Joint Consensus Statement: Public Health Experts Urge CDC's Advisory Committee on Healthcare Infection Control Practices (HICPAC) to Follow the Science and Protect Health Care Workers and Patients

April 18, 2024[1]

In January 2024, CDC returned the *Draft 2024 Guideline to Prevent Transmission of Pathogens in Healthcare Settings* to HICPAC for further work on specific concerns in response to advocacy by public health experts and the public. In its communication to HICPAC, the CDC asked the committee to address core issues around the categories of transmission-based precautions, the use of respiratory protection vs masks, and source control recommendations (**see Background document for more details**).

Public health experts urge HICPAC and its Isolation Precautions Workgroup (IP Workgroup) to significantly strengthen its draft guidance updates in response to CDC's questions and to follow the science and protect health care workers and patients in the following ways:

1. **When Responding to Questions 1-4, HICPAC Should Recognize That Employers and Health Care Facilities Are Responsible for Planning and Implementing Infection Prevention Programs.**
   - Reorient the guidance to recognize that employers and health care facilities, not individual health care workers, hold the responsibility for infection prevention in health care facilities.
   - Recognize that an integrated program, which addresses engineering and work practice controls (e.g., ventilation and isolation of potentially infectious individuals) in addition to personal protective equipment (PPE) according to the hierarchy of controls, is necessary to prevent transmission of infectious diseases to health care workers and patients.

Figure 1: Questions posed to HICPAC by CDC.

1. Should there be a category of Transmission-based Precautions that includes masks (instead of NIOSH Approved® N95® [or higher-level] respirators) for pathogens that spread by the air? Should N95 respirators be recommended for all pathogens that spread by the air?

2. Can the workgroup clarify the criteria that would be used to determine which transmission by air category applies for a pathogen? For the category of Special Air Precautions, can you clarify if this category includes only new or emerging pathogens or if this category might also include other pathogens that are more established? Can you also clarify what constitutes a severe illness?

3. Is the current guideline language sufficient to allow for voluntary use of a NIOSH Approved N95 (or higher-level) respirator? Should the document include a recommendation about healthcare organizations allowing voluntary use?

4. Should there be a recommendation for use of source control in healthcare settings that is broader than current draft recommendations? Should source control be recommended at all times in healthcare facilities?

CDC Safe Healthcare Blog, January 23, 2024.

[1] This Joint Consensus Statement was prepared by a joint work group of the American Public Health Association-Occupational Health Section (APHA-OHS) and American Industrial Hygiene Association (AIHA). It was prepared and endorsed prior to the publication of the new WHO publication: *Global technical consultation report on proposed terminology for pathogens that transmit through the air.* Geneva: World Health Organization; 2024. License: CC BY-NC-SA 3.0 IGO.

- Include the importance of preparedness to ensure effective infection prevention programs. If policies, procedures, and resources are not assembled ahead of time, they will be unavailable when needed to protect health care workers and patients.

2. **When Responding to Questions 1-4, HICPAC Should Recognize the Scientific Research on Aerosol Transmission.**
   - Recognize that distance is only one of many factors that influence infectious disease transmission. Multiple factors, such as time, dose, phase of infection, size and viability of particles shed by infected individuals, environmental factors, etc., contribute to transmission.
   - Recognize that aerosols emitted by infected individuals can travel long distances and remain viable aloft in the air for long periods of time. Focusing only on short-range transmission means that many situations where health care workers and patients are exposed will be missed.
   - Recognize that prevention of aerosol transmission requires the use of multiple measures at the same time in order to minimize the travel of infectious aerosols through the air via engineering controls, work practice controls (e.g., ventilation and isolation of potentially infectious individuals), and PPE.
   - Engage the expertise of aerosol scientists, industrial hygienists, other experts, patients, and frontline health care workers and unions in the IP Workgroup.

3. **When Responding to Questions 1 and 2, HICPAC Should Establish More Robust, Explicit Criteria for Deciding Which Protective Measures are Used for Specific Pathogens.**
   - Create a science-based, explicit framework to determine which protective measures are used for different pathogens, including airborne infection isolation rooms (AIIRs), respiratory protection and other PPE, in addition to other measures.
   - Frameworks used to determine protective measures for different pathogens must include an exposure assessment to determine when, where, how, and at what level employees may be exposed.
   - Frameworks used to determine protective measures for different pathogens must also consider factors that can make an individual health care worker or a member of their household more vulnerable to infection, severe disease, or death such as immunocompromise status, treatments, or medications.
   - Frameworks used to assess the risks from exposure must consider the full range of impacts from infection, including the long-term impacts (like Long Covid and long-term impacts of influenza) in determining the level of protection that is needed. It is not appropriate to limit the assessment of risks and impacts to hospitalizations and deaths, or to assume that the availability of vaccines and treatments is sufficient to protect people from infection and serious outcomes.
   - Engage the expertise of ventilation engineers, industrial hygienists, biosafety experts, other experts, patients, and frontline health care workers and unions in the IP Workgroup.

4. **When Responding to Questions 1 and 3, HICPAC Should Strengthen Respiratory Protection Recommendations and Recognize That NIOSH-Approved Respiratory Protection, Not**

Surgical/Medical Masks, Must Be Used to Protect Health Care Workers from Aerosol Hazards.

- Based on scientific evidence, redo CDC's evidence review regarding the effectiveness of N95 respirators vs surgical/medical masks in protecting health care workers from respiratory illness in conjunction with subject matter experts from CDC's National Institute for Occupational Safety and Health (NIOSH). This evidence must take into account whether respirators were used effectively in the studies (by direct investigator observation), whether filtering facepiece respirators were initially fit-tested, whether users were part of a comprehensive respirator program, and whether respirators were redonned after use.
- Review and utilize the extensive evidence from laboratory studies and non-health care workplaces regarding the effectiveness of N95 filtering facepiece and other respirators to protect against inhalation exposure.
- Follow and clearly state OSHA's requirement that NIOSH-approved respirators be provided when employees are exposed to inhalation hazards, including infectious aerosols, when engineering and other controls do not sufficiently protect against the exposure. This necessitates changing HICPAC's proposed Routine Air Precautions category, which calls for surgical/medical masks rather than respirators and would leave health care workers unprotected, including those who are at higher risk for more serious outcomes due to underlying conditions, age, immune status, etc.
- Explicitly recognize that N95 filtering facepiece respirators offer the minimum level of respiratory protection against inhalation hazards and that other respirators, such as powered air-purifying and elastomeric respirators, offer higher levels of and more reliable protection, and do not experience the same supply chain challenges because they can be safely cleaned and reused without compromising their effectiveness. The guidelines should discuss and provide examples of higher-risk procedures and situations where higher levels of respiratory protection are warranted. The guidelines should not try to redefine surgical masks as acceptable inhalation protection.
- Include recommendations for use of engineering and work practice controls, such as ventilation and patient screening and isolation. When engineering and work practice controls are used effectively, fewer health care workers and patients are exposed, and the number of people who require respirators to prevent exposure is limited.
- Clearly recognize that NIOSH-approved respirators must be used within the context of an Occupational Safety and Health Administration (OSHA)-compliant comprehensive respiratory protection program, including ensuring sufficient supplies and fit testing. Such programs are critical to provide health care workers with a reliable level of respiratory protection and are the legal standard in occupational health for respiratory PPE used to control inhalation hazards.
- Ensure that all health care workers have the right to access and use appropriate respirators, even if the employer has determined that respirators are not required ("voluntary use"), and are included in the full respirator program, including fit testing.
- Engage the expertise of respiratory protection experts, industrial hygienists, other experts, patients, and frontline health care workers and unions in the IP Workgroup.

5. **When Responding to Question 4, HICPAC Should Strengthen Source Control Recommendations.**
    - Expand the definition of source control to include more measures that limit the release of infectious aerosols into shared airspace, including procedures to screen people entering the facility and ensure prompt isolation of potentially infectious persons, improving ventilation in both patient care and non-patient care areas (e.g., lobbies, waiting rooms, hallways, and elevators), and utilizing and expanding the use of AIIRs—in addition to wearing masks and observing cough/respiratory etiquette.
    - Place infectious patients with aerosol-transmissible diseases in AIIRs. If a healthcare facility has an insufficient number of AIIRs, or no AIIRs, to house infectious patients, and cannot transfer these patients to another healthcare facility, HICPAC should include specific recommendations for how facilities can expand or convert spaces to reduce aerosol transmission.
    - Expand the use of AIIRs, including ensuring that for novel and emerging pathogens always start with isolation in an AIIR plus respiratory protection for health care workers entering the room (i.e., emerging pathogens should be classified under Extended Air Precautions, not Special Air Precautions).
    - HICPAC's recommendations, instead of limiting the use of AIIRs, should include recommendations for health care facilities to create plans that can be implemented quickly to expand the number of spaces that can be used as AIIRs when needed (e.g., during an outbreak or surge in cases of respiratory infections).
    - Include recommendations to enhance and test the effectiveness of ventilation and filtration in all areas of the facility, including both patient care and non-patient care areas. CDC should incorporate expertise from ventilation experts in NIOSH and from the American Society for Heating and Air-Conditioning Engineers (ASHRAE).
    - Where cohorting is necessary due to a lack of available isolation facilities, address how cohorting can be effectively accomplished without increasing risk of exposure to health care workers or patients. HICPAC should include recommendations for enhancing protections for health care workers in areas where infectious patients are cohorted due to the higher exposure conditions.
    - Expand the use of masks for source control as a preventive measure, not just in response to high rates of transmission already occurring.
    - Engage the expertise of aerosol scientists, industrial hygienists, ventilation engineers, respiratory protection experts, patients, and frontline health care workers and unions in the IP Workgroup.

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ACI

AFGE

AFL-CIO

AIHA

American Association of Occupational Health Nurses

American Federation of Government Employees

American Federation of State, County and Municipal Employees, AFL-CIO

American Public Health Association

Arts, Crafts & Theater Safety

Association of Occupational and Environmental Clinics

Association of Occupational Health Professionals in Healthcare (AOHP)

BioAbundance

Boychild AIDS Foundation

Canadian Aerosol Transmission Coalition

Canadian Association of PPE Manufacturers (CAPPEM)

Canadian Covid Society

Care Not COVID Chicagoland

Caring Connections Co-op

Celebrate845

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ConnectiCOSH

Covid Action GSO

COVID Safe Campus

Covid Times Health Inclusion

Foundation for Integrative AIDS Research (FIAR)

Health Professionals and Allied Employees

Health Watch USA

Maine Democratic Socialists of America

Marked By Covid

MaskTogetherAmerica

National Nurses United

National Union of Healthcare Workers

New York State Nurses Association

Northeast NY Coalition for Occupational Safety and Health

Nurse Alliance of SEIU California

OPSEU/SEFPO

Pan End It!

Pandemic Equity Initiative

People's CDC

People's Response Network (PRN)

PHILAPOSH

Philly Covid Safe Meet-Ups

Prevention at Work, LLC

Protect our Province New Brunswick

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Stop Bullying Coalition

Summit Exposure and Risk Science LLC

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The Value Alliance

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Lydia Renton, BSc, CIH, ROH, FAIHA, VP, Director Occupational Hygiene & Safety, BluMetric Environmental Inc.

Kathleen Rest, Senior Fellow, Boston University Institute for Global Sustainability

Beth Rettenmund, Patient Advocate

Kevin Riley, Director, UCLA Labor Occupational Safety and Health Program

Dannie Ritchie, MD, MPH, Clinical Assistant Professor of Family Medicine, Alpert Medical School, Brown University

Margaret Robbins, MPH

Milly Rodriguez, MPH, Occupational Health and Safety Specialist, American Federation of Government Employees

Philippe Rola, MD

Jonathan Rosen, Industrial Hygiene Consultant, National Clearinghouse for Worker Safety & Health Training

Mitchel Rosen, Rutgers School of Public Health

Janet Rosenbaum, PhD, AM, Member, Editorial Board, American Journal of Public Health; Member, Editorial Board, Journal of Adolescent Health; Academic Editor, BMC Public Health; Academic Editor, PLOS One; Assistant Professor of Epidemiology, SUNY Downstate SPH

Jon Rosenberg, California Department of Public Health (Retired)

Beth Rosenberg, ScD, MPH, Assoc. Professor, Tufts Medical School, Dept. of Pub. Health and Com. Medicine

Ann Rosenthal, JD, Senior Advisor at OSHA, retired

Jean Ross, RN, President, National Nurses United

Carolyn Rowan

Rachel Rubin

Eileen Ryan, BSN, RN

Janine Ryan, MA

Margarita Salvatore

Deborah Santor, MSW, PA

Hannah Sarlat, Patient Advocate

Jennifer Sarriugarte, RN, MSN, CIC, Infection Prevention TB Nurse, Seattle King County Public Health

Anne Scheetz, MD, FACP

Hank Schiffers, MD, Schiffers Berater im Gesundheitswesen

Nicole Schiro

Judy Schultz, RN, MS

Charles Scott, Patient Advocate

Michael Sebold, Patient Advocate

Ashook Seedarsan

Rhea Sellitto, EMT

Peg Seminario, MS, Safety and Health Director (Retired), AFL-CIO

Serena Chen, CIH

James Sessford, PhD, RKin

Katya Shpilberg, MD, Patient advocate

Margaret Sietsema, PhD, CIH, Assistant professor, University of Illinois Chicago

Rita Silva Leu, Patient Advocate

Nancy Simcox, Associate Teaching Professor, University of Washington

Harold Simon, Patient Advocate

Ian Simpson

Kaitlin Skiba, Patient Advocate and Registered Nurse

Craig Slatin, ScD, MPH, Professor Emeritus, Dept. of Public Health, University of Massachusetts Lowell

Ellen Smith, Home Care Nurse

Marscleite Smith, Infection Preventionist - Prevea Health

Laura Smith

Earl Smith, MD, PhD

Simon Smith, PhD, ARCS, CChem FRSC(UK), Retired after a career in respirator filter development, currently chair of working groups for the International Organization for Standardization and the Canadian Standards Association for development of standards addressing the performance of respirators and their selection and use.

Elle So, Patient Advocate

Deborah Socolar, MPH, Patient Advocate

S. Solimene, Patient Advocate

Vera Soto, MPA

Amber Sousa, Clinical Neuropsychologist

Tamra Speakman (disabled- inactive LVN), Patient Advocate

Scott Squires, Squires Studios

Gregg Stave

Suzanne Steele, MD, Senior Medical Director

Laura Stock, Labor Occupational Health Program

Judy Stone, MD, Infectious Disease physician

Diana Striplin, Patient Advocate

Kaitlin Sundling, MD, PhD, Pathologist in Wisconsin

Sachin Sur

Patrice Sutton, MPH, UCSF Program on Reproductive Health and the Environment

Reema Sweidan, Patient Advocate

Joan Tang, Patient and Community Advocate

Allison Taylor, RN, Pediatric Registered Nurse

Allison Taylor, RN, BSN, Registered Nurse

John Techman, Patient Advocate

Raymond Tellier, MD, MSc, FRCPC, CSPQ, FCCM D(ABMM); Medical Microbiologist, Associate Professor, Dept of Medicine, McGill University Montreal Canada

Jean Theron Willoughby, Patient Advocate and Clinical Herbalist, Associate Member of American Herbalists Guild

Sophie Therrien, Conseillère hygiène du travail

Zoey Thill, MD, MPP, MPH

Andrea Thomas-Bachli, Director, Epidemiology

Jane Thomason, CIH, Lead Industrial Hygienist, National Nurses United

T Thomaston, RN and Patient Advocate

Dixie Thompson, Women's Health Nurse Practitioner (Retired)

Lily Tinkle, MD

K. Nic Tobin, MLS(ASCP)CM, Medical Laboratory Scientist, Michigan Medicine (University of Michigan Health System)

Desiree Torrez, Patient Advocate

Kaila Trawitzki, Patient Advocate

Jessica Tredinnick, MPH, CIH, CSP

Taran Trinnaman, Patient Advocate

Eugenia Tsao, PhD

Valerie Tung, OTR/L

Kathleen Turturice, Patient Advocate

Kelly Tuttle, Nurse Practitioner

Mark Ungrin, PhD, Associate Professor, Interdisciplinary Biomedical Researcher, Faculty of Veterinary Medicine, Department of Biomedical Engineering, University of Calgary

Alison Uhrbach, Patient Advocate

Christina Vaccari, NP

Rita Valenti, RN

Patrick Vaughan, MS, Biomedical engineering and Engineering Mechanics

Nicole Vazquez, Patient Advocate

Fern Viridian, Air Quality/Respiratory PPE Expert

Jaya Virmani, MD

Barbara Volz, Retired MPH

Colleen Wagar, Patient Advocate

Tavi Waits, Massage therapy student and community peer support specialist

Casey Walden, Patient Advocate

Teri Walker, PhD, RN-BC

Randy Walton, Patient Advocate

Andrew Wang, PhD, MPH, CPH

Maia Watkins, Patient Advocate

Eric Weber, University of Arizona

Terrie Weeks, RN, JD

Miriam Weil, Safety coordinator

Laura Welch, MD, Medical director (retired), Center for Construction Research and Training

Carolyn Wember, JD, Patient Advocate

Jane Westerby, Patient Advocate

Caleb Wetzel

Sandra Wicks, BSN, RN

Dorothy Wigmore, MS, MFA, Occupational health specialist

Sara Willette, Iowa COVID-19 Tracker

Auriel Willette, PhD, MS, Associate Professor of Neurology

Allan Williams, MPH, PhD

Oliver Wilson, COVID Safety Community Organizer, Massachusetts Coalition for Health Equity

Peter Woods, RN, APRN, FNP-C

Karen Worthington, MS, RN

Michael Wright, Retired Director of Health, Safety and Environment, United Steelworkers

Keith Wrightson, Assistant Director, Health Issues

Laura Wrzesinski, Licensed Marriage & Family Therapist/Patient Advocate

Catherine Yee, MD, Physician

Lydia Yeh, RN

Martha Young, JD, MBA, Patient Advocate

Cody Youshock, CIH, CSP, CHMM, AIHA

Donna Zankowski, MPH, RN, FAAOHN, Occupational Health and Safety Consultant

Emily Zionts, Patient Advocate

Dick Zoutman, Professor, School of Medicine, Queen's University, Kingston, Ontario

Betsy Zucker, MSN, Nurse Practitioner