move by HICPAC as anything other than literally refusing to protect patients, staff, and communities properly. The science is clear. The evidence shows that the current systems aren't working and need improvement. Why is HICPAC choosing to embrace increased disease burden?

In 2021, when testing and masking were universal, I felt safe enough when receiving routine prenatal care. I felt safe giving birth and allowing my newborn baby to be taken care of in the hospital nursery. I cannot imagine having another baby and being at the mercy of unmasked, untested, often Covid positive medical workers. Well, I can imagine it: I imagine being forced to attempt to care for my newborn while one or both of us is sick with Covid-19, or RSV, or any other airborne illness. Newborns can't even be vaccinated against Covid or wear respirator masks. They are defenseless. Why is HICPAC implementing minimal protection in environments where tiny infants are entirely at the mercy of adults to protect them from preventable disease?

When I imagine having a baby under current conditions, I also imagine the devastation of developing Long Covid from an infection. Parenting is already hard enough without organ damage and other complications. Why isn't HICPAC cognizant of this? Millions of Americans already suffer from Long COVID. This includes children.

People of all ages are positioned to suffer from weakened protections. HICPAC's inappropriately-named "Enhanced Barrier Precautions" concept would radically weaken barrier precaution standards for nursing homes and potentially other health care settings. Why would it ever be considered a good idea to let patients with Candida auris or MRSA interact with other vulnerable patients without restriction? Why would HICPAC encourage letting un-gowned staff work with infected patients? Under the "Enhanced Barrier Precautions" guidelines the staff could then spread dangerous pathogens widely! My elderly father is now in a rehab facility. I am already braced to hear that he has caught a preventable infection there. The HICPAC proposals would make that even more likely.

It doesn't have to be this way. It shouldn't be this way. Medical facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. It can only be beneficial. Less infection is good for patients. Less infection is good for workers. Less infection is good for families. We are already struggling to keep going, to keep up with the demands of work and childcare and maintaining our homes and health.

Please don't make it harder. Improve the systems that we live under, reduce disease burden, and feel proud that you made the world a better place.

Hello,
I am writing to echo the sentiments of the authors below.

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Robin Wallace

Oliver Wilson
Somerville, MA
Massachusetts Coalition for Health Equity
Topic: **Draft 2024 HICPAC Guidance to Prevent Transmission of Pathogens in Healthcare Settings**
My name is Oliver Wilson. I'm submitting a public comment on behalf of Massachusetts Coalition for Health Equity, a diverse coalition of healthcare workers, public health advocates, and community leaders who recognize that equity and justice are essential to the health and wellbeing of all residents of Massachusetts. We are writing to urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance.
For many of our members, our daily lived reality is that we can no longer safely access healthcare. Many of us have medical conditions that, according to the CDC, put us at higher risk of severe outcomes from COVID. As a result, we cannot safely access healthcare unless healthcare providers, patients, and visitors all wear high quality respirator masks such as N95s. One-way masking offers insufficient protection, and data on surgical masks shows they do not provide adequate protection compared to N95 respirator masks worn by both doctor and patient. Note that as the virus continues to mutate, current vaccine technology may be unable to afford even basic protection against COVID, which is transmitted through infectious aerosols and which is asymptomatic in 40% of cases. Anyone (patient or staff) can potentially transmit the infection. The lack of appropriate respiratory protection in healthcare settings will inevitably lead to increased COVID transmission in patients and healthcare workers. Furthermore, COVID in staff will only worsen the healthcare workforce crisis.
Since the end of the federal and state Public Health Emergency on May 13, all hospital systems in Massachusetts have dropped universal masking. Additionally, almost all of our requests for universal masking as a reasonable accommodation under the ADA have been denied. It should be emphasized that The Americans with Disabilities Act safeguards the rights of disabled people, as well as those who live with or care for them. As a result, not only do we put ourselves at risk when we access healthcare, but our federal and human right to safe healthcare is being violated. 200 people from across Massachusetts have signed a public letter saying that they are also locked out of healthcare for similar reasons.
CDC's disgraceful handling of the ongoing pandemic has increased many people's risk should they need to see a healthcare provider. The proposed updates to the 2007 Isolation Precautions guidance weaken infection control in healthcare settings even further.
We urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, HICPAC/CDC's process has been essentially closed to public access or engagement. HICPAC meeting presentations and documents used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Given the broad public interest in

CDC's guidance to protect health care personnel, patients, and the public from infectious diseases, it is particularly concerning that HICPAC/CDC's process is so closed.
We urge HICPAC to fully recognize aerosol transmission (inhalation of small infectious particles) to ensure health care worker and patient protection and to mandate universal masking using high quality respirators (N95 or better) in all healthcare settings.
Today, we join tens of thousands of people across the U.S. to say that we demand care, not COVID.

November 6, 2023

To: Healthcare Infection Control Practices Advisory Committee
Re: HICPAC Meeting, November 2-3, 2023, Infection Control Guidelines, Public Comment

The AFL-CIO is a federation of 60 national unions representing 12.5 million working people across this country, including many health care workers—from registered nurses to environmental service (cleaning) workers. We have been actively engaged in advocating for strong protections to protect health care workers from infectious diseases for decades.

We are providing this written comment after we did not receive communication from CDC/HICPAC about the comment lottery after we registered to provide comments at the November 2-3, 2023 HICPAC meeting. The AFL-CIO also registered and attempted to provide comment at the previous August 22, 2023 meeting; however, we were not called upon.

The AFL-CIO remains deeply concerned that the revisions to CDC's recommendations approved by the HICPAC committee on November 3, 2023 will severely weaken protections for health care workers exposed to infectious diseases that are spread through aerosol transmission. We are also dismayed by the insular nature of the process to create and approve the recommendations that protect health care workers, patients, and communities from infectious diseases.

Our concerns have been expressed publicly at the June 2023 HICPAC meeting where we were permitted to speak; and while the agency has made some efforts to increase transparency since then, these steps have only served as check-box items that have not allowed for meaningful change or input that stakeholders have requested. We expressed these concerns in a letter to the CDC sent on October 18, 2023, along with 15 unions representing health care workers. Our concerns about the insular process' influence on the recommendations made by HICPAC became reality during the November HICPAC meeting.

It is clearer than ever that the HICPAC committee does not value additional input and expertise and has not taken the transparency and process concerns and recommendations of thousands of individuals seriously. The committee still has not involved representative expert scientists, health care workers, patients, expert agencies and other stakeholders, to seek input on the scientific evidence and its application. The draft guidelines released the day before last week's meeting were not provided to the public with ample time for stakeholder review, which prevented informed feedback through a public, transparent docket before they were voted on. Additionally, the committee did not acknowledge or discuss any input or comments made by occupational safety and health, medicine, epidemiology, industrial hygiene, ventilation, aerosol science, and public health experts; health care workers, patients, or their representatives. In

fact, even expert opinions provided by an ex-officio and liaison representative to the committee were largely ignored by leadership during the meeting.

This has resulted in weakened draft health care infection control guidelines sent from HICPAC to CDC that will result in harm to health care workers and patients. The recommendations approved by HICPAC do not recognize the scientific evidence on aerosol transmission of infectious diseases. Instead, they center prevention strategies around short-range droplet transmission, surgical masks and diminish existing practices to use airborne infection isolation rooms for novel pathogens.

The current process and committee leadership has hindered the protection of public health. The HICPAC working group still must be reconstituted to include equal representation of stakeholders and use an open process to receive and respond to public input. The CDC, including HICPAC, has a responsibility to use the best evidence to prevent exposures to infectious diseases and safeguard health care workers, patients and communities. These draft guidelines must be rejected, as they are a step backwards in infection disease protections and will leave health care workers and our communities at risk.
Sincerely,

Rebecca Reindel
Safety and Health Director

My name is Joe Reed, I live at Minneapolis MN, and I work as a therapist at Omni Mental health.

I'm writing to implore decision makers at the CDC to co l sided the rights of people with disabilities and compromised immune systems. We cannot simply ask people at higher risk of COVID infection completely isolate from society. Even basic needs like groceries and healthcare no longer require masks, essentially making it too dangerous for many of our most vulnerable.

Public spaces required for existing, like government facilities, the grocery stores, and hospitals should all require masks. It is unfair to prioritize the comfort of the majority over the lives of the marginalized.

Thank you for your consideration,
Joe

Hi there,

I wanted to make a public comment regarding the HICPAC meeting on Nov 2nd.

The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" rather than infection control. Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

Thank you for your time.

Mandy K. Cohen, MD, MPH
Director
Centers for Disease Control and Prevention

November 1, 2023

Dear Director Cohen,
As the leading professional societies representing infectious diseases physicians, healthcare epidemiologists and other healthcare professionals and scientists dedicated to the prevention, diagnosis, and treatment of infectious diseases, we write to emphasize the critical importance of maintaining the integrity of processes that advise and provide guidance to the Centers for Disease Control and Prevention (CDC) on incorporating best practices for the surveillance and prevention of healthcare-associated infections (HAIs) and the spread of multidrug-resistant infections through the Healthcare Infection Control Practices Advisory Committee (HICPAC).

The HICPAC is a well-respected federal advisory committee with a more than 30-year track record of success. Clinicians, researchers and agencies responsible for assessing the safety and quality of healthcare have long recognized the HICPAC as the deliberative body of select subject matter experts well-versed in the research, evidence, strategies, and challenges of preventing the spread of infectious diseases wherever healthcare is delivered. Guidelines developed by HICPAC cover important topics such as HAI prevention, environmental cleaning, occupational infection prevention, and isolation precautions, and are used as expected standards of care by regulatory agencies.

The members of the HICPAC represent many aspects of expertise in infection prevention (including preventing the transmission of pathogens within healthcare settings to protect patients and healthcare personnel) and antibiotic stewardship and are best positioned to provide recommendations for implementing evidence-based strategies through clinical guidance and guidelines. While each member's expertise and specialty are unique, every member of the committee is appointed based on the recognition and support of their professional or patient/consumer community. Importantly, HICPAC members complete an extensive conflict of interest process to protect HICPAC's work from inappropriate bias. Liaisons from organizations with relevant expertise further inform HICPAC's work and help to ensure all relevant points of view are represented in HICPAC deliberations.

The members of our societies believe that the HICPAC's processes for deliberating over scientific evidence and developing consensus-based recommendations for guidelines are robust, evidence-based, and transparent. In its decades of existence, the HICPAC has maintained the rigor and transparency necessary to ensure that its recommendations lead to the highest quality clinical guidelines and to maintain or increase public confidence.

Fundamentally, the guidelines published by the CDC based on the recommendations of the HICPAC must be rooted in the best available data and appropriately placed in the context of healthcare settings and the complexities healthcare professionals face. Guidelines must reflect the evolution of data, diverse needs of unique patient populations, different roles of healthcare personnel throughout facilities, variability of available resources across vastly different healthcare settings, lessons learned over time, and real-world expertise regarding the application of guidelines.

The specialized training, knowledge and professional experience of members of our professional societies make them uniquely qualified to serve on the HICPAC. They are experts in the fields of infectious diseases, healthcare epidemiology, and infection prevention and are charged with integrating guidelines into daily practice to maximize patient safety goals alongside healthcare personnel safety while avoiding unintended harm. Their day-to-day responsibilities are broad and include leading HAI surveillance activities; detecting, preventing and intervening to stop outbreaks; preventing infections in high-risk patients (e.g., patients receiving organ transplants or cancer care, preterm infants and others with weakened immune systems), leading multi-disciplinary patient safety and healthcare quality initiatives, collaborating with public health entities, and prioritizing resources for HAI prevention in healthcare facilities. During the HICPAC's entire existence, many appointees have also been members of one or more of the ex officio organizational members of the committee.

While we fully support the HICPAC in its current form, we also encourage the CDC to take steps to explore strengthening its process, which must include opportunities for stakeholders to provide feedback. We encourage CDC to make every effort to ensure that concerns are heard and appropriately addressed, particularly when guideline updates result in major changes to current practice. We also encourage consideration of including additional relevant subject matter experts with backgrounds not currently represented on the HICPAC. HICPAC meetings are open to the public and offer opportunities for both written and oral public comments. Although time is limited for receiving and hearing comments from members of the public during public meetings, the societies support exploring ways to make these options more accessible to the audience. When draft guidelines, based on the recommendations of the HICPAC, are published in the *Federal Register*, members of the public should be encouraged to submit their comments to the docket so that CDC may hear the public's concerns, recommendations, and support for draft guidelines before they become final. Comments received during the public posting are all reviewed and evaluated for whether adjustments should be made to the guidance. Each of these opportunities are important for all interested stakeholders to be active participants in the development of clinical guidelines and to ensure that the HICPAC process is inclusive of all relevant voices.

We appreciate the longstanding partnership between CDC, HICPAC, and organizations represented by liaisons. We support the HICPAC's comprehensive evidence-based, inclusive, transparent approach to providing recommendations as part of HAI prevention guideline development and remain committed to this important work.

Sincerely,
Steven K. Schmitt, MD, FIDSA
President, IDSA

Thomas R. Talbot, III, MD, MPH, FSHEA
President-Elect, SHEA

William J. Steinbach, MD, FPIDS
SHEA President, PIDS

Dear Members of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC):

My name is Kristin Van Ramshorst and I am writing to submit my public comment regarding the committee's recent proposals for infection control guidance in healthcare and long-term care

settings. While I am not affiliated with any particular organization, I am a fellow American, human, caregiver, public servant, and disability rights advocate. I'm also a first-wave long-haul COVID sufferer.
I contracted COVID-19 from a family member in February 2020 and have never fully recovered. I am currently 36 years old, and prior to this viral infection, I led a vibrant and healthy life where I worked full-time, volunteered in my community, and had plans to become a clinical social worker. For almost 4 years, I have struggled to function and seek the care needed to treat my myriad of long-haul COVID symptoms. My days are plagued by debilitating chronic fatigue and brain fog, respiratory congestion, erratic heart rate, headaches, whole-body inflammation and pain, dizziness, and gastrointestinal issues. COVID-19 has ruined my life and health, and stolen my future plans. Sadly, my experience is not unique.

Many Americans are facing similar challenges as a result of complications from SARS-CoV-2. What we are experiencing is a global mass disabling event in which many of us will never fully recover and more of us will die. Over the last four years of this global pandemic, we have learned and researched SARS-CoV-2, and now better understand how to prevent and effectively control the spread and impact of this virus. This is through a multi-prong approach to public health that centers on the most vulnerable among us.

My plea to you today is to reject and re-evaluate the drafted guidelines for infection control and mitigation proposed by HICPAC on 11/2/2023. I implore you to center the lived experiences of healthcare professionals and unions, public health and infectious disease experts, patients who are immune-compromised and disabled, BIPOC and LGTBQ+ communities, and the millions of people who have died from complications from SARS-CoV-2. I urge you to update the guidelines to reflect a scientific approach to aerosol transmissive diseases and inhalation protection that's grounded in current data, research, and appropriate public health prevention methods. This should include universal masking in healthcare settings and long-term care facilities (high-quality respirators and N95+ masks), improved ventilation and air filtration in settings of high transmission activity (healthcare, long-term care facilities, education, etc.), appropriate isolation protocols, and supporting further research and community prevention efforts. We cannot accomplish this without transparency from HICPAC, input from the public, expertise and research from those currently working in the field, and collaboration from the many communities impacted.

I appreciate the committee's dedication to patient care, infection mitigation, and accessible public health education. Thank you for taking my comments and those of my peers into consideration.

Sincerely,
Kristin Van Ramshorst, Concerned Citizen
Portland, OR
Organization: N/A

Dear HICPAC,

I am writing today to urge you to strengthen protections against COVID transmission in health care settings.

Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Patients have a right to be protected from dangerous pathogens like COVID while attending necessary healthcare appointments. Likewise, healthcare workers

deserve to be protected from contracting disabling and/or deadly infections on the job. Even from the perspective of cost-efficiency, allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

It also of great importance for the health and transparency of our government, that HICPAC have proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection.

As someone with multiple underlying conditions that make me more vulnerable to the long-term dangers of COVID, and as someone who is concerned for the health and safety of my loved ones, including immunocompromised people, babies too young to be vaccinated, and the general public, I urge you to do the right thing and strengthen protections against COVID transmission in health care settings. Health care settings should be a safe place for all people, including patients and health care workers.

Signed,
Megan Shaughnessy-Mogill
Massachusetts

Deborah G Baron
Aurora, OH
Private citizen living in the community

To whom it may concern:

I am a 75-year-old woman living with my 73-year-old husband and adult daughter. My daughter has rheumatoid arthritis, and the medication she takes makes her immunocompromised. Our family has been living in a semi-lockdown world since March 2020. We are all fully vaccinated (up to date with the current 2023/24 Covid vaccines), but my daughter worries that she is not adequately protected. Due to another medical condition, she reacts strongly to the vaccines, with side effects lingering for weeks. So we all rely on masks for additional protection from all respiratory illnesses, particularly SARS-CoV-2.
All of us wear N95, KF94, or KN95 masks whenever we go into a healthcare facility. We are profoundly disappointed—and angry—that healthcare facilities do not require every employee and visitor to wear a mask at all times. SARS-CoV-2 is now a new fact of daily life that most people want to ignore—at our peril. Surgical masks are NOT adequate to protect against airborne pathogens. Quality respirators such as N95 or better should be the standard, and no employee or patient should be prohibited from wearing them.
The CDC guidelines must state the established fact that SARS-CoV-2 infects people by aerosol transmission. Therefore, healthcare facilities must establish rigorous protocols for preventing “transmission by air,” including better indoor air circulation and ventilation and isolating sick individuals.
Protocols must account for the science showing that each type of infection control measure is most effective when “layered” with other infection control measures to reduce transmission risk. And because much transmission is asymptomatic, all precautions must be universally practiced at all times.
Healthcare settings are where high risk, disabled, and senior individuals will come in contact with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should

employ all precautionary strategies at all times. Yes, it costs money. But overwhelming our healthcare workers with COVID patients hardly seems inexpensive
To our family (two seniors and an immunocompromised adult), it's life-changing to have to live in a world where no one seems to care if we get COVID, or long COVID, or any other serious neurological or cardiac conditions caused by SARS-CoV-2 infection.
I implore you to consider that not all of our citizens are young and healthy. If we're all in this together, let us truly respect all of our rights NOT to be exposed to an often debilitating or deadly virus in places of healing.

Sincerely,
Deborah Baron

Hello. My name is Nicole Limpert and my address is Stoughton, WI. I am a member of the public making a comment about the Infection Control Changes being submitted by HICPAC.

Firstly, I want to thank you for all of the work you do to protect us. I have admired the CDC and others who dedicate their lives to public health for many decades. However, the recent decisions made by the CDC to reduce or eliminate masking and other infectious disease protecting protocols during the current pandemic has frightened, angered, and deflated me.

In December 2019 I was diagnosed with breast cancer at the age of 44. While I have recovered after mastectomy surgery and radiation treatment, I no longer feel safe going to doctor appointments.

No one on my care team wears a mask any longer. Not my oncologist, nurses, imaging techs, no one. My unmasked primary physician assured me last month that I could remove my mask because he just got over Covid. He told me how horrible it was, and how it was probably made worse because he has recently been treated for cancer. I kept my N-95 mask on - like I always do.

I'm not a healthcare professional, but I can read. I understand the dangers of Covid and long Covid. Covid is a biosafety level 3 hazard and spreads via airborne transmission. Yet, my cheap, easy-to-use N-95 masks have so far kept me from getting Covid. Why isn't your agency recommending protection for healthcare workers and patients?

Please do not remove or reduce infection control measures, please recommend the use of N-95 masks, and please recommend filtration devices for clean indoor air.

Thank you.
Nicole

Mark Foley (unaffiliated)
Lebanon, PA

I am a physician who works in a hospital setting and I am concerned about the airborne transmission of COVID. Mask wearing is no long required but I feel that the science still points to the fact that mask wearing will help stop the spread of COVID and provide a safer environment for healthcare workers and patients alike.

We demand a fair process and science-based protections for healthcare workers and patients.

- CDC/HICPAC needs to delay the vote until the public has had ample opportunity to review the draft Isolation Precaution guidance updates
- CDC/HICPAC must hold public meetings ahead of any vote to hear from healthcare workers, patients, and experts outside of infection control who have essential perspectives for updating the Isolation Precaution guidelines.
- CDC/HIPAC must fully recognize the science on aerosol transmission of infectious diseases. They must update the list of diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.
- The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.
- I urge CDC/HIPAC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.
- CDC/HIPAC fails to acknowledge the importance and function of core control measures for infectious aerosols.

Hello,
I realized I did not attach my address in my last comment, so I'm forwarding and attaching it here. Philadelphia PA. I'm discussing the HICPAC proposal draft.
My name is Jennifer Marer, and I'm a recent biology graduate from Case Western Reserve University.
I am resubmitting my previous comment for consideration after seeing HICPAC's proposal, knowing they have ignored both the outcry from public health officials as well as all evidence that shows the disastrous effects of relaxing regulations like they are proposing:
———————————————————————-
My parents are both healthcare workers; my mother is a primary care physician, and my father is an infectious disease specialist.
A family member was hospitalized last winter, likely from enterovirus that caused neuroinflammation. It became immediately clear to me — a sentiment that was reflected by my parents — that if my relative had a COVID infection during this time, they would likely not have survived.
After reading the proposed guidelines, or lack thereof, I am deeply concerned by the absence of prevention measures against airborne pathogens in hospitals —specifically the lack of N-95 quality mask enforcement, air filtration, and ventilation— which puts everyone at risk.
My relative was privileged. They have doctors in the family that are able to get them and all their family members Paxlovid and streamlined access to healthcare. It is horrendous to think that someone needs two family members that go through at least four years of medical school and four years of residency in order to barely survive under the circumstances that our healthcare system has created.
Today I want to emphasize air filtration and ventilation, specifically as it relates to future prevention. If the vast large body of evidence that respirators and proper air filtration are extremely effective for controlling worker exposure to aerosols isn't enough, I'd like to provide another point: that as wildfires continue to rage across North America, forcing people indoors, everyone in those buildings — workers— medical professionals or not— and visitors —patients, relatives, or otherwise— will rely on this filtration.
It is unbelievable to me that with the obvious looming climate crises, housing crises, and continued healthcare crises over our heads, this lack of emphasis on prevention and preparation is not more of a concern.

As healthcare issues compound from all of these crises, healthcare collapses like those seen in the winters of this pandemic will only continue if left unaddressed.
Please enforce mandatory n-95-quality mask requirements and develop a thorough air filtration and ventilation plan for all hospitals. Please lift the onus off of patients advocating for themselves and enforce these obvious regulations for healthcare institutions.
Please do your job.
Signed,

Hello,

Here is my comment for the HICPAC meeting.
Name: Nikita Williams
Charlotte, NC
Organizational Affiliation: None

To get through the ongoing pandemic with as few infections as possible, I have been diligently learning more about the prevention of respiratory pathogen transmission. Thus, I have been following the progress of this committee to better understand what healthcare facilities will become required to do. I am beyond disappointed with the failures of this committee.
This committee is not transparent. The public and relevant experts did not get the chance to review these guidelines in full. There was a significant lack of public voice and representation throughout the process - as seen in the last meeting, where only 14 people were given time to speak. The review on the efficacy of N95 masks is based on flawed studies and runs contrary to decades' worth of research established by researchers in aerosol science and occupational health.
Any person in the United States has been impacted by or knows someone who has been impacted by profit-driven healthcare organizations that skirted their duties of care in order to save money. Giving many of these same multi-million and multi-billion dollar organizations "flexibility" should strike fear into our hearts. They will always choose money over the lives of their patients (customers) and employees. Giving broad discretion will not help hospitals and healthcare facilities in the long term - not when too many people in power chase short-term performance and incentives over long-term objectives. There are too many stories of healthcare workers who are forced to come to work while actively infectious with COVID or the flu or another easily transmissible virus. Giving their employers more leeway will worsen the healthcare worker shortage and negatively impact patient outcomes - killing some, permanently disabling others, etc.
We need common-sense guidance on proper ventilation systems, N95 usage, and proper source control. This committee has shown that it is either unable or unwilling to do so. Their decisions will prove a slow, painful death for far too many people who acquire infections while seeking medical care, as well as people who avoid seeking out care due to a legitimate concern of being infected while doing so.
I, like many others, have lost faith in the CDC. This is another nail in the coffin.

Hello,
My name is Patrick Vaughan, I am an engineer and scientist, I am a member of the public, and I possess no conflicts of interest.
I implore you to reject HICPAC’s draft guidance. HICPAC needs to reconvene a new panel that is balanced with professionals across multiple disciplines which have not been included within this panel. Representatives from aerosol science, occupational health and safety, ventilation/industrial engineering, industrial hygiene, nurses, and patient representatives must

be included within this discussion at minimum. Additionally, to be legitimate, HICPACs new panel must possess the required 14 members as per their charter as opposed to the current illegitimate 9 (3 of whom even penned a letter against universal masking in favor of smiles, presenting a clear anti-science bias). This new HICPAC panel must also host public meetings for direct input sessions with the public, allowing for transparency within the process – including posting draft guidance and recommendations well in advance of important sessions (not the day of!). Furthermore, scientific citations must be required for every proposed guideline or recommendation, as opposed to the currently vague (expert opinion) or (standard practice).
The current draft guidance has systematically weakened numerous recommendations in the guise of “standardization of terminology across the document”, and use of the word soiled over contaminated. To my first point, in patient placement number 5, “anytime room sharing occurs, precautions need to be in place to limit potential for cross-contamination…” was downgraded to “should be in place”. This changes from a must do requirement to a nice to have requirement. Similarly, under routine air precautions “a mask is worn by health care professionals on entry to a room” was downgraded to “health care professionals should use a mask on entry to a room”. The original is written as a requirement, while the revised sentence is a suggestion.
Furthermore, a soiled mask is one that is visibly dirty which makes the burden for changing a mask, cleaning a mask, or even reusing a mask a much higher threshold to meet. Employers would easily misuse this criterion to then ask personnel, “well is your mask soiled? No, then you’re fine to continue wearing it”. When the mask would then be a continued source of contamination and possible infectious transmission to both the healthcare provider and to other patients they are caring for. Furthermore, a well-fitted N95 respirator masking needs to be explicitly defined, as opposed to the incredibly vaguely written ‘source control’ that replaced areas where masks were originally written.
The most egregious example of weakening the guidelines is only saying one ‘should’ use PPE when someone is visibly sick or symptomatic. This completely ignores asymptomatic presentation, which would still result in infection, and completely disregards a patient’s exposure history. Every patient should always be treated as potentially infectious. That is the only way we can significantly reduce nosocomial infections, and to make hospitals safe for the general public once more, and more importantly safe for the immunocompromised and elderly. People should not have to feel that they are putting their life at risk, and are risking long-term disability, when seeking out medical care.
These draft guidelines are atrocious and do nothing but weaken the current standard of care. A new legitimate committee must be convened with an emphasis on crafting guidance that focuses on strengthening recommendations and improving public health care. The current committee has done their best to degrade the recommendations and guidance of medical institutions, in their thinly veiled efforts to save hospitals an extra penny. Do Better.

Healthcare facilities should be a place where one can trust that everything is being done for the best possible health outcomes. The safety measures around infectious disease are critical for this to be the case! The removal of universal masking has already create great threat to those who are the most vulnerable in medical settings-- one way mask is not enough!! Especially when it's not possible in certain procedures or when patients need to eat. Why would you want to lessen safety protocols??

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor

force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

How many infections can a body take before it is disabled? How much do sick days and overtime cost the healthcare system? What about caring for one another and listening to the science that has come out about the long term impacts of Covid on the entire body? Please stop being sketchy and receive proper insight when making this decision.

Thanks,
Charlie

Deborah Gold
Pacifica CA

November 6 2023

Healthcare Infection Control Practices Advisory Committee
HICPAC Committee Management
Centers for Disease Control and Prevention, MS – H16-3
1600 Clifton Road
Atlanta, GA 30329-4027
(Via email: hicpac@cdc.org)

Re: HICPAC Revision of 2007 Isolation Guidelines
I am an industrial hygienist with 30 years of experience in evaluating health and safety in a variety of health care and other environments. I am writing because I am extremely disappointed that neither HICPAC nor the CDC has listened to the many hundreds of comments you have received regarding the inadequacy of the guidelines HICPAC has just approved. The CDC of course bears responsibility for having selected such a narrow committee, and for using a process with no public accountability.
As someone who has facilitated many advisory committee processes for Cal/OSHA, I know that this is not the way advisory processes should work. Legitimate advisory processes must include all stakeholders, or at least all stakeholders who want to participate, and all relevant expertise. Advisory processes must include dialog with the people who show up to participate. In the case of HICPAC, all of the members are drawn from one narrow professional sector, and the members did not respond to public comments and concerns. I also call your attention to the letter dated July 20, 2023 signed by hundreds of experts concerning this process, and the report of the workshop held on October 13, 2023 Preventing Aerosol-Transmissible Diseases in Healthcare Settings: The Need for Protective Guidelines and Standards.1
I am also concerned that the committee voted on a draft of the recommendations, despite concerns raised by several committee members about the specific text of the recommendations. For example, in the discussion of patient placement, the recommendations stated that in “ambulatory” care settings, patients who appear to have require transmission based precautions should be promptly separated. A committee member commented that this recommendation should be changed to indicate that it applies to areas such as the emergency departments of hospitals. The person presenting said that emergency departments and “urgent care” would be considered ambulatory care. While urgent care clinics may be considered ambulatory care, but emergency departments are not generally understood to be in ambulatory care2. It is often the case that symptomatic patients are left in crowded waiting rooms of hospital emergency departments for significant periods of time.

I have personally seen the impact of HICPAC guidelines and other CDC guidance on how health care employers protected, or failed to protect, health care workers from infectious disease during the COVID pandemic. Our health care workers, patients and residents in congregate living facilities, and people incarcerated in prisons and jails, have not been protected. Many have been unnecessarily infected, and some have died.

It is scientifically valid that HICPAC has proposed abandoning the illusion of “droplet” transmission as something distinct from aerosol transmission. But the current proposal is not an improvement because HICPAC is proposing to provide no actual protection against inhalation of infectious aerosols for most aerosol transmissible diseases, to be defined as “routine air”.

Surgical masks do not prevent inhalation of aerosols. The committee has misstated the science on the effectiveness of respirators as compared to surgical masks, choosing to rely on a handful of “randomized controlled trials” (RCTs) and then selecting only the narrowest endpoint. Thus, even the 2009 Loeb study3, which found a statistically significant difference between mask and respirator users on the endpoint of fever (P=.007) and a slightly weaker difference for influenza-like illness (p=0.06), is considered as a negative study because the committee chose only to consider the endpoint of laboratory confirmed influenza. The RCTs chosen do not assess whether respirators were used correctly, which includes using a new filtering facepiece respirator for which the user has been effectively fit-tested each time a respirator is donned, and using it for all patient encounters and exposures. Thus, these studies are biased towards the null hypothesis.

It also does not make sense to recommend respirator use for the “pandemic” phase of a novel pathogen, but not for the phase that precedes or follow a “pandemic.” The organism is the same, its mode of transmission is the same. Only the political context (a declared “pandemic”) is different.

The need for occupational respiratory protection is not determined through RCTs. NIOSH certified respirators are tested for their ability to prevent aerosols from passing through the filtering materials. In an occupational setting, respirators are also fit-tested to ensure that aerosols will not evade the filter by passing through gaps between the respirator and the face. It is on that basis that NIOSH and CDC recommend the use of respirators for infectious aerosols such as TB and measles, and for toxic aerosols such as asbestos and lead.

It is unfortunate that the committee has stated that user discomfort, and failure to have uniform policies for the use of respirators, supports recommending the use of ineffective masks instead. Occupational health professionals, including industrial hygienists, have long recognized that PPE use increases fatigue, and therefore additional rest breaks and other administrative controls such as job rotation, are necessary to support PPE use. The N95 and other filtering facepiece respirators were created in part to address difficulties in using elastomeric respirators in health care environments. However, health care workers should not have to choose between effective personal protective equipment and excessive fatigue. HICPAC recommendations should include strategies for fatigue reduction, including appropriate staffing, as well as a recommendation for research info more comfortable and usable respirator designs.

Airborne infection isolation is one important means for protecting people in health care and in congregate living facilities. For many years, infection control documents have indicated that airborne infection isolation is only necessary to protect against long-distance travel of infectious aerosols including through ventilation systems. However, airborne infection isolation rooms, with higher ventilation rates and negative pressure to surrounding areas, protect workers located within the patient room, as well as those directly outside, or in the pathway of circulating air. The lack of effective procedures to reduce transmission of infectious aerosols containing SARS-CoV-2 contributed to outbreaks of COVID-19 in California’s prisons and health care facilities. HICPAC guidelines should provide information that will lead to appropriate increases in ventilation in health care and congregate living facilities, as well as guidance for establishing effective airborne infection isolation rooms and areas for surge.

Texas in 2014 saw the results of inconsistent and under-protective practices when two health care workers contracted Ebola Virus Disease (EVD) from a patient. After that incident, the CDC realized the necessity for formalized procedures for the donning and doffing of personal protective equipment, and for making available appropriate decontamination areas. Infection control and occupational health expertise must be integrated into the new HICPAC guidance. HICPAC must also learn from the Canadian SARS commission, which looked at the differences in health care associated transmission in the two cities in which patients had become infected in Asia before returning home. The Commission enunciated the important precautionary principle,

"One example was the debate during SARS over whether SARS was transmitted by large droplets or through airborne particles. The point is not who was right and who was wrong in this debate. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.4"

If the new HICPAC guidelines are going to be accepted in the workplace, they must be developed and evaluated in a transparent manner that utilizes the expertise of many fields involved in protecting the health care environment. The letter to the CDC in 2020 from hundreds of aerosol scientists, stating that COVID-19 is transmitted by aerosols, is an example of how aerosol science, industrial hygiene, architects, and engineers must have input into infection control guidance.

All levels of government and private entities rely in HICPAC recommendations not only for daily public health protections but for preparedness for public health emergencies such as the COVID-19 pandemic. Clear recommendations from HICPAC regarding personal protective equipment, engineering controls, surge capacity, and stockpiling are necessary to avoid the societal disruption we all experienced in the past three years.

Finally, I encourage you to broaden participation to include occupational safety and health agencies at the national and state levels, to include health care workers and their unions, and professional organizations so that these guidelines may be comprehensive, and widely accepted.

Thank you for considering my comments.

Sincerely,

Deborah Gold, MPH, CIH

1 https://rutgerstraining.sph.rutgers.edu/PreventATD/download/atdworkshopreport.pdf

2 "Ambulatory care is care provided by health care professionals in outpatient settings. These settings include medical offices and clinics, ambulatory surgery centers, hospital outpatient departments, and dialysis centers." Agency for Healthcare Research and Quality, https://www.ahrq.gov/patient-safety/setings/ambulatory/tools.html#:~:text=Ambulatory%20care%20is%20care%20provided,outpatient%20departments%2C%20and%20dialysis%20centers.

3 Mark Loeb; Nancy Dafoe; James Mahony; et al. Surgical Mask vs N95 Respirator for Preventing Influenza Among Health Care Workers: A Randomized Trial. JAMA. published online Oct 1, 2009; (doi:10.1001/jama.2009.1466)

4 SARS Commission Final Report, Volume 3, p. 1157

As a 73-year-old with co-morbidities, protecting myself from Covid is a critical issue. I managed to remain COVID-free for over 950 days from the beginning of the pandemic. I was fully boosted with a Pfizer bivalent when 90 seconds on the porch interacting with an unmasked grocery delivery person gave me Covid. Recovery was very difficult and took over seven months. I am doubly committed to not catching Covid a second time. That is why the decision on precautions

regarding infection protocols in medical settings is so important to me. I have actively sought out research on the effectiveness of NPI.

This is a personal issue for me. I am at serious risk of another Covid infection. I know 2 people my age who have died and 3 who suffer from Long Covid. Four of them were fully vaccinated, 3 Pfizer 1 Moderna. One friend is a heart transplant recipient who, though fully vaccinated, contracted Covid in a nosocomial infection during a transplant checkup from unmasked medical personnel.

Allowing medical facilities to treat at-risk patients without any masking protocols, or upgrading air filtration and ventilation is a violation of the first rule of medical care, to do no harm. There are numerous studies indicating the effectiveness of N-95 masks and respirators in preventing disease transmission.

I beg you to make a choice that will allow me to engage in much-needed health care without risking another COVID infection, one that could end my life or leave me disabled.

Larry Bruce
Fort Collins, CO

To whom it may concern,

I write to express my firm support for the adoption of universal respirator use in healthcare. The ongoing challenges we face emphasize the need to protect our healthcare workers, patients, and communities.

The COVID-19 pandemic has shown that respirators are a crucial tool in reducing the spread of infectious diseases and safeguarding healthcare workers. Implementing universal respirator use is essential for their safety and for maintaining healthcare services.

I believe this initiative is a vital step towards a safer and more resilient healthcare system. Please consider supporting this important measure for the well-being of all.
--
Amanda Abbott

Name: Gesine Katherine Lohr
Address: Alameda, CA organizational affiliation: None

TOPIC BEING ADDRESSED: HICPAC is in the process of proposing updates to the 2007 Isolation Precautions guidance.
The proposed updates would weaken existing CDC guidance, putting patients and health care workers at significantly increased risks.

I am at higher risk re covid-19 -- 71 years old, have transverse myelitis, multiple sclerosis, had polio as a child, have a connective tissue disorder, asthma, was a preemie and have historically gotten bronchitis every winter.

We need science-based, common sense protections from infection! including recognition that covid-19 is spread by aerosols.

****We must reinstate mask mandates in healthcare settings! First do no harm.

I, and many other higher risk people, are delaying and putting off necessary medical care, because we are in a surge and our healthcare systems have abandoned masking.
I need to schedule an endoscopy, but the Oakland HMO has nearly no masking of their healthcare workers. I need a very overdue eye exam and new prescriptions, I need dental cleanings and dental work. I need MRI/MRA which I'm supposed to get every 2 years to check that I'm not making new cerebral or other aneurysms (I had 2 surgical crainiotomies in 2000 to clip a cerebral aneurysm). I need a dermatology exam. I need a mammogram.

CDC's positions have been extremely harmful to those of us at higher risk -- doctors and administrators at our healthcare providers have told us, "Oh, we're following the CDC guidelines! so you can't ask us to wear masks in healthcare facilities, it's not mandated".

One way masking is significantly insufficient. Many people have caught covid-19 during healthcare appointments/procedures, people who were still being extremely careful to avoid exposures.

You must stop falsely equating N95 masks and surgical masks!
There is huge amounts of data on this. N95 masks are extremely more effective.

Source control and ventilation upgrades must be addressed.

So far in the pandemic, the CDC's work has been appallingly bad, has been very harmful to millions of us.
Those of us at higher risk are now at greater risk than before! which is surreal!

Please don't let corporate healthcare's concerns with costs, interfere with the science.
Public health is not a "you do you" thing, it's pervasive.
HICPAC and the CDC could change and start to show leadership, rather than the appalling abdication of leadership and responsibility they have so far shown during the pandemic.

In my wildest dreams or nightmares, I never would have thought entities like HICPAC and the CDC would abandon critical thinking and bow down to political and corporate pressures, and basically give up on promoting actual public health. Mandating masks in healthcare is not an astoundingly large thing to do!

So, do not weaken the isolation precautions guidance!
Mandate N95 masking in healthcare.
Mandate working towards ventilation improvements, especially in healthcare.
Your 5 day rule is absurdly incorrect! please read the tons of data on this and change your guidance!
And please tell the public, in your updates, that we are not done with the pandemic. Incredibly stupid positions the CDC etc. have taken, mean that much of the public thinks the pandemic is over, and THAT is driving significant infection levels now -- which of course could result in new far worse variants arising. And this keeps the pandemic going, with no end in sight.

You may say, "gee, I wish you had worded your comment more professionally".
For the past several years, I and a zillion people like me, have spent hundreds and thousands of hours writing online, trying to share solid information about the pandemic, trying to teach critical thinking, trying to teach people "the CDC is wrong, here's what's correct" -- while the CDC has

gone "la la la la la". We are tired of being polite! Your failure to support scientifically supported things like
N95 masking, is significantly negatively affecting my health and the health of millions of us at higher risk.

Please consider how your actions currently cause more death and impairment, and please do not weaken the isolation precautions guidance, rather strengthen it.

Dear HICPAC,

As someone whose parents and grandparents and loved ones have all contracted COVID multiple times, including in healthcare settings, I am writing to urge you that:

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.

Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.
Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
I look forward to hopefully seeing strong revised and democratically/expertly developed guidelines.

Emma Hartung
San Jose CA
Showing Up for Racial Justice

I am writing to express deep concern about the HICPAC draft and lack of transparency throughout the process.

As someone who (according to the CDC) is at higher risk of negative COVID-19 outcomes and is already struggling with Long COVID, I have had to postpone or forego multiple necessary medical procedures because my health providers were not willing to provide basic infection control protection such as staff wearing effective respiratory protection like N95 respirators. I urge you to make essential healthcare accessible to millions of Americans like me by implementing healthcare infection control guidelines that fully recognize aerosol transmission of SARS-Cov-2 and establishing rigorous protocols for preventing transmission by air.

Please prioritize the lives of high risk patients, many of whom don't have a choice but to risk exposure to a deadly pathogen in healthcare settings, and the lives and safety of healthcare workers, rather than increased profit margins and flexibility for healthcare employers. COVID-19

transmitted in hospitals has a 10% mortality rate, so minimizing COVID-19 transmission in healthcare settings is crucial to saving numerous patients' lives and allowing disabled, immunocompromised, and high risk people equal access to healthcare services without fear of dying from routine care. While poor infection control may appear to be cheaper in the short term, it will be much more costly in the long run than providing rigorous infection control, such as N95 respiratory protection, fit testing, rapid molecular testing, heightened ventilation and filtration, isolation protocols, and paid medical leave, due to the lives lost and even more people disabled from Long COVID if COVID-19 is allowed to spread unchecked among patients and healthcare workers.

As the nurses union is urging, please reject the current version of HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft." This process should include holding public meetings, making guidelines available to the public for extended review prior to submission to the CDC, and including experts from the fields of occupational health and safety, clean air engineering, aerosol science, industrial hygiene, and respiratory protection as equal members with decision making power.

Sincerely,
Luke Kudryashov, MSI, unaffiliated
Minneapolis, MN

November 6, 2023
Healthcare Infection Control Practices Advisory Committee
Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention

To Whom It May Concern:

I urge the Healthcare Infection Control Practices Advisory Committee (HICPAC) to refrain from adopting guidance for healthcare facilities that offers insufficient protection against transmission of viruses such as SARS-CoV-2. The current draft does not reflect recent evidence sufficiently, and if healthcare facilities operate under this guidance they will see far more of their workers and patients disabled and killed by diseases such as COVID-19 than they would under appropriately protective guidance.

Guidance should not treat surgical masks as respiratory protection and personal protective equipment (PPE) for healthcare workers while reserving use of N95s and other respirators for limited circumstances. The evidence review used to rationalize this decision cherry-picked data and failed to consider all relevant evidence. It must be redone with input from experts in respiratory protection, aerosol science, and occupational health.

Failing to incorporate ventilation and air filtration as a key component of infection control is contrary to basic occupational health practice. As the hierarchy of controls indicates, the most effective protection does not rely solely on individuals using PPE correctly and consistently. A growing body of evidence demonstrates that increased ventilation reduces transmission risk.[1]

The Guardian and Kaiser Health News identified more than 3,600 U.S. healthcare worker deaths from COVID-19 in the pandemic’s first year.[2] Many more healthcare workers have been disabled by long COVID and can no longer work; an analysis of workers’ long COVID compensation claims from the first 16 months of the pandemic found that 30% were from

hospital employees.[3] We will see far more deaths and disability if HICPAC adopts inadequate guidance that ignores important evidence.

I urge HICPAC to halt adoption of guidance that does not emphasize ventilation, filtration, and respirator use and to instead undertake a transparent process involving the appropriate experts in order to develop new guidance for healthcare facilities. Thank you for the opportunity to comment.

Sincerely,
Liz Borkowski, MPH
Washington, DC

[1] Banks GM, Fleck BA, Kroeker E, Dandnayak D, Fleck N, Zhong L, & Hartling L. (2022). The impact of heating, ventilation, and air conditioning design features on the transmission of viruses, including the 2019 novel coronavirus: A systematic review of ventilation and coronavirus. *PLOS Global Public Health*.
hOps://journals.plos.org/globalpublichealth/arHcle?id=10.13ti1/journal.pgph.0000552
[2] Spencer J & Jewe+ C. 12 Months of Trauma: More Than 3,600 US Health Workers Died in Covid's First Year. April 8, 2021. Kaiser Health
News and The Guardian. h+ps://kQealthnews.org/news/arScle/us-health-workers-deaths-covid-lost-on-the-frontline/
[3] Choo M, Moss RJ, & Arnautović N. Long COVID in Workers Compensation: A First Look. October 2022. National Council on Compensation
Insurance, Inc. h+ps://www.ncci.com/ArScles/Documents/Insights-Long-COVID-Insights-Brief.pdf

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Comment r.e. "DRAFT 2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings" discussed and voted on during November 2 and 3, 2023 HICPAC meeting

In the Day 2 "DRAFT 2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings," under "Use of Transmission-Based Precautions to Prevent Transmission through the Air Recommendations:" at lines 441 and 442, you describe the following in lines 459 through 467:

"Extended Air Precautions:
a. A NIOSH-approved® fit-tested N95 (or higher-level) respirator is worn by HCP on room entry, and eye protection is used based on Standard Precautions. (Standard Practice)
b. A private room is indicated. (Standard Practice)
c. An AIIR is required. (Standard Practice)
d. Source control masking is indicated for the patient when they leave their room. (Standard Practice)
e. Travel outside the room should be limited (e.g., for necessary procedures and treatments). (Standard Practice)"

Then, within the Narrative section, in lines 484 through 486, you state:

"Extended Air Precautions are used when providing care to patients with pathogens that are observed to spread efficiently across long distances and over extended times, such that room air needs to be contained (e.g., prevented from moving into the hallway where individuals are not appropriately protected)."

Like it or not, the narrative piece above describes SARS-CoV-2 extremely well. You're literally saying an N95 respirator, at minimum, is indicated for SARS-CoV-2, a pathogen that matches "Extended…" category. Given SARS-CoV-2 is in constant circulation, by your own logic, those "Extended Air Precautions" should be the default at all times. So why aren't they? Everything but the AIIR for every covid-positive patient should be feasible, and you could cohort those

patients together in inpatient rooms. But you would have to tell facilities to actually start testing each person for coronavirus again, symptomatic or not, which most have stopped doing.

You have a duty to follow the science, especially the science you just outlined, regardless of how tired you, CDC, the healthcare industry, and the public is of dealing with coronavirus.

How about recommending universal masking in healthcare environments, for all staff, patients, and visitors? How could a facility control infection when it's knowingly letting pathogens into the air from everyone inside? CDC officially recognized airborne transmission of coronavirus in May 2021, and the virus is still with us, so as a committee focused on infection control that should be top of mind.

Regarding visitors as sources of infection in healthcare settings: Visitors don't know they're "sick" if they're asymptomatic! So yes, per comment by one of your members referencing guidance for public to wear N95 if exposed to covid, visitors should wear N95s and yes, the fact that visitors could infect patients just as much as the other way around should be considered. And everyone in society has been exposed. That's a constant, not a variable. Symptom screening, potential vaccination screening, and hand hygiene are still together inadequate to prevent transmission. Require masking for source control and PPE! Since as your member stated, sometimes patients are in the hospital for days before their pathogen(s) are identified. If you don't have "better testing" right now, the answer is not to wait until that time–the answer is to require masking of everyone who's capable of doing so. Patients, HCW, visitors.

Also, TRANSMISSION-BASED PRECAUTIONS should include source control for HCW at all times. Infection from HCW to patients, visitors, and other HCW is still transmission. Not including that is an unacceptable omission with covid's high asymptomatic spread and prevalence in the community ALL THE TIME, not just seasonally, and the fact HCW are likely to engage in presenteeism (i.e. likely to work) even when not feeling well.

Overall, your draft guidelines sound like they might be acceptable in a world where SARS-CoV-2 didn't exist, but that's not this one.

SARS-CoV-2 NEEDS TO BE CONSIDERED IN STANDARD PRECAUTIONS. IT IS STANDARD AT THIS POINT AND THERE NEEDS TO BE RECOGNITION OF THAT AND RECOMMENDATIONS THAT REFLECT THE NEED TO PROTECT *EVERYONE* in healthcare environments, not only HCW.

Thank you,

Erika Gould
Member, World Health Network

Hello,

My name is Lia Evans, and I am a nonprofit consultant who lives in Los Angeles. I have been struggling with long COVID since contracting the virus in March 2020. I am but one of millions of people in the US whose lives have completely changed overnight and who are desperate for help and support in any way, shape, or form, especially from public health officials whose mandate it is to protect the health of the people they serve.

We have learned so much about COVID over these past few years, including its exponentially costly risks to human health and well-being on a variety of metrics. Asymptomatic spread, combined with the cumulative risks associated with reinfection, have people like me highly concerned about the increasing lack of societal safeguards against the virus, particularly in healthcare settings (which, by virtue of being long haulers, we rely much more upon than ever before).

That said, it is imperative that universal masking be mandated in healthcare settings, and that healthcare professionals be supplied with effective respirators (N95s) and have access to paid leave when ill. Medical professionals are supposed to do no harm, and yet we very-well know that a lack of proven safety measures in healthcare settings has contributed to COVID spread among patients and caused detrimental debilitating, and sometimes deadly, health outcomes.

There is no denying just how important such protections are, and just how much public health's credibility is on the line. I ask that you do the right thing by all of us.

Thank you,

Lia Evans, LCSW
LA, CA

Hello,
I'm contacting you to be included in the public comment. I desperately urge you to diversify your science and make sure people know exactly how COVID-19 is spread. Please listen to the people, keep masks in healthcare settings.

Thank you,

Name - Araceli Estrada
Address - Sun Valley, CA
Organizational affiliation of the speaker - Just a citizen
Topic being addressed - HICPAC Infection Control Changes

Dear CDC/HICPAC,

I would like to submit a public comment in hopes that the committee reconsider its stance on enforcing masks in all healthcare settings.

Last month my entire household was infected with Covid after my mom had a procedure at Kaiser Permanente. She had to get an emergency colonoscopy and endoscopy after previous non-invasive tests were inconclusive. We tried to reschedule these to after the availability of the new XBB booster, especially since our last booster was in NOV of 2022, but the doctor insisted that it was imperative that these procedures/tests get done.

On the day of her procedure, there wasn't a mask in sight. My mother says that she was able to keep her mask on until just before they sedated her and that neither her doctor or any of the assistants in the room had a mask on. When they finally called me into the recovery area to help her wake-up and get dressed to leave, I noticed that not just patients but all workers were also unmasked. I did not have an extra mask and her mask was thrown out, so she tried to cover her nose and mouth with her sweater.

Days later she began to feel a sore throat and an ear ache so we went to urgent care to get her checked out and get a PCR which came back negative. Her symptoms did not improve but rather worsened and 2 days later she tested positive and we began to isolate. A few days after that the rest of my household, including myself, tested positive as well. We all got very sick and tried to get paxlovid but I was only able to get it prescribed for my mom. My father, sister and myself were unable to get this treatment. This was not an easy infection for us as we were extremely debilitated and weak to the point where getting up to prepare food was excruciatingly difficult.

We all tested negative on Sep 28 & 30. Unfortunately, we are still feeling the effects of this infection as we are still dealing with coughs, chest pressure, fatigue and very limited taste and smell. We thought we would be feeling much better and close to normal after a few weeks but we're a little over a month out from testing negative and we have only experienced little improvement.

My family and I have been masking since Feb of 2020. We have sacrificed family dinners, holidays and all gatherings, to help keep ourselves safe from infection and all of the terrible outcomes that we now know from multiple studies can occur with repeated infection. We have never stopped masking and had been able to prevent infection because of it. The only other time we have been infected was back in Jan of 2020 at the start of the pandemic and recovery then was also lengthy; approximately 4 months.

I know that it may seem that transmission rates are low in California but can we truly and honestly say that if we are not actively & appropriately testing? Why were we so easily infected when one member of my household, a senior member of my household, was left vulnerable to infection because of a procedure that she had to have. I know you say we have the tools but it doesn't seem we are using them as I was only able to get my mom a paxlovid prescription but not for myself or any other member of my household.

And the most effective tools which include masking and air filtration are not being utilized. These are proven forms of effective mitigation especially when used in concert, why aren't we requiring them in all public spaces? Especially in hospitals?

This could have all been avoided if hospitals were required to mitigate by masking, installing quality air filtration, promoting hand washing and providing sanitizer for everyone's hands. Especially in areas where patients (immunocompromised or not) will have to remove their mask for treatment or procedures.

My sister was able to remain infection free after her gallbladder surgery at the height of our summer wave last year. The hospital tested patients prior to surgery and masks were still being enforced in healthcare settings. These were effective methods in helping to keep patients, their caretakers/family and staff safe. What's the point of recommending masks if all other forms of mitigation that we know keep people safe are not being implemented? We need to require masks, not recommend them.

Please help those of us who do not want to get infected stay safe. Bring back the requirement for both high quality masks and high quality air filtration in healthcare settings, and send the message that public health really does care for its residents.

Thank you for your time and attention to this matter.

There are many critical errors in HICPAC's proposed revised isolation precautions guidelines. These core concepts of disease spread and mitigation are not being acknowledged or given due consideration:
1. SARS-CoV-2 is airborne. It spreads by inhalation exposure to infectious aerosols at both close and long range. Not by droplets. Not by fomites. It can spread and linger in the air for hours, and can infect in an empty space previously occupied by an infectious person. Approximately half of infections originate from pre-, pauci-, or asymptomatic sources.
2. The equating of surgical masks with N95 respirators for both source control and personal protection is false and goes against abundant, robust data on the superiority of respirators, one-way masking is less effective than universal PPE use, and many patients are unable to effectively wear appropriate protection (e.g. babies, children, the disabled or unconscious, or those undergoing procedures where it is impossible).
3. Arbitrarily assigning tiers of precautions based on reported levels relies on constrained and therefore unreliable testing and reporting, and on lagging indicators such as hospitalizations. While levels of infections, hospitalizations, disabilities and deaths may vary and are certainly undercounted, even at the reported levels they remain consistently significant and warrant ongoing mitigations. Loosening protections when levels are relatively lower is irrational, as time has demonstrated that continued spread consistently drives the evolution of new variants and repeated surges.
3. Transmission of airborne pathogens can be effectively mitigated by readily available measures which prevent the sharing of unfiltered air: consistent, proper respiratory protection, and appropriate indoor air quality controls including ventilation, HEPA filtration, and UV.
4. Vaccines, for which access and uptake in the US are poor, are a necessary but inadequate layer of protection. They temporarily reduce the probability of acute-phase severe infection, hospitalization, and death, but they are inefficient at preventing infection, transmission, and Long Covid.
5. Herd/community immunity is literally unattainable because both vaccine- and infection-derived immunity do not endure over time or against newer variants.
6. Long Covid affects at least 1:5 to 1:7 Americans and it is not linked to acute-phase severity. It is typically disabling and can be fatal, and it affects all ages, including children. Repeated infections do not confer immunity; rather they damage the immune system and increase the risk of developing long Covid. Resources for testing, treatment, and support are lacking. Yet it has been completely omitted from consideration in HICPAC proceedings.
7. No pre-exposure prophylaxis or monoclonal antibody treatments are currently authorized, having been outpaced by evolving variants. Three antivirals are currently authorized: Paxlovid, the price of which has just nearly tripled, Remdesevir, administered by IV and costing thousands, and molnupiravir, currently under suspicion of causing new variants and fueling viral evolution.
8. PCR tests are expensive and difficult to obtain. Lucira is expected to return to market at an inflated cost. Rapid antigen tests have a high false negative rate, the U.S. has not updated specimen collection guidance to include cheek and throat swabbing to improve accuracy, and serial testing to offset low accuracy is expensive.
9. Healthcare workers (HCWs) who are denied appropriate protections are at risk of contracting Covid and of spreading it to coworkers, patients, and visitors as well as to their households. Thousands of HCWs have died of Covid and thousands more have been disabled by long Covid.
10. A recent study found half of HCWs with symptomatic Covid-19 present to work in patient care. Surgical masks, when worn, are inadequate for source control.

11. Both the infectious and those vulnerable to infection congregate in healthcare settings. Many lack the ability to effectively protect themselves from exposure, yet they share waiting rooms, hallways, elevators, restrooms, treatment areas and, with the end of testing on admission, hospital rooms. Risk of infections and their sequelae are causing many people to forego needed care, and when encounters are unavoidable, they are forcibly exposed.
12. Those injured and killed downstream in the chain of Covid transmission are invisible to their infectors in the general public, and the “you do you” approach to infection prevention is a failure of public health. But HCWs, who should know better, can refuse to protect patients if they just don’t feel like it.
Protections should be strengthened, and proper PPE and optimal IAQ should be mandated in all health and dental care settings. By weakening protections, HICPAC is saying that it’s acceptable for HCWs to infect patients and each other because transmission is lower and less impactful, in complete disregard of these facts. HICPAC asks for respectful comments: this asks us to “respectfully" beg HICPAC to do their job and protect us, and to “respectfully" beg HCWs not to infect, maim, and kill us. It is long past time to pause the proceedings, reconstitute HICPAC in compliance with its charter and with the law, factor in all of the evidence, and generate guidelines which DO NO HARM.

Greta Fox, FNP-BC
Brookline, MA
World Health Network

I was dismayed and upset to see that you are not helping to ensure protection against COVID in healthcare settings. Why would we deliberately continue to put those of us most at risk in even more risk by not taking reasonable precautions to protect health in healthcare settings? Why would we subject otherwise healthy individuals to the long-term risks of contracting COVID in public settings and especially in our healthcare settings?

As someone who has lost several family members to COVID, who has a best friend who has been struggling with long COVID for over two years with no end in sight, and as someone who has always been very healthy but now my own immune system has been compromised -- possibly forever -- by COVID, I urge you to reconsider and I support the comment from the People's CDC:

People’s CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including:**
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH’s National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency:**

    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.

- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

BEGGING YOU TO LISTEN TO THE SCIENCE AND TO THE PAIN OF MILLIONS WHO HAVE ALREADY BEEN AFFECTED; PLEASE DO NOT TREAT OUR LIVES AS DISPENSABLE AND OUR SUFFERING AS IRRELEVANT.

-Lara Mercurio

Kate Foley (unaffiliated)
401 Millbridge Dr.
Lebanon, PA 17042

I am a college graduate who lives with at-risk family members and a healthcare professional. I am writing because I am worried about the prevalent airborne transmission of COVID-19. Wearing a mask is not required anymore, but I am positive that the scientific evidence still concludes that wearing a mask will help mitigate the spread of COVID-19 and foster a safer environment for both patients and healthcare workers.

We demand a fair process and science-based protections for healthcare workers and their patients.

- CDC/HICPAC needs to delay the vote until the public has had ample opportunity to review the draft Isolation Precaution guidance updates
- CDC/HICPAC must hold public meetings ahead of any vote to hear from healthcare workers, patients, and experts outside of infection control who have essential perspectives for updating the Isolation Precaution guidelines.
- CDC/HIPAC must fully recognize the science on aerosol transmission of infectious diseases. They must update the list of diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.
- The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.
- I urge CDC/HIPAC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.
- CDC/HIPAC fails to acknowledge the importance and function of core control measures for infectious aerosols.

Dan Leckman
Seattle, WA
No organizational affiliation
Commenting on HICPAC's revised healthcare infection control guidelines

Hello,

I'm writing to comment on HICPAC's proposed revisions to the guidelines for infection control in healthcare.

HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens and establish rigorous protocols to prevent airborne transmission in healthcare settings.

Medical facilities are places everyone must go, where high risk, disabled, and seniors must mingle with infected patients, visitors, and staff. Healthcare facilities and personnel should employ all precautionary strategies, including masking with high-quality masks (N95s or better), at all times to protect themselves and their patients. Surgical masks are not adequate protection against airborne pathogens. Universal masking in N95s or better should be the standard of care and masks should be provided free of cost to employees.

Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

As the nurses union is urging, CDC should reject HICPAC’s draft and “actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft” including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

As a patient, I should not have to risk contracting a disabling disease at every medical or dental appointment. I should not have to perform a risk calculation every time I need to seek care for myself or my family. Healthcare settings should be the safest places in our communities.

The CDC's mandate is to control and prevent disease. As medical professionals, you have committed to 'do no harm.' There is still time to bring your actions into alignment with your stated values. Please do so.

Sincerely,
Dan Leckman

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its

generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.
Regards,
Charu Patel
Los Angeles, CA

Deborah Lefkowitz, PhD, OPN–CG
Healthcare advocate and consumer / health services & policy researcher / oncology patient navigator
Riverside, CA

RE CDC/HICPAC's 2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings
November 6, 2023

I am writing today primarily as a healthcare advocate and consumer. But I also draw on my expertise as a certified oncology patient navigator (OPN–CG) and a PhD-trained academic researcher who studies healthcare service delivery and health policy – including COVID-19 vaccine policy.

I am extremely concerned about the **inadequacy of HICPAC's proposed updates** to the 2007 Isolation Precautions to protect the health of both healthcare workers and patients in healthcare settings. I am equally concerned about the **lack of transparency in HICPAC's work group process and the absence of meaningful public input**.

Inadequate approach to transmission-based precaution recommendations

In the draft guidelines released just prior to the HICPAC Nov 2-3 meeting, recommendations are proposed to "largely address infection prevention strategies available to frontline healthcare personnel (HCP) at the point of care." This is a woefully inadequate approach that downplays the essential role of structural prevention strategies, including improved ventilation. Structural prevention strategies are not available to frontline healthcare personnel at the point of care.

The US Environmental Protection Agency (EPA) "recommends increasing ventilation with outdoor air and air filtration as important components of a larger strategy" to prevent spread of COVID-19 particles that can range in size from droplets to microscopic. The EPA further states:

- Particles from an infected person can move throughout an entire room or indoor space. The particles can also linger in the air after a person has left the room – they can remain

airborne for hours in some cases. (https://www.epa.gov/coronavirus/indoor-air-and-coronavirus-covid-19)

Therefore, prevention strategies must be required at the healthcare facility level. The responsibility for preventing transmission of infectious disease should not be left solely in the hands of frontline HCP.

Making healthcare facilities safe for people with vulnerable health makes them safe for everyone

As someone with vulnerable health, I personally have forgone healthcare on several occasions over the last three years due to not feeling sufficiently safe in healthcare facilities. When I seek healthcare, I need to trust that both my providers and the facility are working at all levels to prevent COVID-19 (and other infectious disease) transmission. I do not believe that prevention should be a judgment call at the point of service based on local conditions similar to a decision one would make about whether or not to take an umbrella based on likelihood of rain. By the time there is indication of a "need" for precautions, it is already too late. Prevention requires acting in advance – not in reaction after the fact.

Patient, HCP, and expert scientific input is needed *before* the CDC/HICPAC vote

It is essential to provide opportunities for timely review of the proposed updated 2024 guidelines and also opportunities for meaningful patient, HCP, and expert scientific input *before* the CDC/HICPAC vote. To date there has been insufficient opportunities for both timely review and meaningful input. I urge CDC/HICPAC to make these opportunities available, and to delay the vote on the proposed 2024 guidance until public input can be integrated into the recommendations.

Name: Abby Mahler
Santa Monica, CA
Organizational Affiliation: None / Self

To whom it may concern,

My name is Abby Mahler, I'm 29 years old, and I have lupus and sjogren's syndrome. I am writing to implore HICPAC to update their infection control guidelines to fully recognize aerosol transmission of SARS-CoV-2, and to establish rigorous protocols for preventing “transmission by air” in order to create a truly effective, layered approach to reduce risk for all in healthcare.

Healthcare settings are where high-risk and/or disabled people (myself included), and the elderly will mingle with infected patients, visitors, and staff. As much of SARS2's transmission is asymptomatic, the best way to ensure mitigation is properly utilized is to establish universal precautions to be practiced at all times.

The draft guidelines do not reflect these risks, rather they aim to maximize flexibility for employers over protections for healthcare workers and patients. These same providers complain about the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance.pdf) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.

Deference to the private sector, to employers, is not your job. You are employed for and by the public; weakening protections will be detrimental for all, employers, patients, and yourselves included. Considering you have no expert members in several crucial fields (including occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection), how are you even qualified to make these recommendations?

Perhaps it is because you lack these experts that your draft inappropriately shifts responsibility and risk to individuals (the workers and patients), focusing almost entirely on what should be the last layer of protection (that is personal protective equipment) while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate, so deadlier and more dangerous than community-acquired COVID. These new guidelines– allowing employers broad discretion to choose, implement, or restrict, their own infection control plans, which are nigh always based in profit motive, or on the misplaced concept that seeing "smiles" (https://www.ktnv.com/news/coronavirus/after-3-years-mask-mandate-lifted-at-sunrise-health-hospitals-in-las-vegas) is more important than infection control– will only increase this statistic, an egregious indifference for human life.

Considering we are already begging you for our lives and that does not appear to be enough, think of the cost: Letting SARS2 spread rampantly will only be more costly in the long run. Preventing infection by requiring N95s, fit testing, rapid molecular testing, ventilation, and isolation will mitigate widespread and repeated infections, therefore avoiding disabling or killing untold numbers of patients and workers in healthcare, as well as other fields. Millions of Americans already suffer from Long COVID, what possible justification is there to raise that number?

As the nurses union is already urging, CDC should reject your (HICPAC's) draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

You need not continue this outrageous dereliction of duty. Do not capitulate to the status quo– overwhelming deference to a private sector obsessed with cost-cutting– do your job. Protect healthcare workers, patients, and indeed, be selfish– protect yourselves. As someone with chronic illness, you'll regret it if you don't.

Abby Mahler

Stacy Foley (unaffiliated)
Lebanon, PA 17042

I am a person with risk factors. I am a mother. I am the wife of a physician who works in a hospital setting. I am very concerned about the airborne transmission of COVID. Masks work. They should be used in healthcare settings at the very least. So many people can't even access medical help without risking their very lives. History has taught us things like the importance of hand washing and filtered water for good health. We know this deadly/disabling virus is transmitted through the air. Why is this even a question? Masks (and air filtration) will help stop the spread of COVID and provide a safer environment for everyone. We're in trouble without it. 1 in 5 get long COVID. Please make it a priority to implement whatever it takes to keep people safe.

We demand a fair process and science-based protections for healthcare workers and patients.

- CDC/HICPAC needs to delay the vote until the public has had ample opportunity to review the draft Isolation Precaution guidance updates
- CDC/HICPAC must hold public meetings ahead of any vote to hear from healthcare workers, patients, and experts outside of infection control who have essential perspectives for updating the Isolation Precaution guidelines.
- CDC/HIPAC must fully recognize the science on aerosol transmission of infectious diseases. They must update the list of diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.
- The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.
- I urge CDC/HIPAC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases.
- CDC/HIPAC fails to acknowledge the importance and function of core control measures for infectious aerosols.

Dear committee members,

I urge you to follow the scientifically sound facts of airborne pathogen transmission. Please resolve to provide guidance that strengthens rather than catastrophically diminishes public health standards that will reduce Covid and other respiratory illness transmission:

-Recognize aerosol transmission
-institute respirator requirements in healthcare settings regardless of vaccine status -Respirators are more effective than surgical masks - raise the standard -universal infrastructure upgrades with clean air tools like HEPA filters -Involve aerosol experts and increase transparency in your communications

The CDC once was a world leader in evidence-based, scientifically sound public health leadership. I implore you to be so again.

Sincerely,
Kelly Cunningham
concerned citizen, Canada

I am an immune compromised individual who is now afraid of going to the hospital if I need to because I could get Covid from the healthcare professionals. This is unacceptable and dangerous for people. Requiring high quality masks and improved ventilation could save many lives and that’s what the cdc is supposed to do. Thank you.

You know darn well that Covid and other fun things are airborne. Hand washing won’t prevent it if you breathe it in. Please keep masks in healthcare.

Thanks,

Jessica White

The new infectious disease guidance is WEAKER than existing guidance. This will result in more deaths from communicable disease. Eugenics, or just incompetence? Or are you bought?

Rescind these worthless new guidelines and keep the existing guidelines, or propose guidelines that increase protections against communicable disease.

Derek Dexheimer
Seattle

To whom it may concern,

As an immunocompromised patient & long-time advocate for others who are at even higher risk than myself, I implore HICPAC to fully recognize that SARS-CoV-2 is spread via aerosol transmission and to establish substantive protocols for preventing such transmission and asymptomatic spread. I've encountered so many healthcare providers who don't understand this basic information and the role of HICPAC is critical in not only educating healthcare workers, but also being clear with patients, providers and administrators about *why* rigorous protocols are necessary.

Since healthcare settings are the main location where disabled, high risk and senior patients come into contact (and often for extended periods of time) with infectious people (patients and staff), healthcare facilities must implement consistent control measures.

It's also critical that HICPAC makes sure that the process for updating your guidelines are fully open and transparent; as it currently stands, concerned people are sending these private emails, but we can't read each others' comments. Your meetings should also be open to the public.

Related, healthcare unions (including occupational safety and health experts within and outside of these unions) and those with expertise around ventilation in healthcare, must be consulted during this process.

Millions of people are already suffering from Long COVID and multiple infections put healthcare workers at higher risk for Long COVID themselves. The healthcare system is already struggling with labor shortages. Patients are already avoiding needed procedures due to fear of infection. And multiple studies are showing that nosocomial infections are more dangerous than community acquired.

Please, please do the right thing here; now is the time to strengthen— not weaken-- airborne infection control.

Sincerely,

Deborah Rosenstein, MA
Massachusetts

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dear HICPAC, I wanted to share a comment —

I demand that you substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines. With the participation of these folks we

can ensure the public is safe.

I demand that you make the process for updating the guidelines fully open and transparent. Everyone is entitled to understanding what has changed. Please, no black-boxed communications.

I demand that you fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. We cannot afford to continue to let down our people like this.

And finally, I want to reiterate that healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. **Therefore, all healthcare facilities should employ precautionary strategies at all times.** It is real disturbing to see how lax even hospitals have become.

We cannot continue to pretend that COVID is over. It is not, and nothing has "returned to normal". Please encourage extensive education.

With thanks,

A concerned citizen.

Covid is airborne! Please bring in the scientists, they have the receipts. Requiring protection in health care settings just makes sense.

Regards,

Kelley Nielsen
Salem OR

My name is Mary Walsh-Hilf my address is Euclid OH and I am writing to comment on the HICPAC infection control recommendations.
As an employee who works in a hospital in a non-clinical setting, I am writing to urge HICPAC to update their guidelines to fully recognize aerosol transmission of SARS-CoV2 and take steps to prevent it. It is not enough to suggest that those entering the hospital put on a surgical mask when they are on patient floors. Much transmission is asymptomatic so precautions must be taken at all times!

Comments on revision of HICPAC/CDC 2007 guidance: Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
Submitted by: Barbara Materna, PhD, Certified Industrial Hygienist (CIH) and retired Chief, Occupational Health Branch, California Department of Public Health, for *11/2023 HICPAC meeting*

After submitting written comments to HICPAC for the June 2023 meeting, I participated in planning a 3-hr online infection prevention workshop, *Preventing Aerosol-Transmissible Diseases in Healthcare Settings: The Need for Protective Guidelines and Standards*, which was hosted by the NY/NY Occupational Health and Safety Center on October 13, 2023. HICPAC and its Work Group tasked with revising the 2007 guidelines should carefully review the

information presented at this workshop and the resulting summary report. The report (p. 4-5) includes a list of 14 recommendations made by participants and attendees. See: https://go.rutgers.edu/PreventATD.

My comments here will supplement recommendations made in this report and also address portions of the draft narrative document made publicly available just before the November meeting.

Regarding HICPAC's process, I am appalled that HICPAC and CDC continue to basically ignore the huge level of public interest and concern expressed to date. Other than dropping mention of COVID-19 and influenza as examples of pathogens that would require the proposed Routine Air Precautions and mask use instead of respirator use to protect healthcare workers, HICPAC has made no evident changes to incorporate broader expertise on its Work Group, consider additional scientific evidence, or make any other significant changes in what is being proposed. The Committee's vote on proposed recommendations, which was made prior to hearing public comment at the meeting, further demonstrated a disregard for the public's expressed concerns.

My personal and professional experience most relevant to HICPAC's guidelines for protection of healthcare personnel (HCP) from aerosol transmissible pathogens arises from 1) assisting in the development and 2009 implementation of Cal/OSHA's Aerosol Transmissible Diseases (ATD) Standard, 2) conducting research and public health prevention efforts during the H1N1 influenza and COVID-19 pandemics, 3) providing training for industrial hygienists and HCP on ATD prevention, and 4) developing educational materials on the use of respirators in healthcare, including the original 2015 version of the NIOSH-OSHA Hospital Respiratory Protection Program Toolkit cited as a resource in the draft narrative.

The HICPAC process to revise the 2007 guidelines displays a clear bias against the use of respiratory protection as one essential control measure to reduce HCP inhalation of infectious aerosols and prevent illness. It also fails to acknowledge that federal law (1970 Occupational Safety & Health Act) requires employers to provide a safe and healthy workplace – which means that if an exposure hazard exists, the employer must take effective steps to control that exposure. To be more specific, once we accept that a pathogen like COVID-19 is transmitted by air, the employer must use effective means to control exposure to individual HCP exposed to that hazard.

HICPAC has done a grave disservice by voting to approve the newly proposed Routine Air Precautions that recommend the use of surgical masks as inhalation protection for pathogens transmitted by air. The draft narrative's description of a third surgical mask function (after splash protection and source control) as providing "filtration of inhaled air" (line 205) is flat out incorrect when it comes to inhalation protection for workers. A mask does *not* provide a reliable, predictable level of protection for HCP from inhalation exposure, as compared to a respirator used within the context of a respirator program. Regardless of the filtration efficacy of the mask material, which may vary widely, there will never be a fit test performed to determine the level of protection afforded the individual HCP wearer, thus leaving HCP inadequately protected. Masks were never designed or intended to provide inhalation protection until we found ourselves ill prepared for the COVID-19 pandemic and lacking supplies of appropriate respirators; this lack of preparedness resulted in an unacceptable number of illnesses and deaths among HCP and other workers. Instead of downgrading recommended protection for an aerosol transmissible pathogen from respirator to mask (based on a number of factors other than what is actually needed for effective inhalation protection), CDC should be recommending better preparedness planning and stockpiling of adequate supplies, increased use of elastomeric respirators for

routine use and surge situations, or other approaches that prioritize HCP protection over the desire for many employers to avoid respirator use and the costs associated with implementation of comprehensive, OSHA-compliant programs.

The draft narrative (lines 477-479) states “Routine Air Precautions are focused on reducing transmission of common, often endemic, respiratory pathogens that spread predominantly over short distances based on observed patterns of transmission, and for which individuals and their communities are likely to have some degree of immunity.” There is no explanation of how CDC will determine which pathogens are spread predominantly over short vs. longer distances, and there is no recognition that infectious aerosols like COVID-19 are now known to spread freely within an enclosed indoor space and can remain suspended in air even after the infection source has left the room. Thus, HICPAC has not moved beyond the “Droplet/Airborne” paradigm and replaced it with something supported by science. Instead, it seems to be ignoring the spread of aerosols over medium distances, relying on availability of vaccines and treatments only despite the existence of individual HCP at higher risk, and maintaining Droplet Precautions’ use of masks not respirators. We can suspect, based on previous Work Group presentations, that COVID-19 and influenza will ultimately be put into this category, thus resulting in weakened protections for HCP. This category of recommended precautions for pathogens transmitted by air must be rejected entirely.

The draft narrative (lines 101-102) describes the limitations of PPE that cause it to be the “least effective” bottom of the hierarchy of controls, such as the need to have it readily available and the failure of HCP to use it correctly. However, this description fails to mention that in many cases PPE is the *only* option for individual HCP protection, and it is the responsibility of employers to provide what it takes to make PPE use effective (e.g., good training, selection of PPE that will be comfortable and fits well, observation of PPE use, program evaluation including obtaining input from PPE users).

The 2nd recommended category, Special Air Precautions, appropriately calls for the use of NIOSH-approved respirators. Inexplicably, this category seems to be limited to new or emerging pathogens. Is HICPAC suggesting that no pathogens transmitted by air other than newly emerging ones and the existing “Airborne” pathogens (already known to travel long distances) will warrant respirator use? That would be essentially maintaining the status quo with Droplet/Airborne precautions plus rolling back current COVID-19 protection. It is highly advisable to assume that a new/emerging pathogen for which we lack information on transmission could be transmitted through the air (as the Cal/OSHA ATD Standard specifies) and to use N95 or higher-level respirators until proven otherwise. However, Special Air Precautions does not call for use of Airborne Infection Isolation. Why would CDC want to allow infectious aerosols of a new/emerging pathogen to escape patient rooms into hallways and spread throughout ahealthcare facility? We know from the COVID-19 experience that failure to properly isolate suspected and confirmed cases resulted in countless preventable illnesses and deaths. Although we lack enough AIIRs in healthcare facilities, HICPAC should still recommend AIIRs here and then say what should happen when they are unavailable (e.g., cohorting). In addition, CDC should promote information about other effective isolation approaches that use ventilation controls to retrofit patient rooms or areas by adding air filtration and creating negative pressure (see available NIOSH information https://www.cdc.gov/niosh/topics/pandemic/rooms.html).

The draft narrative (line 484-486) defines Extended Air Precautions as to be used “when providing care to patients with pathogens that are observed to spread efficiently across long distances and over extended times, such that room air needs to be contained (e.g., prevented

from moving into the hallway where individuals are not appropriately protected).” It is not clear what process, criteria, or scientific evidence will be used to determine which pathogens fall into this category other than the ones already accepted as requiring the current Airborne Precautions. Respiratory protection and effective patient isolation including containment of room air are actually warranted for *any* pathogen spread by air. If HICPAC wants to have 2 categories of Air Precautions – both requiring respiratory protection but only one recommending AIIRs – then the document needs to outline a robust and clear rationale for how pathogens would get assigned to each category. Clearly novel pathogens and airborne pathogens causing severe illness should be assigned to the category recommending use of AIIRs, at least until newer information emerges showing otherwise.

Given the limited and biased scientific evidence review done on efficacy of surgical masks vs. respirators, I am very concerned about how the evidence reviews on modes of transmission for individual pathogens will be done by this Work Group in the next phase of deliberations to create Appendix A. Speakers at the October 13 webinar I referred to earlier presented some very old and newer studies supporting transmission by air for influenza, COVID-19, and other pathogens, including numerous animal studies. It is essential that these reviews be done in a more open and transparent way, with a broad range of scientific evidence reviewed and interpreted without undue bias.

A few additional points about the draft narrative:

- Lines 72-74 “Evidence reviews in this guideline focus on clinical studies with infection outcomes because such studies compare prevention strategies in the context of feasibility, user adherence, and implementation within a hierarchy of controls (e.g., engineering, administrative, and personal protective equipment controls) available in the healthcare setting to reduce risk of infection.” – HICPAC should expand beyond clinical epi studies and include relevant lab and observational studies. The evidence review for surgical masks vs. respirators was inadequate and biased. It should be redone, with the involvement of NIOSH respirator experts.

- Line 158 “Non-latex gloves are available for personnel with latex allergies.” – HICPAC should reword and promote use of non-latex gloves to prevent *new* latex allergies from developing in HCP.

- Lines 203-205 “Masks are devices worn over the nose and mouth that perform three primary functions: … (3) provide filtration of inhaled air.” – Delete this 3rd so-called function. Masks are not designed or intended to filter inhaled air for HCP protection; respirators are. Masks are used and performance for these functions, but it is misleading and incorrect to imply that improvements on masks such as Enhanced Barrier Protection specifications are about anything more than improved source control. The NIOSH web page on barrier face coverings (BFCs) cited in the draft clearly states that “no BFCs, even enhanced BFCs, can replace NIOSH Approved® respirators within a workplace respiratory protection program. Also, performance of BFCs for each person cannot be guaranteed as testing is specific to the BFC, not the individual wearer.”

- Lines 240-241 “Reusable elastomeric respirators are used in some circumstances (e.g., during shortages of disposable respirators).” – I suggest adding other reasons employers may choose to use elastomerics routinely, such as the potential for reduced

costs, better fit, newer designs that might become available and more accepted in healthcare settings, or a desire to reduce waste that requires disposal.

- Lines 252-254 “When respirators are required to be worn as PPE, they are used in the context of a Respiratory Protection Program that complies with the standards established by the Occupational Safety and Health Administration (OSHA) and include medical clearance, training, and fit testing.” – Thank you for including this statement; HICPAC must acknowledge OSHA’s role in worker protection and avoid creating any conflicts with CDC recommendations. It is crucial that employers understand their obligations under OSHA wherever respirators are used as worker protection. During discussion at the meeting, there appeared to be some people who were not in favor of references to OSHA (e.g., mentioning that OSHA allows for voluntary use of respirators by workers in situations where they may not be required); I am in favor of increasing and ensuring a full understanding of OSHA requirements throughout healthcare settings, by both workers and employers.

- Lines 499-501 “Facilities may perform an infection control risk assessment to implement Special Air or Extended Air precautions for patients with certain target pathogens, or for all patients regardless of symptoms or confirmed infection, during certain higher risk procedures.” – This paragraph on aerosol generating procedures (AGPs) is inadequate for highlighting to HCP personnel what kinds of procedures may be higher risk. If a list cannot be developed, I recommend providing at least some examples that are generally agreed on. Also, another approach to enhancing protection that should be mentioned is the use of higher levels of respiratory protection such as powered air purifying respirators (PAPRs), which are required for AGPs under the Cal/OSHA ATD standard.

Thank you for your consideration of these comments.

To Whom It May Concern,
Though the medical establishment was reticent to accept Covid was airborne, it seems that HICPAC is even more hesitant to acknowledge transmission.

Many of us understand that Covid is preventable if we have the will to prevent it. We are horrified that HICPAC is considering loosening measures that mitigate transmission in healthcare environments. At what point did it become acceptable that any of us might get sicker when we visit care providers? Why are you refusing responsibility for nosocomial infections? We’ve noted that only hospital administrations sit on the HIPAC panel— this is inappropriate and inexcusable. Since when has profit been more important than health?

We know the facts: Covid is airborne. The endemic is dangerous. If we don’t mitigate transmission chains, more variants of concern will likely develop. We know Covid is a vascular disease. We know that many, even if not diagnosed with Long Covid (for which there is no solution) will suffer sequelae that affect our long-term longevity, heart health, gut health, brain health. And hey, in the Covid context, those of us who are informed know we *don’t* have to worry about fomites—though in the context of other diseases, fomites are a concern, and hospitals are doing a woefully poor job at basic cleaning.

Any of us armed with this knowledge understand that healthcare settings must subscribe to layers of protection to prevent nosocomial infections: Well-fitting respirators, ventilation + filtration, and improved data collection and dissemination.

I hope you've read the latest JAMA survey on the efficacy of masks. We know the early Cochran study (which Cochran walked back) was flawed and influenced by the Brownstone Institute—which is against all government regulations. At the moment, HICPAC has failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-healthcare workplaces. It is unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

Is it not the CDC's responsibility to establish a high standard for infection control measures?

I urge HICPAC and the CDC to establish an approach in the updated guidance that explains the precautions needed to protect healthcare workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure and select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

Sincerely,
Caroline Alexander
Williamstown, MA

Hello,

I wanted to voice my support regarding an issue of utmost importance: the widespread implementation of respirator usage in healthcare facilities. I am wholeheartedly endorsing this crucial measure to ensure the well-being of our healthcare professionals, patients, and the community at large.

The ongoing pandemic, with a particular focus on the challenges posed by COVID-19, has underscored the undeniable significance of respirators in safeguarding the health and safety of our healthcare heroes. Moreover, it plays a pivotal role in maintaining the resilience of healthcare services, ensuring they can continue to operate efficiently when the need arises.

I firmly believe that advocating for comprehensive respirator adoption is a monumental step forward.

Sincerely,
Shannon Kizer

Hello,

I am writing to submit a written public comment for the upcoming meeting. I am writing in support of universal respirator use in healthcare. We need to keep everyone as safe as possible in healthcare settings an masks are a key to this. We know that so many people fall ill or die from secondary infections acquired in medical settings. There are also so many people foregoing care because masks are not required.

Airborne infections are rampant in healthcare, and this committee needs to add prevention steps to avoid them. Current and proposed guidelines disregard (1) airborne transmission via small aerosols, (2) asymptomatic transmission, and (3) that some procedures require patients to remove their own respirators. Combined, these facts mean that patients cannot safely access care without risking airborne infections such as Covid. This committee has failed to address any of these facts. On the contrary, the committee keeps implying that surgical masks and N95 respirators are equivalent, citing extremely flawed studies such as Radonovich et al (Journal of the American Medical Association, 2019): “Participants were instructed to put on a new device whenever they were positioned within 6 feet (1.83 m) of patients with suspected or confirmed respiratory illness,” thus ignoring small aerosols, which travel farther than 6 feet, and asymptomatic transmission, which happens even in patients without “suspected… respiratory illness.” Based on the principle that patients should not acquire new infections in healthcare, universal respirator use is the best policy. Inexplicably, that’s been ruled out, with public health officials suggesting one-way masking instead. But, as noted, some procedures actually involve the mouth and nose, and require patients to remove their masks in healthcare and dental settings with airborne pathogens, which makes one-way masking unacceptable. The Centers for Disease Control (CDC) and Prevention must stop dodging these issues, and must instead educate the public about respirator use, clean air, and airborne transmission. Airborne transmission of SARS viruses was already demonstrated in 2003 at Amoy Gardens in Hong Kong (McKinney et al, Journal of Environmental Health, 2006), so this education should have begun with SARS-CoV-2 in 2020, but it still needs to be done. Hygiene has historically been strongly resisted even in medical settings. This committee will know well, but other readers may not: when Ignaz Semmelweis proved, in 1847, that obstetricians should sanitize their hands when delivering babies, doctors and hospital administrators were insulted and a major backlash ensued for the next several decades. Tragically, we are seeing a parallel backlash against airborne infection precautions. This tragedy is avoidable, if only this committee would take action to protect patients.

Daniel Fain, PhD
Washington State, USA

COVID-19 infections have killed more than 1 million Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections - especially when disabled people have to go to medical settings oftentimes more frequently than others! SARS-CoV-2 is spread via inhalation of aerosol particles. We need layered protections agains this airborne virus in healthcare settings to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection include high quality respirators such as N95s, ventilation, and air filtration.

We urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

While CDC/HICPAC proposes the new category of “air” transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work

Group’s proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients. It is both unethical and unconscionable that HICPAC and the CDC have developed recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. We demand better protections!
--
COVID Aware TC
Minneapolis and St. Paul

To whom it may concern,

My name is Austin Reitz and I am writing in regard to HICPAC's recent proposed changes about infection control. I am calling on the CDC to reject HICPAC’s draft and begin anew, seeking input from healthcare workers and unions, patients, public health experts, and scientists in the field of respiratory health.

It is essential to acknowledge and understand that COVID-19 continues to injure and harm millions of Americans, be it through causing their deaths or causing them to suffer with Long COVID. Healthcare workers, like all people, must be as protected as possible from COVID-19 infections, especially since they are at a higher risk of exposure due to working in higher risk areas (indoor setting with people moving in and out throughout the day). The guidelines presented by the CDC must fully recognize the aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air”. Transmission of COVID-19 can be asymptomatic, so it follows that any interaction will the same air in a location with high foot traffic (such as a hospital) could be deadly. Precautionary strategies must be implemented for the sake of workers, the elderly, the immunocompromised, the disabled, staff, visitors, and all others. Due to all of these people being in the same area where COVID-19 can be easily contracted, masking with N95s is the least the CDC can mandate.

HICPAC’s draft proposes a less cautious approach to protecting healthcare workers, allowing employers to avoid providing employees with necessary protections. N95 masks, proper ventilation, and air filtration have been shown to protect individuals from contracting COVID-19. It is beyond necessary that the CDC set as high a standard of protection as possible, as the alternative is to allow for the death and injury of not only the everyday person, but the healthcare professionals who spend their time and lives keeping the populace safe and healthy. Anything less than universal practice of all possible precautions is a failure to acknowledge the danger of infectious aerosols and the effectiveness of respirators and ventilation. Limiting the use of these known protections is not only inadequate, it will result in an increase of infections and deaths. Understanding the science behind infectious aerosol transmission and proper respiratory protection is a central concept in protecting healthcare workers and their patients, friends, and families from a deadly disease that still ravages our planet. Immunocompromised individuals are more likely to visit a healthcare facility than non-immunocompromised individuals, so by not implementing protections for the healthcare workers, the already vulnerable are being put at an even greater risk. Nosocomial COVID (transmitted in hospitals) has a 10% mortality rate, which is

deadlier than COVID contracted elsewhere. As a result, these are the places that need a high standard of protection, and the CDC is the organization that can make that happen.

The current draft proposed by HICPAC prioritizes flexibility for employers over the protection of healthcare workers and patients. Allowing for employers to choose whether or not to implement any protections at all will result in more illness and more death. This is an undeniable truth. Even if a facility were to determine different levels of protection based on the level of transmission, due to the lack of tracking and testing for COVID-19, the transmission level is largely unknown and thus such an approach would be faulty at best. Transmission of a variety of diseases would increase under HICPAC's "Enhanced Barrier Precautions", which would allow for barrier precautions in nursing homes and other heathcare settings to be reduced, allowing ungowned staff to potentially spread pathogens from infected to uninfected patients. It is important that all healthcare workers be adequately protected, primarily through the use of N95 respirators or better, which should be the standard. Surgical masks have proven to be inadequate in protecting against airborne pathogens such as SARS-CoV-2. Healthcare employers must not prohibit employees, patients, or visitors from using N95 respirators or other sufficient protective equipment. All healthcare employees must be tested for COVID-19 regularly (as well as other respiratory infections, such as the flu) regularly and consistently. If an individual were to become infected, they must be supported with paid leave or remote work. Infected employees must be allowed to quarantine / self-isolate until their symptoms improve and they test negative consistently. As a part of these protocols to provide the best quality of protection to all healthcare personnel, patients, and the populace, hospitals must provide free vaccination and boosters for the entirety of staff, patients, and visitors.

The above described precautions and the call to reject HICPAC's proposed draft are in line with suggestions from frontline healthcare workers, as per the People's CDC. Just as National Nurses United, I too call for the CDC to reject HICPAC's draft. In its current state, HICPAC is not able to produce an appropriate draft, as it has no members that can claim expertise in occupational health and safety, aerosol science, and respiratory protection. HICPAC will not be able to produce an appropriate draft until it has members with such expertise. Any and all future steps in the process regarding the guidelines must be fully open and transparent to the public. It is essential that the people be able to publicly comment to the CDC on these matters, as opposed to writing in solitude via email (as I am doing in this moment). Final guidelines should include a means of reading the public's comments, as well as why or why not comments were adopted, including scientific rationale.

I hope this message inspires change for the better of all people, especially now during the continual threat of COVID-19.

/s/ Austin Reitz
Aurora OH

November 6, 2023

ECRI WRITTEN COMMENT TO CDC HICPAC

Thank you for this opportunity to provide a written public comment.
My name is Dheerendra Kommala, MD. I am the Chief Medical Officer of ECRI. I have more than 20 years of experience as an academic clinician, researcher, and chief medical officer.

Throughout my career, I have been a vocal advocate for patient safety and a visionary leader managing large teams.

ECRI, headquartered in Plymouth Meeting, Pennsylvania, is a 55-year-old independent, nonprofit organization with a commitment to improving the safety, quality, and cost-effectiveness of healthcare. Since the program's inception in 1997, we have held the formal designation as an Evidence-based Practice Center (EPC), granted by the U.S. Agency for Healthcare Research and Quality. As an EPC, we evaluate, synthesize, and translate the evidence for use by healthcare leaders, policymakers, and clinical practice guideline developers. As a federally certified Patient Safety Organization (PSO), we have collected and analyzed nearly 5 million critical patient safety events and near-miss reports. ECRI is the only organization to hold dual federal designations as an EPC and PSO—allowing us to leverage our interdisciplinary team and assist stakeholders with making informed clinical, research, policy, and care decisions. Furthermore, our team of clinical engineers conduct independent medical device evaluations, with laboratories located in the United States and Malaysia.

In January 2020, ECRI formally affiliated with the Institute for Safe Medication Practices, a global leader in medication safety. Over the past five decades, ECRI has built its reputation on disciplined rigor, with an unwavering commitment to independence according to our founder's principles, Dr. Joel Nobel. Our conflict-of-interest rules are among the strictest in the industry, which assures our integrity and the source of unbiased clinical evidence for clinicians and others around the world while serving as a trusted advisor.

We strongly advocate for evidence-based infection prevention and control practices. ECRI's infection preventionists, clinical epidemiologists, human factors engineers, biomedical engineers, research librarians, physicians, pharmacists, quality improvement credentialed nurses, microbiologists, PhD and master's prepared Public Health epidemiologists, and more provide a comprehensive approach to infectious diseases-related issues that requires high level expertise and collaboration to improve outcomes. Our diverse Infection Prevention team, led by Ericka Kalp, PhD, MPH, CIC, FAPIC, are well-trained and board-certified subject matter experts on the infection prevention and control related issues facing healthcare today. The ECRI team has provided hundreds of proactive infection prevention and control assessments and outbreak response mitigation efforts within U.S. healthcare facilities, while using our multidisciplinary team to pursue excellence in improving outcomes.

In consideration of our expertise and impact in the world of patient safety, infection prevention, and safe medication practices, I request that the Department of Health and Human Services along with the CDC consider including ECRI as an active participant in the work of this important committee as a new Liaison organization, as we promote the use of clinical evidence to guide practice decisions along with the integration of human factors engineering to improve patient outcomes.

In my opinion, ECRI will serve as an invaluable partner to CDC HICPAC because we are committed to work collaboratively as a liaison. Our contribution will provide direct access to our diverse expertise, skills, and experiences that will augment the background and expertise of the current HICPAC members.

Thank you for your time and consideration of my request for Liaison Organization status.

Respectfully submitted,
Dheerendra Komala, MD

Chief Medical Officer
ECRI

Hello my name is Britta Schumann,

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.** All individuals deserve access to safe healthcare with lower risk of nosocomial infections (including SARS-COV-2). Because of the removal of mask mandates in hospitals, many high risk patients such as cancer patients and disabled patients have been forgoing needed medical interventions to avoid risk of infection complications.

Britta Schumann
Library Assistant
Minneapolis, MN

Hi,

There are many critical errors in HICPAC's proposed revised isolation precautions guidelines.

Please:
-Recognize aerosol transmission
-Instate respirator requirements in healthcare regardless of vax status
-Acknowledge Respirators are more effective than surgical masks
-Recommend use of clean air tools like HEPA filters
-Involve aerosol experts and increase transparency

Thank you
-Stephanie Schmit
Everett, MA
Organization: None

Dear Members of the Healthcare Infection Control Practices Advisory Committee:

I am writing as an academic infectious disease physician-scientist with over 20 years of clinical practice experience.

I have followed your committee's work closely, and I would like to share my concern that the HICPAC has failed to involve frontline health care workers (particularly nurses), patients and experts in aerosol transmission in developing its proposed revision of the healthcare infection control guidelines.

The infection control recommendations of the HICPAC committee have tremendous power over people's health and well-being. Public meetings, acceptance of comments, and active engagement of all stakeholders should be expected as part of this process.

I urge the CDC to reject these draft guidelines and engage in a more appropriate public process in revising these important infection control standards.

Sincerely,

Regina LaRocque, MD MPH FIDSA FISTM
Associate Professor of Medicine, Harvard Medical School
Associate Physician, Division of Infectious Diseases
Massachusetts General Hospital
Boston, MA

COVID-19 infections remain a primary concern for me and my family. While I am lucky to not currently have an immune disorder, I have family members who do. The lack of strong CDC guidance and policy regarding filtration of indoor air in public spaces like schools and restaurants already places undue stress on my family. The absolute last place that my loved ones should feel vulnerable and risk serious illness is when seeking health care.
The guidelines in this current draft aim to maximize flexibility for healthcare employers, **not protections for healthcare workers and patients**. They allow employers (the vast majority operating from a profit motive rather than hippocratic philosophy) broad discretion to choose, implement, or restrict their own infection control plans. Many have demonstrated prioritizing seeing "smiles" (https://www.ktnv.com/news/coronavirus/after-3-years-mask-mandate-lifted-at-sunrise-health-hospitals-in-las-vegas) rather than infection control—which should be unacceptable, because it undermines the purpose of healthcare and puts the most vulnerable among us at unnecessary risk for shallow marketing tactics.
The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air." We have better scientific understanding of COVID-19 transmission now than ever before, and failing to make use of this information is a failure to serve US citizens. Protocols *must* account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a **layered approach** to reducing transmission risk. The HICPAC draft also inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the *last* layer of protection—personal protective equipment—while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Most vitally for me and my family, **transmission is often asymptomatic. Therefore, all precautions must be universally practiced at all times**—not just when someone is symptomatic. Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.** This is vital to the safety and health of my family in particular, as noted in my opening to this letter. Furthermore, the currently proposed guidelines call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is very little testing, wastewater monitoring, and tracking and reporting of cases and other data. It is also difficult to access PCR tests, and at-home tests alone are not reliable (nor are people making use of them as often as they ought).
· Healthcare providers complain of the cost of protective measures to stop transmission, but the US Department of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance.pdf) – and does not weigh that cost against profits. The CDC should likewise prioritize life and safety over profits. Furthermore, letting COVID-19 infections run rampant will be more costly in the

long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID, including some of my friends and colleagues. Even more worrying, nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate—so it has proven deadlier and more dangerous than community-acquired COVID. Again, my immune-compromised family members should not have to worry about or delay healthcare because of these concerns.

· With these very real and persistent concerns in mind, I write to you to request that the HICPAC guidelines address the following:

· **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.** Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. **N95 respirators or better should be the standard of care**, and healthcare employers must not prohibit workers or patients from using them. Historically, requiring hand-washing before treating patients was considered inconvenient, despite scientific evidence of its utility in preventing the spread of infection and ensuring better patient outcomes. Now it is de rigueur. Science must lead policy.

· All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season. Personnel who are infectious **must be supported with paid leave, or where appropriate, remote work**, and allowed to stay home until symptoms improve and testing is negative.

· Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors. Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases. Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases—which is why universal masking is still necessary.

While I am submitting this comment in earnest hopes of seeing a future draft of HICPAC that incorporates the above, HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC. **As the nurses union is urging, (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

Thank you,
Heather Lee Birdsong
(she/her or they/them)
Portland, OR

I am writing to implore HICPAC to update their infection control guidelines to fully recognize aerosol transmission and SARS CoV2 and to establish rigorous protocols for preventing transmission by air in order to create a truly effective, layered approach to reduce risk for all in healthcare. Healthcare settings are where high risk and or disabled people, and the elderly, will mingle with infected patients, visitors and staff. SARS CoV2 transmission can be asymptomatic

and many people do not even realize they're sick. The best way to ensure mitigation is properly utilized is to establish universal precautions to be practiced at all times. Draft guidelines do not reflect these risks, rather they aim to maximize flexibility for employers over protections for healthcare workers and patients.These same providers complain about the cost of protective measures to stop transmission. The US Department of Health and Human Services in 2016 deemed an intervention cost-effective if it costs less than $9.6 million per life saved. The CDC should not defer to the private sector to employers. You are employed for and by the public. Reinfections will be detrimental for all employers, patients and yourselves included. Considering you have no expert members and several crucial fields including Occupational Health and Safety, Engineering for Clean Air, Aerosol Science, Industrial Hygiene, and Respiratory Protection, how are you even qualified to make these recommendations? Perhaps it is because you lack these experts that your draft inappropriately shifts responsibility and risk to individuals, the workers and patients. Focusing almost entirely on what should be the last layer of protection, that is personal protective equipment, while failing to set strong standards for other crucial tools such as: ventilation testing and patients and staff and isolation. Nosocomial covid infections that are transmitted in hospitals have a 10% mortality rate, so deadlier and more dangerous than community acquired COVID. These new guidelines allow employers broad discretion to choose, implement or restrict their own infection control plans, which are not always based on profit motive or on the misplaced concept that seeing smiles is more important than infection control will only increase. This is an egregious indifference for human life, considering we are already begging you for our lives, and that does not appear to be enough. Think of the cost. Leaving Covid to spread rampantly will only be more costly in the long run, and preventing infection by requiring N95 fit testing, rapid molecular testing, ventilation and isolation will mitigate widespread and repeated infections, therefore avoiding disabling or killing. Millions of Americans already suffer from long COVID. What possible justification is there for raising that number? As the nurses union is already urging, CDC should reject your HICPAC draft and actively engage the input of frontline healthcare workers, patients and public health experts in developing a new draft, including holding public meetings in a process similar to the meetings held in 1992 to develop guidelines on control of multidrug resistant TB. You need not continue this outrageous dereliction of duty. Do not capitulate to the status quo - overwhelming deference to a private sector obsessed with cost cutting. Do your job. Protect healthcare workers, patients, and indeed be selfish. Protect yourselves as well. We urge you. Please.

Thank you,
Dominique D

Dear CDC,

I am a teacher in a high school in Idaho in an area with a high Covid transmission rate. My students are experiencing numerous sick days, are missing lessons, and are in danger of not passing their classes. Every day, I wear a KN-94 mask to avoid catching Covid from my students, and so far fortunately I have not caught it. Masks work.

It is important for hospitals to exercise the utmost care in preventing the spread of Covid and other respiratory viruses to keep the rest of us safe. This includes high-quality masks for all staff and visitors. In 2020, I lost two friends at a young age because they caught Covid while they were being treated at hospitals. Their deaths were unnecessary and preventable.

Please do your job and keep us safe.

Sincerely,

MaryAnn Smith
Idaho Falls, ID
(teacher, Skyline High School
Idaho Falls, ID)

Hello,

It seems insane to need to beg for this but can you PLEASE make hospitals safer rather than more terrifyingly dangerous? My 82 year old mother who already struggles with previous breathing issues avoided catching Covid for 3 years only to catch it while fighting for her life in a nursing home for rehab after a near death experience. No one in that facility was masking so there was an obvious outbreak of Covid. The facility was already understaffed- leaving my mother and all other patients sitting in their own feces and urine awaiting assistance from the very few nurses and aides on staff. Then they were down employees who were also catching Covid so the care was even less available. Not to mention the additional symptoms my moms frail body almost didn't survive in her weakened state. WHY recreate this situation over and over again? Why harm overworked staff by giving them repeat infections? Why give patients seeking assistance for other health conditions NEW deadly or long-term affecting conditions? Why can we just keep masking in hospitals? Why can't we just create the best ventilation possible? Why is the health of your staff and patients unimportant in a HOSPITAL - of all places?? Why? Make it make sense. Please .

PLEASE!!!!!

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMW1qbnliIn0.5aD1TOMIS6To-CxCXEvMw2WvZhVBFZOMs4Awg74OCIM) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMW1qbnliIn0.5aD1TOMIS6To-CxCXEvMw2WvZhVBFZOMs4Awg74OCIM) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.

- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

If you'd like to comment on specific layers of protection:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoiMW1qbnliIn0.5aD1TOMIS6To-CxCXEvMw2WvZhVBFZOMs4Awg74OCIM) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Thank you for listening,
Jerielle Morwitz

Dear HICPAC Members,

I am reaching out to express my deep concerns about the ongoing COVID-19 policies and the urgent need for improved protective measures in healthcare environments. In this critical time, it is essential to understand the nuances of SARS-CoV-2 transmission and the effectiveness of our current response.

The virus's airborne nature suggests that it can linger in the air and infect spaces long after the departure of an infected person. This characteristic of the virus, coupled with the fact that a significant number of infections are attributed to asymptomatic individuals, presents a challenge for containment that our current methods are not fully addressing. Moreover, the widespread notion that surgical masks offer protection on par with N95 respirators is not substantiated by robust data, which illustrates the latter's superiority.

Furthermore, our tiered precautionary measures rely on variable and often underreported data, which may not provide a reliable foundation for decision-making. History has shown that loosening these measures when reported cases are low leads to recurrent surges and the emergence of new virus variants. Effective mitigation is indeed possible with strategies that prevent the sharing of unfiltered air, such as quality ventilation, filtration, and the use of ultraviolet germicidal irradiation.

Vaccinations have been a cornerstone of our fight against this virus, yet their efficacy is limited to reducing the severity of acute infections rather than preventing transmission or the development of long Covid, which affects a significant portion of the population, with children being no exception.

Concerns also extend to treatments and testing. The antiviral treatments available are either too costly, potentially contributing to viral evolution, or fraught with limitations. The accessibility and accuracy of testing are hindered by high costs and inadequate guidance, complicating the timely and accurate diagnosis of COVID-19.

In the healthcare sector, the absence of adequate protections has tragically resulted in a substantial number of healthcare workers contracting the virus, many succumbing to it or suffering from long-term disabilities due to long Covid. This is exacerbated by the high risk of virus spread within healthcare settings, where the end of routine testing upon admission has increased the likelihood of virus transmission, compelling many to defer essential healthcare services.

The ethical responsibility of healthcare workers and institutions in preventing virus spread cannot be understated. The current individualistic approach to infection prevention has failed as a public health strategy. There is a moral imperative for healthcare workers to adopt stringent measures and for institutions to mandate proper personal protective equipment and optimal indoor air quality.

In light of the aforementioned concerns, I implore HICPAC to revise its guidelines to reflect a more robust and evidence-based approach to COVID-19 protections. It is imperative that the committee align its guidelines with the fundamental principle of medical ethics to "Do No Harm" and act swiftly to safeguard the well-being of both healthcare workers and the public.

Thank you for your attention to these critical issues. I look forward to your action in reconstituting the committee's approach to addressing this public health challenge.

Sincerely,

Nicholas DiBella
Pittsburgh, PA

Comment submitted by Jocelyn Donegan-Peterson

Round Rock, Texas

I have no affiliations or conflicts.

This written comment is regarding HICPAC's Meeting on November 2nd, 2023, and HICPAC's recommendations and guidance concerning Healthcare Prevention and Control.

My comment starts here and is less than one page in length written in 12-point font:

My father is a **GOOD** man, who always worked hard and gives generously to others. In 2018, he almost died of the flu, which left permanent damage to his heart and lungs. All of his doctors still say he **CAN'T** get Covid, the risk to his life is too great. We, and countless others across the nation and globe, only go indoors masked in respirators (n95s or p100s) for necessary medical care. Although my dad can't do many things he should be safely enjoying in retirement with his grandchildren, we're grateful for crucial tools (like effective masks and upgraded ventilation) and the healthcare workers still taking THE most protective measures to help us avoid Covid and keep my dad ALIVE. What continues to **horrify** and **baffle** us, is that the **ONLY** Covid risks we are forced to take are when seeking medical care. Let me say that again: the only Covid risks we are **FORCED** to take with his **LIFE**, and our lives and long-term health, are when we need medical care. That statement doesn't even make sense when you say it out loud, and yet that is the tragic and unavoidable reality for us and so many others right now. The exhausting and **NECESSARY** risk analysis whether that medical appointment or procedure is *worth* possibly contracting Covid, the **VALID** anxiety that now accompanies those appointments and distracts from the medical issue care is being sought for, and the people who have already contracted Covid while seeking medical care…none of those things ever get less surreal because the tools exist to reduce the risks. **You** can make these environments exponentially safer for all, including the **brave** medical professionals constantly working there. The **serious risks** of Covid (short and long-term) have already been confirmed and **reconfirmed** in peer-reviewed studies (and that's not even accounting for what we may continue to learn in the future). Given the lack of effective preventatives and treatments we currently have, more and more people are going to continue to unnecessarily die OR be disabled with Long Covid OR be added to the higher risk pool to where a subsequent Covid infection could kill or disable them. This is unsustainable for our species and our global healthcare systems. **We need the updated guidance to be clear and explicit about the precautions that are needed to protect healthcare workers and patients from infectious diseases, and we need consistent messaging to educate the public about the true dangers of Covid and being disabled by Long Covid, so they understand and support these protocols.** We need you to do everything in your power to protect the lives, and physical and mental health of all of us - **most importantly the highest risk amongst us** and our **precious healthcare workers**. My dad and so many REAL people (children, fathers, mothers, grandparents, husbands, wives) don't deserve to be abandoned, and their lives or long-term health put at **serious** risk just because they need a doctor, or surgery, or are fighting cancer, or are elderly, or are immunocompromised, OR are working as a healthcare worker trying to help **all** of those people. **You are in a position to help all of them, to help all of us. Please…help…us.**
Thank you.

Hello,

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is

spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation. The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Sincerely,
Sarah Warzecha
Racine WI

Daniell Kinder, US citizen, St Louis, Missouri USA, public comment HICPAC 11/06/2023
Why this needs to be standard precaution and not transmission-based: We need standard precautions to now include airborne disease, regardless of epidemiological situation. WHO (https://www.who.int/news/item/13-01-2023-who-updates-covid-19-guidelines-on-masks--treatments-and-patient-care#:~:text=Masks%20continue%20to%20be%20a,of%20the%20COVID%2D19%20globally) says due to the global spread of COVID-19 they no longer base recommendations on local epidemiological situations. It is time HICPAC and CDC do the same.
Why we need ventilation and filtration urgently addressed, and we need universal respirators in use immediately and for the foreseen future: Unlike prior airborne spread disease, COVID-19 is always present and not seasonal, is highly contagious, and is frequently asymptomatic or presymptomatic in nature when it is being spread, meaning that action to clean the air in healthcare facilities is urgently necessary. Healthcare facilities have higher concentrations of ill people and others who are much more at-risk. Healthcare settings are where the high risk, the disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.
Why non-compliance is not a reason to stop infection control requirements: Current HICPAC members have stated that respirators may be uncomfortable; they might cause problems with compliance and so a HICPAC member said that they are not effective because of non-compliance. Surgical masks are not sufficient to protect against airborne pathogens. The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Reducing and confounding safety measures is not what to do when the issue is non-compliance; you address the non-compliance! It is the duty of healthcare professionals and facilities to follow infection control guidance.
We need airborne protections for routine care and we need them to include required respirator masks for all workers in the facility that shares air systems with patients (including medical transports), and we need to recommend for patients and visitors (who are not contraindicated) to wear respirator masks as well. We can stop healthcare acquired infections of COVID-19 and provide safe access to healthcare for all populations by increasing the number of people wearing respirator masks in healthcare settings. I have personally struggled with Long COVID since 2020 and now, over three years after my infection, I have given up on regaining anywhere near the quality of life that I had previously and I cannot continue with the career path I had prior. I have to get routine MRI scans as part of my treatment regimen for a meningioma and migraine disease has gotten immensely worse since COVID. I have been putting off a lot of needed appointments for these conditions as it is unsafe to be in a hospital or healthcare clinic setting with current standards of no respirator masking and healthcare professionals going so far as to physically remove my respirator mask from my face for no necessary reason. My life depends on better infection-prevention standards in healthcare as do the lives of many others.

Hello,

My name is Elizabeth Goldsmith George, I am a caregiver to an elderly veteran immune compromised transplant recipient in Vermont. I’m writing today to ask that the recommendations include the following:

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.

My father needs safe equitable access to healthcare and without the above recommendations his chance of hospital acquired infection is substantial. I'll remind you that no equivalent effective vaccine is available for the immune compromised population, and access to paxlovid is

limited to children over 12 years old and a weight requirement. There are several populations that weakening HCW safety protocols will have irreversible consequences for, please use the science and don't sell our futures.

Thank you for your time,
Elizabeth George

Mary Jirmanus Saba
People's CDC
Malden MA

Good afternoon. My name is Mary Jirmanus Saba. I am a political economist and member of the People's CDC. Before today's meeting, HICPAC got 600 pages of written comment on proposed changes to infection control guidance. The drafts you are voting on do not reflect any of that feedback, and thus you must postpone today's vote. Much of the public comment describes jarring and unsafe experiences of healthcare workers and patients, and actual harm – patients who sought healing at a healthcare appointment but instead contracted COVID or RSV. Patients whose healthcare providers denied reasonable accommodations requests and refused to mask. The People's CDC, a volunteer-run CDC watchdog and public health advocacy group, has received dozens of such complaints. Some said their healthcare employers *even* refused to allow them to wear N95 masks to protect themselves. Many complaints came from patients and workers at Massachusetts General Hospital, Dr. Shenoy's employer – people stating that their federally guaranteed right to safe medical care is being violated. This situation stands to get drastically worse if you continue with these weakened recommendations.

Hospital Association reports hospitals are experiencing "crushing financial challenges," In a brief, Sourav Bose, Serena Dasani from Penn's Leonard Davis Institute of Health Economics, demonstrated that hospitals lost a lot of money due to postponed elective procedures for covid positive patients while hospitals were still required to test patients on admission. The April 5 Boston Globe reported Massachusetts hospital administrators lobbied the DPH to get rid of masks. So, before the CDC changed guidance on masking in healthcare last year, did hospital administrators email Rochelle Walensky just like the CEO of Delta and say "hospitals are losing money – please loosen the rules on preventing Covid and other aerosol transmitted viruses in healthcare? In making these new recommendations, are HICPAC and CDC prioritizing hospital profits over our safety?

Whatever is happening, the consequences of continuing down this path are dire: they empower anti public health forces. Just this past week, the US Senate passed a resolution to ban mask mandates on public transport. Several democrats supported it. If it becomes law, and if we get another novel deadly virus aerosol-transmitted, states cannot mandate masks. Are they going to ban healthcare masks next? You can still do the right thing: delay the vote. Incorporate our comments and base your recommendations on peer-reviewed evidence rather than vague and undefined "expert opinion" which conveniently overlaps with healthcare management priorities. Recognize aerosol transmission and recommend n95 respirators or better for healthcare workers accordingly, recommend upgraded standard ventilation and core control isolation protocols. Make universal masking the new standard of care year-round. Include occupational safety, healthcare union representatives and patient safety groups as voting members of HICPAC. You can still do the right thing, and do no harm. You can and must control and prevent disease. It's literally the CDC's mandate.

I am writing to ensure a new set of Guidelines for the CDC Guidance be developed by a fairly, balanced HICPAC following a transparent process, which acknowledges the overwhelming body of scientific evidence and expert opinion that aerosols are a significant mode of transmission for infectious agents such as Covid-19, influenza, and RSV.
As a family who was infected by covid-19 in early 3/2020, we have three people yet to recover fully. We've suffered with long covid for over 3.5 years. Our family is now comprised of three LC sufferers, a person on immunosuppressants, and several people at high risk of severe disease according to the CDC. We're part of the small population who's trying to do everything we can to not get infected with covid. We mask indoors, avoid large crowds, and have made accommodations for our school aged kids at school. We've noticed that not only have we avoided covid but we've avoided many other infectious pathogens. Our biggest risk is accessing healthcare. When we ask for accommodations such as providers wearing a mask or waiting in our car instead of a crowded waiting room we get a lot of pushback. We need the CDC, and HICPAC, to protect people like us with guidance that will take the onus off of patients to protect themselves. We try to get the majority of our healthcare virtually, but with our chronic illnesses there are times when we have to go in person. During these visits, there are times that we have to unmask to receive care; taking away our only protection. An anecdote that fuels our nightmares: we have a friend who works in healthcare. They went to work after a vacation and didn't realize they were exposed. They were unmasked and symptomatic for days before they got a positive covid test. The amount of people they came in contact with in the healthcare setting is countless. We'll never know how many people were infected by our friend but that number would've been greatly reduced if proper protocols were in place.
We should take our experience from this pandemic and learn from it. We need those in charge to do what is right, not necessarily what is easy and popular. Proper PPE and effective ventilation should be the standard of care in all medical facilities.
Thank you, Michelle Masini, Aurora, IL, immunocompromised long covid sufferer.

I am writing to express my deep concern about the recent revisions to CDC guidance that have the potential to undermine long-standing infection control standards in hospitals, nursing homes, and all healthcare settings across the United States. I firmly believe that these changes do not align with scientific evidence, jeopardize the safety of the people you serve, and do not reflect the desires of patients.

The importance of recognizing and addressing aerosol transmission of SARS-CoV-2 cannot be overstated. The recent revisions to CDC guidelines must acknowledge the airborne nature of the virus and establish rigorous protocols for preventing "transmission by air." It is crucial to implement a layered approach to reducing transmission risk by incorporating multiple infection control measures simultaneously, as scientific evidence has shown that this approach is the most effective.

Moreover, it is essential to recognize that a significant portion of SARS-CoV-2 transmission occurs asymptomatically. As such, all precautions must be universally practiced at all times, both by healthcare workers and patients, to mitigate the risk of infection and transmission. In healthcare settings, where high-risk individuals, the disabled, and seniors interact with infected patients, visitors, and staff, the utmost precautionary strategies should always be employed.

The current draft guidelines seem to prioritize flexibility for healthcare employers over the protection of healthcare workers and patients. Allowing employers broad discretion in choosing and implementing infection control plans based on profit considerations or prioritizing "smiles" over infection control is a concerning approach. Healthcare providers' concerns about the cost of protective measures must be weighed against the cost of human lives. The Department of

Health and Human Services has established cost-effectiveness criteria that do not weigh the cost of protective measures against profits, and neither should the CDC.

Furthermore, the current draft guidelines inappropriately shift responsibility and risk to individual healthcare workers. The focus on personal protective equipment as the last layer of protection neglects other crucial tools, such as ventilation, testing of patients and staff, and isolation. These factors play a vital role in preventing nosocomial COVID and ensuring the safety of both healthcare workers and patients.

In conclusion, it is imperative to address the shortcomings in the current CDC guidelines and prioritize the safety and well-being of healthcare workers, patients, and the broader community. Failing to do so will result in more significant costs in the long run, not only in terms of healthcare resources but also in the physical and economic toll of widespread and repeated infections, including the long-term consequences of Long COVID. The CDC must reevaluate the draft guidelines and ensure they align with the best available scientific evidence and prioritize the health and safety of all stakeholders.

Kathleen Damelio
Canfield, OH

Hello,

I am a healthcare worker in Minnesota who is concerned about the draft for the new Healthcare Infection Control Guidelines. I work in a healthcare setting where high risk people who are chronically ill have weakened immune systems from eating disorders and associated disorders. Visitors, patients and staff all gather together inside, putting each other at risk for transmission of Covid-19. Testing is infrequent and vaccines aren't required even for the residential patients.

Healthcare facilities and personnel should employ all precautionary measures at all times in order to prevent the continued spread of covid 19. In the middle of a shortage of healthcare worker shortage this should be obvious. I have to admit, I am one of thousands of healthcare workers ready to leave the profession all together over the lack of respect and protections. During the height of the pandemic we were hero's, and now we are being left to toil in the ongoing pandemic.

Please set the highest of infection control guidelines, the draft as it currently stands weakens it, and with it the further eroding of American healthcare.

Thank you for your time,

Emma Fitzsimmons

To Whom It May Concern:

I am writing to urge the HICPAC to update infection control guidelines to be consistent with the science and knowledge gained from the COVID pandemic. As a clinical psychologist specializing in adjustment to chronic illness and disability who has immune-compromised patients on my caseload and one who is on an immune-suppressing drug, I am very concerned about infection control in healthcare settings. I was recently on an inpatient telemetry unit here in Pennsylvania and the caregiving staff were not routinely wearing masks, unless specifically

requested to do so or when in the procedure room. I had to have a sign on the door of my room requesting people wear a mask, and to repeatedly remind them to close the door after entering. Also, noteworthy is that none of the healthcare staff wore N95 masks or KN95 masks; they all wore surgical masks, which offer very limited protection for aerosols.. We are currently experiencing low transmission rates of COVID in the Philadelphia area, but other viral infections are also circulating. Fortunately, I have not become ill as a result of my stay in the hospital.

While I have been fortunate not to become ill in a healthcare setting, I stand with the People's CDC recommendations for updating HICPAC's infection control guidelines as follows in order to protect the most vulnerable among us:

· The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
· Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
· **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
· Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
· The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) rather than infection control.
· Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoiMTFndHJpIn0.s5ZsSqQXjjGZ0CUCrql8yaiKgByJRP4t4TOrEGQKbHI) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
· The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
· The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
· Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
· Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

Thank you for your time and attention to this matter.

Susan E. R. Mitchell, Psy.D.
PA Licensed Psychologist
APIT Certified (Authority to Practice
Interjurisdictional Telepsychology
Through PSYPACT)

Hello,
I am a 19 year old who has been disabled by COVID-19 after two infections. I and my community are demanding that instead of completely bulldozing over our safety, you fully recognize aerosol transmission of SARS and SARS-CoV-2 and establish rigorous protocols for prevention of SARS with the involvement of healthcare unions, experts in ventilation safety, and the public. In addition, we demand that you set guidelines that require healthcare facilities to employ precautionary measures at all times--healthcare settings are one of the most high-risk settings for people like myself and I personally know folks who have been infected because doctors and other healthcare staff refused to put their safety first and practice proper air safety.

If you do not comply with our demands and make the process for updating the guidelines as transparent and clear as possible, you will continue to kill and disable millions, including children and elders. We will not forget this.

- Alex.

Greetings HICPAC,

I am providing a written public comment on the Nov. 2-3 HICPAC meeting:

We should strengthen--not weaken--aerosol protection standards for healthcare and hospital settings. This means making fit-tested N95 or better respirators standard (not surgical masks, which are not aerosol-protective) in healthcare and hospital settings. It also means strengthening standards for air ventilation and filtration in all healthcare and hospital settings.

The COVID-19 pandemic is still ongoing, and I am personally avoiding getting healthcare because most doctor's offices and hospitals are not adequately protecting against SARS-CoV-2 transmission, which would require taking the steps I noted above. Everyone should be able to visit a doctor's office or hospital and not fear getting COVID-19 while there, and this is currently not the case.

Healthcare settings are rife with airborne SARS-CoV-2 right now, and we need to do everything we can to stop this, and this begins with HICPAC strengthening standards for respirator use and air ventilation and filtration. I would greatly appreciate it if you would do so.

Thank you,
Shawn Sprague
Washington, DC

You need to delay the vote on guidance updates, and hold public meetings to hear from others regarding health and safety. The prices affects many and needs to be transparent and science-based.

We need to do more to keep medical staff and patients protected from airborne viruses.

Bonnie Smith
Roscoe, IL
Concerned US citizen

Hello,
I'm writing to say that the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation.

I am constantly appalled at how negligent the government is in regards to COVID-19. It has been proven by many studies how transmissible this is, but our government doesn't seem to care about that or all the people that continue to die from COVID due to a lack of any public health education. It's embarrassing and it's disgusting. Are you trying to kill people? Because by the continued weakening of guidelines it sure seems like it.

People my age (32) are going to die from "random," medical issues that "shouldn't happen until older age." It's going to be a result of COVID exposure and the impact COVID has on our bodies, even after we're no longer visibly sick. Even asymptomatic COVID is bad for everyone. It's a result of the lack of care this country has for the general werpublic. People are not stupid, but they don't stand a chance if they're misinformed, or simply uninformed at all. People who pay attention and read the continuous studies coming out about this issue know that using hospital data to demonstrate COVID is misleading because most people have been led to believe it's not a big deal, thanks to messaging from the media and you, the CDC of the United States.

The general public still thinks that rapid tests are a good way to test for covid, but if you read studies you'd know that the rapid tests are not an effective method of preventing the spread of COVID at peak effectiveness due to when they can detect infection vs when a person is actively spreading it, and that only got worse with the advent of Omicron. At this point, they are basically useless now, so people are depending on something that is really just a performative action and not doing anything to help stop the spread of COVID. AND even if they test positive they are able to return to work after the first negative test, which are unreliable and the information surrounding them is wildly misleading. Great. My sister in law got sent tests from the Post Office that were expired. So not only do they not really work anyway, they're expired too. What even is happening in this country? It is exhausting and disgusting how much the medical system profits off of death and illness and injury, and the CDC appears to be a part of that based on how things have gone with COVID since 2020.

Follow these guidelines and act like this actually matters.

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.

    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.

        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
    - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Sorry to the person that had to read this email. You probably don't get paid enough and it's not your fault our country is a disaster and doesn't care if people die from COVID or related issues.

Have a nice day,
Megan Kabler

To whom this may concern,

My name is Michelle Beakley and I happen to be an ambassador for the COVID safe campus program, which is a disabled-led nationwide organization of college students that fights pandemic erasure/academic ableism by helping increase access to COVID safety resources on

campus, implement the necessary layers of COVID protections, shift narratives surrounding COVID, and conduct public health research.
I am writing in support of universal masking in all healthcare settings, with broad use of N95 or better respirators, appropriate ventilatory controls, and other effective methods to reduce the risk of aerosol transmission. Universal masking must be incorporated into CDC guidelines broadly across healthcare settings to protect patients and healthcare workers from transmission from asymptomatic and unrecognized infections that are commonplace in healthcare settings. You are leaders in this field who can improve the standard of infection control, and you must do so to stop further preventable death and disability in the ongoing COVID pandemic.
In healthcare settings, airborne infectious disease transmission from either patients or healthcare workers who may have unrecognized or asymptomatic infections is unfortunately not a rare event. Healthcare-acquired infections are a preventable cause of death and disability, and following an appropriate patient-centered approach, there is no acceptable level of healthcare-acquired infections. The only reasonable goal is to reduce the rates of these infections as low as possible through effective measures. Aerosol transmitted infectious diseases are no exception. In a recent study of patients hospitalized with COVID in the US, 4% of those COVID cases were hospital onset (first positive test after day 7 of hospitalization). As we have learned from HIV and the development of bloodborne pathogen standards, we cannot rely only on case identification via symptoms, testing, or identification of particular risk groups. Such an approach perpetuates stigma and puts both patients and healthcare workers at risk. Universal masking is the straightforward solution.
With respect to transmission-based precautions, in the draft proposal, groupings of “Routine,” “Special” and “Extended Air Precautions” are made using a pseudoscientific explanation that airborne pathogens spread shorter or longer distances on the basis of pathogen factors. There is no demonstrated biophysical mechanism to support such claims–it is a *de facto* perpetuation of droplet dogma that will cause unnecessary death and disability, as loose-fitting surgical masks provide inadequate protection for the wearer against aerosol transmission. Only the Extended Air Precautions incorporate both N95 respirators as well as ventilation controls appropriate to aerosol transmission. An appropriate, science-based proposal would include N95 or better respirators, ventilation controls, and additional multilayered approaches for all airborne pathogens.
Many pathogens, including COVID, can cause a broad spectrum of disease with both short- and long-term consequences. The consequences of infection are unpredictable and depend importantly on medical conditions that may not be recognized prior to exposure. Medical conditions that cause an increased risk of severe COVID are common in the general population, with about 75% of the US population having high risk conditions for severe COVID infection.
It is well past time to incorporate universal masking as a new addition to standard precautions. Universal masking, with broad use of N95 or better respirators, is a precautionary approach that would be a significant improvement for infection control, simplifying the logistics of how and when to mask, and aligning our healthcare precautions with well-established science.

Best regards,
Michelle Beakley
Ambassador - Covid Safe Campus

My name is Hollie, I am from Pittsfield Massachusetts, I am a member of the Massachusetts Coalition for Health Equity, and I had a precondition of a chronic illness before the COVID-19 pandemic arrived. Despite being extremely careful due to my high risk status, I contracted COVID-19 in March 2022, only a few days after the CDC changed the "Community Transmission" map to the "Community Levels" map while simultaneously dropping masking recommendations in public spaces. As the "Community Levels" map obscured the true level of

COVID-19 transmission, I was unaware that my county was at a high level of transmission when I was infected. I was wearing an N95 mask at the time, but since one-way masking does not provide sufficient protection against this extremely- and increasingly- contagious disease, I contracted Covid anyway.
I ended up developing Long Covid which included, among an array of torturous symptoms, full-body, terrifying, Parkinson's-like tremors, muscle twitching, agonizing nerve pain, visual disturbances, insomnia for days on end, and extreme shortness of breath that landed me in the hospital. I wasn't able to function for months and still have symptoms over a year and a half later. Most of the doctors and specialists I reached out to were completely unfamiliar with Long Covid and the Long Covid clinics within the state had waiting lists that stretched for several months at a time.
Thankfully, with time, I have been gradually recovering, but I am constantly daunted by the possibility of reinfection, and therefore relapse, as many Long Covid patients relapse or dramatically decline in their condition upon reinfection (https://www.gavi.org/vaccineswork/new-survey-suggests-reinfection-worsens-long-covid). I am lucky enough to be recovering after my first infection, but many people with Long Covid have not recovered. Next time, I might not be so lucky.
I am fully vaccinated, but studies have shown that vaccination only slightly protects against Long Covid (https://medicine.wustl.edu/news/long-covid-19-poses-risks-to-vaccinated-people-too/). Furthermore, due to the compete lack of mitigations, Covid is evolving at a faster rate than our vaccines can keep up with. As a result, due to the utter lack of consideration of the medically vulnerable in our society, I have had to almost completely isolate myself to avoid reinfection.
As mask mandates have largely been terminated in medical settings, part of this isolation means I can no longer safely receive medical care. As a result, treatment for my Long Covid is now on hold. Furthermore, I'm unable to so much as safely access *basic* healthcare and am daunted with the catch 22 of either neglecting my medical needs or risking Covid reinfection and thus a relapse of Long Covid- which was the single worst and most traumatic experience I have ever had in my life. This is a violation of my body autonomy and my human rights. The fact that the CDC has allowed healthcare settings to become so unsafe for the most vulnerable among us that so many of us are now actively *avoiding* our own healthcare is a reflection of a shameful dereliction of duty. As the mortality rate of nosocomial infections has been shown to be nearly 10% (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10056618/), people are dying needless deaths. How could we let this happen?
The lack of transparency of HICPAC and the weakening of infection control in healthcare settings is alarming- especially to those of us who have already been hit the hardest by the pandemic. The claim that surgical masks are as effective as respirators is false and based on flawed studies with cherry-picked data, as respirators are explicitly designed to protect people from airborne disease whereas surgical masks are not. It is clear, like much of the pandemic, that these decisions are motivated by economic interests- in this case, the economic interests of healthcare employers rather than the wellbeing of healthcare workers and patients. This is simply unacceptable and arguably, criminal.
As I contracted Covid in a one-way masking situation, I know firsthand that one-way masking is not sufficient and we must bring back *universal* masking in healthcare settings as long as Covid is still being transmitted, not just during surges. We also need patients and providers to wear respirators rather than flimsy surgical masks which are not designed to prevent aerosol transmission. Furthermore, we need universal standards for ventilation and air filtration. Cutting corners on a life-or-death issue is abhorrent. It is completely absurd that this needs to be said, but we must invest in *more, not less, protections during an ongoing pandemic* and stop sacrificing people's lives and livelihoods for the profits of the healthcare industry.

As someone who works in healthcare and who also has a partner who now has Long Covid after 1 mild infection six months ago (they were perfectly healthy before,) I urge you to take this message seriously.

I know that many of you are only concerned with profits, but protecting workers is the only way to keep the healthcare industry from collapsing completely. I know that you understand this.

I am writing to demand the following —

1. HICPAC must substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.

2. Make the process for updating the guidelines fully open and transparent.

3. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.

4. Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

- Liz Andrade

I am sending this message to have you please reconsider the changes you are making to COVID-19 precautions.
Covid is still very much a dangerous infection and I am worried that people are not treating it as such. I have multiple immunocompromised friends and family members and worry for their safety (as well as mine) more than I feel I should have to. A lot of people I know are also suffering from long Covid.
Removing guidelines to prevent the spread is worrisome, and frankly irresponsible. Hospital workers should be wearing any equipment necessary (n95s at the VERY least) to prevent any infections from happening. This has been a problem for almost 4 years now and we can do better.

Connor Strahan
Minneapolis, MN

Dear HICPAC Committee,

I am writing to express strong concerns about the safety of healthcare workers and patients in light of the upcoming decision by CDC/HICPAC regarding Isolation Precaution guidance updates.

I firmly believe that the process should be fair and grounded in scientific evidence. My key concerns are as follows:

1. Delay the vote until the public has had ample opportunity to review the draft Isolation Precaution guidance updates.

2. Prior to any vote, hold public meetings to gather input from healthcare workers, patients, and experts outside of infection control who can provide essential perspectives for updating the Isolation Precautions guidance.

3. Fully acknowledge the science regarding aerosol transmission of infectious diseases and update the classification of infectious diseases to include those that can be transmitted via aerosol transmission/inhalation.

4. Recognize that the evidence review on N95 respirator and surgical mask effectiveness was flawed and should be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

5. Maintain a clear and explicit approach in the updated guidance that specifies the precautions necessary to protect healthcare workers and patients. This approach should include assessments, control measures, and a written exposure control plan following the hierarchy of controls.

6. Address the importance of core control measures for infectious aerosols, such as the use of respirators, ventilation, and air filtration. Provide recommendations on ventilation and consider the use of airborne infection isolation rooms (AIIRs) or alternative approaches when AIIRs are not feasible. Emphasize source control to limit the outward emission of infectious aerosols for personal protection.

I believe that implementing these measures is essential to safeguard the health and well-being of healthcare workers and patients. I urge you to prioritize science-based protections and a fair process in this decision-making.

Thank you for your attention to this matter.

Sincerely,

Sonny F
Lowell, MA

Hi, my name is Karissa Elliott. My address is Seattle, WA. I do not have an organizational affiliation, I am in the public. The topic is safety rules for Covid as to your work on the Isolation Precautions rules.

Please make more safety rules. I have long covid and I have been sick since June 2020. I am able to work only a few hours a week and my family has been barely keeping afloat financially even with recieving EBT and Medicaid. Some of my symptoms are expected to improve but others are completely unknown. I work with kids and I've been seeing the memory loss, fatigue, and eye problems (some of my problems) creep up in them as well. I'm getting more and more anxious about going to the hospital for my appointments as the safety precautions have decreased, but covid when transmitted in hospitals is often more deadly than within the community. This disease is horrible to suffer through and we shouldn't subject any more people to this illness.

Also, the more people that get sick, the more government resources will be drawn upon, when our government is already at a crisis-level financial state. It will ultimately cost less to instate safety precautions than it will to let people keep getting sick and 1. be out of work for months to

years at a time 2. develop long term health problems that will be a cost to the government as more and more people are too sick to work enough to be on something other than medicaid.

Please, please help us.

You should include:
-Covid is mostly transmitted through aerosols. The guidelines should include the air quality standards set by ASHRAE.
-N95 masks should be required in all healthcare facilities.
-Heathcare workers should be testing for covid weekly and should be able to have paid isolation/work from home if they are sick.
-Vaccines/boosters should keep happening and be free, but should also say just a vaccine is not 100% and you need to do the other things also. All healthcare workers should be up to date on all vaccines.
-Since a lot of transmission is asymptomatic, all safety rules should be practiced at all times.

Also you should add some people to your team from the fields of occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection, so that they can add their unique perspectives from their specific field of knowledge. And not decrease use of negative pressure rooms.

Thank you for your time. I cannot overstate how direly my life and many of my friends' lives have been impacted by this illness. Please implement these stronger rules.
Sincerely,
Karissa Elliott

I urge you to require universal N95 respirators or better in healthcare settings. Too many people are delaying healthcare appointments because they do not want to risk getting infected by Covid in a healthcare facility. This is particularly important for those patients who need to undergo a procedure where they must take off their own mask such as oral surgery. The onus should not be on sick patients begging their healthcare providers to wear a respirator to avoid an infection from Covid. Patients should not be required to negotiate and enforce infection control in healthcare settings. Instead, it is your duty to provide rules that recognize the overwhelming scientific evidence that N95 respirators are needed for infection control rather than mere surgical masks. Please take an evidence-based approach and require universal N95 respirators or better in healthcare settings.

Thank you,

Lisa Ward

I urge you to reject the proposal by HICPAC, which weakens even the 2007 infectious disease control guidelines for healthcare facilities. Hospital acquired covid has a far, far higher mortality and morbidity rate than community acquired covid. (TB, measles, and other aerosol spread diseases are also increasing, so even if covid were irrelevant, aerosol precautions would still be important) Every person in need of hospital care is by definition vulnerable and the proportion of people with covid in healthcare facilities will always be higher than in the general population. Healthcare workers are being disabled by long covid resulting in short staffing and pressure for remaining staff to report to work even while infectious. This is not sustainable. Covid is known to be spread by infectious aerosols, which may be present even before a person shows covid

symptoms or tests positive. Therefore, N95 or better respirators MUST be required in all patient interactions and in all public areas of healthcare facilities, and for all visitors, and all patients (unless the nature of treatment or their illness, such as sinus surgery, makes it impossible.) Surgical masks have outward leakage of at least 85% at normal respiration rates and are not acceptable substitutes for N95's.
(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8955475/?fbclid=IwAR3zW5mwWUddDuc9V1ac9Pg3WRYDusS_Urmkm_i8Mw6vHxPGjB59fTu5mUg
see fig. 6) Curtains do not stop aerosols either, and the suggestion that curtain precautions are sufficient for diseases spread by aerosols is outrageous.
If you allow these weakened measures to go into effect, covid rates will go up and patients will be forced to calculate the relative risks of catching covid in the hospital versus forgoing needed medical care.
Make hospital acquired covid infections subject to mandatory reporting and require PCR covid testing immediately upon hospital entry (not official admission alone, but also entry into the ER) and again immediately before discharge so that increases in HAI under these weakened regulations will be clearly discernible, making the case for instituting new tougher regulations that take aerosol transmission seriously clear.
The suggestions of HICPAC are dangerous and uninformed. HICPAC must be expanded to include aerosol scientists and engineers and people with expertise in occupational health and safety among its members, and this deeply flawed recommendation must be redrawn. The studies cited by HICPAC that claim to find surgical masks equivalent to N95's were deeply flawed to the point of being ridiculous; comparing infections rates for people wearing surgical masks or no masks to rates for people usually wearing surgical masks or no masks but occasionally wearing N95's, but then only within 6 feet of a known positive case during a recognized aerosol generating procedure is ridiculous, since the total amount of exposure in surgical masks or unmasked is essentially the same (or within the noise) for both groups, since talking or even just breathing are know aerosol generating activities.

On a personal note, my mother was admitted to a hospital with a non-covid related life-threatening emergency. She recovered from the emergency, but while there she caught covid from hospital staff, who were wearing only baggy surgical masks. This formerly active self sufficient woman, who was a gardener and artist and had a rich social life, has been bed bound, unable to walk, and on oxygen therapy 24/7 ever since her hospital acquired covid. Let's make sure it doesn't happen to anyone else. Toughen up the requirements for staff to wear N95's. Do not rubber stamp this vile, irresponsible report that seems to put hospital profits above patient safety.
Sincerely,
Janet Schuresko
Madison, WI

My name is Audre Wirtanen. I am someone who has many of the diagnoses those with long covid accumulate, and covid infections have made my conditions worse. I run a healthcare related non-profit in New York and work toward health justice of the communities we serve.
My comment is that I fully support the comment made on behalf of the People's CDC. I do, however, acknowledge that TENS of millions of people are living with long covid. I am so, so tired of the dismissal of the conditions people are developing. You pretend that they don't exist - that all of you will get off without a scratch. They are so, so real. They are so impactful. This is why we have a labor shortage.
The updated guidelines are detrimental to everyone's safety. I urge you to read the below comment and take it with such seriousness that you understand fully you are contributing to the deaths of so many if you choose to change the proposed guidelines in the ways you plan to.

Shame on you. You are disabling millions and complicating so many other conditions that no one has funding to research.
Please consider your positionality and privilege in these decision making panels/groups - you do not represent everyone if you only hold a select few in hih regard. Please make choices that will protect the most marginalized. Otherwise your medical racism, ableism, and discrimination of poor people will be on full display.
Comment I support 100%:

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. **The CDC ultimately should establish a high standard for infection control measures.** The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed

these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Hello,

Please make Covid-19 precautions universal and year round in hospitals, doctors offices and other healthcare settings. When patients seek medical treatment, they deserve to be treated without having to worry about getting infected with Covid-19 or any other aerosol-spread virus from a healthcare professional. Please bring back protections that include mandatory (and consistent) testing of medical staff for Covid-19, universal PPE by all healthcare staff, and minimum air quality standards set by the ASHRAE. Immunocompromised patients do not deserve to risk their lives every single time they go in for medical care. Healthcare professionals deserve to be protected from Covid-19 year round. This is the bare minimum.

Thank you for your time,
Ezra Tozian

Hello,

I'm writing to ask that you **not** weaken the guidance in Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. The draft recommendations fail to reflect what we've learned about aerosol transmission since the start of the COVID-19 pandemic. The draft recommendations do not adequately provide for the proper control measures – isolation, ventilation, and NIOSH-approved respirators – to protect against transmission of infectious aerosols. The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols. As a patient on an immune suppressant, everytime I go into a medical setting it feels like a gamble. I can't afford to get COVID repeatedly, because my body can't properly fight off viruses. HICPAC needs to take steps to make medical settings safer, not less safe. No one should ever get sick seeking medical care.

Thank you for your consideration.
Annette Majerowicz
Los Angeles, CA

Dear Healthcare Infection Control Practices Advisory Committee (HICPAC)
Ann Lindsay BSN RN CBDCE
West Roxbury, MA

I do not have an organizational affiliation, I am an interested individual. The topic I am emailing you about is the proposed changes to the infection control standards.

I am emailing you asking you to not abandon your responsibility to the public and delegate it to employers to choose what level of infection control to take. This is a clear situation for the authority of the federal government and the CDC to come into play in order to protect people's lives, both provider and patient. I am already delaying healthcare because of the decline of masking in healthcare situations. Going to the doctor or going to work should not increase your chances of acquiring a highly transmissional respiratory virus! Especially when we know there are affordable and effective precautions we can take (N95 masks!)

This is what I would like to see:

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” (https://substack.com/redirect/cb922155-b68a-4db5-acb4-aa1d21f06715?j=eyJ1IjoicmFpYWIifQ.bnPgugwLOf7JoeABbAaZCNPEm9Z9vH9i74ltadlFeqM) rather than infection control.
- Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://substack.com/redirect/647233f0-bd78-487e-b042-8a6bb4477f6f?j=eyJ1IjoicmFpYWIifQ.bnPgugwLOf7JoeABbAaZCNPEm9Z9vH9i74ltadlFeqM) [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

I would also like to note that we need layers of protection:

- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**

- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://substack.com/redirect/c6482664-a183-469c-9e7d-18156343ac81?j=eyJ1IjoicmFpYWIifQ.bnPgugwLOf7JoeABbAaZCNPEm9Z9vH9i74ltadlFeqM) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Lastly, in terms of this process, I'd like to say:

- **As the nurses union is urging, (https://substack.com/redirect/88c55b43-78f5-4bd7-9b60-c67e4f6348b2?j=eyJ1IjoicmFpYWIifQ.bnPgugwLOf7JoeABbAaZCNPEm9Z9vH9i74ltadlFeqM) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Thank you for your time,
Meridith Richmond

To whom it may concern,

CDC should reject HICPAC's draft; engage the input of frontline health care workers, patients, and public health experts in developing a new draft with public meetings.

· The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing transmission by air. Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

· Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times.

· Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved [see, for example, pages 20 and 22 of the PDF file] – and does not weigh that cost against profits, nor should CDC.

· The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.·

Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.

· Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk. · Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

· All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

· Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.

Sincerely,

Robert Woodiwiss (retired; no organizational affiliation)
Cincinnati, OH

To whom it may concern,

Universal masking is necessary to make healthcare settings accessible to all, and especially those st higher risk of complications from COVID.

Vaccines help but do not prevent transmission of COVID. Additionally, surgical masks are not sufficient to prevent transmission.

HICPACs proposals will drastically increase the risk of transmission. There is no valid reason, financial or otherwise, to reduce precautions for transmutable disease. The long term cost on our healthcare system of people with complications post COVID infection vastly surpasses the

cost of preventative measures such as high quality masks, respirators, negative pressure rooms, indoor sir filtering system, etc.

COVID prevention in healthcare settings should be a top priority for the CDC. Instead, we see weakening precautions. Proposals such as this one directly contribute to the death and disabling of the most vulnerable among us.

Please do not make life even harder for folks already struggling to get care.

Thank you,

Em Aufuldish
Takoma Park, Maryland

Please take a moment to reflect on the title of your organization, in particular the 3 words "Infection Control Practices" - in a world where we have allowed, and at times encouraged, the evolution and mutation of SARS2 through multiple years, it is time to take a stronger stand for infection control, not weaken guidelines and procedures.
It has been proven that SARS2 spreads by an airborne/aerosol transmission, and is often transmitted before a person becomes symptomatic. It can spread and linger in the air for hours, and can infect in an empty space previously occupied by an infectious person. The equating of surgical masks with N95 respirators for both source control and personal protection is false and goes against abundant, robust data on the superiority of respirators, one-way masking is less effective than universal PPE use, and many patients are unable to effectively wear appropriate protection (eg babies, children, the disabled or unconscious, or those undergoing procedures where it is impossible). Trying to assign tiers of precautions based on inaccurate reported levels relies on constrained and therefore unreliable testing and reporting, and on lagging indicators such as hospitalizations, which then renders those precautions inadequate and too late. While levels of infections, hospitalizations, disabilities and deaths may vary and are undercounted, even at the reported levels they remain consistently significant and warrant ongoing mitigations. Loosening protections when levels are relatively lower is irrational, as time has repeatedly demonstrated that continued spread consistently drives the evolution of new variants and repeated surges.
Transmission of airborne pathogens can be effectively mitigated by readily available measures which prevent the sharing of unfiltered air: consistent, proper respiratory protection, and appropriate indoor air quality controls including ventilation, HEPA filtration, and UV. Vaccines, for which access & uptake are poor, are a necessary but inadequate layer of protection. They temporarily reduce the probability of acute-phase severity, hospitalization & death but are inefficient at preventing infection, transmission & Long Covid. Herd/community immunity is literally unattainable because both vaccine- and infection-derived immunity do not endure over time or against newer variants. Long Covid affects at least 1:5 to 1:7 patients and it is not linked to acute-phase severity. It is typically disabling and can be fatal, and it affects all ages, including children. Repeated infections do not confer immunity; rather they damage the immune system and increase the risk of developing Long Covid. Resources for testing, treatment, and support are lacking. Yet Long Covid has been completely omitted from consideration in HICPAC proceedings. No pre-exposure prophylaxis or monoclonal antibody treatments are currently authorized, having been outpaced by evolving variants, and only 3 antiviral medications are available, with mixed results. PCR tests are expensive & difficult to obtain, and currently available rapid antigen tests have a high false negative rate, with no updated specimen collection guidance to include cheek and throat swabbing to improve accuracy, & serial testing to offset low accuracy is expensive. Healthcare workers (HCWs) who are denied appropriate

protections are at risk of contracting SARS2 and of spreading it to coworkers, patients, and visitors as well as to their households. Thousands of HCWs have died of SARS2 and thousands more have been disabled by Long Covid. Both the infectious and those vulnerable to infection congregate in healthcare settings. Many lack the ability to effectively protect themselves from exposure, yet they share waiting rooms, hallways, elevators, restrooms, treatment areas and, with the end of testing on admission, hospital rooms. Risk of infections and their sequelae are causing many people to forego needed care, and when encounters are unavoidable, they are forcibly exposed. Those injured & killed downstream in the chain of SARS2 transmission are invisible to their infectors, & the you-do-you approach to infection prevention is a public health failure.But HCWs, who should know better, can refuse to protect patients if they just don't feel like it. Protections should be strengthened, and proper PPE & optimal IAQ should be mandated in all health and dental care settings. By weakening protections, HICPAC is saying that it's acceptable for HCWs to infect patients and each other because transmission is lower and less impactful, in complete disregard of these facts.
We need to improve air quality in health care and continue with layered protections in health care to protect our vulnerable, our health care workers, and our children. HICPAC asks for respectful comments: this asks us to "respectfully" beg HICPAC to do their job and protect us, and to "respectfully" beg HCWs not to infect, maim, and kill us. It is long past time to pause the proceedings, reconstitute HICPAC in compliance with its charter and with the law, factor in all of the evidence, and generate guidelines which DO NO HARM.
Thank you for your consideration,
Donna Bartsch, Alberta, Canada

Hello,

Some concerns I share on HIPAC's proposed revisions:

SARS-CoV-2 is airborne. It spreads by inhalation exposure to infectious aerosols at both close and long range. Not by droplets. Not by fomites. It can spread and linger in the air for hours, and can infect in an empty space previously occupied by an infectious person.

We need updated guidance which includes precautions for airborne transmissions. Ventilation, filtration, effective masking, and vaccines should be top priority. It is imperative the general population understands SARS-CoV-2 is airborne so preventative action can be taken.

Protections should be strengthened, and proper PPE & optimal IAQ should be mandated in all health and dental care settings.

Thank you,

Liela Murphy
NB, Canada

Hello,

I am a US citizen and am deeply troubled by HICPAC's failure to keep working Americans safe as Covid-19 continues to ravage our communities. Most notably, I'm alarmed by the multiple errors contained in HICPAC's proposed recommendations about the science of Covid-19 transmissibility. Surgical masks do not provide adequate protections against a disease transmitted via aerosols. I urge you to require the use of N95 or equivalent respirators in all

heatlhcare settings in order to keep all Americans safe and healthy. I urge you to follow the recommendations of the Peoples' CDC, pasted below.

People's CDC Recommendations for CDC/HICPAC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**

- Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
- Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted

infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Janine Ko
Salem, MA

Hello,

After reviewing the draft guideline released by the Committee, I am deeply concerned by the lack of course correction by this committee after receiving public comments and comments from experts and advocates in this field. We continue to see no seasonal pattern of COVID-19 and after 16 years, this body is taking steps backwards in its updated guideline based on what we now know about aerosol transmission.

I care deeply about this issue because I don't believe in eugenics and that there is massive evidence that patient outcomes are worse in the United States healthcare system compared to other wealthy countries. This is exacerbated when hospitals weaken safety to save money. These guidelines as currently drafted suggest that we will continue to fall behind by not listening to the science, patients, experts, or those who best understand what it takes to create worker safety on the frontlines. This Committee is missing member experts in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection.

A few specific guidelines that I want to raise specific concern about:

- HICPAC's draft "Enhanced Barrier Precautions" would greatly weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.
- HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them. Healthcare facilities are the places that the sickest and most high risk must congregate. They deserve safety all the time.

Thanks,
Maria Starck

As a citizen in Texas, I'm concerned about the ongoing covid-19 pandemic and the variants. I'm disappointed to see lack of clarity and unity on what states and cities do. And I've heard from multiple people in my community about the challenges to making informed decisions about health and risk of getting covid without proper data and information. I urge the HICPAC to enact recommendations from the People's CDC. Outlined below:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
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    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
- Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

To the Healthcare Infection Control Practices Advisory Committee:

My name is Amy Tong, and I live in Salem, Massachusetts.

Despite never seeing anyone outside of my immediate family unmasked, I have now been sick with COVID-19 two times (within a two month span, might I add). Many of my loved ones have been gravely ill and even died because of misinformation from the CDC.

As the CDC has long known, COVID-19 transmission is airborne and moves through the air like smoke. We know what keeps us safer: ventilation, air filtration, and high quality respirators.

I implore you to follow the recommendations from the Peoples' CDC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
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- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).

    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.
        - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
        - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
        - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
    - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
        - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
        - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
        - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
        - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.

        - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
        - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
    - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Best,
Amy Tong

Dear Healthcare Infection Control Advisory Committee
First, thank you for your work at the CDC to help with disease control -- a job that is becoming increasingly important!
With regards to the committee's work, please let science guide decisions and place restrictions or relaxations in policy when the data, -- not politics -- warrant. (Sources of infection rate data, for example, can come from sewage effluent monitoring, etc.)
Please consider stricter and wider masking/respirator wearing mandates for clinical and hospital settings. Also prescribe the use of high-quality masks (e.g. N95) over lesser quality masks. Aerosol transmission studies show the efficacy of such masks. Masking works! I would particularly encourage such requirements in large, open room health settings where multiple patients are being processed for pre/post-operative and only separated by curtain-enclosed bays.
It should be noted that for the past few years, high-income countries, like the United States, are seeing an increase in respiratory diseases. Such diseases put those individuals at higher risk of adverse or deadly outcomes when contracting other communicable respiratory diseases. Pollution and climate change are exacerbating these trends. Herd immunity through vaccination for such communicable diseases as successful as it should be for a variety of reasons. For instance, booster administrations for the latest Covid variants is abysmally low as of a week ago (7% of adults and 2% of children.) It only takes a look to see that in many health-care settings mask use has also dropped. Combined, of course, that means people are contracting communicable respiratory illnesses, including healthcare workers. And the US population has a demographic shift towards a more aged population over 65. Such individuals are more vulnerable to communicable diseases. Please protect our health care workers and the general population with more stringent respirator-wearing mandates.
Thank you.
Dr. S. Robinson

Hello, my name is Evan

I am writing this evening, asking you to reconsider some of the new proposed talking points and suggestions based on the 11/2-3 HICPAC meetings regarding transmission and isolation protocols in healthcare settings. The language in these proposals loosens already lax protocols in doctor’s offices in hospitals, disregarding the airborne spread of COVID.

These new protocols must account for the science showing each infection control measure is the most effective when other control methods are also in place. There must be a layered approach to reducing transmission and infection.

Hospitals are where immunocompromised, disabled, and elderly individuals will regularly mingle and interact with infected individuals.
Therefore all mitigation strategies should be in place at all times for hospital employees to reduce risk of transmission.

Most of the time, transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times for the safety of all individuals in hospital settings.

The new draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. Healthcare employers lament the cost of proper protections, respecting only the rugged individualist approach that has proven to be an abysmal failure. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://www.ktnv.com/news/coronavirus/after-3-years-mask-mandate-lifted-at-sunrise-health-hospitals-in-las-vegas) rather than infection control.

The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little access to testing, inconsistent wastewater monitoring, and next to zero tracking and reporting of cases and other data. There is literally next to no information that would inform the public of community spread and allow the public to make informed decisions. The CDC seems to be pushing a "vaxxed and relaxed" approach to a virus where vaccines have proven to be only so effective, and there is overwhelming evidence that there need to be other layers of protection in place to slow substantial community transmission.

The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation. Ventilation is a crucial step in stemming an airborne viral infection. The new guidelines barely acknowledge the reality of the prevalence of airborne transmission of COVID. It is an airborne virus, and we need to invest in better air quality in all indoor spaces, but especially in hospitals.

Hospital acquired COVID has a documented higher mortality rate than community acquired COVID infections. Letting COVID infections run rampant and unchecked will ultimately be more costly than continuing to ignore the seriousness of the virus. Well fitted respirators and access to molecular testing, proper ventilation are imperative. Widespread repeat infections will disable millions of Americans while millions already suffer with long COVID.

HICPAC's deceptively named "enhanced barrier precautions" fundamentally weaken barrier protection measures in nursing homes and possibly in other healthcare facilities.

The current proposals fall woefully short of the mark and bend to the whims of rugged individualism, which has shown to be the biggest philosophical failing of the entire pandemic. I implore to reconsider, lest countless more Americans become disabled or worse from the unchecked rampant spread of COVID that you have allowed to take root in America.

Respectfully with disappointment,

Evan Fox

To whom it may concern

I am 39 years old and I would like to see 40. I would like to see 60 for that matter but I probably won't because of my underlying conditions. And if I get long Covid, as one out of 10 people who get Covid do, my life will be over. I cannot possibly be in more pain than I am in now, I cannot be on more medication's, I cannot stop seeing doctors. And I cannot get Covid. So what am I supposed to do? I am facing two major surgeries in the next year. I want to be safe and hospitals. But I do not feel safe. So many lives already are ruined from long Covid and from dying from Covid. You should be strengthening precautions and not weakening them. Peoples lives are depending on it. Lives are worth more than economies. Lives are worth more than inconveniences or people not liking the masks.

Sincerely

Kate Ryan
Medford, MA

Hello,

I'm writing today to express my deep concern about infection control guidelines and recommendations being lessened. I have suffered from Long Covid since 12/20, and it has completely debilitated me. I was previously a very active individual, walking an average of 3 miles a day, working a labor intensive full time job, hiking on days off, and doing plenty of outdoor recreational activities. Since January of this year I have been on medical leave because I can no longer handle the physical nature of my work, a position I had worked hard to get. Now I'm completely supported by my partner, and lucky to be in that position, otherwise I'd be homeless. We teeter on the brink of homelessness every month with our bills. My previously mild depression has now deepend to a level I've never previously experienced as I have to mourn every facet of my life that I held dear and have now lost. I question how I will go forward in life in the situation I'm in, especially with the extreme lack of Covid safety being practiced in healthcare settings. I have to wonder if people (government agencies) want me to get better at this point. It's an extremely grim reality to be living in.

You have the power to protect people from my situation. People seeking healthcare is something everyone is entitled to do safely Many people, including me, no longer feel safe seeking out preventative care since Covid-19 continues to rip through our communities. Every interaction is now a cost/benefit analysis. It's an exhausting and unacceptable way to have to live. No one should get sick in a hospital or clinic. Every healthcare worker should be protected from infectious disease. Doctors, nurses, and other support staff already put so much at risk to help us. Infecting them repeatedly with viral illnesses that may leave them forever changed is not the way to thank them for their necessary work. We also weaken our healthcare systems this way. We've already lost countless doctors, nurses, and support staff from either the acute stage of Covid-19 or post-viral illness.

Moving forward, guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air." Airborne transmission of

SARS-CoV-2 has been a well known and internationally acknowledged fact for years now. I thought the USA was supposed to be the best? We were the best and the brightest, on the brink of technology? Why wouldn't we want the best tech when it comes to protecting our people from infection, especially in healthcare scenarios?

Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. This is especially important as much SARS-CoV-2 transmission is completely asymptomatic, and therefore, all precautions must be practiced at all times.

High risk people, disabled people, and seniors are some of those who are seeking out healthcare most often. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times, so these people can access healthcare without further risk to their health.

The safety of healthcare workers and patients should always come before cost concerns. The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations rather than infection control. Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance.pdf) and does not weigh that cost against profits, nor should CDC.

The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data. The HICPAC draft also inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans, including me and multiple family members, already suffer from Long COVID. HICPAC is essentially choosing to let employers save money now which will then be shifted to the government in the long run when more and more people become disabled. After all, every Covid infection increases the likelihood of long covid diagnosis.

Specific layers of protection that need to exist in guidelines moving forward, in not only my opinion, but the opinion of many medical experts and professionals:

- Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.
- HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.

- N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them. Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2.
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
- Continue the use of negative pressure rooms for serious airborne infections like MERS and SARS-CoV-2.
- Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.
- Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases, though Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.

When guidelines are updated, HICPAC needs to include input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB). Also, HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

Thank you for your time. Please take the input you're receiving from patients, healthcare workers, and experts seriously. It's quite literally life or death.

Callie Shields
Ogden, UT

Dear Professionals:

I am writing in regard to your proposal to the CDC about managing the spread of contagious diseases. My name is Esther Howes and I am a retired RN. My home town is Dracut ,Massachusetts. I represent the public,

HICPAC's draft guidance is aimed at frontline nurses and other health care workers, rather than health care employers, shifting responsibility and risk to individual workers to protect the profit of hospitals and organizations..

The focus of HICPAC's draft is almost exclusively on personal protective equipment, and it fails to make strong recommendations on other essential measures, such as ventilation and patient screening and isolatio

- The draft fails to fully comprehend the science on air transmission of infectious diseases and remains focused on short vs far range spread such as proper ventilation in buildings. It supports the disproven droplet-airborne spread and focuses existing practice on using airborne infection isolation rooms for novel pathogens.

- The draft treats surgical masks as respiratory protection and PPE for health care workers exposed to infectious disease transmitted through the air and treats surgical masks as the acceptable practice of protection, reserving N95s/other respirators(which are far more effective than surgical masks) for only specific “special” circumstances.
- The draft is written in a manner that focuses on the needs of employers, not protections for health care workers and patients. All patients and workers need to be protected and the hospital or employer needs to take responsibility for seeing that this happens.

Sincerely,
Esther Howes

Sylvan Rachel
Erie, PA

To whom it may concern at the CDC/HICPAC,

My name is Sylvan Rachel, and I am writing to submit a public comment strongly urging the CDC to reject HICPAC’s draft proposal. The CDC’s HICPAC needs to create a new draft of their Infection Control Guidelines that reflects increasing concerns from healthcare workers, medical professionals, patients, and public health experts. The current guidelines are weak and fatal. The process of making these decisions about nationwide public health protocols needs to be a public one, involving public meetings and open comment periods. The CDC must stop actively hiding and endorsing mass infection, death, and disablement, in the name of profit and “freedom”. The CDC’s failure to act on behalf of what the people call for to protect ourselves and our loved ones is unconstitutional, undemocratic, and ignoring what experts say is necessary and possible in order to prevent mass death, impoverishment, and disablement, at the hands of a virus we know how to stop.

The CDC must reject the proposed changes, which would make the guidelines even more weak, inadequate, and fatal to all US Americans, especially marginalized people and people working in high risk occupations. These proposed changes are a disservice to everyone in this country, and they willfully ignore increasing concerns from healthcare professionals, patients, public health experts, and disabled activists.

The new guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. 60% of transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times. Healthcare settings are where high risk, sick, elderly, and disabled people mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies at all times. The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose, implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing “smiles” rather than infection control.

Healthcare providers complain of the cost of protective measures to stop transmission, but the US Dept. of Health and Human Services in 2016 deemed an intervention cost-effective if it cost less than $9.6 million per life saved (https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/171981/HHS_RIAGuidance

.pdf) – and does not weigh that cost against profits, nor should CDC. The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data. The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

The CDC must respond to the outcry from National Nurses United as well as the Peoples’s CDC. HICPAC must revise the guidelines to adequately reflect the grave threat this virus poses to the health and well-being of this country, and to prioritize harm reduction/safety for patients and healthcare workers, in addition to immunocompromised, disabled, and otherwise marginalized/vulnerable groups.

We will not stand by silently while the CDC endorses a genocide and willfully wages biological warfare against the people.

We will not fall by the wayside.
Sylvan Rachel (He/Him)

Hello,

There are many critical errors in HICPAC's proposed revised isolation precautions guidelines. Please:

- recognize aerosol transmission
- instate respirator requirements in healthcare regardless of vaccination status
- acknowledge respirators are more effective ethan surgical masks
- recommend use of clean air tools like HEPA filters
- involve aerosol experts and increase transparency

Thank you,

Leah Pruente
Jamaica Plain MA

To the Healthcare Infection Control Practices Advisory Committee:

My name is Claire Zuo and I live in Queens, New York. I have been sick with COVID-19 due to getting infected at the dentist’s office (due to healthcare workers not being required to mask and lacking filtration systems) despite masking with a N95 elsewhere, and many people I know have gotten extremely sick and developed chronic illness / long COVID, partly because misinformation and insufficient measures from the CDC.

As the CDC has known, COVID-19 transmission is airborne and moves through the air like smoke. We know what keeps us safer: ventilation, air filtration, and high quality respirators.

I implore you to follow the recommendations from the Peoples' CDC:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
- Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Best,

Claire

This comment is from Mark Lefebvre of Dracut, MA. I am writing as an individual without organizational affiliation. It is about your latest draft recommendations for controlling airborne pathogens.

I am very concerned about the failure of this draft to address the most serious concerns about airborne pathogens. The draft does not reflect the current science on aerosol transmission of infectious diseases. It is too focused on short range transmission and does not adequately address long-range transmission. Instead of strengthening the safeguards against airborne infections, it stays with the the existing (and disproven) droplet-airborne paradigm. This does not make sense. We should at least continue using airborne infection isolation rooms for novel pathogens.

The draft accepts surgical masks as the default respiratory protection for health care workers exposed to infectious disease transmitted through the air. Yet we already know that these masks are inadequate for such protection, and that N95-level protection is what is needed. The many outbreaks of COVID-19 already proved that.

This draft values convenience for employers over protections for health care workers and patients. This is not science and it is not the kind of recommendation we expect from the CDC.

This seems to be a violation of science. And,wWith all the vacancies left unfilled, HICPAC is in violation of its charter. Please remedy this situation as soon as possible and give the American people a scientific recommendation that actually protects them from airborne pathogens based on the scientific evidence we already have.

Thank you for your consideration.

Hello,

I'm writing to you today to submit a public comment regarding the draft of infection control guidelines that are being updated by the Healthcare Infection Control Practices Advisory Committee (HICPAC). First, as a molecular biologist with expertise in antibody assays, I want to make clear that COVID-19 is aerosolized and highly infectious. I agree with thousands of other well-qualified medical and scientific experts that infection control measures and rules in healthcare settings need to be based on current up-to-date evidence-based research, which we have so much more of now after over three and a half years of dealing with a global pandemic. You need to seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including experts in relevant immunology, respiratory, virology, and aerosol science fields, as well as doctors and nurses with frontline experience and expertise in treating patients with COVID-19 and Long COVID.

The scientific consensus of evidence-based research shows that high-quality N95 masks and respirators, as well as KN95 and KF94 masks, are significantly more effective at preventing airborne infections than surgical masks. Mask use in general has also been shown to prevent infection, particularly if all people in a healthcare setting wear them appropriately. I call on you to include requirements in the drafted guidelines for providers and patients to wear high-quality

N95/KN95/KF94 masks in healthcare settings. It is also crucial to reinstate access to effective COVID-19 testing to screen patients coming into hospitals and healthcare facilities. Nosocomial infections are far too prevalent and can mean a death sentence to an inordinately high number of patients, 10% according to the most recent data. Access to safe, supportive, and effective healthcare should be provided to all who need it, and many immunocompromised and disabled patients are at risk of contracting airborne infectious diseases every time they enter healthcare facilities. Unfortunately, people can spread COVID-19 quickly and easily even if they show no symptoms–and the trend of presenteeism is all too real for healthcare workers who fear the consequences of not working when they do have symptoms of infection. This is all the more reason to require masking in healthcare facilities when case numbers are high. However, this is all dependent upon much-needed accurate data from widespread and effective viral testing. Isolation protocols, and the use of HEPA filtration according to current ASHRAE or equivalent evidence-based guidelines, as well as current UV technological advances, should also be put in place to limit the spread of infectious airborne diseases. Medical professionals should strive to do no harm. Without the aforementioned evidence-based infection control measures in place in healthcare settings, you are, in fact, doing harm. I strongly encourage you to revise your drafted guidelines to be more accurately aligned with evidence-based research and empathetic and supportive medical care for all people.

Thank you,
April

To Whom It Concerns,

I am demanding the following:

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

HICPAC must substantially involve healthcare unions, experts in ventilation, occupational safety and the public in drafting guidelines. Make the process for updating guidelines fully open and transparent. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. Health care settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

I am a Black, Queer Artist based in Chicago and I have contracted COVID two times. One of those times was under poor working conditions with minimal COVID mitigations and preventions. This was also when the Public Health Emergency ended. Getting COVID a second time had a very trying impact on me with navigating chest pain, breathing issues, and extreme fatigue. I was terrified that I would face the weary circumstances of navigating Long COVID. I am one of the *few* lucky ones who did not. Still, my infection occurred due negligence of Infectious Disease Policy in a work environment. As a performing artist, there is extreme risk on the job because of little to no COVID prevention or mitigation. Working artists deserve a safe workplace, they deserve clean air from pathogens and pollution, they deserve expansive futures - not ones cut short by on-the-job illness, injury, disability, or death. COVID is a disabling

virus. And I fear if policies, guidelines, and procedures keep going in the direction you are attempting to take it... many - including myself - will unnecessarily suffer and have their lives permanently altered, when it could have been very well prevented.

I urge you to consider these offerings.

Vigilantly Signed,
Jordan Taylor

To whom it may concern,

I'm requesting that you make Covid-19 precautions universal and year round in hospitals, doctors offices and other healthcare settings. When patients seek medical treatment, they deserve to be treated without having to worry about getting infected with Covid-19 or any other aerosol-spread virus from a healthcare professional or fellow person seeking healthcare.

Please bring back protections that include mandatory (and consistent) testing of medical staff for Covid-19, universal PPE by all healthcare staff, and minimum air quality standards set by the ASHRAE.

Immunocompromised patients should not have to risk their lives every single time they go in for medical care. Healthcare professionals deserve to be protected from Covid-19 year round. With so many precautions already taken away, the least we can do is protect people when they are at their most vulnerable.

Sincerely,
Chris Walker
Washington, DC

Marshel Helsper
Hudson, NH

Forwarding the following statement in agreement. Reject the proposal regarding infection control changes. The CDC must mandate the highest possible standards for healthcare for the benefit of the People of the United States of America.

People's CDC Public Comment on HICPAC

Published November 1, 2023

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.
COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high

quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicitly about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.
The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thanks,
Marshel Helsper

To Whom It Concerns,

Jordan Taylor

Chicago, IL
No Organizational Affiliation
Topic Addressed in Subject Line

HICPAC needs proper oversight, including resuming public meetings to address the harm that is being inflicted on the public via nosocomial infection. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10 percent mortality rate. Allowing COVID-19 infections to run rampant will be more expensive than N95s, fit testing, rapid molecular testing, ventilation, and isolation in the long-run because it will cost you your labor force. Millions of Americans are already suffering from Long COVID. Multiple COVID infections put healthcare workers at higher risk for Long COVID disabilities that put them out of work.

HICPAC must substantially involve healthcare unions, experts in ventilation, occupational safety and the public in drafting guidelines. Make the process for updating guidelines fully open and transparent. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. Health care settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

I am a Black, Queer Artist based in Chicago and I have contracted COVID two times. One of those times was under poor working conditions with minimal COVID mitigations and preventions. This was also when the Public Health Emergency ended. Getting COVID a second time had a very trying impact on me with navigating chest pain, breathing issues, and extreme fatigue. I was terrified that I would face the weary circumstances of navigating Long COVID. I am one of the *few* lucky ones who did not. Still, my infection occurred due negligence of Infectious Disease Policy in a work environment. As a performing artist, there is extreme risk on the job because of little to no COVID prevention or mitigation. Working artists deserve a safe workplace, they deserve clean air from pathogens and pollution, they deserve expansive futures - not ones cut short by on-the-job illness, injury, disability, or death. COVID is a disabling virus. And I fear if policies, guidelines, and procedures keep going in the direction you are attempting to take it... many - including myself - will unnecessarily suffer and have their lives permanently altered, when it could have been very well prevented.

I urge you to consider these offerings.

Vigilantly Signed,
Jordan Taylor

To Whom It May Concern,

Please keep masks required for healthcare. It is so important to not only protect the most vulnerable - including the many sick elderly individuals and children and immunocompromised individuals (including transplant recipients and cancer patients) - but also those providing care to these individuals. Many people providing care move in and out of the hospital rooms where our most vulnerable are receiving care and any transmissible infection, especially respiratory infections like Covid-19, can be reduced through the widespread use of masks. It is impossible to know for sure if any healthcare workers, hospital visitors, or patients have Covid-19 unless they are experiencing symptoms, and it is unlikely that everyone is getting tested daily. Even one infection can lead to increased lengths of stay, increased healthcare costs/spending, and poor outcomes. It is the responsibility of this body to continue to uphold required masking to

protect every individual that steps inside a healthcare facility and to provide the standard of care by being an example of empathy and evidence based practice.

I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

Sincerely,
Dani Pezzuto
Organization I work for: UChicago Medicine
Chicago, IL

Hi,

I'm currently attempting to help my mother recover from 3 strokes she had three weeks ago. However, I can't. Because her recovery and my ability to take care of her has been waylaid by COVID. She likely contracted it in the hospital, she wasn't anywhere else before or after, and I contracted it from her. So now we are both I'll and suffering on top of the suffering she's already experienced from her strokes. Please, don't let hospitals governed by their profits make this call. Healthcare settings are where high risk, disabled, and senior people mingle with infected patients and staff, like my 78 year old mom. Healthcare facilities should employ precautionary strategies at all times. Please, don't let COVID win.

Cheers,
Davina

To the Healthcare Infection Control Practices Advisory Committee:

My name is Tyler Im, and I live in Queens, New York.

As someone with an autoimmune disease, navigating the pandemic these past 3+ years has been an incredibly frustrating and scary time, and much of it has been enabled by misinformation regarding the nature of COVID-19 and best practices to avoid its spread.

As the CDC has long known, COVID-19 transmission is airborne and moves through the air like smoke. We know what keeps us safer: ventilation, air filtration, and high quality respirators.

I implore you to follow the recommendations from the Peoples' CDC:

Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders, including:
> Health care personnel and their representatives.
> Industrial hygienists, occupational health nurses, and safety professionals.
> Engineers, including those with expertise in ventilation design and operation
> Research scientists, including those with expertise in aerosols and respiratory protection.

> Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
> Patients, patient advocates, and disability justice groups.

Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.

> Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
> Open work group meetings to the public with virtual options and with ample time set aside for public comments.
> Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
> Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:
> Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
>Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
>Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
> Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
> Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
> Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.

Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.

Pre-symptomatic and pre-positive-test transmission are possible.
Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.

All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.

Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Best,
Tyler Im

Lois Helsper
Hudson, NH

Forwarding the following statement in agreement. Reject the proposal regarding infection control changes. The CDC must mandate the highest possible standards for healthcare for the benefit of the People of the United States of America.
People's CDC Public Comment on HICPAC
Published November 1, 2023
Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicitly about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation

when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thanks,
Lois Helsper

Good evening,

I am writing to demand the following:

1. HICPAC must substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.

2. Make the process for updating the guidelines fully open and transparent.

3. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread.

4. Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

These are all extremely important for the preservation of life and public health. Thank you for your time.

Sincerely,
A concerned citizen

Hi,

My partner is currently halfway across the country attempting to help her mother recover from 3 strokes she had three weeks ago. However, her recovery and my partner's ability to take care of her has been waylaid by COVID-19. Her mother most certainly contracted it in the hospital, since she wasn't anywhere else before or after, and my partner contracted it from her. So now they're both ill and suffering on top of the suffering she's already experienced from her strokes. And I can't even visit them to help out in the short term since I'd be putting myself at risk. Not to mention the extra risk her mother is facing now from complications from COVID after her strokes.

Please, don't let hospitals governed by their profits make this call. Healthcare settings are where high risk, disabled, and senior people mingle with infected patients and staff, like my 78 year old mom. Healthcare facilities should employ precautionary strategies at all times. Please, don't let COVID win.

Thank you,
Isabela Oliveira

As a formerly healthy adult who is now disabled from covid-19, despite receiving a full series of vaccinations, I and all of my loved ones who must now care for me demand that HICPAC:

1) Substantively involve healthcare unions, experts in ventilation and occupational safety, and the public in drafting guidelines.

2) Make the process for updating the guidelines fully open and transparent.

3) Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. 60% of covid transmission is asymptomatic and presymptomatic. The overwhelming evidence and studies must be presented to the public in an appropriate manner.

4) Healthcare settings are when high-risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities must employ precautionary strategies at all times.

I used to be a healthy, active, hard-working 30-year old with two jobs and outdoor activities scheduled in between. Now I am bedbound with multiple disabilities, all of which were determined by medical doctors to be from covid. Tens of millions of Americans have experienced the same fate.

It is not possible to individualize public health. Please find your humanity and make these demands possible.

I am writing on behalf of 11 other folks disabled from covid who can no longer read or type.

With grave regards,
Kristina

Dear Healthcare Infection Control Practices Advisory Committee,

I am a member of the public writing to express my deep concerns over the latest hospital infection control policies proposed by your committee. Everyone deserves to be able to access healthcare safely and without reasonable fear of contracting a serious and preventable virus. The people who are most vulnerable to serious complications from COVID-19, even when vaccinated, are often the people who need to access healthcare facilities the most. Therefore, infection control policies must be made with the most vulnerable in mind.

It has been well-established that SARS-CoV-2 spreads through aerosol transmission, not just through droplet transmission within 6 feet. In fact, it can linger in the air for a substantial amount of time. Asymptomatic spread is also extremely common and must be prevented to the best of our ability. We have a number of tools to reduce this risk, including masks, ventilation, and air filtration. Those tools save lives and prevent disability. They also work best when we use multiple at the same time, because none of them alone is perfect. Therefore, you should establish rigorous protocols for preventing transmission by air, as well as asymptomatic spread.

I believe that HICPAC should involve healthcare unions, ventilation experts, occupational safety experts, and the public in drafting its guidelines. The process must the fully open and transparent.

Vulnerable people should not have to be on the defense when seeking medical care. I was deeply dismayed when my father was recently treated by unmasked healthcare workers while

he recovered from sepsis. At a time when his immune system nearly killed him, he should not have had to worry about getting a serious virus that his recovering body was not equipped to fight off from the very setting that was supposed to help him. Personally, I have avoided healthcare settings because of the lack of COVID safety precautions. Many other people are doing the same and harming their health in the process. Until major, genuinely data-proved advancements are made against COVID-19, healthcare facilities must do everything in their power to make healthcare settings safe for all people.

Sincerely,
Emma Bresnan
Boston, MA

To whom it may concern:

I am writing in regards to the concerning lack of precautions being established by HICPAC. As a member of the vulnerable population that has had to put off medical procedures due to the fear of the greater risk of dying from catching Covid in the hospital, I'd like to second the comment submitted by the people's cdc. Everyone deserves safety:

" COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.
HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.
The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.
CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation."

My name is Beth Lamb, my address is Dallas, Texas, and I am a licensed occupational therapist although I am not currently practicing or affiliated with an organization.

As a healthcare professional and a person with several disabled family members of all ages, I think it is critical to have strong infection control procedures in place to protect both patients and healthcare providers.

Healthcare facilities must meet ASHRAE's indoor air quality standards to control infectious aerosols. Healthcare providers should take universal precautions to avoid transmission of infectious aerosols, including wearing N95 masks. Healthcare facilities should provide free vaccinations, regular testing, and paid leave to staff to protect their health as well as that of their patients.

All people seeking healthcare, but especially those who are already disabled or at risk, should be able to access healthcare without contracting additional illnesses. And healthcare providers should be able to do their important jobs without fear of contracting potentially debilitating diseases at work.

Infection control guidelines must reflect the seriousness of Covid and other airborne illnesses and require evidence based prevention methods such as improved filtration, mask wearing, and testing.

Thank you,
Beth Lamb

Hello,

I am writing to you today as a health care worker who is immunocompromised (currently on CellCept)and working full time. I have major concerns for my own safety and patient safety regarding your current covid guidelines. I would like the CDC to consider involving health care unions and experts in ventilation and occupation health/safety when updating these guidelines

as well as full transparency while updating these guidelines. Our current guidelines are not enough as we are not recognizing aerosol transmission of covid, this places patient and health care workers like me at a major risk. I do not have the financial means to lower my position to part time to reduce exposure. I have to work full time to provide for myself and to afford medical expenses, the added stress of not recognizing the aerosol transmission of covid weighs heavy on my mind everyday, during every shift, and every doctors appointment. The patients I see almost daily have this heavy worry and constant fear. We do not feel safe in any medical setting, we are experiencing high numbers of positive covid cases and seeing little to no health care staff wearing any type of mask. Please, for the disabled and immunocompromised community who are often not heard or seen, please consider us while you're writing these guidelines. We feel forgotten, we don't feel any support from our medical systems. You have the power to help make our community a safer place for ALL. Please, listen to health care unions, transmission experts, and include us in these conversations as this can help save lives.

Thank you for your time.

Angelica Maria Sanchez

Topic: Public Comment for HICPAC
Submitted by: Leslie Van Wassenhove
Organizational affiliation: World Health Network volunteer
Address: Redmond, WA

I was deeply dismayed that HICPAC chose to ignore widely expressed public requests to delay voting on its draft guidelines for infection control in healthcare settings. HICPAC has been given oral and written comments from patients; healthcare workers; and industry experts on aerosol science, ventilation engineering, and other related fields. HICPAC is willfully ignoring feedback from those better qualified to frame these guidelines than current members, who emphasize flexibility over rigor in protecting the public from disease.
The guidelines as they stand following the November 3 vote are egregiously flawed if they are to provide real protection. If they remain dependent on “community transmission” metrics as determinants of when elevated protections are to be deployed, then the data informing this process must be accurate. It is not, especially with regard to COVID. Wastewater tracking, individual testing, and other kinds of data previously reported are no longer reliable, contributing to a false picture of lower community transmission.
Leaving individual institutions to deploy protections at their own discretion additionally dilutes the infection control guidelines’ impact. Non-uniform implementation leads to inconsistent prevention of community spread of any infectious disease. In the case of airborne pathogens, it is not enough for only selective areas of a health care facility to practice higher levels of infection control when air simply cannot be contained. Universal measures throughout a facility, from N95 masking on all occupants to building-level HEPA filtration and ventilation meeting ASHRAE Standard 241 (published July 2023), need to be required.
I will not repeat the additional recommendations numerous organizations and individuals have already provided. I will emphasize, however, that HICPAC would do well to consider these with true seriousness rather than offering performative statements of consideration. There is a concerning lack of transparency in the process allowing the public to access relevant materials well ahead of HICPAC’s meetings, whether it is minutes from prior meetings, upcoming agendas, or actual materials that require time to review. It seems HICPAC strives to minimize outside consideration and input by deliberately limiting such access — to its detriment. Similarly, I cannot imagine that HICPAC allowed itself enough time to review any feedback received during the public comment periods for its November meeting, especially since it addressed none

of the public's recommendations from the first day and proceeded to vote immediately following the public comments presented on the second. This is not only dismissive and disrespectful but a clear signal to the public that our feedback is of no importance to HICPAC's members. Your duty is to do no harm. Please stop skirting this charge with measures of convenience and accept the advice of those offering their help and expertise.

To whom it may concern,

As a community organizer and concerned citizen, I implore HICPAC to fully recognize that SARS-CoV-2 is spread via aerosol transmission and to establish substantive protocols for preventing such transmission and asymptomatic spread. At many doctors appointments, I've encountered so many healthcare providers who don't understand this basic information and the role of HICPAC is critical in not only educating healthcare workers, but also being clear with patients, providers and administrators about *why* rigorous protocols are necessary.

Please, please do the right thing here; now is the time to strengthen— not weaken-- airborne infection control.

Sincerely,
Emilie Hirsch,
Cambridge, Massachusetts

First of all, HICPAC is in violation of its own charter, which requires 14 members; it currently only has 9 members. Therefore, any decisions made by the committee with these 5 vacancies is not valid. Further, there is an imbalance in the makeup of the existing group. Not one aerosol science member is on the committee as a voting member. So too it lacks experts in UV and HEPA filtration, industrial hygiene, respiratory protection, ventilation engineering, and occupational health and safety. This is in violation of FACA, which requires that committee memberships be "fairly balanced in terms of the points of view represented and the functions to be performed." This is heavily reflected in the decisions being made by this committee: the drafts being churned out continue to fail to fully comprehend the science on aerosol transmission of infectious diseases. Instead they remain overly focused on short vs far range transmission. Droplet transmission of COVID as the major form of transmission has already been disproven; it is instead aerosol transmission that is clearly the route of COVID transmission. The draft further rolls back practice on using airborne infection isolation rooms for novel pathogens.
Further, the committee uses disproven ideas that surgical masks are just as effective in preventing transmission of pathogens as respirators, when in fact surgical masks are far less effective, only reserves respirators such as N95 for "special circumstances". The pandemic is still very much not over. This is evident in the uptick of infections and deaths we have seen over the summer and fall. Yet this committee is treating surgical masks as the default respiratory protection for medical settings. Here is an easy-to-find research example to refute this notion
this. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811136. Please stop cherry-picking data to support your ideas that N95s and surgical masks are no different. Conclusions should come from the data, the data shouldn't be warped to fit your pre-formed conclusions. There continues to be no recommendation for ventilation. The AIIRS proposal is neither practical in a real-life setting nor is it efficient. The draft continues to emphasize flexibility of aerosol transmission prevention for employers, placing all the burned on individual workers and patients. These patients and workers may be particularly susceptible to

both infection and long-term disability, which can be quite severe. https://web.archive.org/web/20230826085431/https://www.theatlantic.com/health/archive/2023/07/chronic-fatigue-long-covid-symptoms/674834/

Finally, HICPAC continues to lack transparency that is standard of a CDC committee. Citizens are not given ample time to read drafts before they are voted on. Public meetings to hear from those with crucial perspectives for updating the Isolation Precautions guidance, such as other experts, health care workers and patients, are not held before any vote. The meetings themselves are not made widely available for viewing by those who could not attend. It is important to note the removal of the August meeting from youtube, only to be made public again after public outcry. If a committee is making well-informed, thoughtful, legal decisions, they would have no need to obfuscate.

In your revision of Infection Control Guidelines, you must consider that:

1. COVID has many very serious long-term effects (some leading to premature death) beyond the initial illness, which may seem mild.

2. COVID cases may be asymptomatic, so infection control measures must be employed at all times.

3. Infection control guidelines should be established to benefit the health of workers and patients, not corporate interests.

Thank you,
Ryan Takakawa
Aliso Viejo, CA

To Whom It May Concern:
I am writing to urge HICPAC and the CDC to update the Isolation Precautions Guidance to reflect the airborne nature of and extreme danger posed by Covid-19, to patients and health care workers alike. This guidance should be explicit about mandatory precautions in healthcare settings proven to reduce spread of airborne viruses, and include required N95 or better respirators for all patients, providers, and staff in all medical facilities, adequate ventilation and air filtration systems in these same facilities, and options for remote, home visit, or outdoor patient/provider appointments whenever requested or possible.

I have had diagnosed Long Covid for nearly 4 years and am no longer able to care for myself. Getting to a medical facility is a serious challenge for me at the moment and can fatigue me for weeks and lead to a permanent deterioration in my condition. When it is absolutely necessary for me to enter a medical facility, I face the risk of another Covid infection due to facilities where no one is masked and there is inadequate ventilation, limited options for remote or outdoor appointments. I have delayed and continue to delay necessary testing and treatment for years due to the fact these protections are not in place.

These are unacceptable and completely unnecessary risks no patient should have to face. Please update your guidance to protect the citizens of this country from the threat of Covid-19 and similar airbone pathogens.

Sincerely,

Katherine Copley

My name is Cathasaigh Molek, address White Oak PA. I'm writing in regards to HICPAC's proposed changes to infection control guidelines. I am a disabled, chronically ill person who is already unable to safely access needed medical care because the existing guidelines for infection control are not enough to keep me, and others like me, safe. The proposed guidelines will weaken the level of protection that is already inadequate, that doesn't protect the disabled, the chronically ill, the medical workers, or every other person.

Any new guidelines have to fully recognize that SARS-CoV-2 is transmitted by aerosols, and that much transmission happens asymptomatically. Any guidelines that fail to do this continue to put high risk individuals in a place where they cannot access critical medical care. Proposed guidelines that depend on any level of community transmission are wholly insufficient, as those levels are largely unknown for COVID because there is now very little testing, wastewater monitoring, or tracking and reporting of cases and other data. The HICPAC draft, which inappropriately puts the burden of responsibility and risk assessment on individuals and workers in insufficient.

Infectious diseases put already high risk individuals at risk of dying. They put healthy individuals at risk of becoming disabled. They put everyone at risk, and if the CDC does not care to protect American citizens, then the CDC is not doing it's job. There must be multiple layers of protection in place at all times to protect staff and those seeking care from nosocomial COVID transmission–which has a 10 percent mortality rate–which has proven to be more deadly than community acquired COVID.

The bare minimum of standards must be:
Universal masking with n95 or better masks, as surgical does not provide adequate protection against airborne pathogens, including COVID.
Regular testing of all healthcare personnel for COVID, and testing for flu and RSV during peak seasons.
HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.
Implementation of minimum indoor air quality standards, that have been set by ASHRAE to control infectious aerosols in all healthcare settings.
Paid leave, or where appropriate, remote work, for all personnel who are infected. They should be allowed to stay home until symptoms improve and testing is negative.
Negative pressure rooms, critical for control of MERS, SARS-1, and SARS-CoV-2.

Further, HICPAC currently has no members expert in several crucial fields such as aerosol science, respiratory protection, occupational health and safety, engineering for clean air, and industrial hygiene. It needs such members. Any guidelines changed without the input of these necessary experts cannot be considered. No changes should be made until members are in place that have the knowledge necessary.

Jessica Donley
Cleveland Ohio
Concerned member of the public

Proposed guidance in unacceptable. We need scientifically proven protections against Covid-19 and other airborne pathogens. Such as universal masking with fitted N95 respirators (not surgical masks which are inadequate for source control and personal protection), and working toward proper ventilation and air purification with at least 6 air changes per hour using hepa filters. A lot of transmission is asymptomatic, pre symptomatic, or happens before testing. Anyone can be infectious so these protocols should always be in place for everyone who can mask.
Chronically ill and disabled people are spending precious time and energy begging for protections that should already exist and shouldn't be up for debate. Some of these people were disabled by catching Covid while getting healthcare. We are tired. This is the bare minimum. Accessing medical care should not kill or disable us. I have avoided needed treatment for years because it's not safe. Not all medical care can be received while masked, not all patients are capable of masking, and one way masking is not enough. The burden of safety shouldn't be on the patient alone. And healthcare workers deserve protection too. Healthcare facilities are the one place we should be able to count on not leaving sicker than when we got there.

I shouldn't risk death just by seeking care!

I never thought we would end up discussing guidelines to **weaken** infection control instead of using the knowledge we gathered these past few years to further protect against ALL infections.

We know most respiratory infections' transmission happens through **aerosols**. It's AIRBORNE. This isn't controversial, it was known before 2020, and has only been reaffirmed again and again since the beginning of the pandemic.

Washing hands is good practice and can reduce transmission of many diseases, but it's not enough and won't protect against virus in the air. Just like a loose surgical mask won't be enough.

Everyone needs to be careful about infections! We keep finding out about links between non-communicable diseases like MS and prior infections. We **know** COVID damages many systems of the body.

Infection control is especially important in healthcare, where people are the most vulnerable.

Nosocomial infections have always been an issue, but last spring in Québec (Canada), 37% of people hospitalized with COVID at the time had caught it in hospital! As if that wasn't bad enough, there is more virus circulating now, and it will only get worse if the CDC guidance lowers standards that should be **increased** instead!

I know too many clinically vulnerable people who got infected while at a routine appointment, hospitalized or in the ER.
I know too many who died.

No one can count on vaccines alone. They're essential and protect against severe disease, but don't protect much or at all against infection…
We also need to remember that, for the immunocompromised, vaccines just don't work well, if at all! Treatments are also limited, when they exist!
Even a mild infection can mean a major setback for people like me. But even in the healthy, infections can lead to more health issues, which is just not sustainable!

The CDC guidances are the basis on which most of the world acts. Which is why I'm writing this comment even though I live in Canada. What the CDC says becomes gospel for all public health services everywhere!

But we have a big problem: the current guidelines proposal seems solely based on outdated droplet mitigations and you propose doing even less than before, while we should be doing more!

We need updated infection control practices that are based on the knowledge that most respiratory infections are transmitted **through the air**.

A 2022 study showed that people with primary immune disorders, like me, have a 9-18% risk of dying from COVID, and a 49% risk of being hospitalized[1].
Seeking healthcare shouldn't be what makes me face those odds!

Infection CONTROL needs to do everything possible to CONTROL infections.

Mitigations against airborne illnesses help everyone, and studies have shown it [2]. There are many different layers of protection we can use, from N95 respirators to higher air quality standards. Routine and regular testing as well as isolation are also important. And there are many more.

There are laws that stop people from harming others. We need stronger infection prevention measures, not less, so that **everyone can be safe in healthcare**.

1. https://www.sciencedirect.com/science/article/pii/S1521661622001784?via%3Dihub
2. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00978-8/fulltext

Annie-Danielle Grenier
Anjou (Québec) Canada

My name is Gloria Molek, White Oak PA. I'm writing in regards to HICPAC's proposed changes to infection control guidelines. I am a senior citizen, with a chronically ill daughter, and currently neither of us can access medical care due to the existing guidelines for infection control being inadequate. The proposed guidelines will weaken the meager level of protection that is in place..

Things we know:
Covid is transmitted by aerosols.
Transmission happens asymptomatically in many cases.
Proposed guidelines put high risk individuals in a place where they cannot access critical medical care.
Proposed guidelines that depend on "community transmission" levels are inappropriate, as testing, wastewater monitoring, tracking and reporting of COVID cases and other data are now nearly nonexistent.
COVID, and other infectious diseases put already high risk individuals at risk of dying or further disablement, healthy individuals at risk of becoming disabled, and overall put everyone at risk.

Therefore, there must be a multilayer approach to protection in place at all times to protect both staff and those seeking care.
Any guidelines that do not take into account the following are insufficient and show that the CDC

cares more about corporate America's profits than keeping Americans safe:

Universal masking with n95 or better masks. Surgical masks do not provide adequate protection against airborne pathogens, including COVID.
Regular testing of all healthcare personnel for COVID, and testing for flu and RSV during peak seasons.
Implementation of minimum indoor air quality standards, that have been set by ASHRAE to control infectious aerosols in all healthcare settings.
Paid leave, or where appropriate, remote work, for all personnel who are infected. They should be allowed to stay home until symptoms improve and testing is negative.
Negative pressure rooms, critical for control of MERS, SARS-1, and SARS-CoV-2.

Further, HICPAC currently has no members expert in several crucial fields such as aerosol science, respiratory protection, occupational health and safety, engineering for clean air, and industrial hygiene. It needs such members. Any guidelines changed without the input of these necessary experts cannot be considered. No changes should be made until members are in place that have the knowledge necessary.

Please make the right decision and protect people like myself, my daughter, and healthcare workers.

'Topic: PUBLIC COMMENT re.CDC Infection Control Guidance - 11/6/2023
From: Diane Sheehan
St. Louis, MO

Dear HICPAC/CDC Voting Members,

As you know, your policies can greatly affect the lives of countless men, women and children. Therefore, I implore all members who will be voting on new infection control guidelines to put the health and safety of the AMERICAN PEOPLE above all other considerations.

Please accept these excellent recommendations (assembled by "The People's CDC") as my comment submission, as well.

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**

- Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
- Open work group meetings to the public with virtual options and with ample time set aside for public comments.
- Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
- Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
  - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
  - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
  - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
  - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
  - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
  - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
  - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
  - Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.

- SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Name: Ray J. Soller
Address: Stamford, CT
Topic: Healthcare Infection Control Guidelines
Comment:
I oppose the infection control guidelines as currently drafted. I am immunocompromised with several chronic illnesses and I visit healthcare facilities on an almost weekly basis. Every doctor appointment I have to risk infection, as I have no choice but to be in those spaces for important treatments. Very rarely do I encounter patients or doctors who are wearing PPE.
Occasionally my doctors will put on a surgical mask if I ask them to, but the risk is still extremely high. Many times I am sitting in waiting rooms full of patients who are ill- unmasked, with poor ventilation.

My experience is far from rare. Millions of Americans have health conditions that make them high-risk for COVID-19 and other viruses. Protecting patients and healthcare workers from infection should be #1 priority for healthcare facilities.

Patients and workers should not have to put their health at risk when providing/receiving medical care.

"Living with COVID-19" as an ongoing public health threat means that we need to have infection control measures in place year-round. It doesn't mean we regress and ignore all that we have learned the past 3 years.

- Healthcare personnel should be recommended to wear an N95 respirator or better.
- They should also have access to testing COVID-19, RSV, and flu regularly during peak seasons.
- Personnel need to be supported with paid leave or remote work options.
- Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

To whom this may concern,

I am writing as a health policy professional and patient-advocate regarding the HICPAC Work Group's proposed changes to Isolation Precautions Guidance.
As many other organizations and individuals have noted, there are multiple alarming facets of the proposed change(s) I urge the Committee to consider and reverse course.

First, it is extremely concerning that HICPAC has violated FACA transparency rules on such an important issue. The Committee is arguably still violating Public Law 92-463 by not yet posting Part 2. I am accustomed to submitting public comment **with the full text of the proposed rule change(s) available to read and analyze prior to the submission deadline.** The proposed changes in Part 2 are unknown and have not been posted to the Federal Register for the public to read. The public cannot consent to or adequately criticize the proposed changes in Part 1 as they must be understood in the context of Part 2's precaution recommendations for specific pathogens. Many policy and legal experts who do not work directly on public health issues are still unaware of this proposed guidance change.

Second, the Work Group's proposed changes to Isolation Precautions Guidance are inconsistent with the latest scientific evidence regarding aerosol-based disease transmission, respirator efficacy and effectiveness in clinical settings, and the effectiveness of layered public health approaches. Any risk-benefit analysis that weights patient safety above financial cost would come out in favor of recommending respirator use in **all** clinical care settings and contexts.

Third, as the Committee and Work Group know, these proposed changes pose a major threat to patient safety and patient care. Disability advocates assert that these changes would further threaten healthcare access for vulnerable populations during the ongoing SARS-CoV-2 pandemic and beyond.

Please consider the very human, very deadly impact of the new guidelines. Instead of implementing the posted proposed changes, I urge the Work Group to implement the following recommendations:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:

    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**
    - Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed "transmission by air" category.
    - Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
    - Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
    - Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
    - Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.
- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
    - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
    - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
    - Pre-symptomatic and pre-positive-test transmission are possible.

    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
- **SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:**
    - The CDC's guidance from January 2020 should continue to apply: "Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles."
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.
    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
- Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Ariel Adelman
Health policy professional and patient-advocate

Gillian Ladd

SF, CA

Dear Committee,
I'm a Simultaneous Pancreas & Kidney Transplant Recipient, & I am advocating for Mandatory Respirator use & Clean Air to prevent nosocomial infections that would rob me of my chance to live thanks to 2 organs from a deceased youth.
I was horrified to read on Friday 11/3, HICPAC ignored the growing outcry from patients, healthcare workers, and public health experts, voted to approve draft proposals to revise CDC guidance in the numerous ways that would undermine long-standing infection control standards for hospitals, nursing homes, and all US healthcare settings; why do you consider a immunosuppressed Organ Transplant recipients unworthy of equal access to medical care? What do you have against my deceased donor?

I agree with the 900 experts who wrote this letter to CDC Dir:
https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Surgical masks are NOT RPE. The CDC's NIOSH has repeatedly said that they are not RPE. And RPE is needed for airborne diseases, which the WHO indicates that Covid is - both short and long range.
https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

CDC says "SURGICAL MASKS ARE NOT RESPIRATORY PROTECTION"

https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

In order for Immunocompromised patients to safely access healthcare, universal respirator usage in medical facilities is required- From the parking lot before entry, to the parking lot when you leave- Anything less is theater, akin to taking one's shoes off at the airport.

Only continuous respiratory usage prevents transmission, as shown in the continuous arm of MacIntyre et al (2013).
https://pubmed.ncbi.nlm.nih.gov/23413265/

All other RCTs has donning & doffing of N95s within 6 feet or less of the patients…which defeats the whole purpose of testing N95s against airborne diseases & should not be included in any reviews.

I'm one of the people Public Health officials remain content to let die- multiple comorbidities = "good news" from the former CDC dir. Before my transplant, while suffering with complications from 39 years of juvenile diabetes and approaching kidney failure, I had to have a prophylactic double mastectomy, bilateral, salpingo-oophorectomy, and hysterectomy, just so that I wouldn't develop impending hereditary cancer and be kicked off the organ waitlist. Cool, huh?
I now live in isolation because indoor public places including state and federal facilities have made zero accommodations for the most vulnerable and instead are letting an airborne pandemic run rampant. This has, in turn, decimated the provider population and kindled an attitude of everyone for themselves instead of building a sturdy foundation around the cornerstone of public health: protecting the most vulnerable.

Science has proven that 2-way respirator masking is infinitely safer than any alternative. We also need HEPA air filtration, CO2 monitoring, increased ventilation, & UVC lighting as a minimum standard of care in hospitals & everywhere else with public access. The most vulnerable patients are LOCKED OUT of necessary healthcare because the best weapon to protect everyone against contracting the virus is evidently an “albatross.”
I do everything in my power to protect and honor my donor’s legacy. Why is HICPAC doing everything you can to erase us from history?

Gillian Ladd

To whom it may concern,

My name is Ana Sevilla, and I am a resident in San Antonio, Texas. I have lost my grandmother, who was one of my primary caretakers, to COVID in 2022, and I know she is one of many who has died because not enough mitigation efforts were taken to prevent airborne infection, especially pertaining to COVID-19.

Now, with many hospitals and medical settings dropping their mask mandates, more people than ever are at significant risk of catching a vascular infection as the transmission of this deadly virus continues to run rampant. I urge the CDC HICPAC to take action to honor the Hippocratic oath: Do no harm, and to take specific and strong action to strengthen protections against COVID.

HICPAC must substantively involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines. Make the process for updating the guidelines fully open and transparent. Fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air" and asymptomatic spread. Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. So, healthcare facilities should employ precautionary strategies at all times.

Please help ensure that more people stay healthy and able bodied as this virus continues to spread. More people deserve to have their community survive and thrive while staying protected from this virus, especially in healthcare settings. Thank you.

Topic: Responding to and protesting the new Isolation Precautions Guideline document
Name: Scott Larkin
Address: Trumbull, CT
Organization: The WHN

I’d like to comment on the HICPAC process for updating guidelines. I’ve spent my career working in groups made up of people with different specialties, from accountants to electrical engineers to computer programmers to financial analysts. I can attest to the benefits of an interdisciplinary approach to any problem. The facts that have recently come to light about HICPAC’s membership are troubling, as are the steps that have and have not been taken in this latest round of developing guidance for healthcare systems across the US. To have only 9 members instead of the 14 mandated by the charter is bad enough, but to have a limited scope of expertise is another blow to the integrity of this body and the trust that we the public should place in its decisions.

When I learned that HICPAC has no members who are experts in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection, it put a lot of things into perspective for me. The proposed guidelines are so limited in their scope, it makes sense that several crucial specialties were not consulted. It is clear that HICPAC cannot develop appropriate guidance now, as it is missing basic problem-solving strategies for the issue of airborne hospital acquired infection. Engineering has long been a part of problem solving in medicine, as we have seen with cleaning drinking water to protect people from cholera.

I'm also concerned by the tightened schedule HICPAC has shifted to since the summer of 2023. HICPAC chose to accept public comment on November 2-3, but only posted its preliminary draft online on the morning of November 2. That is a remarkable choice. Was it the result of disorganization, not enough members to complete the work in a timely manner, or an attempt to evade criticism from the public? HICPAC must make any draft guidelines available for the public for a decently in depth review before submission to the CDC. Same day postings are problematic for obvious reasons.

Members of the public deserve to know what is going on with regards to the standard of care they can expect in healthcare settings for themselves and loved ones. HICPAC and CDC should make the process for updating their guidelines open, available, and transparent to the interested public. Final guidelines should include a page that lists the public's comments, and responses from the members why each one was or was not adopted, with references to scientific evidence. The priority should be the science, not hospital budget sheets.

I am writing to urge the CDC/HICPAC to act upon the People's CDC recommendation to correct their review on COVID-19 infection control measures to reflect the science of aerosol transmission. The CDC and HICPAC must use scientific evidence that is up to date with the most current knowledge. The updated guidance must include information regarding multiple control measures that have been proven to effectively prevent transmission of COVID-19. Health workers should be encouraged to employ all precautionary strategies to protect themselves and their vulnerable patients. These strategies include, but are not limited to: wearing a proper fitting respirator, testing regularly, getting paid leave when positive with COVID-19, minimum air quality standards, getting updated vaccines and boosters.

It is imperative that all Americans are receiving accurate information regarding COVID-19 and safety precautions. The COVID-19 pandemic has been mass disabling and the repercussions of the lack of factual information should not be ignored.

To Whom it May Concern,

I know that I am one of many disabled people submitting a public comment out of concern of the trajectory of public health guidance as fascism continues to rise, and while you all continue to enable COVID denialism among the general public. This group has been so shady for months now. You all have purposely ignored professionals' input and are suspiciously moving behind closed doors to reduce public health protections in an updated version of the Isolation Precaution guidance which has not yet been made publicly available, with ample time for review.

WHY THE FUCK are you downplayng aersol trasmission of COVID-19?? Your negligence and complicity in state abandonment has forced so many of us to become citizen scientists,

specializing in public health and science communications. It has been going on four years of enduring this pandemic, and you have not yet updated the list of infectious diseases currently classified as transmitted by
the airborne or droplet routes to those that can be transmitted via
aerosol transmission/inhalation. AND FOURS IN, you have not normalized, and in fact have actively discouraged masking by lying (declaring the pandemic officially over) and
gaslighting the masses (less accessible PCR testing, public unmasked gatherings, private screening measures for the elite while completely turning the public against layers of mitigation).

The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory
protection, aerosol science, and occupational health. Their professional expertise cannot be ignored. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator
effectiveness from laboratory studies and studies in non-health care workplaces. It
is unconscionable that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review. There is blood on all of your hands and you continue to give zero fucks. Every move you make will encounter resistance. If you don't meet our collective demands, we will continue to mobilize against you, as we continue to mourn our dead and help one another survive another day in an ever growing hostile society that has been turned against mitigating dangerous BSL-3 level pathogens.

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed adopting a more “flexible” approach to implementing precautions that recommends only minimal
protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19
pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations. I urge HICPAC and the
CDC to maintain an approach in the updated guidance that is clear and explicit about
the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level
of exposure, select appropriate control measures (including PPE) for each job, task,
and location, and result in a written exposure control plan following the hierarchy of controls. We already have rheumatologists and oncologists not wearing N95s and gaslighting their patients. Nosocomial infections are more likely than those acquired in community settings. For disabled and chronically ill people, that is TERRIFYING and prolongs seeking treatment because we are afraid that these places that are supposed to help us, are far more likely to harm us.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness
of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation. We need a massive structural overhaul and you lot haven't lifted one finger to stop so many people from dying. Do your fucking jobs. What happened to "do no harm"?
--

Holding the line against eugenics,
Ngozi Alston (they/she)

A measly one week comment window is insufficient to afford the public a meaningful opportunity to thoroughly review the requisite materials and supporting documents. I was unable to complete a review of all the requisite information in the small commenting window CDC chose to provide.

Matthew Cortland

HICPAC's draft guidance for source control is both unacceptably vague and inadequate to protect patients. The draft states: "During periods of higher levels of community respiratory virus transmission, facilities should consider implementing one of the tiers of source control" (ln. 505-506).
The document does not specify what counts as "higher" levels of transmission: higher relative to what baseline? Such vagueness would allow a facility to claim that it is following CDC guidelines when not implementing source control for, say, a virus with a high transmission rate for which 4% of the community is infectious because that 4% is not higher than the previous peak of 8% infectious.
Such a scenario should make clear that it makes no sense to make source control depend on the relative level of community transmission rather than on the absolute risk to patients. A patient walking into a hospital in which 4% of the people are infectious with a debilitating virus that spreads via aerosols over long distance is at the same extremely high risk regardless of whether they'd have been at even greater risk two months ago when transmission was even higher. It's just as inadvisable to play Russian roulette with an 8-chambered pistol today regardless of whether you played it with a 6-chambered one last week.
Additionally, it's frankly bizarre that the recommendations merely state that facilities "should consider" implementing source control. Recommendations generally advise people what to do once they are already considering which action to take or if they are about to take an action that is imprudent. If a patient is considering undergoing a particular treatment and asks a doctor for a recommendation, it's no help at all for the doctor to recommend that they continue considering. What the patient needs is advice as to whether the treatment will fulfill their goals or not. Similarly, if a doctor is considering injecting a patient with a lethal dose of potassium, it helps no one for the CDC to recommend that the doctor consider not doing so.
The CDC should recommend, *simpliciter*, that facilities implement effective source control when community transmission puts patients at unacceptably high risk of morbidity or death—even when that high risk has been ongoing and largely unchanged for, say, four years or more.
The source control at each of the two "tiers of source control" is ineffective for most airborne transmission. Each tier has people use masks—rather than respirators—as source control (ln. 507-510). But, masks—as opposed to respirators—are largely ineffective at preventing airborne transmission via aerosols that travel long distances. There should be a tier of source control that has both patients, visitors and HCPs wear well-fitting respirators within the facility that is recommended when dealing with high levels of transmission of viruses that transmit via aerosols across long distances and lead to high rates of morbidity for which there are not effective treatments or vaccines (as is currently the case, of course, with the sequelae of SARS-CoV-2).

Andrew Knoll, Ph.D.—*Unaffiliated*
Sewanee, TN

To the members of HICPAC,

I'm writing to you as a citizen and person who's smart enough to value not only their own life and health, but the lives and health of all people, and who expects the same consideration from their neighbors, and from bodies like HICPAC and the CDC. I understand that I'm only as safe as the most vulnerable person I know. I understand the importance of public health, and I know that every single person deserves health and safety and organizations that promote their health and safety. This isn't rocket science, and it isn't bleeding heart liberalism. It's just common sense.

COVID-19 infections are surging, because little is being done to prevent or track transmission, and people are continuing to contract a potentially fatal disease in large numbers. It is therefore NOT the time to relax standards for infection control in healthcare. It is NOT time to ignore nurses and infectious disease experts. It's time to acknowledge that SARS-CoV-2 is airborne, and to actually make the effort to limit transmission, and to require the use of respirator style masks and regular testing to protect both our already overwhelmed healthcare workers and patients of all ages and abilities. Yes, masks and other mitigations will come at some expense - but allowing unchecked transmission of a debilitating disease will be far more expensive.

I think that you all know this, though. You know that requiring mitigations and infection control is more cost-effective that relaxing infection control standards, and also that reducing transmission is the only ethically defensible approach. Act accordingly. Get it together, HICPAC.

Jamie Varriale
Little Neck, NY

Hello Communication Employees of the CDC,

I hope this email finds you well. Unfortunately, I am very unwell. My name is Nicole and I'm a senior in college studying psychology and statistics (I hope to become a social worker!). The reason I am very unwell is because I got COVID 7 times in the past year. This has given me multiple medical issues (confirmed by multiple PCPs, cardiologist, extremely smart and accomplished immunologist, and infectious disease specialist) that I could go into if you like, but I respect your time, so I will leave it at "every day is miserable and I miss the way my body used to be."

I am writing to you to ask you to please, PLEASE consider stronger infection control so that more people do not end up like me!!!!!!!!!!!!!!!!!!!!!!!!!

Here are some of my demands, as inspired by the People'sCDC:

- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- The proposed guidelines currently call for varying levels of protection that depend on the level of “community transmission” of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal

protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.

- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
    - my college has already seen this point in practice, because isolating me 6 times including housing, meals, school health center medical costs, and etc. cost them far more than it would have cost them to provide and mandate masks for the student body
- **Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.**
- **HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.**
    - THIS IS DUMB!!!!!!! MRSA PARALYSES PEOPLE! EVEN IF YOU DON'T BELIEVE IN LONG COVID, YOU GOTTA BELIEVE IN MRSA!
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
- **As the nurses union is urging, (https://www.nationalnursesunited.org/press/nnu-condemns-cdc-committee-for-voting-to-finalize-draft-infection-control-guidance) CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings** (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
- **HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields** such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
- HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.
- CDC and HICPAC should make the process for updating guidelines fully open and transparent.

Thank you for reading this! I sincerely wish joy, peace, and health to you and your families. I know that working in a place where you read public comments can probably be draining, and want to acknowledge your hard work that probably faces the brunt of a lot of people's anger. Thanks for all you do.

All best,
Nicole Reardon

Hello,

I wanted to drop a quick message to express my full support for universal respirator use in healthcare. These times have made it crystal clear that we've got to keep our healthcare workers, patients, and everyone safe.

With COVID-19 in the picture, it's evident that respirators are a must for protecting healthcare workers and keeping medical services going strong. Let's get behind universal respirator use to make sure our healthcare system is safer and more resilient.

Thank you,
Rebecca
Portland, OR

Dear CDC/HICPAC, union officials, experts and journalists CC'ed with this email,

I am an international expert on respiratory protection for pandemics who's worked behind the scenes with the CDC, White House, members of Congress, news organizations, as well as the National Academies of Science, Engineering and Medicine (NASEM), on ways to improve public health during pandemics, raise awareness to overlooked respiratory protections and help shed light to overlooked government failures. I am writing this thorough email not only to leave comments on the new PPE policies but also to show the need for an urgent and thorough investigation by Congress and the media to learn why the CDC has continued to act in bad faith and put public health, national security and the economy at risk.

I've attached this email as a word document as well in order for it to be easier to share with others. This email will include 2 parts. Part 1 will be to help you understand how the conclusions drawn by the HICPAC committee and the CDC on N95s offering similar protections as an N95 were inaccurately interpreted and what the report shockingly left out.

Part 2 of this email/letter will provide direct evidence to show how the CDC has continued to go out of their way during the pandemic to spread misinformation, how they've refuse to correct inaccurate information being used to craft major policies by other agencies as well as the White House, how they knowingly left workers at undue risk, how they helped corporations profit from CDC failures, how the agency was politicized across both administrations, and how the CDC lacks competent leadership.

Part 1 – New HICPAC/CDC recommendations on surgical masks offering the same level of protection as an N95

The report HICPAC and the CDC used to base their new PPE policies on failed to mention that the N95s in the studies they looked at were not used in a manner to protect healthcare workers from airborne transmission nor did it explain that N95s are the lowest level of protection available for protection from airborne transmission and that much better protection could/should be used if the goal is to reduce the risk to the lowest possible levels.

Workers were told to only put on an N95 when within 6 feet of an infected individual. This resulted in a lot of preventable infections because:

A) with airborne transmission, the virus travels much farther than 6 feet so HCWs could've breathed in an infectious dose of the virus before getting within 6 feet of an infected patient. This makes it impossible to know how or when a worker was actually infected.

B) the virus can linger in the air and infect a worker that was never in the same room or area at the same time an infected individual. An infected patient or worker travelling through the hospital can infect those following behind them minutes to hours later. An infected individual walking by an unmasked worker at a nurse's station for example could accidentally spread the virus through fleeting exposure. This is why the risk is not just within 6 feet of a patient but throughout the entire hospital. Without always donning an N95 or higher in a non properly ventilated area, a worker can become infected while never knowing the location of where that transmission occurred.

C) with asymptomatic transmission, it's impossible to know everyone who's infectious so unless you wear an N95 around everyone, you could easily get infected & not know when, where or why that infection occurred.

In addition to those flaws which the CDC conveniently left out of their reports, they also left out that workers using N95s were told to reuse them up to 20 times and that N95s no longer having a effective seal after 2-3 uses. On average, workers using N95s 20 times could not rely on those protections for the last 17 uses or 85% of the time. In addition, since the Battelle disinfection process meant workers were sharing their N95s with others, it meant that 20 different people could potentially be bending the metal nose piece on the N95. So many people bending the nose piece means an N95 might no longer have a reliable seal.

To have the best chances of an N95 working as they are intended, an N95 is never supposed to be reused or used for more than a few hours. Even when N95 shortages were over, workers were often using the same N95 for an 8-16 hour shift.

The most shocking part of the CDC/HICPAC report is that there was no mention that better options than N95s were also available and that we didn't need to keep a low bar for safety when it comes to protecting front line workers. The report failed to mention the past CDC pandemic plan to put elastomeric respirators into widespread use or mention elastomeric respirators at all.

Elastomeric respirators (including those with and without exhalation valves) provide a better seal than N95s, provide better filtration than N95s, are more comfortable to wear than N95s, CDC studies show they are preferred by workers over N95s, are readily available from dozens of manufacturers, are in the National Strategic Stockpile, are significantly more cost effective than N95s and have successfully been used by infectious disease hospitals since the 90s as well as hospitals during the SARS and H1N1 pandemic. The American College of Surgeons study from the 1st wave showed that elastomeric respirators were successful in protecting healthcare workers at the Alleghany Health Network during the 1st wave that not a single worker out of the 2000 that used them, wanted to stop using them and go back to using N95s at the end of the trial.

In March 2020, before the federal government told workers they had to reuse N95s for weeks because nothing else was available to protect them, OSHA released workplace guidelines explaining N95 reuse was dangerous and if not enough N95s were available, hospitals needed to upgrade protections from N95s to elastomeric respirators since they offered better protection and comfort vs an N95.

Despite OSHA writing policies that if hospitals don't have enough N95s, they should be upgrading workers to higher levels of protection including elastomeric respirators, those policies were never followed and hospitals violating those policies never faced any type of corrective action.

A May 2020 New York Times investigation found that hospitals that learned about their importance and used them, saved countless lives and didn't have to struggle with keeping workers safe during the N95 shortages. A July 2022 New York Times investigation explains how the failure by the CDC to let the public know about the importance of elastomeric respirators as well as abandoning their pandemic plan to put them into widespread use resulted in thousands of preventable deaths among healthcare workers.

In September 2019, the CDC was sharing their pandemic plan to put elastomeric respirators into widespread use at large national conferences. Among things they explained were that using elastomeric respirators during pandemics would limit the harm that could come to frontline workers due to anticipated N95 shortages that would occur.

With safer and more protective options than N95s, the debate shouldn't be on if workers should use N95s or surgical masks interchangeably, it should be on who should be given elastomeric respirators and who should be using N95s. Elastomeric respirators are not only what unions have asked for, top experts and government officials worked together on two major reports which explain the need to provide elastomeric respirators as a priority to workers.

The Rockefeller Foundation released this report with experts last year on how those at the highest risk of infection should be upgraded to elastomeric respirators for the rest of the pandemic and for future pandemics.

Gryphon Scientific worked with industry and government to write this report released last month which explains how during the next pandemic, we will be 10-100 times the amount of N95s needed to be able to keep frontline workers protected in the first 100 days. It also explains how all workers that work around others should be using elastomeric respirators and how N95s should be reserved only for those that rarely work around others.

Since the 90s, study after study shows why elastomeric respirators provide the best protection. Even for highest risk work such as healthcare workers performing AGMPs such as occupational CPR, while N95s can lose their seal during quick head movements about 28% of the time, elastomeric respirators never lose their seal.

The federal government told their own OSHA workplace inspectors visiting workplaces experiencing deadly outbreaksknow that the minimum level of protection for them was an elastomeric respirator.

For those of you reading this that would like CDC, FDA, OSHA, FEMA or White House documents on how elastomeric respirators should be put into widespread use during pandemics or biological attacks, please get in touch with me. Also please remember that if a healthcare workers is forced to use a surgical mask, they should also be provided with a 50 cent piece of rubber called a mask brace which helps seal the mask so contaminated air doesn't easily leak though the sides like they do with normal surgical masks.

Part 2 – direct evidence of how the CDC has gone out of their way to keep workers in harms way, help large corporations profit of the CDC's wrongdoing, and how top officials can no longer be trusted to perform their duties.

In March 2020, in order to help Battelle secure a $400 million no bid government contract, the CDC quietly abandoned their pandemic plan to put elastomeric respirators into widespread use and refused to challenge President Trump's public statement to the FDA that nothing else was available to protect workers except for reusing N95s. Top officials within the CDC including NIOSH Director John Howard were well aware that reusing N95s would put workers at great risk and that using elastomeric respirators was what hospitals needed to do.

In May 2020, John Howard testified in Congressional hearings that N95s reuse was extremely dangerous, not well studies and only to be done as a last resort if everything was done to find elastomeric respirators. Internal emails from March 2020 show that John was letting others know that OSHA inspectors were turning to elastomeric respirators to protect themselves from Covid.

Those same internal emails show that the CDC was privately discussing the May 2020 New York Times investigation into the failure by the CDC to put elastomeric respirators into widespread use and that John was wondering what to tell "smart people" asking about elastomeric respirators after reading that investigation.

NIOSH was also well aware that there was a great need to promote the importance of elastomeric respirators so they would be well known. 3 years before the pandemic, NIOSH made a social media post and blogpost on the need to promote them since they would be overlooked during pandemics without proper PSAs.

In May 2020, President Obama's CDC Director, Tom Frieden, explained how outrageous it was that the CDC failed to put elastomeric respirators into widespread use or promote their use as this was what the CDC planned to do during pandemics when he was leading the agency. Tom explained how it bewildered him how the CDC didn't want to use or even talk about elastomeric respirators, but that using them could help eliminate the widespread infections that were occurring. Despite knowing so many lives were being lost because elastomeric respirators weren't being used, Tom was not alerting Congress to this failure so it went undetected.

It wasn't after unions starting having town halls and issuing letters on the need to upgrade workers to elastomeric respirators from N95s that the CDC decided to launch studies into elastomeric respirators. The CDC used those studies with original end dates of December 2021 as an excuse of why they couldn't let the public know about their importance. Those studies were not to be able to learn more about elastomeric respirators as a lot was already known.

The CDC wanted to see if healthcare workers would want to use them after a large study already showed 2000 out of 2000 healthcare workers who used them during the first wave refused to stop using them and go back to using N95s at the end of the trial. The CDC kept their studies on how to disinfect going well into 2023 despite infectious disease hospitals successfully disinfecting many different types of viruses for decades. Disinfection should not have limited the CDC from speaking up about their importance either as they explained in 2021 that there was only a 1/10,000 chance of getting infected by touching a contaminated surface.

The CDC also wanted people to believe exhalation valves posed a great danger to the public after airlines asked them to too help prevent the public from using them. The internal emails

from John Howard shows the CDC was well aware that exhalation valves were not as dangerous as the public continues to be lead to believe. At a November 2020 HICPAC meeting, the minutes show the CDC was explaining how they were about to release studies to show respirators with exhalation valves were good to use, even for source control protection.

In December 2020, the CDC released a report explaining how respirators with exhalation valves provided better source control protection than surgical masks and that covering the valve to gain additional protection was very easy to do.

POAM 23 is a federal task force I used to sit on. It is a task force for President Biden dedicated to having experts, government officials and other stakeholders learn how to improve PPE and PPE supply chains during pandemics and biological threats. It is also lead by a Director within the CDC. In our March 2022 meeting, we learned that the government never had any data to show that exhalation valves posed a danger to patients if the worker was infectious.
Half of our April 2022 POAM meeting was on how the government wanted to transition all healthcare workers to reusable elastomeric respirators and talked about two large studies.

In early 2022, I had two meetings with the White House about major ongoing failures including how the government was allowing social media companies and others like Google to actively censor the public online to make it hard for them to find N95s and elastomeric respirators as well as the many failures that occurred around elastomeric respirators. I also met with Senator Brown and Senator Baldwin's team about the failures around elastomeric respirators. Each time I spoke to a member of Congress, their staff, the White House and even top officials at ASPR and HHS about elastomeric respirators, it was the first time they had heard elastomeric respirators could be used for Covid.

In January 2022, while working with Senators on a letter that was hand delivered to President Biden about the need to stop public health and national security gaps from growing due to the collapse of the domestic mask injury, I spoke to Naveed Jazayeri, Senator Peters' senior staff member on the failures around elastomeric respirators and he was supposed to ensure the Covid Oversight Committee looked into them.

In March 2022, while meeting privately with several Directors within the CDC and their staff including John Howard, I spoke of the failures around elastomeric respirators as well as the need to be transparent with the public about their importance. During that meeting, I cited study after study which they claimed to have never heard of and then told me they wouldn't alert the public to their importance until they were further along with the studies they started in September 2020. Those studies were completed and results shared at a July and August 2022 CDC webinar but never shared with the general public.

Since the CDC, White House and Congress refused to take the problems with elastomeric respirators seriously, I worked with Andrew Jacobs on this New York Times investigation released in early July 2022.
Since I was asked to present at the July 2022 POAM meeting, I took the opportunity to create a presentation that talked about many of the CDC's failures including those around elastomeric respirators. I talked about the problems, how to solve them and the many benefits to solving them.

Unfortunately, on the day of the meeting, I was asked to share the presentation and then after sharing it, I was told I couldn't present that month and they would find a future date for me to share that presentation. The task force never did allow me to present it at a future date either.

Had it been shared, top government officials, unions, experts and key stakeholders would've been made aware of the many failures and it would've meant the CDC would no longer be able to mislead the public to believe all healthcare workers should have as protection was a surgical mask or N95.

I was interviewed by Beth Mueller and Nathaniel West, 2 top investigators from the Covid Oversight Committee weeks after the New York Times article based on my resources came out however there was never any follow up and none of the failures in communication were corrected. Since I was unable to get the Covid Oversight Committee, members of Congress, the White House and top staff within the CDC from alerting the public or correcting the failures, I reached out to the CDC Director's office.

Since the CDC Director had just shared internal reports of how the CDC made a lot of mistakes and she would ensure the agency was transparent and would work hard to regain the public's trust in the institution, I thought I finally had a chance to have the negligence fully investigated and corrected. It took over 5 months to get a response. The CDC Director asked John Howard to write a letter back to me in which John explains the CDC was supposed to promote elastomeric respirators and ensure they were used and he claimed that's exactly was was occurring.

The decision to allow the online censorship around elastomeric respirators and to tell the public to actively avoid using them not only hurt healthcare workers in the U.S., it also hurt workers around the world. In Canada, because their government weren't fully aware of their importance, the stockpiles they purchased in the first wave to bring a quick end to N95 shortages and infections in health care settings were instead locked up. A stockpile of 500,000 elastomeric respirators is about to expire in one province, while in another province, a stockpile of 100,000 elastomeric respirators is in storage with no plans to ever use them.

Union leaders from the National Nurses United union told me in May 2020 that hospitals were telling nurses that they had to reuse N95s because their stockpiles of elastomeric respirators were being kept for future waves. The National Strategic Stockpile also has a massive amount of elastomeric respirators that are not being used.

Storing elastomeric respirators during pandemics makes zero sense since they are made to be reused for years. The Maryland School of Medicine used elastomeric respirators during H1N1 then put then in storage once that virus went away. They then took the respirators from the H1N1 pandemic and used them for protection from Covid.

If the government had spent the $400 million they gave Battelle to instead buy elastomeric respirator, there would've been enough elastomeric respirators for 18 million healthcare workers along millions of police officers, fire fighters and paramedics. Diverting that money for a process that was known would put workers in harms way is something that will likely occur again in future pandemics since we quietly returned to N95 shortages last year.

In another federal task force I sat on called Supply Chain Resiliency Working Group (SCRWG) we learned that many States were quietly reporting widespread N95 shortages. During the May and June 2022 meetings, the government said a lot of States reported an inability to find a 3 day supply of N95s. At the June meeting, I asked what the government was doing to help connect hospitals experiencing shortages with manufacturers that had them readily available.

I was told the government wasn't sure what their data meant and then the July meeting was cancelled days prior to the meeting and future supply chain meetings were cancelled. At my August 2022 meeting with the White House, I told them about the widespread N95 shortages hospitals were back to facing and how the FDA needed to issue a statement so social media companies knew to stop their online censorship so that manufacturers could get their masks to those that needed them. I explained that if the White House wanted healthcare workers to be able to have N95s going forward, they needed to save what was left of the domestic mask industry since 4/5 manufacturers closed down since 2021 and 10,000 workers making medical masks were let go during that time.

Instead of help prevent the shortages from getting worse, the federal government decided to hide those shortages. In late August 2022, the FDA issued a statement that N95 shortages could finally be declared over since hospitals had all the N95s needed for "future demand". What that their statement left out was that it only met future demand because the CDC would be removing mask protections from healthcare settings weeks later.

The federal government spanning both administrations have gone out of their way to ensure workers would not have the N95s needed to do their jobs safely. In November 2020, the White House and CDC learned that hospitals were still telling workers to reuse N95s because they were unaware that over 20 new manufacturers had them readily available. The CDC Directors office told staff including John Howard to ensure hospitals would learn about all the new manufacturers so that they wouldn't keep falsely believing their was a need to take safety shortcuts.

As HCWs were dying in large numbers, top CDC officials decided to ignore the request to correct this oversight. When the AP News investigated, the CDC claimed they could not alert hospitals that they could turn to all the new manufacturers of N95s since there were policies in place that they interpreted to mean that alerting hospitals to other manufacturers besides 3M could be seen as playing favorites.

While the CDC claimed they couldn't help protect the millions of at risk healthcare workers due to policies, the government had the ability to quickly change policies when it suited them. At the same time the CDC claimed policies were preventing them from alerting hospitals that N95 shortages were over and the problem was due to awareness of the new manufacturers, FEMA was quietly updating polices to allow export of N95s since manufacturers no longer had room to store all the millions of N95s they had in excess since they couldn't sell them to hospitals and the government also banned their sales to the public.

In the spring of 2021, OSHA was about to revolutionize protections for all workers and ensure all employers provided their workers with medical masks which was a promise President Biden made to voters in the 2020 election. This would've protected the workforce and supply chain leading to less inflation, it would've protected public health so hospitals would not be overwhelmed and it would've protected the economy from the impacts of the spread of transmission in the workplace.

Unfortunately, after OSHA sent its draft to the White House for the urgent need to protect workers from Covid since vaccines would not be good enough, those protections were removed. While the safety of the general workforce was abandoned, OSHA did release new guidelines for healthcare workers saying that they know were banned from using surgical masks around suspected/confirmed patients with Covid and only N95s and elastomeric respirators would be safe enough to use going forward.

Before Delta was able to do so much damage to public health and the economy, the government had a chance to finally make it right by workers. Because of a leaked study on how common breakthrough infections were, the CDC Directors office had to issue a press release explaining that the CDC learned masks would be needed going forward since vaccines were determined not to be effective at stopping transmission.

The CDC explained that without masks, workers would unknowingly infect others. You now have to dig deep to find that press release since the CDC decided to delete the original press release from their website last month however that webpage can still be found using the internet archives such as the wayback machine.

The CDC then refused to correct the White House when the White House kept saying workers including essential workers should be fired for not getting vaccinated to prevent the spread to others. Even earlier this year, internal White House memos show that President Biden wanted healthcare workers to be fired for not getting vaccinated to prevent transmission to their patients. Memo's show that the White House believe EVERYTHING should be done to prevent the spread to their patients and that a Supreme Court decision also makes that assessment. If the White House thinks everything should be done to prevent the spread of Covid to patients then by removing mask mandates in healthcare settings months prior, they knowingly violated that Supreme Court decision.

If the White House and CDC believe it is important to keep workers and patients safe plus to ensure Supreme Court decisions are not violated, then workers should be given the masks with the highest levels of protection including elastomeric respirators without exhalation valves.

In addition, the federal government has no plans to ensure N95s are even available for healthcare workers and have planned the collapse of the domestic mask industry since the summer of 2021 after learning vaccines failed to stop transmission. The government decided in October 2021 that they would not only allow the domestic mask industry to collapse, they decided to use the collapse as an excuse to give 3M no bid government contracts for N95s.

Senators have long known the government was putting the economy, national security, our supply chains and public health at risk by allowing the domestic mask industry to collapse. In October 2021, a dozen Senators wrote a letter that explained we needed to save the domestic mask industry and not saving it would put the country in harms way.

Months later, close to 2 dozen Senators worked with me on this letter that was hand delivered to President Biden about the dire state of the country's domestic mask manufacturing. Unfortunately, once Democrats received this letter in February 2022 by their polling firm Impact Research, they decided it was best to follow the recommendations to gain votes in the 2022 midterms by politicizing the pandemic and ensuring masks are not used and so they stopped trying to expose failures and save the domestic mask industry which resulted in the widespread shortages by hospital months later.

Because less masks are available, we will have no choice but to rely on pharmaceutical options going forward despite their side effects and large costs. A lot of people are struggling to be able to afford to pay rent/mortgage, buy food to put on their table and pay their other bills and they cannot afford the $1000+ price tag for Paxlovid for every round needed each time they get infected. Ensuring cost effective options like elastomeric respirators make their way to lower income individuals looking for protection means that they don't have to risk getting infected and

having to choose to pay rent that month or take Paxlovid and lower their chances of hospitalizations and death.

The CDC has deleted other important things from their website that could be used by investigative journalists, lawyers and members of Congress to launch investigations into their failures. The CDC also recently deleted their 2017 Powerpoint presentation on how putting elastomeric respirators into widespread use was essential and would prevent the anticipated N95 shortages from occurring.

Deleting evidence of their negligence is a big reason why Congress, unions and the media cannot wait to launch investigations as well as go to court to ensure further documentation and evidence is not destroyed.

I close this letter by saying that despite getting it so wrong for so many years, the CDC has an opportunity to make it right but in order to do so, they need to be transparent, accountable and ensure they have competent officials in the agency that will not allow the government to knowingly spread dangerous information and keep the world in the dark about important things like elastomeric respirators. Since the CDC lacks competent officials or staff that understand how to interpret studies and masks, I've included a mask classification system I created in 2021 called the Simplified Mask Identification Table (SMIT).

The SMIT system can be used by the CDC, public, unions, employers and anyone else trying to learn the level of protection each type of mask offers for droplet as well as airborne protection for the wearer and for those around the wearer if infected.

Kind regards,
Nicolas Smit

Greetings,
My name is Sheila Mitchell. I am a retired emergency room physician, and my husband is a recently retired internist. I am writing to you in regards to the CDC/HICPAC draft Isolation Precautions recommendations, which unfortunately appears to be lacking in science-based recommendations.
The recent Sars-CoV-2 pandemic was a sad illustration of how badly the United States needs clear and concise guidelines for how to handle the transmission of pathogens via inhalation of aerosols. **Scientific** guidelines and protocols are desperately needed by healthcare providers as well as the public in order to protect themselves, their patients, and those they come into contact with. Thank you for organizing to address that.
I am requesting that you seriously consider adding the following:
1. **Education on the limitations of surgical masks** should be mandatory in all healthcare settings where they are currently being used.
2. **Science-based protocols** should be implemented which includes assessments that evaluate the level of exposure, and selects appropriate control measures and PPE for each job, task, and location. This should be implemented for all respiratory pathogens.
3. **Please add in the importance of ventilation** for controlling worker exposure, as well as airborne infection isolation rooms.
It is a good time to follow up the fatigue from the pandemic with some positive learning from it. The thought of repeating all of our mistakes, without substantial signs of insight from government agencies or the healthcare industry, would really be a huge lost opportunity.
PLEASE reconsider these suggestions (as well as the many other comments made by

concerned individuals), and rework your recommendations to have a better finished product that we can all be proud of. We all deserve better protection.
Thank you for taking the time to read my comments.
Sincerely,
Sheila Mitchell MD (ret)
Ashland, Wisconsin

Hello,

I am writing to demand support for mandatory universal respirator use in healthcare. The onset of the COVID-19 pandemic has made it clear that it is our moral imperative to keep our healthcare workers, patients, and everyone safe.

With COVID-19 cases remaining high year-round, it's evident that respirators are needed for protecting healthcare workers and keeping medical services going strong. Please endorse and codify universal respirator use to make sure our healthcare system is safer and more resilient.

Thanks,
Julia Conger

Dear HICPAC committee,

I fully support the statements made here by Andrew Wang and Raj Chaklashiya:

Public Comment by Andrew Wang, PhD, MPH and Raj Chaklashiya, on behalf of the People's CDC, submitted to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding the inadequacy of proposed updated guidelines.

COVID-19 infections injure, harm, and cause mortality among Americans. Based on both case counts and estimates, millions of Americans also are suffering from Long COVID. It is important that everyone in healthcare settings is protected from COVID-19 infections. SARS-CoV-2 is spread via inhalation of aerosol particles with a higher risk at indoor settings compared to outdoor settings. Healthcare settings must employ layers of protection to ensure the highest quality of care and to prevent healthcare acquired conditions. Layers of protection including high quality respirators such as N95s, ventilation, and air filtration have been demonstrated to protect individuals from a COVID-19 infection.

HICPAC's Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions that lends to minimal protections and allows health care employers an undefined broad discretion to create their infection control plans. The CDC ultimately should establish a high standard for infection control measures. The proposed approach was implemented by the CDC since the start of the COVID-19 pandemic that has enabled health care employers to avoid providing necessary protections for health care personnel and patients, based on cost considerations. As a result, I urge HICPAC and the CDC to establish an approach in the updated guidance explicit about precautions needed to protect health care workers and patients from infectious diseases. This protective approach must include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, resulting in a written exposure control plan following the hierarchy of controls.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") – but fails to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There are significant errors in the new draft recommended categories of "air" and "touch" as modes of transmission for healthcare-related infections. While CDC/HICPAC proposes the new category of "air" transmission, they fail to recognize the critical role of inhalation and continue to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is also important to update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission/inhalation.The Work Group's proposals ultimately weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients.

The current evidence review on N95 respirator and surgical mask effectiveness used for developing the proposed approach is flawed and must incorporate evidence from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review focused on findings from a randomized controlled trial that was limited in its generalizability and failed to achieve a conclusion on N95 respirators and surgical masks. The review omitted other applicable data and studies. In particular, it failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is both unethical and unconscionable that HICPAC and the CDC have developed these recommendations that severely impact the lives and health of workers and patients on severely limited review.

CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Anne-Lise François
Associate Professor, English and Comparative Literature
University of California, Berkeley

- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing "transmission by air."
- Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.
- **Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.**
- Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**
- The draft guidelines aim to maximize flexibility for healthcare employers, not protections for healthcare workers and patients. They allow employers broad discretion to choose,

implement or restrict, their own infection control plans, which may be based on profit considerations or on prioritizing seeing "smiles" (https://www.ktnv.com/news/coronavirus/after-3-years-mask-mandate-lifted-at-sunrise-health-hospitals-in-las-vegas) rather than infection control.

- The proposed guidelines currently call for varying levels of protection that depend on the level of "community transmission" of a pathogen, but for COVID in particular, those levels are largely unknown because there is now very little testing, wastewater monitoring, and tracking and reporting of cases and other data.
- The HICPAC draft inappropriately shifts responsibility and risk to individual workers, focusing almost entirely on what should be the last layer of protection – personal protective equipment – while failing to set strong standards for other crucial tools such as ventilation, testing of patients and staff, and isolation.
- Nosocomial COVID (transmitted in hospitals) has a 10 percent mortality rate – so it has proven deadlier and more dangerous than community-acquired COVID.
- Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.
- **Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.**
- All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
- Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative
- Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases.

https://www.news-medical.net/news/20231101/Masking-up-matters-High-quality-studies-confirm-face-masks-significantly-curb-COVID-19-spread.aspx?fbclid=IwAR1YIpfy_GHFDo0Wra4Dh7RMyMkL67hy5XClw8z9gnZjxCyL0kw-3LVix0w

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Erika Ritzel
Minneapolis
Breast Cancer Survivor

Hello,

Please account for airborne transmission and make healthcare locations safe for Healthcare workers and vulnerable patients! My younger sister nearly died of covid double pneumonia, despite being young, vaccinated, and healthy. As a healthcare worker, she was exposed to covid because she was working with sick patients and unable to make them mask. She was in and out of the ER seven times over 5 weeks and then briefly was out on disability. Masks make sense. They save money, keep staffing adequate, and save lives! Our workers deserve better!

We need n95 or similar support in far more conditions for high risk patients and those who care or need to protect their health.

• CDC/HICPAC must fully recognize the science on aerosol transmission of infectious

diseases and update the list of infectious diseases currently classified as transmitted by the airborne or droplet routes to those that can be transmitted via aerosol transmission /inhalation.

• The evidence review on N95 respirator and surgical mask effectiveness was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N95 respirators and surgical masks, omitting other applicable data and studies. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces. It is unconscionable that HICPAC and the CDC are basing recommendations that impact the lives and health of workers and patients on such a biased review.

• HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to avoid providing necessary protection for health care personnel and patients, based on cost considerations.

I urge HICPAC and the
CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions that are needed to protect health care workers and patients from infectious diseases. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written exposure control plan following the hierarchy of controls.

• CDC/HICPAC inexplicably fails to acknowledge the importance and function of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker
exposure to infectious aerosols have not been considered. There are no recommendations on ventilation. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, is significantly limited. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Thank you,
Amanda Yoder
Chesapeake, VA

Please reject the current draft of revised healthcare infection control guidelines. We need stronger protections from SARS-CoV-2 (COVID) that recognize aerosol transmission of the disease and aim to prevent airborne infections. We need multiple layers of protection as studies have shown that individual control measures are more effect in conjunction with other control measures as opposed to on their own. Transmissions can be from asymptomatic carriers, and vaccines reduce but do not stop transmission, therefore protections should be in place at all times to prevent as many occurrences of infection as possible.

Individuals at higher risk of death or becoming disabled from COVID *need* access to healthcare. Acceding healthcare should not require them to put their lives at further risk. I say this as the

mother of a higher-risk child who is routinely in a variety of healthcare settings to continue accessing treatments my child requires. Please require healthcare professionals and facilities to employ preventative measures at all times. Please require anyone entering a healthcare facility to wear a mask at all times. Speaking of masks, surgical masks are not adequate to protect against airborne pathogens, including COVID. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

These measures should not be based on local transmission levels as these are largely no longer being tracked. Nor should these measures be optional for healthcare employers—allowing them flexibility in this matter severely impacts the safety of their employees and patients, which is of far greater concern.

Not working to decrease COVID transmission will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolating those who ate infected because widespread and repeated infections will disable countless workers in healthcare (as well as other fields).

Please reject the current draft and actively seek out the guidance of patients, public health experts, and frontline healthcare workers—not their employers—in developing a new draft.

Thank you for your consideration of the lives at stake here,
Aubree Wickline
San Diego, CA
I am not affiliated with any organization; I am a concerned patient and parent.

- Hello,
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- **My name is Vanessa Villanueva, I live at Moreno Valley and am concerned about the topic of HICPAC Infection Control Changes.** I have family and friends who are immunocompromised, who frequent the hospital and have to navigate the pandemic using any defenses and tools they can muster on minimum wage. It is wholly unjust for us to have healthcare systems and structures that are neglecting the safety of the very people it is meant to care for. I myself have had experiences with healthcare professionals who not only are not masked but shame me for masking for my own safety, referring to the lack of mandates for masking and other precautions in hospitals. These "professionals' are emboldened to dismiss our concerns, concerns that are not only valid but can be life or death for some of us, because of the lack of intentional precaution in policy such as Infection Control.
- I am asking for this intentionality in upcoming Infection Control Changes. We need these changes in healthcare settings to really protect and provide for our most medically vulnerable. We need guidelines based in science that are aggressive in keeping healthcare spaces safe for sick and immunocompromised community members to feel comfortable navigating and being in for long periods of time. We need a protocol that requires healthcare personnel to be vaccinated and to mask as well as use other precautionary tools such as air purifiers, proper air ventilation, COVID tests, etc in their spaces.
- The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Additionally, much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times. Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation

because widespread and repeated infections will disable countless workers in healthcare as well as other fields. Millions of Americans already suffer from Long COVID.

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        - HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely. All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.
        - Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
        -
            - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings. Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases. Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors. Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.
                - As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).
                - HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.
                - Again, I am asking that this information be used to guide the intentionality that my community, my neighbours, family and friends, and I can be protected by. We want to live long, healthy lives and we cannot do this without your efforts to implement strong Infection Control structures. Please, do what will help protect us all.
                -

Thank you,
Vanessa Villanueva

I strongly oppose HICPAC's proposed changes to infection control guidance. Science shows that a layered approach to infection control, where multiple measures are implemented, is the most effective way to reduce transmission risk, and protocols must account for this. In particular,

universal masking is necessary to make healthcare settings safer for all and more accessible to people especially at risk. No one should have to choose between getting COVID and going without essential healthcare. Additionally, surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. I regularly wear an N95 to protect myself and those around me, so it is completely reasonable and necessary for healthcare workers and patients facing much higher levels of COVID exposure to be provided with N95 or better respirators.

It is unacceptable that none of HICPAC's members are experts in occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, or respiratory protection. The CDC must listen to organizations such as National Nurses United and the People's CDC by rejecting HICPAC's draft and developing a new draft in collaboration with patients, healthcare workers, and public health experts. If the CDC and HICPAC refuse to listen to the concerns of those impacted by and knowledgeable about infection control, they will be responsible for the resulting preventable spread of illness and death among healthcare workers and patients.

Claire Wang
Boston, MA

My elderly mother has cancer, and part of her lung was removed because of it. Her doctor told us that if she gets Covid, she will die. While some of her healthcare appointments can be done over the phone, others, like getting pet scans, brain scans and bloodwork, have to be done in a healthcare facility.

Every time we go to one of her appointments, she is at risk of getting Covid (and so am I). We are also at risk of getting other airborne diseases.

Why are you subjecting any patient, visitor, or health care worker to healthcare settings where they can get Covid and other infectious diseases?

It is a scientific fact that Covid is airborne, as are other infectious diseases. Therefore, masks that can protect people from getting Covid etc. (at least N95 or higher filtration) should be required in health care settings, along with air filtration that can prevent the spread of disease. Ventilation should also be required.

Doing anything less portrays a careless disregard for people’s health and well-being.

In all honesty, I shouldn’t have to write this letter. People shouldn’t have to be writing to you to ask for these protective measures. You’re supposed to be protecting us.

Why aren’t you?

HICPAC’s Work Group on the Isolation Precautions Guidance has proposed a less cautious approach to implementing precautions, leading to minimal protections.

In addition, the less cautious approach will allow health care employers an undefined, broad discretion to create their own infection control plans.

We’re currently experiencing what happens under these conditions: masks aren’t required in most health care settings, there are no air filters and there’s little to no ventilation. People are putting their health and often their lives at risk simply by going to get health care.

The CDC should establish a high standard for infection control measures.

I urge HICPAC and the CDC to establish an approach in the updated guidance that is explicit about precautions needed to protect health care workers, patients, and visitors from infectious diseases, including requiring N95 masks (or higher filtration), air filters, and sufficient ventilation.

Please do these things, at the very least. Our lives are at stake.

Hello,

The HICPAC recommendations are unethical to the highest point. Having a safe access to health care is of the utmost importance. Preventing infections is fundamental.

SARS-CoV-2 is aerosolized and is transmitted asymptomatically and symptomatically. People may feel fine and yet be infectious and spread the virus in their path. Why are the health care workers and visitors wishes weighing more than the patients right to receive care without being infected?

In addition to this, why would being infected while receiving care be tolerated, downplayed? Research, clinical practice, and data indicate SARS-CoV-2 infections lead to more complicated recoveries, the exacerbation of preexisting health conditions, the development of new ones (e.g. Long Covid for which there are no treatments to this day), and premature deaths.

The absence of required masking in health care settings is an important risk factor and an accessibility issue for the population at high risk (e.g. the moderately to severely immunocompromised population). Americans avoiding/limiting care as a result of an unsafe environment is unacceptable. How can it be justified to trivialize a virus known to contribute to poor health outcomes during and after the acute phase of infection? How is it ethical to force patients such an organ transplant patients, cancer patients, dialysis patients, NICU patients, cardiology patients, etc. to go through difficult and costly treatment protocols while doing nothing to prevent them from being infected while receiving much needed care?

It is also critical to note that placing patients in a position where they have to ask nurses, doctors, etc. to wear a mask places them in an already asymmetrical position of power which must be avoided. Putting patients in a constant state of self-advocacy is unconscionable.

In other words, wether professionals want to wear a mask or not, prefer wearing a mask or not weighs little to nothing in comparison to the complications, loss of quality of life, and premature death patients may experience as a result of the absence of appropriate mitigations in health care settings.

Finally, it is fundamental to remember there are no prophylactic treatments for the immunocompromised and no treatments for Long Covid. First-line treatments (Paxlovid, Remdesivir, Molnupiravir) remain limited, have contraindications, are not easy to access, etc. The U.S. population had a poor booster uptake during the previous vaccination campaign (18%) and the vaccination rate during the ongoing vaccination campaign is even poorer (4% of the population).

In sum, the HICPAC is expected to work in the interest of the population Transparency is key and the representation of the patient's needs is critical. The current proposed recommendations

are of no service to the population and the workforce. We ask the CDC Director to return the recommendations to the HICPAC table as they do not meet the needs of the population.

Americans deserve a great quality of care - not poorer health and largely preventable death.

Thank you for your attention.

Dapnee Venneman
Naperville IL

I'm writing as someone with a disabling autoimmune condition, as well as a disaster researcher. I'm concerned about the proposed changes to Isolation Precautions Guidance and sincerely hope that you change course, as these changes fly in the face of the latest evidence regarding aerosol-based transmission, respirator efficacy, and the effectiveness of multi-layeres public health approaches.

These changes risk patient safety and care, and place disabled patients at even greater risk of disease impact. Further, these changes will negatively effect access to care for disabled people not just for the ongoing SARS-CoV-2 pandemic but future health emergencies.

Please reconsider the potentially deadly proposed changes, and consider the following:

- **Seek input on proposed changes during the development of the draft guidelines, using the Federal Register public notice process and town hall meetings with virtual options, from the public and all key stakeholders,** including:
    - Health care personnel and their representatives.
    - Industrial hygienists, occupational health nurses, and safety professionals.
    - Engineers, including those with expertise in ventilation design and operation
    - Research scientists, including those with expertise in aerosols and respiratory protection.
    - Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).
    - Patients, patient advocates, and disability justice groups.
- **Make the process for updating the guidelines fully open and transparent. HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.:**
    - Use the Federal Register public notice process to announce the meetings, agendas, draft work products, and planned attendees, as well as to solicit written and oral public comments.
    - Open work group meetings to the public with virtual options and with ample time set aside for public comments.
    - Post work group reports, all presentations to the workgroup and committee, public comments, and transcripts and recordings of the HICPAC meetings on the CDC website in a timely fashion (within 30 days).
    - Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.
- **Ensure the CDC's and HICPAC's understanding and assessment of key scientific evidence is up to date with the most current knowledge by seeking input from a multidisciplinary set of scientific researchers and the key stakeholders, and by making those written reviews publicly available:**

- Fully recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols and establish the highest infection prevention protocols for any proposed “transmission by air” category.
- Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).
- Communicate that each infection control measure is most effective when the other infection control measures are also implemented in a layered approach to reducing transmission risk.
- Implement mandatory continuing education with updated aerosol infection transmission information and fit testing for all healthcare personnel.
- Recommend development and implementation of education about updated aerosol infection transmission information for all patients and their visitors, in the form of videos and pamphlets that are accessible to all patient populations.

- **Create concise control guidelines that recognize transmission characteristics of SARS-CoV-2.**
  - Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.
  - Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ all precautionary strategies.
  - Pre-symptomatic and pre-positive-test transmission are possible.
    - Guidance around what to do when one tests positive must include the latest scientific evidence on how long one is contagious before testing positive and/or showing symptoms so individuals know who to inform about exposures.
    - All people should be presumed infectious because they might be, and should take all precautions against spreading the virus.
    - Test all healthcare personnel regularly, including everyone who reports to a healthcare facility of any size or type. Anyone with symptoms of aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, must not enter the healthcare facility and must be supported with paid leave, or if appropriate, remote work.
  - SARS-CoV-2 is aerosol-transmitted and can remain suspended in the air for hours, similar to measles. Therefore, guidance should state:
    - The CDC’s guidance from January 2020 should continue to apply: “Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room sufficient time has elapsed for enough air changes to remove potentially infectious particles.”
    - Healthcare organizations should maintain and strengthen respiratory protection and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation and transmission of infectious aerosols.
    - Universal PPE for healthcare workers and patients in healthcare settings should be employed at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.

    - Fitted N95s respirator-type masks clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. HICPAC should emphasize procedures that would significantly improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings.
    - Outdoor transmission is possible. When communicating transmission risk in crowded spaces, explicitly state that it includes outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents (as may be used for health fairs and other healthcare outreach events).
  - Healthcare systems should encourage free vaccination and boosters as recommended per age-appropriate ACIP schedules for all aerosol-transmitted infectious diseases for all healthcare personnel, patients, and visitors, unless medically contraindicated.

Greetings,

I'm reaching out to encourage HICPAC to make evidence-based recommendations to the CDC. Specifically regarding preventing transmission:

(1) The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing airborne transmission. Many studies have now confirmed that COVID is airborne and that longer range transmission is possible, especially without mitigations. See: https://academic.oup.com/cid/article/76/5/786/6773834 and https://www.bmj.com/content/377/bmj-2021-068743

(2) Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk. This is sometimes referred to as a "Swiss cheese" approach. When multiple mitigations (e.g., masks, ventilation, etc.) are in place, patient harm is reduced. See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8514562/

(3) Much transmission is asymptomatic, with estimates showing around 40% or more of cases are asymptomatic. Therefore, all precautions must be universally practiced at all times. See: https://www.acpjournals.org/doi/full/10.7326/M20-6976#:~:text=Indiana%20(23).-,The%20proportion%20of%20persons%20who%20tested%20positive%20but%20had%20no,%2C%2043.6%25%20to%2061.8%25).

(4) Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, healthcare facilities and personnel should employ precautionary strategies - including an importantly, masking - at all times. Until building regulations and infrastructure commonly or universally address cleaning the air with exceptional ventilation and HEPA filters, masks are an incredibly effective and low cost solution to stop COVID spread. There is overwhelming evidence that masks work, but a few studies include: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10446908/ and https://www.science.org/doi/10.1126/science.abg6296

Additionally, nosocomial COVID has a relatively high mortality rate (one study showing 8.4% at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10056618/#:~:text=From%2014%2C667%20admitted%20patients%2C%20167,14%20patients%20(8.4%25)%20died.). Sick, recently hospitalized, and recovering people deserve better, as do the healthcare workers who care for them and run the risk of disability with each infection. Recent studies put the risk of long covid at about 10% per infection (see one here: https://www.nih.gov/news-events/news-releases/large-study-provides-scientists-deeper-insight-into-long-covid-symptoms).

I would urge HICPAC and the CDC to consider the cost of letting COVID-19 infections run rampant, economically as well as morally and ethically. COVID has been a leading cause of death and disability each year since it emerged. I'm reminded of a quote by former U.S. Vice President Hubert Humphrey, who in 1977 - almost 50 years ago! - spoke about "the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped." These are the people being treated in healthcare settings.

Let's do better by them and the workers caring for them. Please recommend protections like masks, ventilation, and filtration in healthcare settings.

Thank you,
Megan Lizik, writing in a personal capacity
Glen Ellyn, IL

Justin Clarel
Fanwood, NJ
No organizational affiliation

RE: Inadequacy of proposed updated guidelines

Since mask mandates were abandoned in healthcare settings, I have delayed treatment for chronic health issues and routine care appointments to avoid contact with unmasked healthcare workers and patients who may spread COVID-19. Too many people are navigating similar challenges, needing to decide whether seeking care in a risky setting is worth it. This unfair, inequitable, and dangerous reality should not be the case. Disabled, immunocompromised, and other COVID-aware people have been pushed out of public life and away from necessary medical care. HICPAC and the CDC can implement guidelines to ensure healthcare settings are safe for everyone.

I strongly urge HICPAC and the CDC to strengthen the current guidelines to adequately protect workers and patients from the spread of COVID-19. The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Protocols must account for the science showing that each infection control measure is most effective when other infection control measures are also implemented in a layered approach to reducing transmission risk.

Given that much transmission is asymptomatic, all precautions must be practiced universally at all times. Universal masking with N95 respirators or better is necessary to make healthcare settings safer and accessible for all. Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors. Hospitals and healthcare systems should also require staff to be up to date on vaccinations for all aerosol-transmitted infectious diseases. Because vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted

infectious diseases, clean air, paid leave, testing, and universal masking with N95s or better should be standard. All healthcare personnel should be tested for COVID-19 regularly. Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative. Facilities should implement minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols) that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

COVID-19 is still deadly and disabling. There is no good reason COVID-19 should be allowed to run rampant through hospitals and healthcare systems as it has been. People are more important than profits. Please do the right thing and make the necessary changes to protect workers and patients from SARS-CoV-2.

Dear HICPAC Committee,

I am a public health PhD candidate and a POTS patient. Due to this condition, I am at high risk for severe health outcomes from any sort of infection, and I also frequently have appointments at healthcare facilities. I am deeply concerned about the changing guidelines for infection control in healthcare settings.

COVID-19 and several other viruses spread through airborne transmission. No patient should ever have to risk an infection while receiving essential medical care. No healthcare worker should ever have to risk an infection while doing their job and providing essential care to patients. A healthcare worker shortage would also be catastrophic for an already spread-thin healthcare system. Healthcare settings must require adequate layers of protection, including air ventilation and filtration, and high quality respirators such as KN95s and N95s in all patient care areas.

Thank you for your consideration.

Sincerely,
Priya Midha, MS
PhD Candidate in Public Health, Epidemiology Specialization
Kent State University

Dear HICPAC,

I am a PhD student in Language and Information Technologies at Carnegie Mellon University. I am also immunocompromised. I am writing to urge you to take infection control in hospitals seriously.Your guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.” Furthermore, since much transmission is asymptomatic, these guidelines must be practiced universally at all times.

I was infected with COVID through a forced shared housing situation in March 2022. Since then, I have had long COVID symptoms including a daily chronic cough, excruciating headaches and neck pain, insomnia (partially compounded by the headaches and cough), and chest pain that has caused me to miss work and school on multiple occasions. As a result, I need frequent visits to healthcare settings, including diagnostic imaging and physical therapy, as well as

emergency room visits for when the chest pain becomes unbearable. However, I have not been able to get all the treatment I need due to a lack of universal infection control protocols.

Just this week, my doctor ordered a cervical spine x-ray because of my long COVID-induced neck pain. However, upon walking into the imaging center, the room was unventilated, full of coughing, unmasked patients, and at best, the staff was wearing surgical masks. Due to my unique face structure and supply chain issues, I have not been able to find a metal-free respirator to wear during x-rays or MRI's. Thus, the cervical spine x-ray would have required me to remove my mask in an unventilated room full of sick and contagious patients, and now, I am left without critical diagnostic imaging for my long COVID-induced condition.

Hospital acquired COVID has a 10% mortality rate, so it has proven to be deadlier and more dangerous than community-acquired COVID. I should not have to risk getting reinfected with a virus that has already debilitated me, just to get treatment for the lasting effects of my first infection with the same virus. I urge you to implement universal N95+ masking, HEPA + negative pressure ventilation, regular testing of hospital staff, and strict COVID isolation protocols in all healthcare settings, as this will cost you less in the long run.

Karina

Name: Isabela S. McClintock
Address: Germantown, MD
Organizational affiliation: COVID Safe MD

Written Comment to CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) Standard Precautions against Transmission of Airborne Pathogens, per instructions at https://www.federalregister.gov/documents/2023/10/10/2023-22327/healthcare-infection-control-practices-advisory-committee-hicpac.

HICPAC's revised healthcare infection control guidelines must fully recognize aerosol transmission of SARS-CoV-2 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8831082/). In order to prevent the transmission of this airborne pathogen, infection control guidelines must include a layered protection approach including high-quality, well-fitting, NIOSH N95 respirators to be worn at all times by healthcare staff, upgraded ventilation, use minimum indoor air quality standards (https://www.ashrae.org/technical-resources/bookstore/ashrae-standard-241-control-of-infectious-aerosols), and routine COVID-19 testing for ALL healthcare personnel.

COVID-19 can be transmitted asymptomatically (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8654597/), in order to stop the spread all precautions must be universally practiced at all times.

In order to draft appropriate guidance on airborne respiratory infection control, HICPAC must expand its membership to include Subject Matter Experts including, but not limited to, air cleaning and ventilation engineers, aerosol scientists, and occupational safety and health experts.

CDC and HICPAC should make the process for updating guidelines fully open and transparent.

Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Please protect all patients and healthcare personnel from the spread of COVID-19.

To the HICPAC Work Group:

My name is Caitlin McKenna, no organizational affiliation (Oakland CA). I am writing as a public health researcher regarding the HICPAC Work Group's proposed changes to Isolation Precautions Guidance. As many other organizations and individuals have noted, there are multiple alarming facets of the proposed change(s). I urge the Committee to consider and reverse course.

First, it is extremely concerning that HICPAC has violated FACA transparency rules on such an important issue. The Committee is still violating Public Law 92-463 by not yet posting Part 2. I am accustomed to submitting public comments with the full text of the proposed rule change(s) available to read and analyze prior to the submission deadline. The proposed changes in Part 2 are unknown and have not been posted to the Federal Register for the public to read. The public cannot consent to or adequately criticize the proposed changes in Part 1 as they must be understood in the context of Part 2's precaution recommendations for specific pathogens. Many policy and legal experts who do not work directly on public health issues are still unaware of this proposed guidance change.

Second, the Work Group's proposed changes to Isolation Precautions Guidance are inconsistent with the latest scientific evidence regarding aerosol-based disease transmission, respirator efficacy and effectiveness in clinical settings, and the effectiveness of layered public health approaches. Any risk-benefit analysis that weighs patient safety above financial cost would come out in favor of recommending respirator use in all clinical care settings and contexts.

Third, as the Committee and Work Group know, these proposed changes pose a major threat to patient safety and patient care. Disability advocates assert these changes would further threaten healthcare access for vulnerable populations during the ongoing SARS-CoV-2 pandemic and beyond.

Please consider the very human, very deadly impact of the new guidelines. Instead of implementing the posted proposed changes, I urge the Work Group to implement the following recommendations: https://peoplescdc.org/2023/11/01/recommendations-for-hicpac/

Topic: Healthcare Infection Control Practices— specifically regarding the abandonment of universal masking, universal precautions, and the clinically vulnerable population.

I am writing as a concerned private citizen who is both immunocompromised and immunosupressed. I have a b-cell blood cancer which puts me at high risk for severe SARS-Cov-2 or death from SARS-Cov-2. I am on an ongoing immunosuppressive treatment which makes my risks, noted above, higher still.

My third strike? I did not receive any antibodies from the SARS-Cov-2 vaccines. So for those arguing that precautions beyond life saving vaccines are unnecessary, please remember those who did not get a protective response.

The dropping of universal masking with the blessings of the CDC has put me in a difficult position, essentially deciding whether I forego routine and specialty care or risk further disability,

even death.

Of course there were still risks (and will still be risks) when universal masking was in place. But there were fewer risks.

When a local hospital abandoned universal masking, I asked one of the administrators about the hospital still having some areas with masking, but no way to get to those areas without going through waiting areas, check-ins, crowded hallways and so on. His observation was that the chances of getting covid in a hallway were low.

Fine. I don't actually believe that because SARS-Cov-2 is airborne and can linger in the air for hours. Even so, shouldn't we be working toward making the risk as *low* as we can? To take as many mitigation measures that can to help reduce the spread of covid and other communicable diseases? At least in medical facilities, dental offices, and so on— places where some of us have no choice but to go.

Because universal masking has ended in my area, it means the following:

- I have decided not to try a new cancer treatment because it means more frequent lab appointments. When universal masking was initially dropped, labs were deemed low risk areas. But now I don't believe they're even masking in the "high risk areas" such as oncology clinics, transplant clinics, etc. They're also not taking any measures to help improve indoor air quality.

-I have opted to not go to any in-person doctor appointments— only labwork. My healthcare is now a mix of Internet and home-remedy based.

-A family member living with me was going to go in to have a health concern checked on, but it was at that time local healthcare clinics abandoned universal masking and so has opted not to get medical care in order to avoid exposure risks/bringing it home to me.

-Checking in with optometrists and dentists regarding SARS-Cov-2 precautions leaves me further abandoned. Basically they say they can only follow what the CDC says, and right now universal masking isn't supported by the CDC. I haven't been to the dentist or the optometrist since 2019.

-there are more examples I could provide, but these should give a bit of an overview of some of the impacts I'm facing from your decisions.

Everyone wants to revert to living like it's 2019. And yet the CDC is gutting public health and universal precautions to the point that it's as if we've reverted to living like it's 1349, instead. I imagine handwashing will be the next victim.

By the way, that whole "leaving it up to the individual" to assess their own risk is the antithesis of public health. Followed by systematically removing the accurate information and manipulation of the metrics so assessing one's individual risks became impossible, is nothing less than heinous.

It's not too late to restore public health to what it was before the pandemic. It won't be easy because of all the damage that's been done these last few years. But it starts by not watering down healthcare infection control practices beyond where they already are.

Please help those of us who are immunocompromised and/or immunosupressed— as well as those who are working in healthcare facilities— by continuing to include universal masking and universal precaution protocols as part of the infection control practices, and by strengthening infection control practices instead of weakening them further.

Sincerely,
Beth Rettenmund

I am writing to express my concern about the proposed relaxation of critically important infection control guidelines in healthcare facilities.

I am immunocompromised from chemotherapy (Rituxan) treatment. I also have Type 1 Diabetes. My health problems require frequent visits to doctors offices and the hospital. These are places that should be safe for everyone to access. Nobody should be at risk of contracting a nosocomial infection when receiving healthcare.

I ask that you strengthen and expand the current guidelines to make healthcare accessible for everyone. This would include mandatory masking by staff in all healthcare facilities and masking for patients in ambulatory facilities. It would also include high standards for ventilation and air filtration in all medical facilities.

We are currently seeing rising cases of SARS-Cov-2 across the country. Please do everything possible to make medical spaces safe for us.

Sincerely,
Clare Venus

Henry Strozier, private
South Egremont, Ma.

Dear HICPAC,
I grew up in Atlanta (my father was a professor at Emory) and when the CDC was established we all thought your role to protect public health was extremely important.

Then, something obviously bad happened. Because now, you no longer seem to be concerned with the welfare of human beings, their lives, or their diseases.

Your resistance to applying Covid safety rules to hospitals makes me wonder if someone is paying you off for your vote or if you just don't care.

At present, the entire CDC is a disaster, doing more harm than good. What in the hell happened to you?

Very sincerely,
Henry E. Strozier

Hello,

I'd like to comment on HICPAC's proposed revision of healthcare infection control guidelines.

It's imperative that the guidelines recognize that Covid 19 is transmissible by air, and include rigorous protocols and protections to prevent Covid to be transmitted to patients in healthcare settings.

Since much transmission is asymptomatic, precautions should be taken at all times, especially in healthcare settings by both staff and patients. Universal masking is necessary to make healthcare settings safe for all, especially for those who are at risk.

Surgical masks are not adequate to protect against airborne diseases. N95 or better should should the standard in healthcare settings.

Since mask mandates in healthcare settings have been relaxed, it has been challenging to ensure my household can safely get the care they need. Additionally, this has lead to added cost and complexity, which is borne by those who need care most.

For these reasons, I strongly urge HICPAC to adopt stronger protections than those proposed in the revised guidelines.

Andrew Matsuoka
Brooklyn, NY

The guidelines must fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing “transmission by air.”

Much transmission is asymptomatic. Therefore, all precautions must be universally practiced at all times.

Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

Healthcare settings are where high risk, disabled, and seniors will mingle with infected patients, visitors, and staff. Therefore, **healthcare facilities and personnel should employ all precautionary strategies at all times.**

As a chronically ill, immunocompromised American, I am at higher risk for bad outcomes from a Covid-19 infection. I am at higher risk for Long Covid. As someone with MS, I want to keep avoiding infection in order to not risk further brain damage. However, your proposed changes weaken protections so much that you would make it even more dangerous than it is now to seek healthcare. Already dangerous to seek Healthcare since everyone forgot about the meaning of public health. There's a lot of lip service paid to protecting the vulnerable and the immunocompromised, and an emphasis on “we have the tools” but the tools are useless if you refuse to use them. This includes N95 or better respirators for healthcare professionals. Actions speak louder than words.

The policy you have proposed and decided upon will weaken already lacking protections for all patients, but it is particularly dangerous for those of us with weakened immune systems, the elderly, and infants.
Wearing a loose-fitting surgical mask is not equivalent to wearing an
N95 or better respirator mask. To make a statement of equivalence between them is an outright lie and we are seeing it for what it is.

Nurses have come out against this policy, physicians, other immunocompromised Americans. We all see the truth of leaving us even further behind.
To change the rules and not require supplies that actually work for staff is a betrayal of the American people and your mission to protect us. Please do not shirk duty and responsibility by weakening these protections and further drive patients into foregoing healthcare more than we already have been since this pandemic began. It is not over.

With little to no public safety protections available, data rendered very limited, little testing being recorded, and no efforts to control transmission, the least you can do is allow those of us who are interested in additional protections to not severely weaken protections in healthcare. This should go without saying—that Americans should be able to seek healthcare without risking infection with a deadly and disabling virus that we have only middling protection from without the use of respirators, air circulation and ventilation standards, and easily accessible data.

The long-term systemic impact of Covid-19 infection is terrifying. Let us protect ourselves, and importantly, let healthcare professionals be responsible for protecting us enough that we can seek care more safely.
Do what you know is effective and morally right.

Thank you,
Christina González,
Concerned citizen from New York
Forest Hills, NY

Dear HICPAC,

Per the instructions at https://www.cdc.gov/hicpac/meeting.html I am submitting public comments, as an individual, not representative.

The recommendations for infection prevention and control reflect a failure to accommodate to the new reality of endemic SARS-CoV-2.

The principal reality is the continuing ubiquitous presence in the population of people who are infectious with SARS-CoV-2, a large fraction of the time without symptoms. People seeking healthcare should not be forced into exposure to SARS-CoV-2. Many procedures or treatments require that patients expose themselves to the air around them. It is of the utmost importance therefore that this air be kept free of infectious agents. This requires that staff and other patients be either rigorously screened for SARS-CoV-2 infection and if infected, kept away from other persons' shared air, or that respirator source control be used ubiquitously.

Pleated surgical masks, which cannot provide effective source control, have no place in this new pathology landscape.

The high documented rates of "presenteeism" of symptomatic staff [1,2], in addition to the high rates of asymptomatic transmission of COVID-19, mean that respirators must be mandatory for healthcare workers.

Vulnerable patients are avoiding healthcare because of the risk of being infected with SARS-CoV-2. There needs to be a mechanism by which patients can be assured that a given facility is preventing nosocomial SARS-CoV-2 infection. That requires new reporting and disclosing regulations for healthcare facilities.

HICPAC has not only failed to incorporate the realities of the pandemic and continuing high rates of SARS-CoV-2 infection in the population, but has narrowed the scope of its purview to frontline healthcare workers, leaving whole aspects of infection prevention unattended to by any Federal agency.

The absence of diverse perspectives among the HICPAC members—where all but 2 have administrator titles—may be the cause of these failures, and should be remedied by appointing occupational safety experts, nurses, aerosol experts, biologists not involved in hospital management, and people with other necessary perspectives.

Sincerely,

Lee Altenberg

Citations:

[1] Kinman, Gail, and Christine Grant. "Presenteeism during the COVID-19 pandemic: risks and solutions." *Occupational Medicine* 71.6-7 (2021): 243-244.
[2] Linsenmeyer, Katherine, et al. "Sickness presenteeism in healthcare workers during the coronavirus disease 2019 (COVID-19) pandemic: an observational cohort study." *Infection Control & Hospital Epidemiology* (2023): 1-4.

I would like to repeat the comments of Greta Fox:

There are many critical errors in HICPAC's proposed revised isolation precautions guidelines. These core concepts of disease spread and mitigation are not being acknowledged or given due consideration:
1. SARS-CoV-2 is airborne. It spreads by inhalation exposure to infectious aerosols at both close and long range. Not by droplets. Not by fomites. It can spread and linger in the air for hours, and can infect in an empty space previously occupied by an infectious person. Approximately half of infections originate from pre-, pauci-, or asymptomatic sources.
2. The equating of surgical masks with N95 respirators for both source control and personal protection is false and goes against abundant, robust data on the superiority of respirators, one-way masking is less effective than universal PPE use, and many patients are unable to effectively wear appropriate protection (eg babies, children, the disabled or unconscious, or those undergoing procedures where it is impossible).
3. Arbitrarily assigning tiers of precautions based on reported levels relies on constrained and therefore unreliable testing and reporting, and on lagging indicators such as hospitalizations. While levels of infections, hospitalizations, disabilities and deaths may vary and are undercounted, even at the reported levels they remain consistently significant and warrant ongoing mitigations.
Loosening protections when levels are relatively lower is irrational, as time has repeatedly demonstrated that continued spread consistently drives the evolution of new variants and repeated surges.
4. Transmission of airborne pathogens can be effectively mitigated by readily available measures which prevent the sharing of unfiltered air: consistent, proper respiratory protection, and appropriate indoor air quality controls including ventilation, HEPA filtration, and UV.

5. Vaccines, for which access & uptake in the US are poor, are a necessary but inadequate layer of protection. They temporarily reduce the probability of acute-phase severity, hospitalization & death but are inefficient at preventing infection, transmission & Long Covid.
6. Herd/community immunity is literally unattainable because both vaccine- and infection-derived immunity do not endure over time or against newer variants.
7. Long Covid affects at least 1:5 to 1:7 Americans and it is not linked to acute-phase severity. It is typically disabling and can be fatal, and it affects all ages, including children.
Repeated infections do not confer immunity; rather they damage the immune system and increase the risk of developing long Covid. Resources for testing, treatment, and support are lacking. Yet #longCovid has been completely omitted from consideration in HICPAC proceedings.
8. No pre-exposure prophylaxis or monoclonal antibody treatments are currently authorized, having been outpaced by evolving variants. Three antivirals are currently authorized:

Paxlovid, the price of which has just nearly tripled, Remdesevir, administered by IV and costing thousands, and molnupiravir, currently under suspicion of causing new variants and fueling viral evolution
9. PCR tests are expensive & difficult to obtain. Lucira is expected to return to market at an inflated cost. Rapid antigen tests have a high false negative rate, the U.S. has not updated specimen collection guidance
to include cheek and throat swabbing to improve accuracy, & serial testing to offset low accuracy is expensive.
10. Healthcare workers (HCWs) who are denied appropriate protections are at risk of contracting Covid and of spreading it to coworkers, patients, and visitors as well as to their households. Thousands of HCWs have died of Covid and thousands more have been disabled by long Covid.
11. A recent study found half of healthcare workers with symptomatic Covid-19 present to work in patient care. Surgical masks, when worn, are inadequate for source control.
12. Both the infectious and those vulnerable to infection congregate in healthcare settings. Many lack the ability to effectively protect themselves from exposure, yet they share waiting rooms, hallways, elevators, restrooms, treatment areas
and, with the end of testing on admission, hospital rooms. Risk of infections and their sequelae are causing many people to forego needed care, and when encounters are unavoidable, they are forcibly exposed.
13.Those injured & killed downstream in the chain of Covid transmission are invisible to their infectors, & the you-do-you approach to infection prevention is a public health failure.But HCWs, who should know better, can refuse to protect patients if they just don’t feel like it.
Protections should be strengthened, and proper PPE & optimal IAQ should be mandated in all health and dental care settings. By weakening protections, HICPAC is saying that it’s acceptable for HCWs to infect patients and each other because transmission is lower and less impactful,
in complete disregard of these facts. HICPAC asks for respectful comments: this asks us to “respectfully” beg HICPAC to do their job and protect us, and to “respectfully” beg HCWs not to infect, maim, and kill us.
It is long past time to pause the proceedings, reconstitute HICPAC in compliance with its charter and with the law, factor in all of the evidence, and generate guidelines which DO NO HARM.

Nina Pepe

Topic: infectious disease guidance
Name: Norah Mason

Cleveland, Ohio
concerned private citizen

I am a teacher. My main job is to protect my kids, and that's a lot harder to do these days with Covid running wild.

Healthcare professionals are supposed to protect their patients. It is insane that hospitals and healthcare facilities are not doing more to prevent infections.

We need:
Upgraded ventilation/air purification and monies for continuous monitoring and upgrades/replacement filters as needed.

Respirators (NOT baggy blues) for ALL medical facility staff (including cleaners, office staff, etc.) to be provided by the facilities for free to staff. We need high-quality masks (N95+) available to patients. Staff should be fit tested so that they find respirators that will better protect them and those around them. Patients should be offered respirators in different styles and sizes. I find duckbill respirators generally fit the widest variety of faces.

Hospital reporting of Covid, flu, and other communicable diseases must be shared with the general public in a way that is accessible and digestible by the public.

We can't go back and change the failures which have led to so many Long Covid cases/severe illnesses and death, but we can move forward and protect people from now on. Doing anything less is a failure of doing the most important job: protecting others.

Dear Members of the Healthcare Infection Control Practices Advisory Committee,

I'm Farheen Malik, a UX design lead at Google in NYC and a volunteer for People's CDC. I'm writing about the critical topic of the proposed revisions (https://www.healthwatchusa.org/HWUSA-Presentations-Community/PDF-Downloads/20230608-CDC-IP_Workgroup_HICPAC-FINAL.pdf) to the Isolation Precautions guidance.

Living with chronic illness and disability, my life is deeply linked to the healthcare system. The concern of increased illness due to COVID-19 infection from healthcare settings, affecting my ability to work, weighs heavily on my mind. Navigating appointments at different hospitals and clinics each week is a reality for me.

In this context, I want to express my heartfelt concerns about the proposed "flexible" approach to infection control. The experiences of the COVID-19 pandemic have shown that a flexible approach, driven by cost considerations, can lead to inadequate protection for both healthcare personnel and patients. Given my exposure to healthcare settings, I and others similar to me are frequently at risk, and uncertainty in infection control measures intensifies this risk. The very places that should offer healing become potential sources of danger due to the uncertainty surrounding infection control measures.

I urge HICPAC and the CDC to recognize the significant role of aerosol transmission in disease spread. Clear precautions are vital to protect patients, healthcare workers, and individuals like me. A protective approach should include exposure assessments, precise control measures like

Personal Protective Equipment (PPE)—including universal masking in healthcare with broad use of well-fitting N95 or better respirators—and written exposure control plans.

In conclusion, prioritizing a clear approach to protect vulnerable individuals and healthcare workers is paramount. Our health and lives, along with your public institution's integrity as one that is "saving lives, protecting people" [source (https://www.cdc.gov/about/)], depend on it.

Thank you for your attention.

Sincerely,
Farheen Malik (she/her)
Brooklyn, NY

My name is Jennifer Radomski and I am an immunocompromised patient with several chronic illnesses and I am afraid to see my doctors since there are no longer any protections for vulnerable people like me. HELP US.

Universal masking in healthcare should be just as ubiquitous as handwashing.

“Robust available data support the use of face masks in community settings to reduce transmission of SARS-CoV-2 and should inform future responses to epidemics and pandemics caused by respiratory viruses.”
Quoted from a recent meta-analysis of over 40 studies, published October 31st :
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811136

You are utterly failing at your duty and sentencing patients and practitioners to death if you move forward with your current draft. For the 8th straight week over 1000 US citizens have died from COVID.

Jennifer Radomski
Columbus, Ohio

My name is Lisa Foreman. I’m a nurse practitioner with over 20 years of clinical experience. I want to address the need to require respirators and other airborne pathogen mitigations in all healthcare settings. Everyone here today— all of you at CDC, HICPAC committee, and those giving public comments— we all know and have known for years that Covid and other respiratory pathogens are primarily airborne. We have seen the long-worshipped droplet theory disproven, and now even business magazines and mainstream media acknowledge that respiratory pathogens can spread like smoke, and that those aerosols can hang in the air for hours and travel much further than six feet in indoor spaces. We know that breathing and speaking are aerosol-generating procedures. Half of healthcare workers go to work with symptomatic Covid infections, and over half of Covid-19 infections are asymptomatic. This underscores the urgent need for source control with N95 or elastomeric respirators. Randomized controlled trials are appropriate for interventions such as pharmaceuticals, but they are the wrong metric and totally unneeded here. Respirators take advantage of principles of physics which were established decades ago. In addition, surgical masks are not appropriate personal protective equipment for prevention of airborne pathogen transmission. Engineers, aerosol scientists, and organizations like NIOSH should be allowed to lead in the development and implementation of proper personal protective equipment and air quality recommendations.

Many people have put off dental work, surgeries, and procedures for years now due to the absence of adequate airborne pathogen mitigations resulting in the inability to safely access care. I have heard many stories from those who went for these procedures only to leave infected. Someone said: "My biggest fear these days is that I will one day be unable to avoid a doctor or dentist." It is wholly unethical to ask them to assume a 10% mortality risk from a healthcare-acquired Covid infection. They depend on us to protect them, and we are morally obligated to do so. We should not be giving patients one disease while treating them for another. We can't ignore this because it's uncomfortable or expensive or a reminder that we're still in a pandemic. We all know what needs to be done here. Please give us overarching guidelines for standard precautions that address mode-congruent prevention of airborne respiratory pathogen transmission. Let's be the adults in the room and do it. Thank you.

Lisa Foreman, APRN-BC
Decatur, GA

I'm writing to say that I was alarmed by HICPAC's draft proposal to revise CDC guidance on infection control policies. We need a much higher standard than what the draft proposal offers, one that combines PPE including respiratory protection for aerosol transmissible diseases, clean air/ventilation, screening/testing/isolation as well as other measures that will keep facility staff and members of the public safe. As we know, the majority of covid transmission is asymptomatic, so these precautions must be universally practiced at all times to protect patients and staff as well as the general public.

I'm further alarmed by the fact that only five days were allowed for public comment and that the entire process seems directed towards an outcome directed by corporate profit margins and political expediency to declare the pandemic over rather than public health. This draft ignores input from aerosol transmission experts as well as frontline nurses and doctors and the general public.

We know from studies like the Lancet's in 2020 that a universal health care system would save an estimated 68,000 lives per year and $631 billion dollars per year. The system we have continues to grow costs at the expense of public health and this draft on infection control seems to do the same. We should reject that approach and save both money and lives with stronger protections for the public.

Daniel Mason
Whitman, MA
No organizational affiliation

To HICPAC:

I am submitting a written comment for the November 2-3, 2023 HICPAC meeting. The written comment is regarding the Isolation Precautions Guideline and is below.

Rone
Member of the public
California

Both CDC [1] and WHO [2] have stated that COVID can be transmitted via airborne route through inhalation of infectious aerosols. For other airborne infections, such as measles and TB,

CDC guidelines specify the use of respirators (N95, N99, N100, etc.) for airborne infection control [3][4]. For SARS, which is from the same family of Sarbecovirus that COVID is in, CDC guidelines also specify the use N95 respirator or better [5].

According to NIOSH, "surgical masks, sometimes referred to as facemasks, are different than respirators and are not designed nor approved to provide protection against airborne particles. Surgical masks are designed to provide barrier protection against droplets, however they are not regulated for particulate filtration efficiency and they do not form an adequate seal to the wearer's face to be relied upon for respiratory protection. Without an adequate seal, air and small particles leak around the edges of the respirator and into the wearer's breathing zone." [6]

Similarly, OSHA states that "facemasks do not seal tightly to the wearer's face, do not provide the wearer with a reliable level of protection from inhaling smaller airborne particles, and are not considered respiratory protection." [7]

It is clear from NIOSH and OSHA guidance that surgical/medical facemasks are not designed to seal tightly to the wearer's face and are not adequate when airborne infections, such as COVID, are present.

Furthermore, patients in hospitals and healthcare settings include immunocompromised patients, cancer patients, and other highly vulnerable patients. For example, the mortality rate of patients with nosocomial acquired COVID at a hospital was over 8%, significantly higher than the mortality rate in the general population [8]. In Australia, more than 600 patients have died after suffering from hospital-acquired COVID [9]. As seen from these examples, patients in healthcare settings can be highly vulnerable to nosocomial acquired COVID infections.

Patients who are in hospitals and healthcare settings should have reassurance that airborne infection control measures are deployed to prevent the spread of airborne infections, such as COVID. Subjecting patients to nosocomial infections due to inadequate airborne infection control measures is not consistent with the ethical principles in the American Medical Association Code of Ethics.
In addition, healthcare providers who expose patients to nosocomial infections due to inadequate airborne infection control measures may be held liable. As an example, a senior care facility and 3 managers were criminally charged in connection with 14 COVID-related deaths at the facility due to negligence [10]. As explained in [11], hospitals have a duty to take reasonable measures to protect patients, and failure to deploy appropriate infection control measures, including airborne infection control, can expose hospitals to liability.

1. https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html

2. https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

3. https://www.cdc.gov/measles/hcp/index.html

4. https://www.cdc.gov/tb/publications/factsheets/prevention/rphcs.htm

5. https://www.cdc.gov/niosh/npptl/topics/respirators/factsheets/respsars.html

6. https://blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/

7. https://www.osha.gov/sites/default/files/publications/OSHA3767.pdf

8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10056618/

9. https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html

10. https://www.foxla.com/news/senior-care-facility-charged-in-connection-with-14-covid-related-deaths

11. https://blog.petrieflom.law.harvard.edu/2023/02/20/hospital-liability-covid-infection/

To Whom It May Concern,

I am writing about the recent proposed guidelines for infection control, and I have great concern for their seeming inadequacy in addressing the issue at hand.

Given the nature of the COVID-19 virus being both highly transmissible via air and very often transmitted asymptomatically, it is insufficient to practice precautions only during periods of "higher levels of...transmission"; for the aforementioned reasons, these periods would be impossible to identify. The only way to implement these precautions in any way that will be effective is by implementing universal practice at all times.

It is also very common knowledge, and has been for a quite a long time, that infection control measures are by far most effective when implemented in a layered approach, with all precautions exercised in tandem, rather than selecting only a single precaution to practice.

Given these factors, and the nature of the people who frequent healthcare settings—sick, elderly, and disabled individuals—it is imperative that mask mandates be universally implemented at all times in healthcare settings, in order to minimize the risk that is posed to these populations. As a disabled individual myself, this is of particular concern to me.

Lastly, it is well-known that standard surgical masks are inadequate in protecting against airborne pathogens. Instead, the standard mask used in healthcare settings should be the N95 respirator, which has been proven to actually protect against such pathogens.

Thank you for your consideration,

Tempest Baum
Baltimore, MD
No organizational affiliation

Hello,

I write to urge HICPAC and the CDC to update the Isolation Precautions Guidance to reflect the airborne nature of, and extreme danger posed by Covid-19, to patients and health care workers alike. This guidance should provide specific mandatory precautions in healthcare settings which have been proven to reduce spread of airborne viruses; and include required N95 or better

respirators for all patients, providers, and staff in all medical facilities, adequate ventilation and air filtration systems in these same facilities, and options for remote, home visit, or outdoor patient/provider appointments whenever requested or possible.

My girlfriend has been diagnosed with Long Covid for nearly 4 years and is no longer able to care for herself. Getting to a medical facility is a serious challenge for her at the moment and can fatigue her for weeks, and lead to a permanent deterioration in her condition. When it is absolutely necessary for her to enter a medical facility, she faces the risk of another Covid infection due to facilities where no one is masked and there is inadequate ventilation, as well as limited options for remote or outdoor appointments. She has delayed and continues to delay necessary testing and treatment for years due to the fact these protections are not in place.

These are unacceptable and completely unnecessary risks no patient should have to face. Please update your guidance to protect the citizens of this country from the threat of Covid-19 and similar airbone pathogens.

Sincerely,

-Jordan Bunn

I am writing about the HICPAC draft of guidance for updating the CDC guidelines about COVID-19 precautions in healthcare settings. I'm writing because I care deeply about COVID safety in our communities. I have long COVID and it has been extremely difficult for me, my loved ones, and my workplace. Because of my long COVID, I have had to take an extended leave from work, don't know if or when I'll be able to return to work, and have had to rely on friends and family members for support with basic aspects of life. This disease has been devastating, and I don't want anyone else to have to experience it. I have multiple family members, now including myself, with chronic illnesses who need to spend a lot of time in healthcare facilities. If they are exposed to COVID while receiving care for their other conditions, they are at high risk of severe illness or death. So you can see why the need for these protections is deeply personal to me.

The guidelines need to fully acknowledge aerosol transmission of SARS-CoV-2. They must establish rigorous protocols for preventing transmission by air. The protocols need to account for the science that shows that a layered approach to reducing transmission risk is required. Each infection control measure is most effective when other infection control measures are also implemented.

Additionally, because a lot of transmission is asymptomatic, all precautions must be universally practiced at all times, not just by people with symptoms of covid-19. In healthcare settings, high risk people, disabled people like myself, and seniors mingle with infected patients, visitors, and staff. Thus, healthcare facilities and personnel should employ all precautionary strategies at all times.

We need universal masking with N-95 or better masks, regular testing of all healthcare personnel, paid leave and remote work options for workers who are sick, vaccine requirements for all staff to be up to date on all aerosol-transmitted infectious diseases, and free vaccines offered to all healthcare staff, patients, and visitors by hospitals and other healthcare facilities. Additionally, air quality is an essential piece of the protocols and facilities should implement the minimum indoor air quality standards that have been set by The American Society of Heating,

Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.

Letting COVID-19 infections run rampant will be more costly in the long run than providing N95s, fit testing, rapid molecular testing, ventilation, and isolation because widespread and repeated infections will continue to disable countless workers in healthcare as well as other fields. Millions of Americans such as myself already suffer from Long COVID.

Thank you for your consideration

Claire Petri
Philadelphia, PA

The revisions of HICPAC's infection control guidelines fail to adequately address the concerns of healthcare workers, public health experts, and patients. Many of these workers are on the front lines and already put their lives at risk every day. These weak guidelines will put further pressure on these workers, contributing to staffing shortages and reducing quality of care.

Simple changes can be made to the guidelines that would benefit workers and patients. First and foremost, universal masking is necessary to make healthcare accessible to everyone, and the masking standard for workers needs to be upgraded from surgicals to n95s, which are significantly more effective at reducing transmission of airborne pathogens (according to many studies that were omitted from the evidence review). People are avoiding necessary medical care because of the current lackadaisical guidelines; prioritizing the use of surgical masks over n95s, failing to rmaintain ventilation and air quality standards, and avoiding precautionary measures in general will only make that worse. The mortality rate of nosocomial COVID is already 10%. Without strong masking and ventilation guidelines, even more vulnerable patients will be affected by this. We should be aiming for less deaths, not more.

I urge HICPAC to look towards the recommendations of the People's CDC and National Nurses United to create a new draft that prioritizes the safety of workers and patients, making healthcare safer for everyone.

Claire O'Brocta
Baltimore, MD
(no organizational affiliation)

Dear HICPAC Contact,
Healthcare settings are where high risk, disabled, and seniors mingle with infected patients and staff. It is therefore crucial that healthcare facilities employ precautionary strategies at all times.
I am writing to urge you to fully recognize aerosol transmission of SARS-CoV-2 and establish rigorous protocols for preventing transmission by air and asymptomatic spread. It is critical that you make the process for updating the guidelines fully open and transparent.
I am also urging you to substantially involve healthcare unions, experts in ventilation and occupational safety and the public in drafting guidelines.

Thank you,
Cristina Jasen

Clinical Research Coordinator
Philadelphia, PA

Hello,

I'm a concerned member of the public and student of biology who prioritizes infection control and the honoring of public health practices to help prevent undue collective suffering. I am extremely disturbed and appalled by the proposed infection control guidelines changes. Your decisions and proposed changes are detrimental to the public on a massive scale. To ignore the science and outcry of healthcare professionals and qualified researchers about aerosolized transmission of COVID-19, and to continuously refuse to implement improved infection control guidelines for the public and in healthcare facilities, is negligent, frightening, and bizarre. I and other members of the public who have chronic conditions are being forced to put off important appointments and necessary medical/dental care due to the changes you've made to infection control policies that do not reflect quality and substantial evidence. A layered approach, including requiring QUALITY (KN95 or N95) masks in healthcare facilities (at least for the healthcare workers!) and improving indoor air quality, is the optimal way to proceed. To continue to casually "recommend" masks, or flat-out dismiss the clear evidence that quality masks are needed to protect the public from COVID-19, is responsible for cases of disability, death, and human suffering. These decisions are impeding vulnerable patients in a variety of forms from protecting their health and receiving timely diagnoses and treatment for an array of conditions. I have not been able to get necessary dental work, cariology workups, GI workups, labwork, treatment for a breathing issue, and other medical assistance due to healthcare workers following no COVID-19 prevention protocols. Family members have had to skip dental work. I have had to walk out of offices and skip minor procedures because healthcare workers would not mask, and I am currently in a fragile medical state and can't risk COVID-19. I know, even with my challenges, I am in a far better position than other vulnerable individuals, such as cancer patients, transplant recipients, and child with immune conditions. This is absolutely unacceptable to impose on the public--You exist to protect the public. Those of us who care about preventing and protecting ourselves and others from potential disability and death from COVID-19 have watched, baffled, as healthcare workers and the CDC have refused to protect and care for us. It is almost impossible now to find dental and medical offices that will wear KN95 or N95 masks--Most won't wear any masks at all, and some have an attitude if you even inquire. To dismiss the seriousness of this issue and push your changes through, changes based on data that has been debunked, is irresponsible, dangerous, callous and cruel. You and our healthcare workers who will not protect us are actively causing harm and increasing cases of disease with this negligence. It is your duty to put ego in the backseat, and let empathy and ethics drive--It is your duty to protect the public and scrutinize data with a fine-toothed comb, an open heart, and a strict adherence to protective measures. Otherwise, what will we do? Continue to put off care because we simply cannot access it safely, and medical facilities think they don't have to concern themselves? This is not the time for lax infection control--We are coming upon flu season and healthcare workers should protect us, first and foremost. No one should be at a high risk of catching COVID-19 in a heatlhcare setting. Masks are commonplace in Japanese healthcare--It only makes sense, after everything our population has been through the past several years, to protect patients as best we can, and ensure they are as safe as possible when seeking help from professionals. These decisions and guideline changes do not demonstrate the excellence, professionalism, empathy, or data we should be proud to expect of the U.S. healthcare system. I implore you, despite the difficulty that can come with it, to consider how it would feel to be a vulnerable person who cannot access care because of your changes, or to have difficulty finding care for your most valued loved one. Please consider listening to the science on aerosols and the necessity of masking, healthy indoor air, increased vaccination

access, and a layered approach to improved infection control. This is imperative in both our current circumstances, as well as the inevitable future healthcare crises/pandemics to come. The healthcare system has been on the verge of collapse several times due to COVID-19, with hospitals and urgent cares too full to effectively care for those in need. Please prevent unnecessary issues and harm in the population right away. I am incredibly grateful for your time and consideration; this is extremely important to me, my loved ones, and my community members. Please protect us.

Thank you,

Brittany Nicole Meyer
San Diego, CA
No organizational affiliation--I align with many of the perspectives of the People's CDC, immunologists, and epidemiologists specializing in infectious disease and respiratory health.

The covid-19 pandemic remains an ongoing problem that continues to harm the health and safety of healthcare workers and patients. While hospitalizations and death have gone down thanks to vaccinations, the vaccines have limited effectiveness against Long Covid. A recent study from the NIH's RECOVER initiative found that 10% of people in the study got Long Covid even after vaccination. Additionally, Covid vaccine efficacy wanes over time, and many people are not up-to-date on their vaccines, and are therefore at heightened risk, as are people with health conditions that either make them unable to get vaccines, that render vaccines ineffective, or that make them at higher risk from covid-19 even after vaccination. Vaccines also reduce but do not prevent covid-19 transmission.

Therefore, it is extremely important that HICPAC recognize in its guidance that covid-19 is still an ongoing threat to public health, and work to normalize other precautions in addition to vaccines to protect both patients and staff in healthcare settings. In particular, HICPAC should fully recognize aerosol transmission of covid-19, and require the use of the equivalent of N95 respirators in all healthcare settings (if not even greater levels of protection such as P100 elastomeric masks or PAPRs for healthcare staff). The science shows surgical masks are not adequate and respirators (which are designed to fit the face, not hang loosely) are much more effective. Because much of covid-19 transmission is asymptomatic, N95 respirators (or respirators offering equivalent protection) must be required for everyone in healthcare settings universally, regardless of whether they are showing symptoms or not. Particularly since people at high-risk from covid-19 infections such as immunocompromised or elderly people cannot avoid healthcare settings, so the precautionary principle should be applied at all times. Current draft guidelines maximize flexibility for healthcare employers, not protections for healthcare workers and patients, which means there is the strong risk of healthcare employers creating guidelines based on profit instead of infection control. Additionally, the science shows covid-19 protections work best when multiple infection control measures are layered on top of each other. Therefore, in addition to N95 respirators (or better), HICPAC should also promote fit testing for healthcare staff, regular covid-19 testing of healthcare staff (as well as testing for flu and RSV during the peak season), improved ventilation in healthcare settings according to at least the minimum ASHRAE standards to control infectious aerosols, and isolation of infected patients. Infected staff should be supported with paid leave or where appropriate remote work and required to stay home until symptoms improve and their tests are negative. Additionally, while vaccines are not adequate on their own to deal with covid-19 they are still a useful tool when combined with other precautions and should be provided free to all patients, staff, and visitors. Healthcare systems should require all in-person staff to be up-to-date with their vaccines for all aerosol-transmitted infectious diseases. These measures may seem like a higher cost, but will

eventually pay for themselves, as healthcare workers and patients eventually getting long covid after being infected with covid-19 over and over would be even more costly.

Sincerely,
Leora Matison
Patient and concerned member of the public

To the members of HICPAC,
I'm a Health Sciences student with a focus in Public Health. I'm also a medically vulnerable patient. I have experienced healthcare-acquired infection from workers wearing surgical masks instead of N95s, and I still cannot safely access healthcare since most medical providers do not use adequate infection control practices to address the ongoing airborne SARS-CoV-2 pandemic. This access barrier has only been worsened by public health leaders like the CDC progressively dismantling pandemic precautions. I outlined some of these experiences in my August public comment, but my testimony clearly had no impact on the Committee. When I started writing my public comment for your November meeting, I was originally going to beg you to delay the vote and consider our voices in the process, but since you didn't heed others who begged for the same thing and voted anyway, I had to change the direction of my statement accordingly.
HICPAC has deserted countless people by voting to move forward with guidance that is scientifically unsound to say the very least. It is obvious that those of us who rely the most on infection control practices are not supported by and do not support some of the updated recommendations, namely the failure to implement airborne-appropriate protective measures as standard practice during an airborne pandemic. There were over 600 pages of public comments decrying the draft document in August, yet this seems to have had no effect. Despite numerous experts censuring the unscientific grounds of your recommendations, and despite patients explaining how your decision endangers us—some of us literally pleading for our lives—you have chosen to ignore us all. You have closed your eyes and covered your ears to the cries for help from the people you have an obligation to protect. Your disregard undermines patients' rights to safe healthcare and healthcare workers' rights to safe work. It also violates several tenets of biomedical ethics; intentionally neglecting necessary safety measures is an injustice that benefits no one (except the capitalists who don't want to spend money to save disabled folks' lives,) does not uphold the mandate of non-maleficence, and robs us of our ability to consent. I should not be expected to consent to disability or death from a hazardous infectious disease in order to access healthcare, yet I am forcibly exposed every time I go to the hospital, since they don't use the infection control practices necessary to protect patients. Making life-or-death decisions based on data that you yourselves have admitted is suspect, then not deferring to experts who have told you that you're in the wrong, is a dishonor to science itself.
Since I can no longer implore you to change your votes, instead I'll emphasize the impact that your votes have on us: if CDC concurs with your recommendations and puts them into practice, the disabilities and deaths that result will be on your hands.
Much like David Wojnarowicz's quote, "IF I DIE OF AIDS—FORGET BURIAL—JUST DROP MY BODY ON THE STEPS OF THE FDA," you are running the risk of having patients say the same about you. "IF I DIE OF HEALTHCARE-ACQUIRED COVID—FORGET BURIAL—JUST DROP MY BODY ON THE STEPS OF THE CDC."
I'll reiterate what I said in my August public comment to see if it gets through this time: public health policy must involve the input of the public! Countless lives depend on you!
Sincerely, A. Jurman

Name: Joseph Quigley

Address: Kalamazoo MI
Organizational Affiliation: None
Topic: Regarding the inadequacy of proposed updated guidelines.

Regarding Protection
Universal masking is necessary to make healthcare settings safer for all, and more accessible to people especially at risk.

HICPAC's deceptively-named "Enhanced Barrier Precautions" scheme would radically weaken barrier precaution standards for nursing homes and potentially other health care settings, letting patients with Candida auris or MRSA interact with other vulnerable patients without restriction, and letting un-gowned staff work with infected patients and thus the staff could then spread dangerous pathogens widely.

Surgical masks are not adequate to protect against airborne pathogens, including SARS-CoV-2. N95 respirators or better should be the standard of care, and healthcare employers must not prohibit workers or patients from using them.

All healthcare personnel should be tested for COVID-19 regularly and for RSV and flu regularly during peak season.

Personnel who are infectious must be supported with paid leave, or where appropriate, remote work, and allowed to stay home until symptoms improve and testing is negative.
Facilities should implement minimum indoor air quality standards that have been set by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) to control infectious aerosols in all healthcare settings.
HICPAC's proposal would reduce use of an essential tool – negative pressure rooms – for MERS, SARS-1, and SARS-CoV-2, though all are very serious airborne infections.

Vaccines reduce BUT DO NOT STOP transmission of aerosol-transmitted infectious diseases. Hospitals and healthcare systems should provide free vaccination and boosters for staff, patients, and visitors.

Hospitals and healthcare systems should require staff to be up to date on vaccinations (based on ACIP schedules) for all aerosol-transmitted infectious diseases.

Regarding Updating Guidelines
As the nurses union is urging, CDC should reject HICPAC's draft and "actively engage the input of frontline health care workers, patients, and public health experts in developing a new draft" including holding public meetings (in a process similar to the meetings held in 1992 to help develop guidelines on control of multidrug-resistant TB).

HICPAC cannot develop appropriate guidance now, as it has no members expert in several crucial fields such as occupational health and safety, engineering for clean air, aerosol science, industrial hygiene, and respiratory protection. It needs such members.

HICPAC made a show of accepting public comment on 11/2-3, but only posted its preliminary draft online on the morning of 11/2. It must make any draft guidelines available for the public for much more extended review before submission to the CDC.

CDC and HICPAC should make the process for updating guidelines fully open and transparent.

Final guidelines should include an attachment that lists the public's comments, and why each one was or was not adopted, with references to scientific evidence.

Thank you,
Joseph Quigley