**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

## August 22, 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
Erica Shenoy, MD, PhD
Sharon Wright, MD, MPH

***Ex Officio* Members**
Scott Cooper, Centers for Medicare & Medicaid Services (CMS)
David Henderson, MD, National Institutes of Health (NIH)
Tracy Ulderich, Food and Drug Administration (FDA)
Jimi Risse, RN, Indian Health Service (IHS)
Leyi Lin, MD, Agency for Healthcare Research and Quality (AHRQ)

**Liaison Representatives**
Nicole Anselme, PhD, MBA, MSM, American Nurses Association (ANA)
Hilary Babcock, MD, MPH, Society for Healthcare Epidemiology of America (SHEA)
Crystal Bowens, DHA, MSN, RN, LNHA, GERO-BC, PMP, American Health Care Association (AHCA)
Paul Conway, American Association of Kidney Patients (AAKP)
Karen DeKay, MSN, RN, CNOR, CIC, Association of periOperative Registered Nurses (AORN) Mary Alice Lavin, BSN, Association for Professionals in Infection Control and Epidemiology (APIC) Chris Lombardozzi, America's Essential Hospitals (AEH)
Lisa McGiffert, Patient Safety Action Network (PSAN)
Karen Ravin, MD, Pediatric Infectious Diseases Society (PIDS)
Mark Russi, MD, MPH, American College of Occupational and Environmental Medicine (ACOEM)
Robert Sawyer, MD, Surgical Site Infection Society (SIS)
Benjamin Schwartz, MD, National Association of County and City Health Officials (NACCHO) Valerie Vaughn, MD, MSc, Society of Hospital Medicine (SHM)
Tiffany Wiksten, BSN, APN, DNP, The Joint Commission (TJC)

**CDC Representatives**
Michael Bell, MD
Sydnee Byrd, MPA
Beth Golshir, MPH
Alexander J. Kallen, MD, MPH
Aaron Kofman, MD
David Kuhar, MD
Michele Neuburger, DDS, MPH
Laura Wells, MA

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

**Healthcare Infection Control Practices Advisory Committee (HICPAC)**

August 22, 2023
Atlanta, Georgia

**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 August 22, 2023.

# Tuesday, August 22, 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 August 22, 2023 HICPAC meeting at 12:00 PM Eastern Time (ET), welcomed everyone, and called the roll. Quorum was established for the purpose of continuing the meeting, but not for voting. 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.
- Dr. Kristina Bryant receives research support from Gilead and Pfizer.

Ms. Byrd indicated that public comment was scheduled following the presentations. 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 August 22, 2023 virtual HICPAC meeting. He reminded everyone that nominations for membership on HICPAC are being accepted and that suggestions for potential members should be submitted to hicpac@cdc.gov before September 29, 2023. He noted that HICPAC presentations would be posted to the website and sent to all registrants after the conclusion of the meeting. There are still some challenges with some of the packages for members, so Dr. Sharon Wright will serve as HICPAC's Interim Chair until the end of the year. Dr. Wright is the Chief Infection Prevention Officer for Beth Israel Lahey Health. She is an Associate Professor of Medicine at the Harvard Medical School and Faculty of the Division of Infectious Diseases at Beth Israel Deaconess Medical Center. Dr. Wright received her medical degree from the Columbia College of Physicians and Surgeons and her Master's Degree in Public Health from the Harvard School of Public Health. In addition to her many other accomplishments, she is Past President of the Board of Trustees for SHEA. Dr. Kallen expressed gratitude to Dr. Wright for assisting HICPAC through the rest of the year.

CDC has been receiving many questions about how the HICPAC guideline process works. To assist in answering this question, a timeline has been posted to the HICPAC website to provide a sense of how the HICPAC process works. Dr. Kallen took a few moments to provide a high-level description of that process, explaining that HICPAC guideline development is a long and complicated process—especially as it relates to the *Isolation Guidelines*. Basically, the process begins with a HICPAC Work Group (WG) that works to identify and resolve issues and adjudicate the more controversial points. The WG presents all of its findings to the full committee, which is the actual decision-making body that makes recommendations to CDC once the WG has completed its process. Once the full HICPAC votes to approve the recommendations, they are then forwarded to CDC where they are reviewed, adjusted as needed, and approved by CDC. Once that approval process is completed, CDC submits the recommendations to the *Federal Register* for public comment, which is a critical part of the process. Once public comments are received, they are provided to the WG for adjudication. The adjudicated comments are then presented to the full HICPAC for additional review and vote. Once approved by the full HICPAC, the recommendations are submitted again to CDC for final review and submission to the CDC clearance process. If cleared, the recommendations become CDC guidance.

## Division of Healthcare Quality Promotion (DHQP) Update

**Michael Bell, MD**
**HICPAC Designated Federal Officer**

Dr. Bell provided a brief DHQP update. He underscored the process clarification that Dr. Kallen presented, emphasizing that there has been some misunderstanding about where HICPAC is in the process and clarified that HICPAC has not received presentation of draft language that is ready for a vote in any way. When a WG has a draft ready, it is presented in a public meeting to the full HICPAC. Once reviewed and voted upon to be moved forward to CDC, CDC reviews the guideline and submits it to the *Federal Register* where it will be open for public comments for a 60-day period. Specifically in terms of the *Isolation Guideline*, the WG includes multiple experts across the spectrum of occupational health, infectious diseases, and so forth. Still, they want others who wish to do so to have an opportunity to provide input. He apologized that the brevity of the meeting was such that they would not be able to hear from everyone who wanted to comment but encouraged submission of written comments for inclusion in the proceedings.

As the end of the summer approaches, there are slowly increasing hospitalizations related to COVID-19. Additionally, the onset of the respiratory virus season raises concerns about respiratory syncytial virus (RSV) and influenza. DHQP is thinking through how best to capture information that will be helpful to CDC. The agency is working on a new Respiratory Virus Index (RVI) that will be refined over the coming weeks and should become available before the season begins. There also are discussions about how to maintain visibility on issues such as bed availability at the community-level, which has been very important for jurisdictions. Consideration also is being given to ways to monitor vaccine uptake in nursing homes and other health systems. The return of v-safe[sm] is anticipated, which originally was established to track COVID-19 vaccine safety. The original platform was donated, so it was taken down and a more permanent platform is being developed that should be up and running in the coming several weeks. Autumn planning is highly focused on respiratory viruses and making sure that the agency is well-positioned to understand what is occurring.

## Isolation Precautions Guideline Workgroup (WG) Update

**Michael Lin, MD, MPH**
**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 a brief recap of the June 2023 Isolation Precautions Guideline WG's presentation, a review of the updated timeline, and the topics of Enhanced Barrier Precautions (EBP) and Standard Precautions.

Beginning with the recap of the June 2023 session, Dr. Lin reminded everyone that on the first day, the WG presented its recommendations for the guideline framework for the following sections:

- ❑ **Section A:** Overview of Transmission of Pathogens in Healthcare Settings
- ❑ **Section B:** Fundamental Elements Needed to Prevent Transmission of Pathogens in Healthcare Settings
- ❑ **Section C:** Precautions to Prevent Transmission of Pathogens in Healthcare Settings, with Evidence Review
    - Proposed transmission-based precautions framework for (1) Transmission by Air; (2) Transmission by Touch, healthcare facilities other than skilled nursing facilities (SNFs); and (3) Transmission by Touch, SNFs

The second day of the meeting included a discussion of the criteria considerations for Enhanced Barrier Precautions.

The timeline for guideline development and HICPAC discussion and vote was updated to provide an opportunity to review feedback and address unresolved issues. The WG expressed gratitude to HICPAC members and liaison members and the general public for feedback provided during the June 2023 HICPAC meeting, as well as to the CDC HICPAC Long-Term Care Post-Acute Care WG and additional CDC's National Institute for Occupational Safety and Health (NIOSH) subject matter experts (SMEs) for their feedback to the WG. The updated timeline included this virtual meeting during which EBP and Standard Precautions would be

further discussed. In addition, the HICPAC in-person meeting to be convened on November 2-3, 2023 is the tentative target for HICPAC's review of the draft guideline and a vote. If approved, the committee's recommendations would be sent to CDC for review prior to the public comment period.

**Enhanced Barrier Precautions (EBP)**

In the June 2023 HICPAC meeting, the WG presented a draft framework for EBP implementation in SNFs for discussion as noted earlier. The purpose of this session was to present updated language for the EBP criteria. In terms of background, EBP refers to the use of gowns and gloves by healthcare personnel (HCP) in SNFs during high-contact resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing. Examples of high contact activities include dressing, bathing or showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. It takes into account the special circumstances of care in a nursing home (e.g., home-like environment) and barriers to implementing Contact Precautions, such as restriction to the resident's room.[1]

In 2019, CDC introduced EBP as a personal protective equipment (PPE) approach to apply to residents with infection or colonization with novel or targeted MDROs when Contact Precautions do not otherwise apply. In 2021, a HICPAC White Paper[2] added consideration of applying EBP to residents with "Wounds or indwelling medical devices, regardless of MDRO colonization status."

Supportive evidence for EBP includes several studies that demonstrated that high-contact activities were associated with gown or glove contamination of HCP.[3] Furthermore, a pilot study with a 2-month baseline and 2-month intervention design of targeted gown and glove use for residents with wounds and devices in 2 nursing homes demonstrated a significant decrease of *Staphylococcus aureus* (*S. aureus*) acquisition among residents from about 16.8% to 6.7%.[4]

Shown here is a draft framework for transmission-based precautions to prevent transmission by touch for SNFs:

[1] https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html; https://www.cdc.gov/hai/containment/faqs.html

[2] "Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities" June 2021. https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html

[3] Roghmann MC, et al. "Transmission of methicillin-resistant Staphylococcus aureus (MRSA) to healthcare worker gowns and gloves during care of nursing home; residents." Infect Control & Hosp Epidemiol 36.9 (2015): 1050-1057; Pineles, L., D. J. Morgan, and A. Lydecker. "Transmission of MRSA to healthcare worker gowns and gloves during care of nursing home residents in VA community living centers." Am J Infect Control 45 (2017): 947-953; Blanco, Natalia, et al. "Transmission of resistant gram-negative bacteria to health care worker gowns and gloves during care of nursing home residents in Veterans Affairs community living centers." Antimicrob Agents Chemother 61.10 (2017): 10-1128; and Blanco, Natalia, et al. "Transmission of resistant Gram-negative bacteria to healthcare personnel gowns and gloves during care of residents in community-based nursing facilities." Infect Control & Hosp Epidemiol 39.12 (2018): 1425-1430

[4] Lydecker, Alison D., et al. "Targeted gown and glove use to prevent Staphylococcus aureus acquisition in community-based nursing homes: A pilot study." Infect Control & Hosp Epidemiol 42.4 (2021): 448-454

**DRAFT: Use of Transmission-Based Precautions to Prevent Transmission by Touch for Skilled Nursing Facilities**

| Label | PPE | Situation | Dedicated Medical Equipment | Single Occupancy | Example Applications |
|---|---|---|---|---|---|
| **Contact Precautions** | Gown/Glove for all activities | Any entry into designated patient space | Yes | Preferred; if not available, then cohort | Organisms specified in Appendix A<br><br>During MDRO outbreaks (time-limited) |
| **Enhanced Barrier Precautions** | Gown/glove during high contact patient care activities | When Contact Precautions do not otherwise apply):<br><br>Indicated for<br>• Residents with infection or colonization with an MDRO<br><br>Consider for<br>• 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 | MDROs targeted by CDC |

Standard Precautions applies to all situations regardless of Transmission-Based Precautions used

There are 2 categories of precautions presented in the rows "Contact Precautions" and "Enhanced Barrier Precautions." The yellow highlights identify specific wording for discussion. Contact Precautions in SNFs would involve gown and glove for all activities for any entry into a designated patient's space, dedicated medical equipment would be required, single occupancy would be preferred and if not available, then cohort. Example applications would be organisms specified in Appendix A, such as norovirus*, Clostridioides difficile*, and scabies. Contact Precautions also would be indicated during MDRO outbreaks in a time-limited fashion.

EBP involve gown and glove use during high-contact patient care activities. When Contact Precautions do not otherwise apply, EBP would be indicated for residents with infection or colonization with an MDRO. EBP would be considered for residents at high risk for MDRO colonization, regardless of known MDRO status (e.g., residents with wounds or indwelling medical devices). Dedicated medical equipment would not be required, cleaning and disinfecting equipment between residents would be in accordance with Standard Precautions. Single occupancy would not be required. Example applications include MDROs targeted by CDC, such as carbapenem-resistant Enterobacterales (CRE).

One note is that the EBP framework here will make the first indication for residents with infection or colonization with an MDRO a definitive recommendation based on the recognition that this approach would be residents-centered, particularly with the allowance for residents to leave their rooms. It would make the second indication of residents at high risk for MDRO colonization a consideration rather than a definitive recommendation, reflecting the promising but limited evidence and experience with such a risk-based approach.

In conclusion, Dr. Lin posed the following topics for HICPAC discussion:

- ❑ **Topic 1:** Feedback on Enhanced Barrier Precautions indications

- ❑ **Topic 2:** For Contact Precautions in healthcare facilities (both SNF and non-SNF) and feedback on use of the term "designated patient space"
  - Most commonly, "designated patient space" would represent a patient/resident's room, but would allow application to a broader range of patient care areas in healthcare facilities (e.g., post-procedure recovery area, infusion center)

**Discussion Points**

*For this discussion, HICPAC members, ex officios, and liaison representatives raised the following questions, observations, and suggestions/recommendations:*

In response to a HICPAC request for clarity about the first indication regarding residents with infection or colonization and single occupancy and whether that meant discordant MDROs could be cohorted under the EBP definition, Dr. Lin responded that in ideal situations, facilities would have a lot of leeway in terms of separating MDROs based on like types. Because EBP is more of a long-term approach, there will be more flexibility in residents having a mix of different types of MDROs within the same room. As written, there is some flexibility. The WG can look at that question in more detail in terms of whether there should be further specification. Even CRE often times may have a phenotypic or resistance definition though the mechanism that is epidemiologically important may not be known. There are challenges to cohorting over the long-term that may be limited by the ability of laboratories to identify mechanisms. There is an intent with EBP that using gown and glove for high-contact activities would reduce spread.

Related to the designated care space, HICPAC asked whether there was consideration for not just entry, like crossing the threshold of some designated space, but focusing on gown and glove use for contact with the patient or the patient's environment. There are many instances in which one might enter a patient care space but not actually touch the patient or touch the patient's environment. This could reduce the use of gowns and gloves for those activities. Dr. Lin clarified that the intent of Contact Precautions is to use gown and gloves when there is contact with the patient or the environment. Facilities have operationalized that in different ways. Some recommend or mandate that as soon as someone crosses the threshold, even if not intending to touch the patient or the environment, that gown and gloves should be utilized. Use of the term "designated patient space" could allow for some flexibility in designating a safe zone, which some hospitals have used with the intent of using Contact Precautions to prevent touching the patient or environment by the HCP.

Regarding applied EBP outside of SNF, HICPAC suggested consideration for other congregate care settings with similar sorts of activities and set-ups, such as behavioral health or other facilities, where there may be benefit from this approach.

Dr. Bell emphasized that even in SNFs, if Contact Isolation is required (e.g., during a CRE outbreak), Contact Precautions are expected to be used. The EBP approach is not a replacement for Contact Precautions, but instead is a way of driving better implementation of what should be under Standard Precautions. If someone's clothing or hands could be soiled while performing a procedure, that individual would appropriately use gowns and gloves as indicated for that procedure. In this instance, the intent is that if a resident is likely to be colonized, the HCP should not be making that decision on their own. They simply should wear gown and gloves when handling a device or wound during close contact care. It is an aggressive version of Standard Precautions as opposed to Contact Isolation where everything is sealed into one space. That is an important point for people to be thinking about, because it is the opposite of some of the information that has been circulating that misses the point.

A liaison representative, speaking on their own behalf, appreciated the difference HICPAC is trying to make with this designation. However, the challenge is operationalizing it. For instance, it is not clear what to tell the environmental services (EVS) worker in the context of a long-term care facility in terms of trying to standardize the distinction of whether the worker needs to wear a gown in order to clean and be in contact with the environment. EVS workers are not providing

direct patient care or changing a dressing on a wound, but they are cleaning the room. What will the EVS worker be told if they are cleaning the room of a *Candida auris* (*C. auris*) patient on EBP in terms of whether they need to wear PPE, what types of disinfectant to use, et cetera? There are others besides nurses and physicians who will be taking care of patients (e.g., respiratory therapists, EVS workers, nutrition, et cetera). In addition, these individuals are going room-to-room delivering care as well. In addition, some patients will be going to common areas (e.g., rehabilitation, nutrition rooms, dining halls, et cetera). During Contact Precautions, these patients are told that they may not go to common areas. However, they would be allowed to do so under EBP. This is sending mixed messages and resulting in push back from nursing homes and in-patient rehabilitation facilities. It is important for the wording to be at a third-grade level so that it is understandable by all staff. When these patients are discharged, they might not do any of these things and then show up in the clinics with no barrier precautions just like any other patient.

Dr. Bell acknowledged that it is probably important to review the wording again. There are some details in the language that address some of these concerns. First and foremost, if any staff member is going to do a wound dressing change, handle a catheter bag, or handle a patient dress or do toileting, they too would have to use PPE because EBP is about the activity. EBP is like Standard Precautions in that if someone is going to touch something, they wear gloves. If someone is just going into the room and not touching the patient, they should not have to wear anything. That is the context for the first part of the concern. The second is that someone with *C. auris* during an outbreak would be in Contact Isolation. Then they would not be going to the cafeteria. If somebody has a wound that is dressed but needs to be maintained and cared for, the person handling that wound needs to wear gown and gloves, but the person does not need to be locked in their room when the wound is dressed and managed appropriately. This is a way for someone with a wound to be able to have a normal quality of life in their residence, which happens to be a nursing home, but at the same time ensure that anyone handling that wound or its dressing uses appropriate PPE to keep from contaminating themselves or carrying organisms to another person.

Dr. Lin added that many of the operationalization questions are on the CDC FAQ website for EBP, which have been implemented for several years.

HICPAC noted that it is one thing to think about operationalizing from the worker's perspective, but thought also must be given to the employer's perspective (e.g., hospital owners, nursing home owners). Those are the people who are going to provide the support to implement these guidelines. The language must be clear and imperative so that they fully understand what is required. While CDC does not have the authority to "require" certain things, they do have the standing to say, "This is what everyone should be doing in order to maintain safety for your workers and your patients."

APIC expressed gratitude for the separation of "indicated" criteria and "consider" criteria. As this was implemented in many Illinois facilities, that seems to be where people become stuck. Stating clearly that it is indicated for someone who has infection or colonization, but considering it for others who are at high-risk for acquisition will be helpful for facilities when they implement. It will be extremely important for facilities to completely train their staff before they implement. Some of the nuances that have been discussed need to be built into that training in order to make sure that everyone understands what the expectations are.

**Standard Precautions**

Dr Wright indicated that the goal of this presentation was to discuss whether aspects of Standard Precautions should be updated for the 2024 guideline. To review a few key concepts, Standard Precautions are the basic practices that apply to all patient care regardless of the patient's suspected or confirmed infectious state and apply to all settings where care is delivered. Standard Precautions have multi-directional benefits. They protect HCP from acquiring infection from patients and prevent HCP or the healthcare environment from transmitting pathogens to patients.

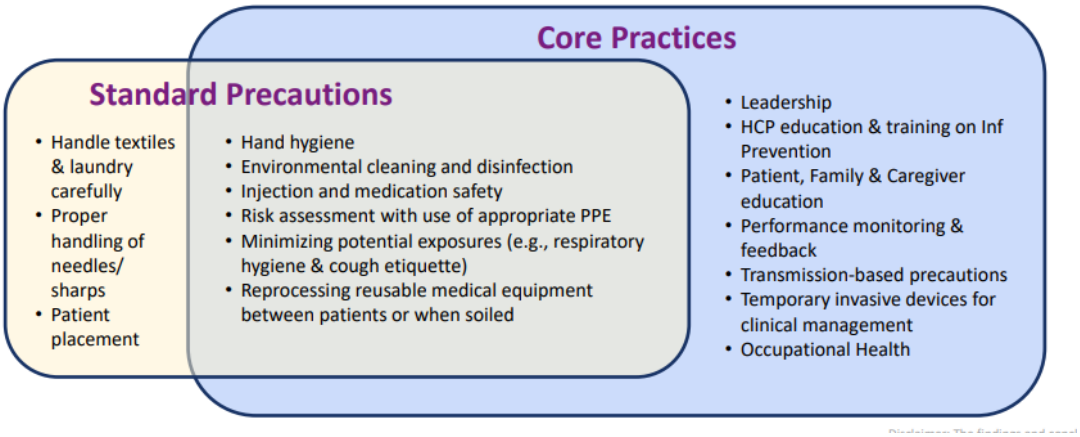
In terms of the evolution of Standard Precautions, the term "Standard Precautions" and its contents have changed over time. Given that, the WG wanted to briefly review that as they consider whether any changes are necessary. Although isolation techniques for use in hospitals have existed since 1970, the concept of Standard Precautions really began in earnest in the *1983 CDC Guideline for Isolation Precautions in Hospitals*. This document provided 2 systems for isolation, which were not that different from what is done now (e.g., category-specific and disease-specific). It was in this document that the blood precautions, which were first introduced in the 1970s, were expanded to include body fluids. The isolation category that was created was named "Blood and Body Fluid Precautions." This also emphasized decision-making by the user as to what was needed, similar to Standard Precautions today. From 1985 to 1988, the term "Universal Precautions" was used. That was developed in response to the HIV/AIDS epidemic and importantly dictated the application of blood and body fluid precautions to all patients regardless of their infection status. However, it did not apply to certain body fluids such as feces, nasal secretions, sputum, or urine unless they were contaminated by visible blood. PPE was added to protect HCP from mucous membrane exposures, as well as specific recommendations for handling needles and other sharp devices. In 1987, an additional concept was added of "Body Substance Isolation," which emphasized avoiding contact with all moist and potentially infectious body substances, except for sweat—even if blood was not present. This shared some features with Universal Precautions, but not all. It also was somewhat weak on transmission by large droplets or by contact with dry surfaces.

In 1996, the *Guideline for Isolation Precautions in Hospitals* was prepared by HICPAC. In addition to the Transmission Precaution categories, it melded the major features of Universal Precautions and Body Substance Isolation into Standard Precautions to be used with all patients at all times. That was the first time the term was used. In 2007, the guideline that the WG is updating now continued the use of the "Standard Precautions" category with a few updates to include additional components, such as "Handling of Textiles" and "Laundry and Environmental Disinfection." In 2017, HICPAC published a White Paper called "Core Infection Prevention Practices for Safe Healthcare Delivery", which selected from all healthcare infection control guidelines those that were intended to serve as a standard reference or a standard of care that was anticipated not likely to be updated or changed based on additional evidence coming forward. This was an attempt to outline a core set of infection prevention and control practices that are required in all healthcare settings regardless of the type of care provided.

In 2022, as presented during the November 2022 HICPAC meeting, Core Practices moved from this HICPAC recommendation to CDC guidance and a web page was created. It was intended to become the main reference for Standard Precautions and had links to a web page on Standard Precautions for more details. However, that [web page] was last updated in 2016. There were no intended changes in Standard Precautions with the 2022 Core Practices guidance update, but it seems to have a focus on application by frontline staff. For example,

there is less emphasis on textiles and laundry and inclusion of new areas based on lessons learned from COVID-19 and other outbreaks, such as broadening the minimizing potential exposure section to include early detection and management, considering universal masking during periods of high respiratory virus transmission, and explicitly stating information about prepping medications in clean areas (e.g., not adjacent to potential sources of contamination like sinks).

It is important to note that not all components of Standard Precautions are emphasized in the Core Practices Guideline, which is illustrated by this graphic:




There is not a complete overlap between the Standard Precautions website and the Core Practices Guidelines. There is much more on the right of the Core Practices rectangle that are not a part of Standard Precautions. Very important for infection prevention and control, the Standard Precautions have almost complete overlap with Core Practices. As mentioned earlier, there are 3 areas that are not in as much detail or in Core Practices (e.g., handling textiles and laundry carefully, proper handling of needles and sharps, and patient placement). All of the Standard Precautions elements are contained in the current 2007 Isolation Guideline. The intent of this discussion is to ensure that all of these pieces have homes if they are still thought to be important. This table has more details about what is in the 2007 Isolation Guideline:

| Component | Description |
|---|---|
| **Hand Hygiene** | Emphasized in Core Practices and in 2002 Hand Hygiene guidance |
| **Personal Protective Equipment (PPE)** | Risk assessment with use of appropriate PPE (e.g., gloves, gowns, face masks) based on activities being performed |
| **Patient Care Equipment** | Reprocessing of reusable medical equipment between each patient or when soiled |
| **Care of the Environment** | Environmental cleaning and disinfection |
| **Textiles and Laundry** | Referenced in Environmental Infection Control Guideline |
| **Needles and Other Sharps** | Proper handling of needles and other sharps (e.g., avoid recapping) |
| **Patient Placement** | Patient Placement |
| **Respiratory Hygiene/ Cough Etiquette** | Minimizing Potential Exposures (e.g., respiratory hygiene and cough etiquette) |
| **Safe Injection Practices** | Single-use, disposable needle per injection. Use of single-dose vials preferred. |
| **Use of Masks for Insertion of Catheters or Lumbar Injection Procedures** | Now combined with Safe Injection Practices |

Reiterating that the goal is to have a draft Precautions document to present to HICPAC for

review, discussion, and a vote during the November 2023 meeting, Dr. Wright posed the following topics for discussion and shared a table showing a crosswalk for Standard Precaution components:

- Three components were added to Standard Precautions in the 2007 Isolation Guideline:
  - Are there components that should be added or removed from Standard Precautions?
  - Are there other modifications to Standard Precautions, including the name, that should be considered?

| 2007 Isolation Precautions Guideline | CDC Core Practices Standard Precautions | Additional Notes for 2024/Links |
|---|---|---|
| **Hand Hygiene** | Hand Hygiene | Guidelines for Hand Hygiene (2002) |
| **Personal Protective Equipment (PPE)** | Risk assessment with use of appropriate PPE (e.g., gloves, gowns, face masks) based on activities being performed | Detail in Core Practices may be sufficient |
| **Patient-care Equipment** | Reprocessing of reusable medical equipment between each patient or when soiled | CDC Guideline for Disinfection and Sterilization in Healthcare Facilities |
| **Care of the Environment** | Environmental cleaning and disinfection | CDC Guidelines for Environmental Infection Control in Health-Care Facilities<br>CDC Guideline for Disinfection and Sterilization in Healthcare Facilities |
| **Textiles and Laundry** | not included. | Link to Environmental Infection Control Guideline |
| **Needles and other sharps** | not included. | In Core Practices, Occupational Health section |
| **Patient Placement** | not included. | Potential expansion of proposed 2024 guideline and pathogen-specific sections (Part 2/Appendix A) |
| **Respiratory Hygiene / Cough Etiquette** | Minimizing Potential Exposures (e.g., respiratory hygiene and cough etiquette) | Detail in Core Practices may be sufficient |
| **Safe Injection Practices (e.g., single-use, disposable needle per injection; use of single-dose vials preferred)** | Injection and medication safety | Detail in Core Practices may be sufficient |
| **Use of masks for insertion of catheters or lumbar injection procedures** | Injection and medication safety | Detail in Core Practices may be sufficient |

## Discussion Points

*For this discussion, HICPAC members, ex officios, and liaison representatives raised the following questions, observations, and suggestions/recommendations:*

- A HICPAC member commented that it is important not to lose information on textiles and laundry.

- A HICPAC member commented that patient placement is specific generally to pathogens, so it makes sense for it not to be considered part of Standard Precautions because it is covered elsewhere.

- A HICPAC member asked for clarification on the needles and sharps discussion and stated that sometimes needles and other sharps are bucketed with safe injection, but there are different concepts there. Partly it is protection of the HCP and there also is protection of the patient. It was not clear whether the recommendation was to think of needles and other sharps separate from safe injection practices or to collapse them and cover occupational health and the patient safety components.

  - Dr. Wright responded that the WG had not settled on anything particular. They were thinking that there is an Occupational Health section in Core Practices where this could be incorporated. The intention may be there, but perhaps it is just not highlighted, so the WG agrees that potentially that section could be enhanced so that the information would not be lost, at least in that level of detail.

- A liaison representative made a comment about separating sharps safety and injection safety and said that many facilities perceive this (sharp safety) as an occupational risk and do not have a concept of safe injection practices for the patient or resident. The member supported having them in 2 separate categories. Needles and sharps should be included under the Occupational Health section of Core Practices to make it clear that there is a component that relates to occupational health, but there is a separate component that many facilities don't necessarily recognize about the safe injection practices that protect the patient or resident.

- Dr. Wright clarified that safe injection practices are in Core Practices already. It is the piece about the sharps handling that is not highlighted at the same level of detail. It was not intended to be lost. It is just in more detail in the current 2007 guideline.

- A HICPAC and WG member commented that the problem with the term "Standard Precautions" could be addressed by more education and training of the healthcare workforce. Since the WG is taking the time to review the contents and revise some verbiage within the 2007 guideline, they also should take the opportunity to consider or at least address renaming this term. Standard Precautions is the critical cornerstone of preventing HAIs. The term "Standard Precautions" is potentially too complex or too vague for all levels of HCP to immediately understand what is being conveyed. Perhaps there is a better term that captures the main objectives of Standard Precautions and would be more immediately understood by all HCP. An example would be "Every Patient Precautions (EPP)." The member stated that the WG would like to hear additional suggestions.

  - Dr. Bell reminded everyone that Canada uses the term "Routine Practices." There always is benefit in harmonizing across borders. If truly leaning toward fresh nomenclature, that might be an option. Other ways of garnering additional attention and focus on these constant requirements for safety would be welcomed. He did not think CDC had a preference and that this is where robust conversation would be particularly helpful in terms of sharing additional options or ways of making the existing terminology more effective.

  - A HICPAC and WG member supported keeping the term "Standard Precautions" because it has been used and taught for many years in the classroom and real-world settings. These are basic standards of care that should be done for all patients to keep the employee and patient safe from pretty much everything except droplet or airborne pathogens. It has been more successful in some facilities compared to others. Smaller facilities do support and have time for in-person education, staff meetings, et cetera. Focusing on standard of care, using it for everybody, and disseminating good education tools that can be used by Infection Preventionists (IPs) in the field would be a good approach. Even if the name is changed, it still has to be taught. It would be difficult to explain to those who already have learned it why, if the content is not being changed, the name is being changed. This is likely to be confusing to people.

  - A HICPAC and WG member commented that there has been some confusion with the term "Standard Precautions" with regard to "precautions" because there also are "Transmission-Based Precautions."

- The HICPAC and WG member commented that the “precautions” part is critical because things could change while someone is in the room that results in them needing to have gown and gloves readily available.

- A liaison representative commented that looking at the 3 categories that are on the sideline that do not overlap with Core Practices highlights that those actually belong under the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. For a long time, the implementation of Standard Precautions often was highlighted as meeting the essence of the OSHA Bloodborne Pathogen Standard. Perhaps there is a place to include linens and sharps safety because it appears that those are all part of Universal Precautions for OSHA Bloodborne Pathogens, which was the progression of how Standard Precautions was developed initially.

## Healthcare Personnel Guideline Workgroup Update

**Colleen Kraft, MD**
**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 Healthcare Personnel Guideline Workgroup’s (HCP WG’s) charge was to focus on pathogen-specific issues for Infection Control in Healthcare Personnel. 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.[5] The WG is now working its way through the pathogen sections 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.[6]

Regarding the current status report, Measles, Mumps, Rubella, and Varicella completed clearance and are posted to the *Federal Register*. The deadline to submit public comments is September 15, 2023. The Pregnant HCP section completed the 60-day public comment section and received one comment from APIC in support of the guidance. Cytomegalovirus (CMV) and Parvovirus B19 are in clearance, and the Conjunctivitis section will go into clearance very soon. *S. aureus* is on hold pending a literature review. “On Deck” are Scabies/Pediculosis, Hepatitis A, Bloodborne Pathogens (Hepatitis B, Hepatitis C, HIV), Herpes, Tuberculosis (TB), and Viral Respiratory Infections.

The public comment for pregnant HCP reads as follows:

> “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

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

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 the draft guideline for pregnant HCP, which reads:

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)

While the intent was for HICPAC to vote on this recommendation during this meeting, this vote was tabled given that there was not a voting quorum.

**Discussion Points**

No comments or questions.

## US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus (HIV) and Recommendations for Post-Exposure Prophylaxis (PEP): Draft Update

**Aaron Kofman, MD**
**Prevention and Response Branch**
**Division of Healthcare Quality Promotion**
**National Center for Emerging and Zoonotic Infectious Diseases**
**Centers for Disease Control and Prevention**

Dr. Kofman provided the background and rationale for the proposed update of the *US Public Health Service (USPHS) Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus (HIV) and Recommendations for Post-Exposure Prophylaxis (PEP)* and provided a summary of key draft recommendations. The last guideline update was in 2013. At that time, the key recommendations included the following:

- ❑ Use of raltegravir (Isentress) + tenofovir disoproxil fumarate/emtricitabine (Truvada) as the first-line PEP regimen, and other 3-drug regimens as alternatives
- ❑ An option to conclude exposed healthcare worker follow-up HIV testing at 4 months if using a 4$^{th}$ generation HIV antigen/antibody test

In terms of what has changed since 2013, there is now availability of new antiretroviral agents and regimens. Most notably, this includes a number of second-generation integrase strand transfer inhibitors (INSTIs) that have higher genetic barriers to resistance. These include dolutegravir approved in 2013 shortly after the last guideline update and bictegravir approved in 2018. There also was the advent of the principle Undetectable + Untransmittable (U=U) in the field of HIV prevention, with data demonstrating the protection that undetectable viral loads afforded. There have been no new documented occupational transmissions of HIV in the US in

that time. In addition, the FDA-approved qualitative nucleic acid test (NAT) for HIV diagnosis was approved in 2020. This has the shortest available diagnostic window for HIV, which is able to detect infection within 10 to 33 days after exposure.

These changes offer an opportunity to update recommendations for PEP regimens to include the latest antiretroviral therapy (ART) agents. In addition, these changes offered the opportunity to review the risk for transmission from patients with undetectable viral loads, the diagnostic testing timeframe, and the interval from exposure after which there is no benefit to determine if updates are needed. The review also offers an opportunity to align with forthcoming non-occupational HIV PEP recommendations from the CDC Division of HIV Prevention. In terms of the timeline, this effort began in February 2022 and involved the formulation of a USPHS WG with representatives from CDC, NIH, FDA, and HRSA. Key questions were identified, and a targeted systematic literature review was conducted where needed. An initial set of preliminary recommendations was developed and presented to an outside expert panel for feedback. The intent of this session was to present the draft recommendations to HICPAC. During September and October 2023, the draft recommendations will be prepared for posting in the *Federal Register*. Comments received in response to the Federal Register publication will be incorporated and publication of the guideline is anticipated in February 2024.

Dr. Kofman then reviewed the new draft recommendations, pointing out that anything shown in bold represented new draft recommendations and otherwise was a restating or re-clarification of the same recommendation that existed in 2013:

**Draft Recommendations for the Management of HCP with an Occupational Exposure to HIV**

- ❑ HCP should report occupational exposures to blood and body fluids as soon as possible to occupational services.
- ❑ For HCP who have an occupational exposure to HIV, PEP should be initiated as soon as possible up to 72 hours after the exposure, and taken for 28 days.
- ❑ Initiating therapy after a longer interval might still be considered for exposures that represent a high risk of transmission.
- ❑ Whenever possible, the HIV status of the source patient should be determined to guide appropriate use of HIV PEP.
- ❑ Administration of HIV PEP should not be delayed while waiting for the source patient's test results.
- ❑ If HIV PEP is initiated by exposed HCP and the source patient is later determined to be HIV negative, PEP should be discontinued, and no further HIV follow-up testing is indicated for exposed HCP.
- ❑ Re-evaluation of exposed HCP is recommended within 72 hours after occupational exposure to assess for further counseling needs for exposed HCP and PEP tolerability.
- ❑ Provide counseling to exposed HCP in accordance with CDC recommendations for HCP with occupational exposures, including the importance of adherence to HIV PEP.

**Draft Recommendations for the Management of Pregnant or Breastfeeding HCP with an Occupational Exposure to HIV**

- ❑ The decision to offer HIV PEP to pregnant or exposed breastfeeding HCP should be based on the same considerations that apply to any HCP who sustains an occupational exposure to HIV.

- ❑ Additional counseling of exposed breastfeeding HCP should include risks and benefits of continued breastfeeding while taking PEP and while being monitored for HIV seroconversion, versus interrupting breastfeeding.

**Draft Preferred HIV PEP Regimens – INSTI + 2 NRTIs**

- ❑ **Biktarvy 1 PO once daily (bictegravir [BIC] 50 mg + tenofovir AF [TAF] 25 mg + emtricitabine [FTC] 200 mg)**

**OR**

- ❑ **Dolutegravir (Tivicay; DTG) 50 mg PO once daily + emtricitabine (FTC) 200 mg OR lamivudine† (3TC) 300 mg + tenofovir AF (TAF) 25 mg OR tenofovir DF† (TDF) 300 mg**

***Regimens within categories are listed in alphabetical order and not according to preference. †Generic versions are available for tenofovir DF and lamivudine and may be used instead of the fixed-dose tablets Truvada (TDF+FTC) or Descovy (TAF+FTC).**

**Draft Alternative HIV PEP Regimens – PI + 2 NRTIs**

- ❑ **Prezcobix, 1 PO once daily (darunavir [DRV] 800 mg + cobicistat 150 mg) + emtricitabine (FTC) 200 mg OR lamivudine† (3TC) 300 mg + tenofovir AF (TAF) 25 mg OR tenofovir DF† (TDF) 300 mg**

**OR**

- ❑ **Symtuza, 1 PO once daily (darunavir [DRV] 800 mg + cobicistat 150 mg + tenofovir alafenamide [TAF] 10 mg + emtricitabine [FTC] 200 mg)**

***Regimens within categories are listed in alphabetical order and not according to preference. †Generic versions are available for tenofovir DF and lamivudine and may be used instead of the fixed-dose tablets Truvada (TDF+FTC) or Descovy (TAF+FTC).**

**Draft Alternative HIV PEP Regimen – NNRTI + 2 NRTIs**

- ❑ **Delstrigo, 1 PO once daily (doravirine [Pifeltro; DOR] 100 mg + tenofovir DF† [TDF] 300 mg + lamivudine† [3TC] 300 mg)**

**OR**

- ❑ **Doravirine (Pifeltro; DOR) 100 mg once daily + emtricitabine [FTC] 200 mg OR lamivudine† [3TC] 300 mg + tenofovir AF [TAF] 25 mg OR tenofovir DF† [TDF] 300 mg**

***Regimens within categories are listed in alphabetical order and not according to preference. †Generic versions are available for tenofovir DF and lamivudine and may be used instead of the fixed-dose tablets Truvada (TDF+FTC) or Descovy (TAF+FTC).**

**Draft Alternative HIV PEP Regimens* - INSTI + 2 NRTIs**

- ❑ **Genvoya, 1 PO once daily (elvitegravir [EVG] 150 mg + cobicistat 150 mg + tenofovir AF 10 mg + emtricitabine [FTC] 200 mg)**

**OR**

- ❑ **Stribild, 1 PO once daily (elvitegravir [EVG] 150 mg + cobicistat 150 mg + tenofovir DF 300 mg + emtricitabine [FTC] 200 mg)**

**OR**

- ❑ **Raltegravir (Isentress; RAL) 400 mg PO twice daily + emtricitabine [FTC] 200 mg OR lamivudine† [3TC] 300 mg + tenofovir AF [TAF] 25 mg OR tenofovir DF† [TDF] 300 mg**

***Regimens within categories are listed in alphabetical order and not according to preference. †Generic versions are available for tenofovir DF and lamivudine and may be used instead of the fixed-dose tablets Truvada (TDF+FTC) or Descovy (TAF+FTC).**

**Draft Preferred HIV PEP Regimens for Recipients with Kidney Disease (CrCl>5 or on hemodialysis)**

**INSTI + 2 NRTIs:**

- ❑ **Dolutegravir (Tivicay; DTG) 50 mg PO once daily + Dose-reduced* Emtricitabine (FTC) OR lamivudine (3TC) + Dose-reduced Tenofovir DF (TDF) or Tenofovir AF (AF)**

**OR**

- ❑ **Raltegravir (Isentress; RAL) 400 mg PO twice daily + Dose-reduced* Emtricitabine (FTC) OR lamivudine (3TC) + Dose-reduced Tenofovir DF (TDF) or Tenofovir AF (AF)**

**PI + 2 NRTIs:**

- ❑ **Prezcobix 1 PO once daily (Darunavir [DRV] 800 mg + cobicistat 150 mg) + Dose-reduced* Emtricitabine (FTC) OR lamivudine (3TC) + Dose-reduced Tenofovir DF (TDF) or Tenofovir AF (AF)**

**OR**

**NNRTI + 2 NRTIs:**

- ❑ **Doravirine (Pifeltro; DOR) 100 mg 1 PO once daily + Dose-reduced* Emtricitabine (FTC) OR lamivudine (3TC) + Dose-reduced Tenofovir DF (TDF) or Tenofovir AF (AF)**

***Regimens within categories are listed in alphabetical order and not according to preference. †Generic versions are available for tenofovir DF and lamivudine and may be used instead of the fixed-dose tablets Truvada (TDF+FTC) or Descovy (TAF+FTC).**

**Draft Preferred HIV PEP Regimens for Pregnant HCP**

- ❑ **Same as for non-pregnant patients with exception of:**
  - **Biktarvy recommended as alternative due to incomplete data on pharmacokinetics in 2nd and 3rd trimesters**
  - **Regimens containing cobicistat (Genvoya, Stribild) not recommended due to reduced plasma drug exposure in pregnancy**

**Draft Recommendations for PEP in the Setting of Exposures to Source Patients with HIV and Undetectable Serum Viral Load**

- **For HCP who have an occupational exposure to HIV and the source patient is known or found to have an undetectable serum viral load:**
    a. **HIV PEP should be offered to exposed HCP.**
    b. **The decision to not take or discontinue PEP early should be made on a case-by-case basis with shared decision-making involving exposed HCP.**

**Draft Recommendations for Laboratory Testing of the Exposed HCP**

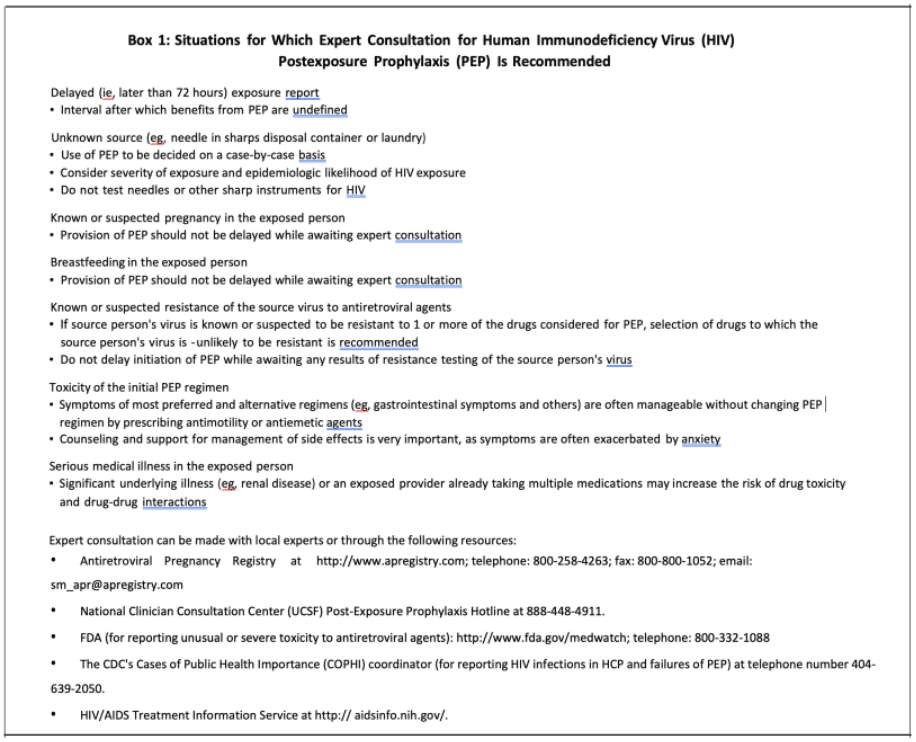
- Baseline laboratory tests of exposed HCP should be performed as soon as possible after exposure and should include:
    a. A rapid or lab-based fourth generation HIV Ag/Ab combination immunoassay.
    b. Serum creatinine, aspartate transaminase (AST) and alanine transaminase (ALT).

- **Follow-up laboratory testing of the exposed HCP should include:**
    a. **Interim test at weeks 4-6 post-exposure: Lab-based HIV Ag/Ab combination immunoassay and qualitative nucleic acid test (NAT) for all exposed HCP who had PEP initiated more than 24 hours after a single exposure, or who missed any PEP doses.**
    b. **Final test at week 12 post exposure: Lab-based HIV Ag/Ab combination immunoassay and qualitative nucleic acid test (NAT) for all exposed HCP regardless of PEP administration or adherence.**

- **Routine follow-up testing of serum creatinine, AST and ALT is not necessary unless baseline tests are abnormal or there are clinical indications, such as signs or symptoms concerning for kidney or liver injury.**

**Draft Recommendations for Expert Consultation for HIV PEP**

1. Situations for which expert consultation is recommended for HIV PEP are described in Box 1 below.
2. Obtaining expert consultation should not delay timely initiation of PEP.



**Box 1: Situations for Which Expert Consultation for Human Immunodeficiency Virus (HIV) Postexposure Prophylaxis (PEP) Is Recommended**

Delayed (ie, later than 72 hours) exposure report
- Interval after which benefits from PEP are undefined

Unknown source (eg, needle in sharps disposal container or laundry)
- Use of PEP to be decided on a case-by-case basis
- Consider severity of exposure and epidemiologic likelihood of HIV exposure
- Do not test needles or other sharp instruments for HIV

Known or suspected pregnancy in the exposed person
- Provision of PEP should not be delayed while awaiting expert consultation

Breastfeeding in the exposed person
- Provision of PEP should not be delayed while awaiting expert consultation

Known or suspected resistance of the source virus to antiretroviral agents
- If source person's virus is known or suspected to be resistant to 1 or more of the drugs considered for PEP, selection of drugs to which the source person's virus is -unlikely to be resistant is recommended
- Do not delay initiation of PEP while awaiting any results of resistance testing of the source person's virus

Toxicity of the initial PEP regimen
- Symptoms of most preferred and alternative regimens (eg, gastrointestinal symptoms and others) are often manageable without changing PEP regimen by prescribing antimotility or antiemetic agents
- Counseling and support for management of side effects is very important, as symptoms are often exacerbated by anxiety

Serious medical illness in the exposed person
- Significant underlying illness (eg, renal disease) or an exposed provider already taking multiple medications may increase the risk of drug toxicity and drug-drug interactions

Expert consultation can be made with local experts or through the following resources:
- Antiretroviral Pregnancy Registry at http://www.apregistry.com; telephone: 800-258-4263; fax: 800-800-1052; email: sm_apr@apregistry.com
- National Clinician Consultation Center (UCSF) Post-Exposure Prophylaxis Hotline at 888-448-4911.
- FDA (for reporting unusual or severe toxicity to antiretroviral agents): http://www.fda.gov/medwatch; telephone: 800-332-1088
- The CDC's Cases of Public Health Importance (COPHI) coordinator (for reporting HIV infections in HCP and failures of PEP) at telephone number 404-639-2050.
- HIV/AIDS Treatment Information Service at http:// aidsinfo.nih.gov/.

## Discussion Points

*For this discussion, HICPAC members, ex officios, and liaison representatives raised the following questions, observations, and suggestions/recommendations:*

HICPAC observed that for HCP who have an occupational exposure to HIV when the source patient is known or found to have an undetectable serum viral load, questions are likely to arise regarding the time window for checking the viral load in terms of shared decision-making. This also comes up in terms of a pregnant person presenting in labor.

Dr. Kofman indicated that based on the status of the review, there is not much data to guide an easy answer to that question or in general for source patient viral load testing. Realistically, the current thought process regarding how to frame this is that how knowledge of undetectability essentially would be discretionary on the basis of the expert. As a general maxim, the recommendation is that PEP still would be given.

Dr. Bell inquired as to whether Dr. Kofman would be able to provide a sense of where the major departures are between occupational and non-occupational post-exposure and if he foresees any potential for confusion or challenges related to those.

Dr. Kofman said he thought they were 98% aligned, certainly on broad principles. Some questions might arise about the drug regimens and U=U where there is a lot more data. The occupational setting has different types of exposures, a lot less data, and a lot more unknowns. While there still will be alignments logically, it is possible they may lead to slightly different recommendations in some cases. Regardless, the should still have the same logical underpinnings.

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

**Aaron Kofman, MD**
**Prevention and Response Branch**
**Division of Healthcare Quality Promotion**
**National Center for Emerging and Zoonotic Infectious Diseases**
**Centers for Disease Control and Prevention**

Dr. Kofman provided the rationale for and review of the proposed update of the *Patient Placement and PPE Recommendations for Andes and Nipah Viruses (Appendix A).* The impetus for the update was inspired by a number of recent examples over the last several years that have served as reminders of the risk that exists for importation of non-Ebola viral hemorrhagic fever (VHF) pathogens into the US. This year, there were Marburg outbreaks at the same time in Equatorial Guinea and Tanzania. This periodically raised concern for importation, or at least situations in which Marburg was in the differential diagnosis for returning travelers from those regions. Lassa fever and Crimean Congo Hemorrhagic Fever (CCHF) are often possible diagnoses for returning ill travelers from endemic regions. There also were 2 US patients this year for whom Nipah virus was on the differential diagnosis. In 2018, there was a single imported Andes virus case, which is a type of hantavirus that is transmissible from person-to-person. All of these episodes raised questions about the recommendations for PPE and patient placement, so CDC wanted to standardize the recommendations and make sure that the right approach was in place for all of these pathogens.

During the June 2023 HICPAC meeting, Dr. Kofman presented proposed updates to PPE and patient placement recommendations for Lassa, CCHF, Marburg, and South American Hemorrhagic Fever viruses, which HICPAC approved (e.g., same PPE and patient placement recommendations as for Ebola). HICPAC requested additional clarification regarding the Andes and Nipah recommendations because they are slightly different from the recommendations for the other pathogens. Since that meeting, the WG convened to clarify the recommendations.

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 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 AIIR, and for PPE to include gown, gloves, eye protection, and an N95 respirator or higher.

Nipah virus is transmitted to humans from its reservoir in bats in Southeast Asia, particularly Bangladesh, Malaysia, and India. It may also be transmitted from human to human. Clinical illness includes a prodromal phase with fever, headache, myalgia, dizziness, respiratory symptoms, and vomiting. It can progress to neurological symptoms within a 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. In the 2018 outbreak in India, there was a case-patient sitting in a hallway awaiting a CT scan for several hours. During that time, various HCP passed in and out of the hallway. Some of them got Nipah and died, but had no actual contact with the patient they passed by in the hall or with other known case-patients. Nipah virus has been detected in body fluids, including 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 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.

Given that there was not a voting quorum, the vote on the clarified recommendations was tabled until the next HICPAC meeting.

**Discussion Points**

*For this discussion, HICPAC members, ex officios, and liaison representatives raised the following questions, observations, and suggestions/recommendations:*

The work being done on this is appreciated. It is sobering to think about the viruses that have been experienced in other places that are not thought about much in this country.

Dr. Bell thanked Dr. Kofman and the ad hoc WG for completing these clarifications quickly and for the work that they did to make everything more similar to Ebola and moving everything into one general category, even if it meant up-regulating or increasing the amount of protection. The simplicity of implementation and consistency is extremely helpful. He asked Dr. Kraft to speak to how she saw this being operationalized from an implementation perspective in terms of routine care versus a specialty care unit.

Dr. Kraft responded that her experience was that even with the emergence of COVID, her organization always begins with the Specialty Care Unit because a lot of these illnesses have not been seen in the US. For practical reasons, patients of concern are placed in biocontainment and then stepped down as diagnoses are determined or transmission is understood. In the past, it has been easier to start higher and step down rather than assuming the transmission of an illness not seen domestically and posing risks to HCP.

It also is important to keep in mind that not all facilities have biocontainment, Specialty Care Units, and/or other resources such as those that Emory Clinic has.

## Public Comment

**Seifer Almasy**
**Member of the Public**

My name is Seifer Almasy. I'm a member of the public providing a comment. COVID remains a significant health threat, with 1 in 10 infections leaving people with long-term health impacts. The unchecked prevalence of COVID-19 and other airborne illnesses within our healthcare facilities makes healthcare visits dangerous for everyone, especially higher risk populations such as immunocompromised people, older adults, and people with disabilities. The situation personally impacts me because I do not want to risk long-term health impacts while attending routine healthcare appointments. I am deeply concerned that a long-term health impact will take away my access to my livelihood and my hobbies. Unfortunately, I have experienced skepticism, denial, and hostility while advocating for my own safety to healthcare providers. Hours of phone calls, emails, and research regarding the infection control policies of my local health care providers conclude with no assurance that providers will wear respirators to protect me. At times, it has been up to me to educate my healthcare providers on the importance of infection control via respirators. It should not be up to any patient to plead for their own safety. Most hospitals in my state were protecting patients from COVID with universal masking protections from the start of the pandemic, but essentially all of the hospitals in the state withdrew these protections abruptly this Spring. Reinstating universal masking would help ensure that we leave no one behind in accessing healthcare. It would also create safer workplaces for our healthcare workers. Therefore, CDC and HICPAC must take action to protect patients, healthcare workers, and visitors to healthcare facilities. CDC/HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens. Additionally, CDC/HICPAC must maintain and strengthen respiratory protection and other protections for healthcare workers caring for patients with suspected or confirmed respiratory infections. Also, the CDC must 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 present or may be present in healthcare settings. Don't adopt a crisis standards approach. Finally, CDC/HICPAC should engage with stakeholders, including direct care healthcare workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates. I think it's pretty clear to all of you that my comments are on the same theme as everyone else who has spoken to this meeting. Do better. I yield my time.

**Yaneer Bar-Yam, PhD**
**Professor & President, New England Complex Systems Institute**
**Co-Founder, World Health Network (WHN)**

My name is Yaneer Bar-Yam. I am Professor and President of the New England Complex Systems Institute (NECSI) and a Co-Founder of the World Health Network (WHN). We are concerned about proper infection prevention in healthcare. Since there are many more people here than time for comments allows, we will be hosting a recorded Zoom on Thursday, August 24, 2023 at 1:00 PM ET for anyone who wants to comment. HICPAC members are welcomed, and we will make the recordings available to HICPAC and the public. This will ensure that more voices are heard on this critical topic. You can sign up at whn.global/hicpaccomments. Thank you for your attention.

**Deborah Gold**
**Certified Industrial Hygienist**
**Retired Annuitant, Cal/OSHA**

My name is Deborah Gold. Thank you for the opportunity to provide some brief comments on behalf of Cal/OSHA, California's OSHA State Plan. I also refer you to the May 31st letter from our Deputy Chief, Eric Berg, and the July letter signed by 900 public health experts. We are seriously concerned about the lack of transparency and openness in this process. Despite repeated requests, we have not seen a draft of the proposed guidelines. We have not seen the minutes of working groups or even of the previous meeting. Working group meetings have not been advertised or open to the public. If we learned nothing from the tremendous illness and loss of life during the past 3 years of the COVID crisis, it is how important it is that public health recommendations be clear and strong enough to protect both individual workers and patients and the healthcare system as a whole. At various points in the pandemic, we have seen massive personnel and equipment shortages that put lives at risk. As with Cal/OSHA, the CDC process must include all stakeholders, including affected workers, their unions, and experts from various disciplines and must be publicly transparent. California/OSHA has an aerosol transmissible disease standard which requires that novel respiratory pathogens be considered airborne for the purpose of employee protection, including the use of respirators. But repeatedly, employers have ignored these requirements and claimed that they were confused by CDC guidelines. This has resulted in a very resource-intensive enforcement effort by Cal/OSHA to ensure that at least minimum protections for the healthcare workforce. Insufficiently protected workers and the facilities in which they work have suffered unnecessarily and many still do. It is important that public health messaging be consistent, and that the CDC establish credibility if we are to control communicable disease. Public health message consistency must be based on protecting workers and the public and not be the result of demands for unquestioning loyalty to weak and unprotective guidelines. We are a state OSHA program. We rely on NIOSH-certified respirators to protect ourselves and the workers of California. The CDC must not undermine respiratory protection regulation by making the false and misleading claim that there is no difference in protection between respirators, which are designed and independently certified to protect against inhalation of small particle aerosols, and surgical masks which do not. We do not rely on randomized controlled trials to require certified respirators for workers exposed to lead, asbestos, and other harmful aerosols. It would be unethical to do so. Personal protective equipment is only part of reducing transmission in healthcare facilities and other congregate environments. We saw COVIDcovid-19 blaze through health facilities and prisons because they lacked effective means of isolation and comprehensive infection control programs. The little we have seen of the draft guideline does not include a thorough discussion of isolation and does not include early identification and isolation of infected people. Thank you.

**Liv Grace**
**Member of the Public**

My name is Liv Grace. I'm 36 and physically disabled as well as chronically ill. I have a number of autoimmune diseases, including lupus. I already live with many of the conditions associated with long COVID, such as POTS (postural orthostatic tachycardia syndrome), lung disease, and kidney disease. Additionally, I'm immunodeficient on top of the immunosuppression for my lupus medication. I'm also a cancer survivor. People often comment that I live with so much illness and they say how hard that must be, but what is many times more difficult is being unable to safely access medical care. Last December, I caught RSV from my infusion center because my nurse, who knew she had been exposed to RSV, refused to wear an N95. That turned into pneumonia. Two weeks after recovering and returning to my infusions, I caught COVID there

just a few days before my birthday in February after 2 months of recovery time from pneumonia. I then caught COVID a second time while getting necessary post-COVID blood work in April, barely after recovering from February's infection. One-way N95 masking is not enough for me. I have not gotten medical care since April because of the reality that I will get sick again as long as medical providers refuse to practice respiratory hygiene. I attempted many times to implement ADA accommodations that would allow me to wait in my car rather than the waiting rooms and would require medical staff to wear an N95 while treating me. Over and over again, medical establishments refused. My appeals were rejected. I was told that it was impossible to accommodate my needs as a high-risk, severely immunocompromised person. I am still recovering from back-to-back COVID. I now suffer from increased kidney issues and new heart issues. I had to start taking a blood thinner and a statin to reduce my risk for a catastrophic cardiovascular event. Without medical care, my health will deteriorate to the point of needing hospitalization where I will have even more exposure to unmasked staff. This is a catch-22. Either access care and catch COVID and other dangerous to me infections to the point of further endangering my life, or do not get care at all and endanger my life. 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. This is eugenics. I'm Jewish and I see the writing on the wall—the history of not only the holocaust, but many genocides, including the ongoing genocide of indigenous people that target disabled people first. I am literally begging for something to be done. Thank you.

**Paul Hennessy**
**Member of the Public**

I am just a member of the public. No affiliation. I want to talk about clean indoor air. This is the most effective tool for fighting a wide variety of airborne illnesses and it will help with patients and medical staff alike. The CDC and HICPAC do not acknowledge the importance and function of core control measures for infectious aerosols. Wearing respirators and having ventilated clean indoor air and air filtration reduces transmission of not just COVID but also RSV, flu, common colds, and more. Notice I said “respirators.” N95 respirators offer better protection than surgical masks. All masks are not created equal. Respirators must remain in healthcare on top of improved indoor air quality. Any future airborne illnesses or pandemics will also be helpless against ventilation, respirators, and air filtration. Ventilation protects the vaccinated and unvaccinated alike. We cannot risk death, disablement, or even disruption when a simple answer is right in front of us. Failing to do so is the equivalent of not wearing gloves or washing your hands. It is incredibly dangerous to ignore this. There are currently no recommendations on ventilation, which is absurd. The proposed use of airborne infection isolation rooms or other approaches to isolation is far too limited. Ventilation works against all variants of COVID, which is extremely transmissible and airborne. Ventilation and air filtration also helps workers be more alert, which improves air quality and the quality of work. We must go above and beyond with these safety precautions. The benefits of clean indoor air are tremendous. If I, a member of the public, can easily figure out how viral transmission works and how respirators and ventilation help, surely you can too. You are ignoring decades of research. On top of that, your Work Group on Isolation Precautions only recommends the bare minimum of protection and allows healthcare workers to create an isolation control plan. This is unacceptable because in the past, it allowed employers to avoid protecting employees because they didn’t want to spend more money. Healthcare is more important than profit. I urge the CDC and HICPAC to increase transparency in public engagement because of situations like this. We deserve input on protecting ourselves from airborne infectious diseases. The current process is flawed and closed off. Thank you.

**Gwendolyn Hill**
**Full-Time Student, University of California Los Angeles**
**Basic Intern, Cedar Sinai Medical Center**

Hello. My name is Gwendolyn Hill. I'm a full-time student at the University of California Los Angeles, as well as a recent intern at Cedar Sinai Medical Center. I have now had 3 confirmed cases of COVID despite my best efforts to avoid infection. My most recent infections have resulted in long-term symptoms such as gastrointestinal issues, trouble breathing, heart palpitations, and chest pain, all of which require me to go to the hospital. Before COVID, I had been extremely active with no standing health problems. Now I fear even more for my health as Los Angeles County has dropped the mask mandate in healthcare as of August 11th. Myself and my friends and family have been actively avoiding going to the hospital to receive the care we need because we cannot risk another COVID infection or any other respiratory infection. When I put in requests for providers to wear N95s, they get denied. Unfortunately, as a student of UCLA, I cannot put my life on hold. I am forced to go into classrooms where no one is masking—forced to choose between my career and myself. At the very least, I expect healthcare facilities to be taking the utmost precautions to prevent healthcare-acquired infections. The United States Environmental Protection Agency recognizes that COVID is spread through aerosolized particles. Therefore, standard precautions due to transmission by air should involve universal, high quality, well-fitting N95 masks, frequent testing, proper ventilation, air cleaning and purifying technology, isolation, and other PPE. As you suggested during the meeting, the fewer individual risk assessments that each person has to do, the better. People need to be able to trust that the guidelines in place ensure their safety. The standard precautions you provided today in the meeting mentioned a risk assessment with the use of appropriate PPE based on activity. However, although you can claim that one might not always need to wear gloves if their duties are just sitting at a computer, everybody shares the activity of breathing. Healthcare facilities are where some of the most vulnerable people of our population have to frequent or stay. It is the responsibility of HICPAC and the CDC to ensure, on a federal level, that healthcare facilities are taking the aforementioned steps to reduce COVID transmission and help ensure that people are not leaving sicker than they came. As the committee understands, once rules are put into place, they become habitual practice for people. Our bodies are fueling the COVID variants that continue to emerge. When COVID is copying itself inside millions of people unchecked, it continues to harm many people and place extreme strain on our healthcare system. I urge HICPAC and the CDC to take in these public comments and perspectives with open minds and to open further meetings for public comment and for public input. The people are telling you exactly what needs to be done to protect us and I urge you to listen. Thank you.

**Pantea Javidan, PhD, MSc, JD**
**Faculty, Stanford University**

I'm Dr. Pantea Javidan, faculty at Stanford University, speaking on behalf of myself as an academic who researches the inequities of pandemic policy and who is deeply concerned for loved ones suffering from long COVID or who have been diagnosed with chronic conditions such as cancer during the pandemic, including oral cancers for which they’re unable to mask themselves during examinations and treatments. I come before you today to stress the vital importance of ensuring that the updated guidelines being considered fully reflect a solidly scientific understanding of aerosol transmission, especially as confirmed during the COVID-19 pandemic, and that they are crafted to fully protect against infectious aerosols. Please take seriously the hundreds of experts in the most relevant fields who have written a well-informed warning against the plan to weaken guidance for healthcare respiratory protection and infection

control. Nosocomial COVID has proven deadlier and more dangerous than community-acquired COVID, with a 10% mortality rate according to the most recent and reliable reports. When healthcare settings are infecting patients while COVID continues to be the third leading cause of death, it deters many from seeking medical care. As someone who insists on high standards of methodology for myself, peers, and students, it is alarming that the CDC and HICPAC process lacks essential inputs from crucial stakeholders, lacks transparency and public engagement, and encourages minimal standards of protection, which is deeply troubling in light of nosocomial COVID. Experts are urging HICPAC and CDC to open the process for public access and insist on a clear protective approach, recognizing the science of aerosol transmission, including inhalation protection. The existing review on N95 respirators versus surgical masks is flawed and requires re-evaluation with expert guidance. Failure to acknowledge vital control measures like N95 respirators, ventilation, and air filtration for controlling exposure to infectious aerosols must be corrected. Rather than regressing backward and erasing pandemic lessons, please maintain and strengthen protocols for prevention and control of aerosolized pathogens in light of SARS-CoV-2. Please center the most vulnerable and understand the unequal and unfair power dynamics of an oral cancer patient having to repeatedly request healthcare personnel to wear an N95 every time they enter the room. Health care is a human right.

**Nathanael Nerode**
**Representing Himself & Partner**

I'm Nathaniel Nerode. I spoke previously at a previous meeting. My partner was infected by doctors' offices twice where they were not wearing surgical masks. She has not been infected anywhere else. I have not been infected because I used respirator masks at home. Respirator masks work as everyone else has said, so I'd like to talk about something else. I'm a professional investor with over 30 years of experience. Using respirator masks will be profitable for any hospital or doctor who is using them. A fully reusable P100 respirator, which lasts for years, costs about $40 retail versus if a nurse acquires an airborne infection at work and is out sick for one day that costs thousands of dollars. If the nurse is so sick they can't work anymore, that could cost hundreds of thousands of dollars. When a patient is infected, and you've already heard about several, that creates liability costs for the hospital in the hundreds of thousands of dollars. But worse, it creates a reputational issue. As you've already heard, people are avoiding going to the hospital, people are avoiding routine healthcare, and people are avoiding elective procedures. My family certainly is. We are avoiding them because the hospitals are not safe. This is a huge loss in revenue for the hospitals. So, you have one choice. You can buy a $40 respirator for each of your staff and train them to use it cheap or you can face hundreds of millions of dollars in liability, in disabled staff, in costs to replace your disabled staff, in reputational damage, in people avoiding your hospitals because they don't want to get infected. So, my professional financial advice as a professional investor with 30 years of financial analysis experience is that every healthcare office ought to be using respirator masks. It is clear economically that this would be profitable. For some reason, they aren't doing it. It should be standard precautions, it should be ordered from the CDC, and there is no reason to give them any discretion because they will all profit from doing it. Thank you.

**Shea O'Neil**
**Volunteer, World Health Network**
**Advocate, Disabled Patient Rights**
**Sole Caretaker of a High-Risk Son with a Disability**

I'm Shea O'Neill, a World Health Network volunteer, a patient, disabled rights advocate, and soul caretaker of one son, high-risk person with disability. It is quite obvious that your last

discussions from meetings did not inspire confidence amongst the public and your ability to, without bias, pass guidance and standards that will deal with the dreadful rise in infections in healthcare facilities—again not mentioned today, interestingly. It is really clear in wildfire smoke messaging that you wear N95 respirator masks, and that surgical cloth and dust masks aren't going to cut it. You would never in peak wildfire times emit smoke or tell firefighters, vulnerable people, or even healthy people, “Hey, you know what? I think we need more real-world studies. Wear surgicals for now.” Or “Actually, wildfires typically aren't all year long, so we will change the guidance to surgical instead.” These things do not make sense and do not protect people—not for fires, not for COVID-19—both aerosols. The fact that in your past meeting you use widely criticized studies, failed to mention any with continued use of N95s in healthcare settings studies which show that they do lower infections, the fact that you highlighted mask discomfort and ignored long COVID and how damaging and widespread its effects are—I don't know if this is ignorance, immorality, if it's conflict of interest, or money, or psychological coping at play, but I'll tell you, science and logic are not at the table and they need to be brought back. It is not complex. It is very simple and clear that N95s offer adequate protection from aerosols, that 2-way protection is much better than 1-way, that hospitals are full of vulnerable populations, that doctors should not infect patients, and that healthcare is a human right. We need N95 respirator masks in healthcare facilities to protect both staff and patients. There are many reasons why this is. Just a few of the studies show that more than half of transmission is from asymptomatic carriers and COVID-19 is airborne and highly contagious. Hospital-acquired COVID-19 has a 10% mortality rate. For the past year, nearly a third of COVID-19 cases in hospitals in England were hospital-acquired infections. A 2023 *JAMA* study on Omicron variants showed that hospital-acquired COVID-19 was associated with approximately one and a half higher risk of all-cause mortality in hospitals compared with influenza. A 2023 study showed COVID-19 infections make people's existing illnesses worse. Research on viral genomic sequences during COVID-19 outbreaks in hospitals demonstrated healthcare workers were responsible for much of the spread in the hospital ward. Long COVID continues to cause severe long-term consequences for millions, with one study finding that those that develop long COVID have a 38% chance of developing a disability that prevents them from returning to work. Another indicating that 27% of healthcare workers develop long COVID. While reported acute phase deaths are down, COVID-19 continues to kill and many patients in healthcare settings are high risk for severe COVID-19. I'm one of the people who are high risk, and my life depends on getting better protection in healthcare. Thank you.

**Jocelyn Donnegan Peterson**
**Member of the Public**

I’m Jocelyn Donnegan Peterson. 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 for necessary medical care. It’s the only time we go inside. Although my dad can't do many things he should be safely enjoying in retirement with his grandchildren, we are grateful for crucial tools like effective masks, upgraded ventilation, along with the healthcare workers still taking the most protective measures to help us avoid COVID. What continues to horrify and baffle us is that the only COVID risks we are forced to take are when seeking out 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 is 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. 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 will 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 and long-term health put at serious risk just because they need a doctor, or a surgery, or fighting cancer, or elderly, or immunocompromised, or work 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.

**Peg Seminario**
**Industrial Hygienist**

Thank you very much. My name is Peg Seminario. I'm an industrial hygienist and served for 30 years as a safety and health director at the AFL-CIO until my retirement in 2019 where I specialize in occupational safety and health policy and regulatory matters, including work on healthcare worker protections for infectious diseases. I was one of the authors of a letter to CDC director Mandy Cohen from 900 public health and medical experts in July expressing great concern about CDC/HICPAC's update of the guidelines on isolation precautions, both about the closed non-transparent process and the failure to address and protect against aerosol transmission of infectious diseases. Late Friday, we received a response from CDC to our letter informing us that HICPAC would not be voting on the recommendations today, which we appreciate, but we are deeply dismayed that the CDC response did not address any of our substantive concerns about the weakness of the guidelines nor provide any indication that CDC or HICPAC intends to open up the guideline development process to involve key experts and stakeholders. We urge you to change course. The majority of HICPAC and work group members are infectious disease professionals from hospitals or large healthcare organizations. They do not include representatives of healthcare workers or patients who have different interests and different views. As we have just heard from many of the commenters. HICPAC members are not experts in aerosol transmission ventilation, respiratory protection, or industrial hygiene—the kind of experts with deep knowledge and experience on how infectious diseases are transmitted and effectively controlled. For more than 3 years, we have all been immersed in efforts to protect the public patients and healthcare workers from COVID-19 infection and death. We have failed miserably in those efforts. Over 100 million have been affected. Over a million people have died in healthcare settings where we don't have a lot of information. We know that hundreds of thousands of healthcare workers and patients have been infected and thousands have died. Today, those infections and deaths continue to occur. The latest CDC data from nursing homes reports that since mid-June, the number and rate of nursing home staff infected with COVID has tripled and more than doubled among nursing home residents. COVID deaths

among nursing home residents has increased by 60%. In July, deaths among nursing home residents accounted for nearly 20% of all COVID deaths in the United States—20% of COVID deaths are healthcare infection-related. Clearly, CDC and hospital infection control professionals are still failing to protect healthcare workers and patients. We need to do more. CDC must develop strong infection control guidelines that fully protect against aerosol transmission and open up the development process to include necessary experts and members of the public.

**Kaitlin Sundling, MD, PhD**
**Physician Scientists, Pathologist, and Assistant Professor**
**Member, The People's CDC**

I am Kaitlin Sundling, an MD/PhD, Physician Scientists, Pathologist, and Assistant Professor in Madison, Wisconsin. I have no conflicts to disclose. I'm a member of the People's CDC. I'm speaking today in support of universal masking in healthcare, ideally with broad use of well-fitting N95 or better respirators as a new addition to Standard Precautions. Now is the time to use what we've learned from HIV and bloodborne pathogens. Matching our understanding of the science of aerosol transmission to our precautions in healthcare allows us to work to build public trust and destigmatize aerosol-transmitted infectious diseases, especially where asymptomatic transmission is common, as with COVID. Denying the well-proven science of N95 respirators would be a significant step backwards. There is no physical basis to support the idea that different aerosol pathogens travel different distances. Appropriate isolation for known or suspected aerosol pathogen infections of any kind, including COVID, must include N95 respirators at minimum and appropriate ventilation controls. I want to share a couple of experiences where universal airborne precautions would have prevented exposure from my own work as a pathologist and as medical director of a health professional training program. While I was in my fellowship training at a well-known Boston hospital, I found out I had been exposed to tuberculosis when I had performed a small biopsy of a neck lymph node on a patient who, as far as we knew, lacked any symptoms or history that would have caused us to suspect the infection. More recently, one of my students was also exposed to tuberculosis on a lung biopsy procedure where cancer had been the suspected diagnosis. If we only protect ourselves against known or certain exposures, we put both patients and workers at risk. We need to expand, not reduce, the use of N95 or better respiratory protection, including elastomeric respirators with source control and PAPRs in healthcare settings. Lastly, and most importantly, we have a duty to protect our patients. I've had multiple people in my community ask if I, as a pathologist and laboratory-based clinician, can be their primary care provider. It is incredibly sad to me that so few of my fellow healthcare providers are wearing masks to protect themselves and their patients. Some are not even willing to mask upon request. Where providers are masking, our patients, including those who are immunocompromised, still face unmasked waiting rooms and other spaces with shared air. Should patients have to ask their surgeon to wear sterile gloves? Putting the burden of protection on patients is not an appropriate infection control approach. In conclusion, I call on you, members of the CDC's HICPAC committee, to recommend universal masking in health care, ideally with the broad use of well-fitting N95 or better respirators as a new addition to Standard Precautions. Thank you.

**Rachel Weintraub**
**Executive Director, Coalition for Sensible Safeguards**

Good afternoon. Thank you for this opportunity to provide public comment today. My name is Rachel Weintraub, Executive Director of the Coalition for Sensible Safeguards, or CSS. CSS is an alliance of more than 170 consumer, labor, scientific, research, faith, community,

environmental, small business, good government, public health, and public interest groups representing millions of Americans. We are joined in the belief that our country's system of regulatory safeguards should secure our quality of life, pave the way for a sound economy, and benefit us all. Federal regulations dealing with food and consumer products, safe air and drinking water, safe working conditions, equal opportunity, and reliable financial structures protect all of us from harm. Failure to provide adequate safeguards diminishes our economic well-being, undermines public health and safety, and allows special interests to escape accountability for their actions. We seek to ensure that our critical public protections are not rolled back and that federal agencies have the funding, authority, fair processes in place, and appropriate expertise at the table to defend, promulgate, and strengthen important protections. HICPAC is charted under the Federal Advisory Committee Act, FACA, and should operate with openness and full transparency. It is from this perspective that we urge HICPAC, the CDC, and the relevant work groups to take the following immediate 2 actions to correct their review and decision-making processes and recommendations. First, seek input on proposed changes during the development of the draft guidelines from the public and all key stakeholders, including healthcare 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; and experts in respiratory protection. Second, make the process for updating the guidelines fully open and transparent. Open work group meetings to the public, through which the work group should show the evidence sources being reviewed by the work group. Post-work group reports, all presentations to the work group committee, and transcripts recordings of the HICPAC meetings on the website in a timely fashion. For example, make meetings of the June meetings available to everyone as the recommendations are being developed and before finalization and voting by HICPAC. We urge HICPAC to create a public docket on the development of the guidelines that includes all meeting minutes, draft guidelines, all scientific evidence used in the development of the guidelines, and all written comments from the public. Inform the public in advance when there will be a vote. We thank you for making this public comment possible and urge you to take immediate steps to increase the openness and transparency of this process. Thank you.

**Oliver Wilson**
**Member, Massachusetts Coalition for Health Equity**
**White, Queer, Trans Person**
**Community Organizer**

Hi. My name is Oliver Wilson. I'm a member of the Massachusetts Coalition for Health Equity (MCHE). I'm also a white, queer, trans person, as well as a community organizer and a patient. Today, I'm here to urge HICPAC and CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions Guidance. I'd like to share my daily lived reality just like many others have done before me. I can no longer safely access healthcare. I have a health condition that according to the CDC puts me at higher risk of severe outcomes from COVID. As a result, I cannot safely access healthcare unless healthcare providers, patients, and visitors are wearing masks. Since the end of the federal and state Public Health Emergency on May 13th, all of my healthcare providers have dropped universal masking. Additionally, all of my requests for universal masking as a reasonable accommodation under the ADA have been denied. As a result, I am locked out of healthcare. My federal right and human right to have healthcare is being violated. 200 people from across Massachusetts have signed a public letter saying that they are also locked out of healthcare for the same reason. CDC’s disgraceful handling of the ongoing pandemic has directly contributed to myself and many other people being locked out of healthcare. The proposed updates to the 2007 Isolation Precautions

Guidance weaken infection control in healthcare settings even further. I urge HICPAC and CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions Guidance. So far, CDC and HICPAC's process has been 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 healthcare personnel, patients, and the public from infectious diseases, it is especially concerning that CDC's/HICPAC's process is so closed. I also urge HICPAC to fully recognize aerosol transmission (i.e., inhalation of small infectious particles) to ensure healthcare worker and patient protection and to mandate universal masking using high quality respirators, N95 or better, in all healthcare settings. Today, I joined tens of thousands of people across the US to say that we demand care not COVID. Thank you.

## Closing Remarks

**Sharon Wright, MD, MPH**
**Interim HICPAC Chair**

Dr. Wright thanked all of the presenters and everyone who participated in the meeting. She recapped what HICPAC heard throughout the day.

Dr. Bell provided a DHQP update, including a continuation of Dr. Kallen's summation of the HICPAC guideline process, particularly as related to the Isolation Guideline. He also mentioned that CDC is working on a Respiratory Viral Index to capture information on incidence of several respiratory viruses, with the hope that this will be available before the traditional respiratory viral season begins in earnest in the fall.

The Isolation Precautions Guideline WG provided an update on EBP and Standard Precautions and there was an informative discussion of EBP on indications for use in residents with infection or colonization with MDRO, including considerations for residents at high-risk for MDRO colonization regardless of their MDRO status, such as those with indwelling medical devices. There was a comment raised about use in other congregate settings and discussion of the change from implementation of Contact Precautions upon room entry to the use of the term "Designated Patient Space" to apply more easily to all healthcare settings. That will be taken back to the WG for discussion of the language in this section. The evolution and contents of Standard Precautions were described and there was discussion about Core Practices being the home for Standard Precautions, with a focus on application by frontline staff, where to place certain components, and potential renaming of the term "Standard Precautions."

They heard an update from Dr. Kraft about the great progress on various sections of the HCP Guideline. The pregnant HCP section stating that HCP should not be routinely excluded from work based only on the basis of their pregnancy received one favorable comment during its comment period in the *Federal Register*. However, the vote was deferred until the next meeting due to lack of a voting quorum. Several other pathogens are either on deck, in literature review, or having their scope defined.

Dr. Kofman presented on the US Public Health Service Occupational PEP Guideline, which was last updated in 2013. New recommendations included draft changes to the preferred HIV PEP regimen as well as alternative HIV PEP regimens and those for special populations, including recipients with kidney disease and pregnant HCP. There was a discussion about

recommendations for PEP in exposures to source patients with HIV with an undetectable viral load and an update to recommendations for laboratory testing. The guideline will undergo public comment in the *Federal Register* in September or October when it is ready, with anticipated publication in February 2024. Dr. Kofman also presented on the Patient Placement and PPE

Recommendations for Selected Viral Hemorrhagic Fevers during the June 2023 meeting during which HICPAC requested additional clarification on Andes and Nipah viruses. The recommendations were put forward for Andes and clinically stable suspect cases of Nipah to require gown, gloves, eye protection, and an N95 respirator or higher level of respiratory protection and use of an AIIR. The recommendation for either confirmed Nipah virus or clinically unstable suspect cases of Nipah were proposed to use PPE according to the clinically unstable VHF guidance. HICPAC members expressed appreciation for the detailed work and the simpler, more easily implementable guidance to keep HCP safe. The vote was deferred to the next HICPAC meeting due to lack of a voting quorum.

With no additional business raised or comments/questions posed, HICPAC stood adjourned at 2:29 PM on August 22, 2023.

# Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the August 22, 2023 meeting of the Healthcare Infection Control Practices Advisory Committee (HICPAC), CDC are accurate and complete.

_____ _____

Date Interim Chair, HICPAC

## Attachment #1: Acronyms Used in this Document

| Acronym | Expansion |
|---|---|
| AAKP | American Association of Kidney Patients |
| ACOEM | American College of Occupational and Environmental Medicine |
| ACS | American College of Surgeons |
| AEs | Adverse Events |
| AEH | America's Essential Hospitals |
| AHA | American Hospital Association |
| AHCA | American Health Care Association |
| AHRQ | Agency for Healthcare Research and Quality |
| AIIR | Airborne Infection Isolation Room |
| ALT | Alanine Transaminase |
| ANA | American Nurses Association |
| AORN | Association of periOperative Registered Nurses |
| APHA | American Public Health Association |
| APIC | Association of Professionals of Infection Control and Epidemiology |
| ART | Antiretroviral Therapy |
| ASN | American Society of Nephrology |
| ASPN | American Society of Pediatric Nephrology |
| ASPR | Administration for Strategic Preparedness and Response |
| AST | American Society of Transplantation |
| AST | Aspartate Transaminase |
| *C. auris* | *Candida auris* |
| CCHF | Crimean Congo Hemorrhagic Fever |
| CCTI | Cambridge Communications & Training Institute |
| CDC | Centers for Disease Control and Prevention |
| CKD | Chronic Kidney Disease |
| CMS | Centers for Medicare and Medicaid Services |
| CMV | Cytomegalovirus |
| COI | Conflicts of Interest |
| COVID | Coronavirus Disease |
| CRE | Carbapenem-Resistant Enterobacterales |
| DFO | Designated Federal Official |
| DHQP | Division of Healthcare Quality Promotion |
| EBP | Enhanced Barrier Precautions |
| ET | Eastern Time |
| EVD | Ebola Virus Disease |
| EVS | Environmental Services |
| FDA | (United States) Food and Drug Administration |
| FQHC | Federally Qualified Healthcare Center |
| HAI | Healthcare-Associated Infection |
| HCP | Healthcare Personnel |
| HCW | Healthcare Workers |
| HHS | (United States Department of) Health and Human Services |
| HICPAC | Healthcare Infection Control Practices Advisory Committee |
| HIV | Human Immunodeficiency Virus |
| HRSA | Health Resources and Services Administration |

| Acronym | Expansion |
|---|---|
| IDSA | Infectious Disease Society of America |
| IHS | Indian Health Service |
| ILI | Influenza-Like Illness |
| INSTIs | Integrase Strand Transfer Inhibitors |
| IPC | Infection Prevention Control |
| IPs | Infection Preventionists |
| LTCF | Long-Term Care Facilities |
| MCHE | Massachusetts Coalition for Health Equity |
| MDROs | Multi-Drug Resistant Organisms |
| NACCHO | National Association of County and City Health Officials |
| NACI | National Advisory Committee on Immunization |
| NAT | Nucleic Acid Test |
| NCEZID | National Center for Emerging and Zoonotic Infectious Diseases |
| NECSI | New England Complex Systems Institute |
| NHSN | National Healthcare Safety Network |
| NIH | National Institutes of Health |
| NIOSH | National Institute for Occupational Safety and Health |
| OSHA | Occupational Safety and Health Administration |
| PAPR | Powered Air-Purifying Respirator |
| PBMC | Peripheral Blood Mononuclear Cell |
| PEP | Post-Exposure Prophylaxis |
| PHE | Public Health Emergency |
| PHAC | Public Health Agency of Canada |
| PIDS | Pediatric Infectious Disease Society |
| POTS | Postural Orthostatic Tachycardia Syndrome |
| PPE | Personal Protective Equipment |
| PSAN | Patient Safety Action Network |
| Q&A | Question and Answer |
| RA | Retired Annuitant |
| RCT | Randomized Control Trial |
| RN | Registered Nurse |
| RSV | Respiratory Syncytial Virus |
| RVI | Respiratory Virus Index |
| *S. aureus* | *Staphylococcus aureus* |
| SAHF | South American Hemorrhagic Fevers |
| SARS | Severe Acute Respiratory Syndrome |
| SCCM | Society for Critical Care Medicine |
| SHEA | Society for Healthcare Epidemiology of America |
| SHM | Society of Hospital Medicine |
| SNF | Skilled Nursing Facility |
| SIS | Surgical Site Infection Society |
| SMEs | Subject Matter Experts |
| TB | Tuberculosis |
| TJC | The Joint Commission |
| UCLA | University of California Los Angeles |
| US | United States |
| USPHS | United States Public Health Service |
| U=U | Undetectable + Untransmittable |

| Acronym | Expansion |
|---|---|
| VHF | Viral Hemorrhagic Fevers |
| VRI | Viral Respiratory Infection |
| WG | Workgroup |
| WHN | World Health Network |
| WHO | World Health Organization |

## Attachment #2: Public Comment Submitted in Writing

Good morning,

As an American citizen, I am disappointed in HICPAC's continuous downplay of COVID and the effectiveness of high quality masks. Surgical masks may prevent some spread of airborne pathogens, but it is well known that N95s do a better job. Why would you choose masks that may be "good enough" if there is a better, equally accessible option. There is no reason for choosing a tool (masks) that is worse at its intended purpose unless you do not care about the outcome. Sick people are supposed to go to hospitals and other healthcare facilities. Universal masking in these settings is a good change that needs to be implemented going forward so that we can prevent the next pandemic from taking hold in this country. Please make the decision that is best for the health of the American people.

Emily Carlson

---

Please urge all healthcare facilities to mandate masks in healthcare. It is so disheartening to go to a hospital for a medical test and have an unmasked person right beside you possibly infecting you with COVID. Your actions are critical to stopping the spread of COVID-19. Moving forward, we must all remain vigilant and continue taking steps to mitigate the spread of the virus to protect each other and our loved ones.

Dawn Shay
Pontiac, IL

---

I am shocked but not surprised that the CDC continues to downplay sensible and cheap precautions against long and/or severe covid by not strongly recommending masks in ill-ventilated crowded indoor settings, not requiring them in health care or other institutional settings with vulnerable people, and by not insisting that the masks be of N95 quality.

And CDC leaves it to volunteers and other, wiser nations to carefully track covid cases, outcomes and strains.

CDC will go down in history for its cowardice once again (as it did with AIDS and gun violence) for prioritizing funding from conservative congressional politicians over the science and the medical duty of care.

Dorie Klein

---

The healthcare system should be a place of healing, where the risk of acquiring infections is minimized. Strong, consistent infection control practices, long recognized as a key gauge of medical care quality, are crucial to limit COVID’s spread. Without these practices, healthcare acquired COVID infections (HAIs) will remain high. Hospitals must adequately measure and track COVID HAIs, therefore COVID must be added to the list of other conditions tracked in the Hospital-Acquired Condition Reduction Program conducted by Centers for Medicare and Medicaid (CMS) and measured by the Center for Disease Control and Prevention (CDC).

Removing masks and hospital pre-procedure COVID testing in healthcare puts both patients and healthcare workers at risk, which could place even more strain on the healthcare system

amidst severe staffing shortages. The absence of masking and other strong COVID prevention practices is also deterring many people from seeking care.

We urge you, as a steward of the American public's health, to act in the best interests of all of us, and especially the most at risk, and have Medicare require masking in patient care areas and public spaces of all healthcare settings and include metrics for hospital onset - COVID in the Hospital-Acquired Condition (HAC) Reduction Program,. CMS must include universal masking and hospital COVID admission testing as part of their payment requirements when they consider 2024's Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, inclusive of the HAC Reduction Program, Docket (CMS-2023-0057) (https://www.regulations.gov/document/CMS-2023-0057-0003).

Grace Kistner
BSBA, BSN-RN, CCRN

---

Please implement policy to require universal masking 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.

Sara

---

Hello:

I am hereby stating my opinion as a concerned citizen and public health professional that universal masking should be reinstated in healthcare.

It is clear that N-95 masks greatly reduce the spread of COVID and at the very least should be used in healthcare settings , preferably everywhere but at the very least in healthcare to protect vulnerable individuals.

Thank you,

Angie Bartok

---

Please set policy that all healthcare providers require masks.

We know Covid exploits weakness and where people are compromised is when getting medical treatment and tests. Preventing transmission among the vulnerable population is supposed to be of utmost importance, reinstitute masks in this environment.

Thank you.
Patrick
Cambria CA

---

Name: Paul Hennessy
Organization: None
Topic: Update Infection Control Guidance in Health Care Settings/Clean Indoor Air

I urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

• Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
• Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

I am concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

Thank you for your time, Paul Hennessy

---

My mom has multiple conditions that make her vulnerable to COVID complications and because of her kidney function can't take paxlovid. Taking her to the emergency room has been terrifying because it's full of unmasked, presumably sick people. Having unmasked medical staff is also

upsetting and sometimes they are rude about putting on masks when asked, which makes being honest, open, and vulnerable with them unpleasant to say the least.

There are many universal precautions we use in health care now that we didn't use to. When we know better, we should do better. Keep masks in health care!

Sincerely,

Mary Laura Calhoun

---

Dear HICPAC members

As a health care professional myself as well as a high risk patient, I urge you to reconsider universal masking in health care settings. Multiple strains of covid are coactive at the present time and neither the current nor the upcoming vaccine are effective against all of them. This situation will only worsen as fall sets in. People are still being disabled and killed every day from covid. Why would we not want to prevent this whenever we can? After all, do no harm.

Thank you for your consideration.

Jan Willer, Ph.D.

---

To whom it may concern:

It is high time the U.S. took the lead in the west in promoting the use of high-quality, N-95/KN94 respirators as a proven method to reduce the transmission/spread of airborne pathogens, especially in healthcare settings. Universal masking in healthcare settings needs to be a requirement, not a suggestion. Not doing so makes these vital service providers less accessible to vulnerable populations.

The public can be educated to understand that masks do prevent harm and reduce the risk of infection, especially in crowded indoor spaces where there are likely to be infectious individuals, such as hospitals, medical facilities, and pharmacies. Masking during the flu season has been a cultural norm in the Far East for decades. The U.S. can validate and model masking as an optimal behavior that promotes health maintenance, especially during the winter influenza season when other airborne diseases also tend to spike. We now understand that COVID is NOT "another influenza" because it can and does cause lasting damage that results in long term disabilities and loss of good health, even in younger individuals. It is irresponsible from a public health policy standpoint to ignore this knowledge and not give the public the information and policies that could protect millions, easily and inexpensively, from harm.

Other policy recommendations that would be welcomed include continued tracking and reporting of healthcare-acquired infections, and promoting infrastructure spending on aging facilities to improve indoor ventilation. There has been little movement in the past 100 years to measure indoor air quality and to make improvements in air handling that promotes more rapid fresh-air exchanges. Better ventilation can greatly improve indoor air quality and make indoor spaces safer for workers.

Many thanks, Dara Schumaier,
Milton, Delaware

---

Please consider making masks mandatory again in health care settings.  There are many vulnerable people and it is not onerous for everyone to mask up in quality masks.

Thank you for considering this perspective.

Sincerely,

Robin Hoffmann

Professor Emerita of Administration of Justice

---

Good morning,

As an American citizen, I am disappointed in HICPAC's continuous downplay of COVID and the effectiveness of high quality masks. Surgical masks may prevent some spread of airborne pathogens, but it is well known that N95s do a better job. Why would you choose masks that may be "good enough" if there is a better, equally accessible option. There is no reason for choosing a tool (masks) that is worse at its intended purpose unless you do not care about the outcome. Sick people are supposed to go to hospitals and other healthcare facilities. Universal masking in these settings is a good change that needs to be implemented going forward so that we can prevent the next pandemic from taking hold in this country. Please make the decision that is best for the health of the American people.

High quality masking, at least a K95, is required in healthcare facilities to keep patients safe. It is unconscionably that in the face of an ongoing covid threat that you have eliminated required masking in healthcare facilities.

KC Holeyfield MD
Palo Alto, CA

---

To whom it may concern:

I am troubled by your recent meeting where it was suggested there was little need for the use of N95 respirators to protect against the spread of COVID and other airborne pathogens, erroneously claiming that surgical masks might be enough to prevent spread. This has been proven time and time again not to be the case.

It is far past time to reinstate universal masking in health care. Vulnerable patients should not be placed at risk of contacting COVID or other airborne illnesses when seeking care for illness. We should, instead, be doing everything that we can to ensure that all those in healthcare settings--patients and healthcare workers--are protected against disease, rather than subject to unnecessary risks. This means universal masking is needed.

Please reinstate these rules. Please protect the vulnerable rather than placing them at greater risk when they are at their most vulnerable. All best, K. Angus

Please consider requiring N95 masks in healthcare settings. It has been proven they are quite effective when both parties in enclosed environments are wearing NIOSH certified N 95 masks. Without this people like myself will delay getting care because we do not feed safe. Anything less erodes public trust.

SARS Covid 19 is ever evolving into more infectious variants. It is still a class level 3 pathogen. We have procedures for tuberculosis, Covid should be part of the same protective protocols.

Make health care safe for all!

Sincerely,
Kathryn Madden
Augusta, GA

---

As a kidney transplant patient, I am among the 7 million immunocomromised/immunosuppressed (incl. patients undergoing cancer treatments) who are extremely susceptible to getting infected by Covid 19. I urge you to consider reinstating masking in healthcare settings. It will allow us to get our care without fear of dying.
Please remember what it felt like in March of 2020. Weren't you terrified? Well, we are still in that situation, only worse because no one else is masking. There are treatments , but many of us cannot take them because of contraindications with our medications or do not have access to them. Vaccines do not work for us and you haven't come up with any new treatment options. So until you do, please consider us and our right to receiving healthcare in a safe setting.
Thank you,
Barbara Schreiber Parnell

---

Hello,
Please put masks back in healthcare. I am afraid to seek healthcare because masks are not required or used in hospitals and other medical settings.
Covid19 causes longterm complications in 20% per infection as per the CDC…this includes neurological issues, fatigue, CNS issues, autoimmune diseases & more. NIH says 1/10 get long covid.
How can you look at these statistics for a BSL-3 virus with long term complications and not require masks in healthcare.
It makes no sense, you know what the virus is going to do, you know the population is going to get more and more sick, you know the covid induced immune dysregulation will cause opportunistic diseases, you know around 1/10th of the country has long covid… you know 6000 a week are dying… you know reinfections are worse than the first infection… you know about the strokes and blood clots covid causes… You are public health, you need to recommend n95s in healthcare or how can you deny your policy is eugenics and to weaken the US population, to create a dependency on specialists and drugs instead of promoting health and wellness.
I wonder how big a hit the military will take, the physical power but also brain power.
Why can't you do your public health job and recommend the right thing? Who do you answer too? The government may not know how bad covid is long term, but the CDC knows… please do the right thing and recommend masks in all healthcare especially dentists. Doctors offices always give the excuse for not masking as " we are following CDC guidelines".
We would be better off with no CDC then at least the doctors office has to say it's their choice to infect patients… now they blame CDC…
Also people deserve to be educated about the risks of Covid. Where are the advertisements on bus stops like HIV, where are the commercials to protect from long covid by masking? Let people decide with the information. There are many more dead and with covid induced Aquired immune deficiency than from HIV… it is temporary but with reinfections its constant, yet people are clueless about long covid risk, it's your obligation to educate people to make informed decision. In 5 years who will be blamed for not doing media rounds and messaging for people to protect themselves. The vaccine doesn't protect you much from long covid…right now all we

have is masks and cleaning air…please promote it or at very least inform and push to require masks in healthcare…
Thank you, Elisabeth

---

Hello,

I would like to make a comment for the Healthcare Infection Control Practices Advisory Committee's upcoming meeting.

My comment is this: Please reinstate universal masking in healthcare for the safety of the general American public, and especially those at higher risk of complications from Covid! Covid has clearly not disappeared; in fact, as of 7/24/2023, the Covid Data Tracker section of the CDC website states: "Covid-19 indicators, including hospital admissions, emergency department visits, test positivity, and wastewater levels, are increasing nationally." Covid is an airborne virus. Masks can help reduce transmission of Covid and protect individuals from contracting the virus. Avoiding a Covid infection or reinfection can be especially important for higher risk Americans such as the elderly, the immunocompromised, pregnant individuals, and babies and young children.

I am an immunocompromised American myself. While generally in good health, I must take several immunosuppressant medications because of my health condition. This puts me at increased risk of contracting Covid and experiencing lingering effects from infection; therefore, I am very careful to protect myself as much as I can by staying up to date on my Covid vaccinations and wearing a mask in any indoor public setting I enter. However, as you know, vaccinations do not prevent infection, and one-way masking is not perfect and not 100% protective. I must visit several doctor's offices frequently because of my health condition. Since mask requirements were lifted in healthcare settings this spring, I feel very vulnerable every time I go to a doctor's visit. I am almost always the only person masked in the doctor's office, which I find distressing and threatening to my health. Shouldn't a doctor's office or hospital be the ONE PLACE that higher risk individuals can feel safe from the threat of contracting Covid? Healthcare workers have worn gloves ever since the emergence of HIV to protect themselves from infection, and that has never changed — why would masks to protect against an airborne respiratory virus be any different? Why isn't my right to avoid Covid infection as a PATIENT as important as a doctor or nurse's right to protect themself from HIV infection?

To me, it is a shocking dereliction of duty that healthcare workers no longer wear masks to protect their patients. I am equally surprised and disheartened that the CDC — literally, the Centers for Disease CONTROL and PREVENTION — allowed hospitals and doctor's offices to drop universal masking, despite the clear evidence that masks work to prevent the spread of Covid. I hope that the HICPAC will reconsider the data and reinstate universal masking. No American should have to risk a Covid infection or reinfection, or the debilitating effects of post-viral illness, to receive necessary medical care, or have to consider whether visiting a doctor is worth the risk of contracting Covid.

Thank you,
Leila Rice
Lambertville, NJ

---

To the HICPAC:

We need masks in healthcare settings! It is absolutely wild to me that in a context where people go when they are sick, masks are not required as a matter of course. This should have been the case before COVID, and it should certainly be the case now.

Ever since masks mandates for healthcare settings have been dropped, I am very nervous to visit the doctor or hospital for fear that I will leave more sick than when I entered. This is especially the case for pediatric healthcare facilities since my child is too young to wear a mask (not quite two years old).

Please consider the health of EVERYONE in this country and push for masks in healthcare!

Sincerely,

L. Logan Bell

---

Hear HICPAC folks,

We need to take a step backwards and reinstate mask requirements in healthcare facilities --

It is insane that mask requirements there have been removed. This means that people who are more at risk for covid-19, like myself, are now even MORE at risk, if we dare to go to a healthcare facility for needed care. Consequently many of us are skipping needed care.

Let the party goers have their concerts, movies, festivals, restaurants, house parties, vacation travel, but LET US HAVE A SAFER SPACE IN HEALTHCARE FACILITIES!

Gesine Lohr

---

Hello,

I've read that at your last HICPAC meeting you downplayed the need for N95 respirators for COVID (and similar pathogens). I am 75 years old, have had asthma since age 3 and had part of my right lung removed at age 10. With two risk factors, age and pulmonary disease, for greater complications from COVID, it is critical that the medical environments I may need to visit be as protected as possible. That includes the ongoing use of N95 respirators in medical offices.

Please do not abandon the preventive measure of N95 masking in medical settings.

My best regards,

Camille Warren, Raleigh, NC

---

Hello,

I would like to comment on how much we have learned over the last few years in respect to high-quality masks and how they can do much to reduce spread of infectious disease. While it is difficult to study, universal masking in healthcare settings has an excellent rationale. If there is a good chance it can help reduce spread of disease to those most vulnerable, then institutions that provide medical care should institute universal masking.

And, if we are going to require universal masking, we should use the best masks. N95 at minimum would be that, not blue surgical masks that were common prior to the pandemic in healthcare settings.

Daniel Libertz

Ladies & Gentlemen,

It has come to my attention that your committee is beginning to downplay the need for masking and other protocols in healthcare settings. Please don't do this! While the emergency portion of the covid pandemic may be over, the pandemic is Not over and continues to cause thousands of hospitalizations and hundreds of deaths on a weekly basis in the USA and worldwide.

As you are well aware Covid is an airborne disease that is easily transferred from person to person. I know this first hand. I went to my dentist's office in April for a cleaning and checkup. Within a week's time I had Covid. I rechecked with everyone I had encountered that week and no other place I visited had any instances of Covid within their offices. I am retired and do not have a robust schedule, so it was fairly easy to identify where I most likely picked up the disease. Dentists offices need to have robust air purification systems and/or UV lights to sanitize the room where patient after patient have their teeth cleaned filling the air with aerosols just waiting for the next patient to arrive and infect them. Some studies show that these Covid aerosols can survive for well over an hour. So many people (workers and subsequent patients) can be infected by one dental patient who has Covid.

I do not only have myself to be concerned about. My husband is also retired and has numerous underlying conditions which makes Covid much more dangerous for him. While we have both been vaccinated each and every time we are eligible and we were both able to take Paxlovid for this recent infection, we are also very aware that with each infection, long covid is a possibility. My husband, unfortunately, got Covid Rebound after his Paxlovid regimen was completed.

I urge each and every one of you to continue to take Covid very seriously. Please return to KN95 or higher masking in All healthcare settings for all employees and patients. Please require other stringent protocols for places like dentist's offices where lots of aerosols are a part of their practice.

Thank you for your time and consideration on this important topic.

Sincerely,

Joyce E. Green

Robinson, TX

Topic: Update Infection Control Guidance in Health Care Settings/Clean Indoor Air

I urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens,

including SARS-CoV-2 and others, including:

• Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
• Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

I am concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.
Thank you for your time

---

We need universal, N95 respirator masking in all healthcare facilities.

And people need access to no-cost antigen and PCR testing.

COVID is not going away, long COVID is a significant risk even for the young and the vaccinated. Let's not make it harder for people to avoid getting infected.

Susan Donaldson MD

Northampton, MA

---

We need N95's in healthcare, especially now in light of the current surge. Please protect our country's citizens.

Thank you.

Kathy Cook

---

I am contacting you regarding the upcoming HICPAC meeting, and requesting to have guidelines updated for infection control to prevent the ongoing death, and increased life threatening illnesses being spread within medical facilities, by requiring permanent N95 mask mandates.

As a disabled parent who has long covid, and is raising a disabled child who has chronic, complex medical conditions; I have had to choose between getting needed medical care and risk catching Covid19, or another respiratory illness, or forgo needed medical care in order to stay illness free.

This is not a decision I take lightly. However, I cannot risk my child's life (she get's status seizures and breathing suppression from respiratory viruses), by trying to get medical care. Due to her upper airway restriction and other ongoing medical complications, she cannot safely mask, thus we require others to wear N95 masks in order to keep her from catching dangerous respiratory viruses.

Due to mask mandates being removed , we have been forced to forgo: Craniofacial clinic appointments, ENT exams, OT/PT, Pediatric specialist appointments such as Nuerology, GI, and important blood draws.

My child and I were in a car accident in December 2022, and have yet to locate a clinic that will wear N95 masks so we can get care for chiropractic, PT and massage.

These are some of the needed medical care my child and I have been forced to forgo as medical settings become less accessible and more exclusionary towards disabled/ chronically ill folx. Without robust protections from airborne diseases, many will be forced to forgo crucial medical care supports. HICPAC has the power and ability to change these exclusionary practices.

We need strong proposals that reflect the best current knowledge on significantly reducing transmission, not simply what's minimally viable. Please include those most impacted in more open discussions, please listen to the experts who have recommended effective measures of preventing transmission, and delay voting until these actions are taken

- Need for transparency in HICPAC's planning and for involvement on development from stakeholders including clients, Disabled community members, Black and Native communities, personnel, and other experts
- Must fully recognize aerosol/inhalation transmission of SARS-CoV-2 and other infectious aerosols and describe in detail the proposed "air" transmission category
- Updated guidance should include the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including ventilation, isolation, respiratory protection, and other PPE

- Establish universal masking with N95s as minimum requirement
- Track hospital-acquired infections
- Delay voting on guidance until these matters have been addressed
- The lack of proper infection control measures is an equity issue as Black, Native, and disabled folks are disproportionately impacted by COVID-19 and other infectious diseases

I am in a group of other Covid cautious pro/ N95 mask folx, most of which are also disabled and/or caregivers or medical professionals.

I look forward to attending this meeting and providing valuable information for HICPAC to make informed decisions regarding infection control guidelines.

Regards,

Emilyfern aka: Juniper's Mama

---

I am the spouse of Emily Fern and I am Juniper's dad. Please help make medical settings safe for my daughter by improving respiratory illness mitigation through mask mandates especially in medical settings.

It's heartbreaking to take my daughter to her providers and bring her home with other illnesses that appear days afterwards.

In hospital settings alone she has contracted confirmed cases of fifth disease and roseola, not to mention the many other illnesses.

Now with symptomless carriers of very contagious variants of covid, this clearly requires mitigation. NO ONE should want to get covid, it's novel, causes long covid, triggers other and past disease (i.e. varicella recently in myself), and disability for many people. We don't yet know if it will go dormant and come back like chickenpox/shingles.

Soapbox: Why aren't our doctors leading with multistep mitigation plans beyond masking, including ventilation? Are they tired after the pandemic, overwhelmed since folx don't wear proper or properly fitted masks, did fascist anti vaccine anti maskers scare them??? Please step up for the vulnerable as my spouse says below.

Michael Paruch

Oregon USA

---

To whom it may concern: as you meet to discuss infection control proactive a in this country, I would like to voice my opinion that we need N95 respirators as part of the standard in infection control for COVID and other airborne pathogens. And I beseech you to maintain high levels of infection control and to reinstate universal masking in healthcare. As a person with chronic illness, I am risking serious infection from COVID by going into my critical appointments at the hospital and the lack of masking has me skipping all but the most critical appointments because the risk is too great as people cough and sneeze in tight waiting rooms and practitioners work on me without a mask. Hospitals are one public space that vulnerable people have no choice but to go. At least that one space should be made safer with masks required for all. Please reinstate the mask mandate in hospitals.

Best,
Lyndsey Ellis
Arlington VA

---

Hello -

I am writing to share my feelings in advance of the August 22 meeting you were holding. As someone who has had a compromised immune system for 14 years, who has had three bouts of COVID-19, and who is suffering from long Covid, I strongly urge you to strengthen the protections in place in the US for anyone in a hospital to stay safe from airborne pathogens.

I have frequent encounters with healthcare settings, and I now routinely find myself as the only person wearing a mask. It's very upsetting to feel so vulnerable in a place that should feel safe.

I was hospitalized in 2017 for a bacterial infection, and I was put into isolation given the state of my immune system. Everyone who came in and out had to take precautions like masking, and it was a common sense step in keeping me safe. That was before a worldwide, airborne pandemic, and those steps were greatly appreciated.

For the last 3 1/2 years, everyone has had the vulnerability that I had then. Covid is still injuring, disabling, and killing so many people who we could easily protect. Wearing high-quality masks, not just loose fitting surgical masks, in a medical setting is the logical step we can add to our routines from the experience of the past few years, and move forward with as a way to keep people safer in healthcare settings.

When AIDS was at the front of everyone's mind in the 80s and early 90s, universal surgical glove wearing in hospitals was one take away, as was increased use of wearing condoms during sex. That was a health emergency that we learned something from and as a result, we changed our behavior.

If we learn nothing from the millions of deaths and millions more disabled due to COVID-19, we are damning ourselves to untold suffering moving forward. It is such a simple step to insist that hospitals and care taking facilities remain a place where everyone can come for safety. Making masks optional is abandoning so many Americans to preventable illness.

I hope he will take these simple steps to protect yourselves, to protect me, and to protect us all.

Thank you,
Dave Ruder
Brooklyn, NY

---

I’m writing to insist that you reinstate rules that medical personnel wear masks. They are endangering their patients and not following their own rule of “Do No Harm”.

Thank you,
Debra Di Maio

---

As a physician and a utilizer of health care services, I am dismayed to see that fewer and fewer health facilities are utilizing infection control techniques. As Covid is upticking again and the danger of Long Covid remains, and as many other aerosol transmitted infections exist, it is imperative that publichealth guidelines continue to require effective masking and ventilation . This is most true in indoor settings occupied by vulnerable populations and continuously exposed health workers. We now have the science to know what works but we must use it.

Ellen Isaacs, MD

Asst Prof NY Med College, ret

Member APHA

---

I am not an infectious disease expert, but I am someone that recently went through open heart surgery, living with risk factors for serious complications from COVID.

It was always reassuring to have health care professionals who were taking care of me wearing N95 masks - because they reduced the risk of my contracting COVID during an extensive 10 day period in the hospital.

My understanding is that COVID can be spread through aerosols and that medical masks are not sufficient to prevent this spread.

Please prioritize patient’s health in issuing your guidelines.

Bob Goonin
Minneapolis, MN
No organizational affiliation

---

I am writing to you as a mother, a partner, and a healthy middle aged person who saw my blood pressure spike for almost a year after my case of COVID—I am so disturbed that we have backed off from any sort of attempts to control the spread of COVID, and I'm particularly upset that in order to access other health care for myself and my children I have to risk a COVID infection and potential long COVID. I shouldn't be afraid that going to the hospital will make me less healthy than when I went in.

Please stop bowing to Republican pressures and denialism and actually do public health.

Miriam Tell
Albany, NY

---

Healthcare facilities—among the likeliest places to encounter people with COVID-19—are where are health and well-being should be most protected; but now, the most at-risk among us are being subjected to the fear and undue stress of going to their doctor for care and potentially getting COVID-19 instead. Given the broad public interest in CDC’s guidance to protect healthcare personnel, patients, and the public from airborne infectious diseases, it is unacceptable that CDC/HICPAC’s processes are so closed. I urge CDC/HICPAC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance.
We are all aware of the devastation wrought by COVID-19, particularly among older adults, people with disabilities, and people of color. Even if those with underlying health conditions wear their own respirators, they still face an increased risk of infection imposed on them when they try

to access in-person medical care in “mask optional” settings. Those who are at risk for severe COVID-19 outcomes are not being forced to accept the unnecessary risk of close proximity to unmasked individuals of unknown infection status—in lobbies, corridors, elevators, waiting rooms, and restrooms. While some hospitals say patients can request their “team to wear a respirator in the exam room, due to the asymmetrical power relation between patients and providers—particularly for patients who are women, people of color, or otherwise marginalized—many do not feel comfortable asking their provider to wear a respirator, nor should the burden of ensuring that this accessibility need is met be placed on them.
The Work Group on the Isolation Precautions Guide has failed to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. Consequently, there are significant errors in the new draft recommended categories of “air” and “touch” modes of transmission for healthcare-related infections. CDC/HICPAC fails to recognize the critical role of inhalation and, instead, continue to recommend loose-fitting surgical masks, which do not provide respiratory protection against inhalation of infectious aerosols. It is, rather, N95 respirators that are widely recognized as effective and relatively inexpensive infection control measures to protect both the workforce and those being treated in healthcare settings.
Overwhelmingly, CDC/HICPAC has failed to acknowledge the importance of core control measures for infectious aerosols. The large body of evidence on the effectiveness of respirators,
rather than loose-fitting surgical masks, as well as the importance of ventilation and filtration for controlling both patient and worker exposure to infectious aerosols, have not been considered. Currently, the new draft contains no recommendations on ventilation. Additionally, source control
is not adequately considered in the context of personal protection from inhalation.
It is imperative to protect the most at-risk among us from involuntary exposure to SARS2, which includes protecting the frontline, essential healthcare workers who are already in short supply.
**Megan Doherty, *Disability Lead***
**Chicago, IL**

---

Please reinstate universal masking in the healthcare industry! This is a no-brainer and must be done to ensure the safety of all!

Lisa Carpus

---

To HICPAC and CDC

As a severely immunocompromised citizen with a primary immune disease that carries a high mortality risk if I should get COVID, I am deeply in need of the protections the CDC can provide. I know I speak for many others with a vast array of medical disabilities.

I am concerned that the HICPAC/CDC has not offered more transparency and allowed general public knowledge of and engagement in the process. I also am concerned about insufficient input from medical care providers and scientists, as well as the substantial immune disabled community.

It is clear the science on aerosol transmission and control measures for infectious aerosols is key to public health and disease control, presumably your primary mission. This deserves thorough study, acknowledgement and extensive problem mitigation beyond the “gesture” of surgical masks.

By far the foremost issue to me (and countless others) is that health care settings be safe enough that providers can work in and patients utilize medical facilities, especially the most vulnerable among us. I have not obtained necessary health care since the end of COVID restrictions in such facilities because I must ponder each foray with the question of whether the problem justifies the inevitable level of exposure from being indoors with unmasked patients and staff with unknown monitoring of air exchange and filtration.

The pandemic is not over, as the death toll continues. That is a fact. We need to return to gathering more facts and documentation and tracking of cases and exposure. For someone like me the pandemic may never be completely over but it is in the hands of the CDC to make the world at least partially livable and safer for me. The immune disabled community, medical providers and the general public deserve nothing less.

Thank you
Jean Wolitzer

---

To whom it may concern,

I'm horrified at what year 4 of the covid pandemic has looked like. I would have never thought that the last and most essential place medically vulnerable people must go to in person sometimes would end up being a danger to our lives.

The decision to remove mask mandates in healthcare is so nonsensical I can't wrap my head around why anyone, especially public health leaders, would think it makes sense to expose vulnerable patients to a safety level 3 biohazard that we don't even know the potential long term effects of. A virus that can cause debilitating disease for months or years, that damages the vascular system, the organs, the brain, increasing risk for heart attack, stroke, diabetes, and now we're learning it may even trigger Parkinson's Disease, the CDC has decided to freely spread?

If these unhealthy decisions aren't reversed, there may very well be class action lawsuits against the state, and whoever is responsible for making decisions that so seriously impact our health, once more of the public realizes just how harmful this virus can be to every organ and system in the body. The CDC has made these statements itself about covid's dangers, so the only responsible thing to do is to make sure public institutions that medically vulnerable people rely on have measures in place to protect the people inside them by requiring masks and clean air.

The majority of people want this.

I shared someone's post supporting keeping masks in healthcare a couple days ago on my business's Instagram account and it's gotten more positive engagement than my regular content has been getting with over 4,000 likes and counting. With the horrible reach of that platform these days, I think that's a big deal. Polls support this as well.

Assuming people don't care about their health and the health of their loves ones was a huge mistake, and if you don't rectify it, then I hope any attempts at justice in the courts will force that rectification. So many people's disability and death is your responsibility and you should be doing everything you can to fix this error and save lives.

Angela Jarman

---

Hi, as an expert that has worked with the CDC and White House on overlooked pandemic failures (most of which have yet to be corrected), I have the following questions for the August HICPAC meeting:

-what benefit was gained by deciding to reuse N95s up to 20 times instead of following the original CDC pandemic plan to put elastomeric respirators into widespread use and will N95 reuse be recommended over elastomeric respirators if there is a return to N95 shortages?

-after the CDC did a blog post in 2017 and reported in their pandemic plans on the need ensure elastomeric respirators were well promoted to ensure they wouldn't couldn't to be overlooked, why has the agency refused to listen to their own recommendations and will they start to promote their importance on social media, at press conferences and finally include them in mask charts alongside surgical masks

https://blogs.cdc.gov/niosh-science-blog/2017/07/06/elastomerics/

-why is the CDC continuing to tell the public to avoid valved respirators and to instead use surgical masks for source control when it has been well established and studies by the CDC that valved respirators provide better source control than surgical masks

https://www.cdc.gov/niosh/docs/2021-107/default.html

-why is the CDC refusing to recommend widespread use of N95s and elastomeric respirators over surgical masks when they have already stated that surgical masks will not offer RELIABLE protection and if the continue to promote the use of surgical masks, will they only recommend them if masks that do provide reliable protection such as N95s or elastomeric respirators are not available

https://www.cdc.gov/niosh/npptl/pdfs/UnderstandingDifference3-508.pdf

-since masks that provide reliable protection from airborne transmission such as N95s and elastomeric respirators also provide better protection against droplets than surgical masks, why take undue risk by

starting with lower levels of protection even when it is unknown if a new virus is spread by airborne or droplets?

-after over 5000 HCWs died following the decision to use surgical masks and reuse N95s while discouraging the use of elastomeric respirators, what will be done to ensure a failure like that never happens again

-when elastomeric respirators had been safely reused for decades by infectious disease doctors like those at the Texas Center for Infectious Diseases plus had long been proven effective while N95 reuse had never been proven safe nor effective, why did the CDC decide to implement N95 reuse and spend the next 3 years studying elastomeric respirators

-in May 2020 Congressional hearings, NIOSH Director John Howard testified that before reusing N95s, hospitals needed to ensure everything was done to provide HCWs with elastomeric respirators since N95 reuse was supposed to be a last resort option and not an alternative. NNU copresident Zenei Cortez explained at a town hall that hospitals were purposely withholding elastomeric respirators from nurses as they were dying en made on a daily basic so why was that rule not enforced nor properly communicated to hospitals.

https://www.congress.gov/event/116th-congress/house-event/LC66152/text

-since the CDC refused to publicly promote elastomeric respirators, countries like Canada that had large government stockpiles of those respirators have kept those stockpiles locked up since the 1st wave despite N95 shortages that lasted years. What is the CDC planning to do to ensure the international community is made aware of the importance of elastomeric respirators so they can both use them and study how to best use them?

In a May 2020 New York Times investigation, federal agencies blamed each other for the failure to ensure elastomeric respirators were known or promoted. A July 2022 New York Times investigation had the CDC explain they could not let the public know about the importance of elastomeric respirators due to ongoing studies on disinfection and to see if HCWs would want to use them. In 2021, it was discovered that Covid was airborne but surface transmission was not a source of concern. In a large study published in June 2020 by the American College of Surgeons and the Allegheny Health Network, not a single HCW wanted to stop using elastomeric respirators after a four week trial and go back to N95s. Why was there a need to do further studies and why was there a need to keep misleading the public to believe only N95s and KN95s were known to EFFECTIVELY protect the wearing from Covid

https://www.nytimes.com/2020/05/27/us/coronavirus-masks-elastomeric-respirators.html?auth=login-google

https://www.nytimes.com/2022/07/03/health/covid-ppe-masks-health-care.html

https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/press-releases/2020/reusable-masks-061220/

Kind regards,
Nicolas Smit

---

Greetings,

My name is Alex Fay and I'm a community health nurse in Seattle, WA. I don't have any organizational affiliation. I'm writing to give comment on the HICPAC's efforts to update the Isolation Precautions Guidance. I have been a nurse since 2020, and entered the workforce when COVID first hit. During the past three years, I have worked through countless COVID outbreaks, and have managed to keep myself safe due in no small part to the PPE, HEPA filters, and routine testing my workplace provided.

HICPAC's Work Group on the Isolation Precautions Guidance is proposing a more "flexible" approach that gives health care employers broad discretion to create infection control plans, which leaves the door open for unsafe and unjust policy creation and implementation. I urge HICPAC and the CDC to make it clear and explicit in the updated guidance that strong precautions are needed to protect healthcare workers and providers from infectious diseases. This includes assessments to evaluate level of exposure, control measures needed, and a written exposure control plan.

If HICPAC and the CDC weaken infection control guidance in healthcare, it will have negative health impacts on both healthcare workers and patients seeking care. By reducing precautions, we will see an increase in the spread of respiratory illnesses like COVID, which has both acute and long-term health effects. Many nurses have already left the bedside due to the short

staffing, lack of PPE, and long hours that they worked during the pandemic. Weakening infection control policies will cause even more nurses to leave the field and create an even more unsafe and unjust environment in healthcare facilities. It is a health care employers' duty to keep both their staff and their patients safe, and this includes providing adequate PPE (such as N95s and PAPRs) and ventilation in their facilities. I urge HICPAC and the CDC to include frontline workers, safety professionals, and other experts in the process of updating infection control guidance, to ensure that it is safe and effective for those who will be most affected by its implementation.

Thank you,

Alex Fay
BSN, RN

---

To whom it may concern,
From a public health perspective it seems like a no brainer to maintain high levels of infection control by reinstating universal masking in healthcare settings. When we discovered the effectiveness of hand washing in infection control we didn't do it for two years then stop so we could get back to "normal." Thank you for your time,

Joseph Martino

---

Submitter Name: Paul Henenssy
Organizational Affiliation: None

Topic: Update Infection Control Guidance in Health Care Settings/Clean Indoor Air

I urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

• Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
• Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection

available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

I am concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

Thank you for your time

---

To whom it may concern,

I am writing to submit a written comment to the CDC's Healthcare Infection Control Practices Advisory Committee meeting on August 22nd.

I work in a healthcare setting on inpatient units with children who have a range of chronic health conditions. The fact that the CDC has rescinded the mask mandate for healthcare professionals is appalling and I have seen the direct negative impacts that have occurred. The patients who I work with are no longer safe in their healthcare setting. Every day, they are at risk of their nurse, doctor, therapist, etc. bringing COVID into their room and for some that has occurred to detrimental effects. Patients deserve to be protected, and removing the mask mandate is failing them.

The CDC's choices have been completely unfounded in science. Wastewater data shows that COVID is clearly still ongoing in the US, and it is once again even more on the rise. The CDC has chosen to abandon the American people, to turn a blind eye and ignore the reality that there are easy mitigation methods we could all be taking. I am writing to demand that the CDC reinstate the healthcare mask mandate so sick children can be protected while they receive care. HICPAC should incorporate universal masking into standard precautions across healthcare settings and recommend the use of N95 respirators broadly. I am also writing for the CDC to put out accurate COVID guidance, including return to tracking cases so people can be well-informed of their risk, enforce masking in indoor spaces and the need for good air filtration, and give people easy access to COVID tests.

The CDC is supposed to be the country's public health expert, and yet it is ignoring every clear and rational public health protocol. I demand that the CDC does better for us all.

Sincerely,

Katherine Pedrick

---

Please advocate for increased public oversight of the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC), the committee that oversees policies on the prevention of infectious diseases in healthcare settings. Policies need to be developed with the input of impacted stakeholders, such as health workers and patients. I am concerned that the CDC will soon profoundly weaken its Infection Control guidance which could place health workers and patients at risk of short- and long-term harm and even death from infectious diseases. Universal masking is a simple measure to reduce the risk of infectious disease transmission that has been implemented broadly in healthcare settings for the last three years. HICPAC should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators. (1) Instead, in June 2023, the CDC HICPAC Isolation Precautions workgroup formally proposed changing CDC guidance to recommend health workers wear loose-fitting surgical masks (2), which are less effective with airborne infectious diseases, to care for patients with COVID and other infectious diseases such as Middle East Respiratory Syndrome (MERS) or Severe Acute Respiratory Syndrome (SARS), rather than fit-tested N95 respirators or more protective equipment, which are much more effective with airborne diseases.

Adopting this policy will endanger millions of workers and patients across the country. Airborne infectious diseases such as COVID-19 are transmitted in the air we all share, which is why wearing high-quality, face fitting respirators is important to prevent transmission, in combination with ventilation and other layers of protection (3). COVID-19 has already caused over 42,000 deaths this year (4), placing it among the top 10 killers in the US in 2023, and 15.8% of U.S. adults have experienced Long COVID (5), a condition that persists after initial recovery from a COVID infection. Similarly, other airborne diseases such as MERS or SARS could also lead to large numbers of hospitalizations and deaths, the 2015 MERS crisis led to 38 deaths among 186 diagnosed cases in South Korea, and the 2002-2004 SARS crisis led to 774 deaths among 8,000 diagnosed cases across several countries in Asia and Canada.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms (6), they may pass it to their coworkers or patients in maskless healthcare settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages.

The recommendations were based upon a widely-critiqued (7), flawed literature review. The guidance even contradicts the CDC's own data which demonstrated that continuous use of N95 and KN95 respirators cut the odds of infection by 83% compared to 66% with surgical masks (8). Nearly 900 experts and over 1000 members of the public have already signed an open letter urging the CDC to strengthen, rather than to weaken its infection control guidelines, and to open the process of infection control guidelines to include more stakeholders and interdisciplinary experts (9).

CDC/HICPAC decisions are made undemocratically and developed behind closed doors, without input from nurses unions, healthcare workers, patient, disability and elder advocacy groups or even independent aerosol experts, occupational safety professionals and industrial hygienists. In the last public meeting, CDC/HICPAC voted on a proposal before hearing public comment – an example of lack of inclusion. Even though CDC/HICPAC is part of a Federal agency, they have not made their draft protocols available to the public – unlike other CDC

committees. We only have access to a barebones PowerPoint from CDC/HICPAC's last meeting on June 8-9 2023, which outlines the proposed changes (2). The meeting notes are not made available in a timely manner, and are still not available from the June meeting (10). The HICPAC committee is packed with representatives from the hospital industry, and lacks procedures for meaningful public input.

The American Hospital Association has explicitly declared that hospitals are facing a "crushing" financial crisis (11). Given this, I am concerned that the hospitals may be pursuing this short-sighted infection control approach to reduce their expenses by cutting fit-testing programs and limiting access to N95 respirators and other airborne protections. However, increasing rates of health worker COVID infections will further worker shortages and may lead to additional disabilities caused by Long COVID. Ultimately, infection control that ensures the highest protection of healthcare workers and patients based on evidence-based science, and integrates the input of stakeholders is a necessary approach.

References:

(1) Kalu IC, Henderson DK, Weber DJ, Haessler S. Back to the future: Redefining "universal precautions" to include masking for all patient encounters. Infect Control Hosp Epidemiol. Published online February 10, 2023:1-2. doi:10.1017/ice.2023.2 https://pubmed.ncbi.nlm.nih.gov/36762631/

(2) Isolation Precautions Guideline Workgroup - Co-Chairs: Michael Lin, MD, MPH and Sharon Wright, MD, MPH - HICPAC June 8, 2023 https://drive.google.com/file/d/14s40YHjuZxMQ_ZOx2qXIdsPDxD0641_b/view?usp=sharing

(3) EPA - Implementing a Layered Approach to Address COVID-19 in Public Indoor Spaces https://www.epa.gov/coronavirus/implementing-layered-approach-address-covid-19-public-indoor-spaces

(4) COVID Data Tracker - Trends in United States COVID-19 Hospitalizations, Deaths, Emergency Department (ED) Visits, and Test Positivity by Geographic Area https://covid.cdc.gov/covid-data-tracker/#trends_totaldeaths_select_00

(5) CDC - National Center for Health Statistics - Long COVID - Household Pulse Survey https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

(6) Johansson MA, Quandelacy TM, Kada S, Prasad PV, Steele M, Brooks JT, Slayton RB, Biggerstaff M, Butler JC. SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. JAMA Netw Open. 2021 Jan 4;4(1):e2035057. doi: 10.1001/jamanetworkopen.2020.35057. Erratum in: JAMA Netw Open. 2021 Feb 1;4(2):e211383. PMID: 33410879; PMCID: PMC7791354. https://pubmed.ncbi.nlm.nih.gov/33410879/

(7) Why the CDC's New Mask Guideline Proposal May Actually Imperil Frontline Workers. "The decisions some of these public health people are making are not getting better. They're getting worse." by Katie MacBride, The Daily Beast, Updated Jul. 01, 2023 3:40PM EDT / Published Jun. 30, 2023 11:47PM EDT https://www.thedailybeast.com/new-cdc-mask-guidelines-may-actually-imperil-frontline-workers-experts-say

(8) Andrejko KL, Pry JM, Myers JF, et al. Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection — California, February–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:212–216. DOI: http://dx.doi.org/10.15585/mmwr.mm7106e1

(9) National Nurses United - Urge the CDC and HICPAC to fully recognize aerosol transmission and protect health care workers and patients https://www.nationalnursesunited.org/urge-the-cdc-and-hicpac-to-fully-recognize-aerosol-transmission

(10) CDC - Healthcare Infection Control Practices Advisory Committee (HICPAC) - Meeting Minutes https://www.cdc.gov/hicpac/minutes.html

(11) Becker's Healthcare - Congress can take action to help healthcare deal with 'crushing' financial challenges, AHA urges - by Nick Thomas - Tuesday, October 25th, 2022 https://www.beckershospitalreview.com/finance/congress-can-take-action-to-help-healthcare-deal-with-crushing-financial-challenges-aha-urges.html
Steven V. Joyal, MD
Chief Medical Officer

---

Submitter: John Meszaros, Ph.D.
Organizational Affiliation: Independent Researcher
To the CDC HICPAC:
I am writing to urge the committee to create better standards for ventilation and to reduce aerosol transmission of COVID-19 as well as other respiratory viruses. 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 has not been considered. There are no further recommendations from the HICPAC 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.
On a personal level, I do not believe I should be exposed to COVID or other viruses by simply going to a doctor's office or any other public place. I understand the fatigue on masking but, considering we as a country have not implemented any alternatives, it is still our main defense against COVID. I think air purification and Far-UV technology could greatly improve indoor air safety, but, without support from the CDC, and HICPAC in particular, it will make it very difficult for *individuals* to push for this change. I am urging the committee to act and push for public indoor air purification.
Thank you for your time,
John Meszaros

---

Dear HICPAC,

I'm very concerned about the lack of transparency in updating the Isolation Precautions. Over 900 public health experts have sent a letter to Dr. Cohen to express their concerns about the updates and its process. Most concerning is the lack of shareholder input across multiple industries. There has been little opportunity for public engagement or access to information. HICPAC meeting documents and presentations have not been publicly posted, which is a stark contrast to other federal advisory committees, including those at the CDC. The CDC has made comments about their desire to increase public trust – why hide these documents?

The approach proposed encourages "flexibility" that give healthcare workers broad discretion to create their own infection control plans. This is disturbing, considering how many healthcare institutions are owned by private equity firms and other organizations with an emphasis on the bottom line. This "flexibility" gives a cover to minimize worthwhile costs associated with protecting employees and patients. Clear and explicit guidelines are necessary when lives are at stake. The proposed terminology also fails to fully acknowledge aerosolized transmission and how inhalation of aerosolized pathogens remain a risk in healthcare. Surgical/medical masks are insufficient protection against aerosolized transmission. I do not understand why that would be considered sufficient. The evidence review of N95 effectiveness was also questionable when there are a variety of robust and well-designed studies that

demonstrate that N95 masks are more effective than surgical masks. The proposed guidelines also do not acknowledge the importance of ventilation or air filtration.

In conclusion, the HICPAC proposed guidelines send the message that patients and healthcare workers are an acceptable sacrifice in the name of profit. I am not in the medical field, but living with a highly infectious pathogen in my community for three years has resulted in me diving into research and listening to experts to protect myself. I was under the impression that the precautionary principle was necessary in situations where one risks their life or their health. Why create guidelines that do the opposite? That weaken protections in the wake of increased knowledge of aerosolized transmission and the effectiveness of respirators? What's next – should handwashing and glove usage become discretionary precautions?

Sincerely,
Nikita Williams
Organizational Affiliation: UNC Charlotte

---

I am an aerosol scientist and have done research on airborne transmission of SARS-CoV-2 and other pathogens. I am extremely concerned that the proposed HICPAC guidelines are very insufficient and inconsistent with the science, and will expose both health care workers and patients to avoidable risks of infection, death, and disability.

I am also very concerned from the lack of ANY researchers highly active on aerosol research or airborne transmission in the HICPAC panel. The expertise of the panel seems very narrow, and not representative of modern science or of what science has learned about this topic during the pandemic.

An example of a recent Nature paper that used the DELPHI method to compile the consensus of 400 experts from 100 countries, in which I participated is here: https://www.nature.com/articles/s41586-022-05398-2. Its conclusions are at odds with the current HICPAC proposals.

It does seem that the historical misunderstanding or airborne transmission by the CDC, summarized in this recent peer-reviewed paper https://doi.org/10.1111/ina.13070, continues to date. It is essential that the CDC learns from its past mistakes and includes a broader range of disciplines representative of the modern science of airborne transmission in this process.

Jose-Luis Jimenez, PhD
Distinguished Professor
University of Colorado-Boulder

---

Clinical (Patients) and Occupational Safety (HCW) in healthcare settings is an ethical issue, since we do know which quality standards based on scientific evidences (EBM+) are necessary for re-orienting non-pharmaceutical interventions (Vaccines+) from mitigation to prevention of airborne diseases. Primary prevention of a preventable harm is a must, a goal and a debt.

Our proposal called #LAS7CAPAS (the 7 layers, in English: https://drive.google.com/file/d/1QSPWiFwgNhFRiiO16Y-li5cMMf_tLmx4/view?usp=drivesdk) recognizes the new paradigm of #COVIDisAirborne and the ongoing risk of a slow disaster because of #LONGCOVID... but also the Precautionary, Quality

and Equity principles in Health. Respiratory pathogens preparedness with #LAS7CAPAS means to reduce the emergent risk of rapid disasters and even catastrophes because of seasonal (endemic) and outbreaking (pandemic) airborne diseases.

On August 2023, the WHO already has updated "Infection prevention and control in the context of coronavirus disease (COVID-19): a living guideline" and has delivered "Report of the Review Committee regarding standing recommendations for COVID-19". So the CDC should make it still better, by regulating universally the quality standards proposed for NPI:
- Distancing 2-3 meters
- Respirator N95/FFP2 fitted
- Ventilation CO2 <550-700ppm
- Filtration HEPA/MERV13 >6-12ACH.

With this state of the art, every Patients have the right of being protected for #LONGCOVID in health care settings and every HCW have the right to know how to prevent Airborne Diseases with standardized non-pharmaceutical interventions. Airborne Precautions (Distancing, Respirator, Ventilation, Filtration) must be recognized as Standard Precautions since everyone generates respiratory aerosols and respiratory pathogens can be transmitted without respiratory symptoms.

Respecfully

Jaime Acevedo, MD
President, on behalf of the Crisis Prevention Center of ONG DESINFLÁMATE Foundation for Social Medicine
@ongdesinflamate
+56989290095
Holanda 3, Buin, Región Metropolitana de Santiago, Chile.

---

Seeking preventive medical care has become inaccessible to immunocompromised people, like myself, due to complete and utter lack of safety since mask mandates were removed. Every healthcare worker fighting against mandatory masking in Healthcare will be looked upon by future generations like the contemporaries of Dr Semmelweis who stripped him of his medical license and institutionalized him until his untimely death, all for his crime introducing handwashing. Do not make the mistake of past generations wasting decades and killing untold numbers before implementing lifesaving practices that we can prove work!
Jennifer Radomski
Gahanna, OH

---

Dear Sir or Madam,

I am urging the HICPAC to require PPE in all healthcare settings (and long term care facilities). I also urge that the type of PPE be N95 respirators, at minimum, in order to prevent airborne virus infection.

From Tuberculosis to Covid-19 and MERS, in addition to influenzas and other viruses, N95 respirators or greater, are the bare minimum to protect patients from acquiring infections within healthcare settings.

For patients to have to weigh seeking medical care versus risking infection of biosafety level-3 viruses (Covid-19/SARS and Tuberculosis, as examples) is a risk assessment that no American

should have to make. It is truly dystopian and a sign of how far this country has reversed it's status as having the best health care system in the world.

What a shame.

Unlike N95 respirators, surgical masks do not form a seal and, thus, will not prevent the spread of airborne viruses between and among healthcare workers and patients. Please make N95 respirators the standard in all healthcare facilities.

Regards,

Gina Carole

---

Hello HICPAC,

My name is River Andres (they/them), and I live at Urbana Illinois, and I am a Physician Assistant at Plume, a remote telehealth company serving the transgender population. I used to work with Champaign Urbana Public Health Department (CUPHD) back in 2019-2021, as the pandemic was kicking off.

In the US healthcare market, individual clinics, hospitals, and other agencies follow guidelines established by their superiors to avoid being reprimanded, penalized or shut down. Individual health care workers (HCW) are at the mercy of whatever Personal Protective Equipment (PPE) is REQUIRED by those protocols. During the early pandemic, because of lax protocols, we were often given less than what we needed to safely care for our patients, and to stay safe ourselves. As a result, the pandemic has been exponentially more deadly than it needed to be. Now, as a result of guidelines updated by HICPAC, we will likely see even more deadly outcomes.

As you loosen precautions and water down protections for staff, you are blowing through necessary barriers to Covid-19, and you are allowing employers to put all of us at risk for the benefit of their bottom line. 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.

Your updates have also failed to incorporate essential input from frontline healthcare personnel, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. I urge you to SLOW DOWN and open up the process to effectively engage these experts in developing drafts. I also urge you to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance.

STOP MAKING THE SAME SHORT-SIGHTED CAPITALIST MISTAKES AND PROTECT YOUR PEOPLE.

Thank you,

- River Andres, PA-C

---

To whom it may concern,

My name is Kendra. I am a former healthcare worker. I previously also served as an Academic Advisor at a public four-year university. My caseload was predominantly aspiring healthcare professional students. I served as the team lead for our Pre-Nursing Advisors and was a member of the Health Profession Advisors of North Carolina. I attended annual conferences that consisted of visits to medical schools throughout North Carolina. We met with program chairs of various medical programs and discussed current trends and topics within the healthcare industry to best prepare our students. I earned a Master's Degree in Higher Education Leadership and a Bachelor of Science in Psychology, with a concentration in Health Studies. My concentration consists of Nursing prerequisite courses, as well as public health courses.

I worked with students during the height of this ongoing pandemic, many of whom were front line workers in healthcare. One of my students took care of my family member who was on a ventilator. I am deeply troubled by proposals to lessen the guidelines to protect patients and healthcare workers.

I worked as a CNA in college, earning my certification in high school. I once worked with a TB patient and recall the seriousness of the situation expressed by the nurse who helped me don my PPE so I could safely enter the patient's room and take their vitals. However, I was taught droplet precautions for other respiratory diseases such as the flu and common colds. I was nearly hospitalized with H1N1 in college and suffered from colds and flus nearly every year of my life. After transitioning to higher education, I still continued droplet precautions in my office. I was notorious for having a stockpile of Clorox wipes and hand sanitizer. I would wipe down all surfaces in my office between students and would go to the restroom to wash my hands after appointments. Yet, I was infected with respiratory illnesses every year. However, since SARS-COV-2 has been allowed to spread indefinitely, I have added airborne precautions to my daily life. We keep windows open in our home and HEPAs running throughout. I also wear an N95 mask anytime I am around anyone outside of my home. I also refrain from dining at restaurants and with anyone outside of my home. I have not been sick since 2019. This is the longest amount of time I have ever gone without illness. There are numerous studies to back up my anecdote as well. It is clear that we need clean air, and that in the case of respiratory illness, it is more important than hand washing.When you know better, you do better.

It seems that the CDC has caved to corporate and political pressure. I am ashamed. Your negligence and lies led to the death of my grandma. She died from SARS-COV-2 because family members believed your lies. You have killed millions and disabled millions more. The further removal of protections will ensure more death and disability for decades to come. Your actions have consequences, not just for healthcare workers and patients, but for all industries. I was basically told I should be willing to risk my life and health for my former job and CDC guidance was read back to me. I was mocked for suggesting that N95s, rather than a company branded cloth mask, was needed. You have lied about the severity and long term effects of SARS-COV-2, as well as the effectiveness of airborne protections. There is another way that does not involve mass death and disability and you know it. Perhaps you will get back to your job of Public Health. You are not economists, nor politicians. Stay in your lane. Tell the truth. It is the only way forward.

Sincerely,

Kendra

To Whom it May Concern,

This spring, my uncle had a scheduled surgery for which he was admitted to the hospital. He knew he had a hospital stay ahead of him, and planned to be there for 2 weeks. He was recovering well from his surgery, and set to discharge on time (after being in the hospital for 12 days). The day before he was to go home, he got sick and tested positive for covid. He was in the hospital for 6 additional weeks battling covid. This was very stressful for him, and for his family. He became very weak, developed bedsores, and was depressed from being in the hospital for so long. He was finally discharged with home health services, and needed physical therapy upon returning home since the covid infection left him at risk of falling. His original discharge plan, pre-covid, was not going to require home health. The hospital he was at had staff still masking, but it was not encouraged of visitors. He had multiple unmasked visitors as did everyone else on his floor.

People recovering from serious surgeries and injuries should not have to face a covid infection. People need to be taught that covid is still around and still a serious illness for many. No, it is not a cold and it never will be. The flu is the flu, covid is covid, and a cold is a cold. They're all different viruses, and covid will never be a cold with the way it attaches to ace2 receptors which are throughout the body. It circulates year-round and is more contagious than other respiratory viruses we're used to. Better ventilation and air purification could make a huge difference. Wearing a mask to visit someone in the hospital is not a hardship, and everyone should be encouraged to do this. Where is the education, the compassion, and the common sense?

Anonymous
DFW, Texas

---

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. Thank you for your time.

Devin Kreitman

New Brunswick, NJ

---

Terrie Weeks, RN, JD, Member of the Public
Re: Updating of CDC Guidelines re: Prevention of HAI

I am writing to express my concern about the draft recommendations to be considered on August 22. 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 draft recommendations, 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 is nonsensical on its face and ignores the science of airborne virus transmission, flouting decades of advances in aerosol science, and what has been confirmed in the past three years of the pandemic. Without N95 respirators for COVID care, and no consistent standards for healthcare ventilation, healthcare workers are more likely to catch and spread COVID to patients and coworkers. By limiting airborne precautions for other airborne diseases, healthcare facilities may face similar 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. There is a large body of evidence on the effectiveness of respirators and the importance of ventilation for controlling worker exposure to infectious aerosols which appears not to have been considered at all.

In addition, there has been a troubling lack of transparency in the process of arriving at these recommendations. Working group meetings regarding the guidance updates are not open to the public. Updates from the working group to HICPAC are not publicly posted. Meeting minutes are not posted. Meeting summaries are posted months after the fact. The public may make comment during each HICPAC meeting, but there is no other mechanism for HICPAC or its working groups to garner input from the frontline health care workers, unions who represent them, and patients who will be impacted by the updated guidance. In addition, the working group does not appear to have solicited input from aerosol scientists and occupational safety and health experts.

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 “crisis standards.”Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to provide inadequate protection based on cost considerations, instead of basing protections for health care personnel and patients on exposure assessments. The crisis standards allowed and enabled health care employers to race to the lowest standard, which led directly to an uncounted number of SARS2 infections among patients and health care workers, their families, and their communities. Embracing this approach in all infection control programs will have disastrous impacts on health care worker and patient safety.

---

TO: HICPAC Meeting, August 22, 2023 - Isolation Precaution Guidelines RE: Modes of Transmission and Appropriate Infection Control Measures

CDC and HICPAC have held onto their default droplet transmission paradigm for infectious respiratory diseases far too long at the expense of the health and safety of healthcare workers and their patients. HICPAC must abandon its erroneous assumption that infectious respiratory diseases occur primarily via droplet transmission unless proven otherwise. Instead, it must replace the droplet paradigm with an assumption that all respiratory infectious diseases arise from aerosol transmission unless scientific evidence indicates otherwise. This precautionary and proactive approach regarding transmission, coupled with appropriate and comprehensive infection control measures, will protect the health and lives of both healthcare workers and patients.

The COVID-19 pandemic experience presents a strong rationale for adopting this revised transmission assumption. CDC resisted and failed to recognize at the outset of the pandemic the evidence that SARS-CoV-2 was causing infection via aerosol transmission. It held onto the

droplet transmission assumption despite overwhelming scientific evidence of aerosol transmission for SARS-CoV-2 and other respiratory infectious viruses (1, 2, 3). As a consequence of this resistance, recommendations for protecting workers in health care and patients were inadequate, and delayed, for providing protection against an airborne infectious agent. A substantial body of scientific evidence supports HICPAC adopting an aerosol transmission default for infectious respiratory diseases (4, 5).

Protecting healthcare workers and patients from exposure to aerosol transmitted infectious respiratory agents requires providing comprehensive infection control measures. Those measures include engineering controls such as ventilation and negative pressure isolation as well as respiratory protection using NIOSH approved devices in an OSHA 1910.134 compliant respiratory protection program.

Bill Kojola, MS

Industrial Hygienist

AFL-CIO (retired)

1. Morawska L. and Milton D.K. (2020). It Is Time to Address Airborne Transmission of Coronavirus Disease 2019 (COVID-19). Clinical Infectious Diseases, 2020;71 (9):2311-3. DOI: 10.1093/cid/ciaa939.

2. Tellier R. (2022) COVID-19: The Case for Aerosol Transmission. Interface Focus 12: 20210072.

https //doi org/10.1098/rsfs.2021.0072.

3. Jimenez J.L. et al (2022). What were the historical reasons for the resistance to recognizing airborne transmission during the COVID-19 pandemic? Indoor Air Vol. 32, Issue 8: e13070.

https.//doiorg/10 1111/ina 13070.

4. Tang J.W. et al (2022). Hypothesis: All respiratory viruses (including SARS-CoV-2) are aerosol-transmitted. Indoor Air. 2022;32:e12937. https://doi org/10 1111/ina 12937.

5. Tang J.W. et al (2023). Airborne transmission of respiratory viruses including severe acute respiratory syndrome coronavirus 2. Curr Opin Pulm Med 2023, 29:000-000. DOI:10.1097/MCP.0000000000000947.

---

RE: Public Comment, CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) -- Aug. 22, 2023.

I would like to summarize some of the concerns we have regarding the proposed CDC recommendations for infection control. I feel there is a lack of will to implement needed strategies. This must stop or countless American lives will be lost. The CDC should not muster its scientific and political might to discredit aerosol science and thereby give facilities a pass to justify their lack of implementation of needed protections. The sole reliance on randomized controlled trials is ill-advised since their primary utility is in drug and therapeutic research. When this methodology is applied to public health, there are too many ethical concerns and biases created to rely on randomized control trials as the primary tool for guidance. This is the same tactic that science deniers and extremists have used to discredit masking. The path forward is clear. The prevention of spread for all respiratory pathogens should require N95 masks or

PAPRs. Surgical masks do not prevent the spread of aerosolized pathogens. Aerosolizing procedures aerosolize all pathogens and are not required to spread airborne diseases. An airborne pathogen can be spread by talking and breathing. We must formulate healthcare strategies to protect the most vulnerable who seek care. This includes those who are immunosuppressed, have an autoimmune disease and those who have received transplants and seek care for unrelated illnesses. The CDC should make sure their recommendations protect these individuals and are in compliance with the ADA. The CDC should require reporting of healthcare acquisitions of all major pathogens and should estimate hospital acquisitions of SARS-CoV-2 by determining all hospital presentations which occurred after admission and then adjusting this data with community rates of asymptomatic infections. Finally, the CDC needs to focus on screening, decolonization, and knowing a patient's microbiome. In nursing home settings, Enhanced Barrier Precautions will not stop the spread of dangerous pathogens such as MRSA, CRE and *Candida auris*. EBP may even promote spread, by providing a false sense of security. A better strategy is screening and decolonization and if this fails, cohorting patients with compatible microbiomes.

According to the United States Department of Human Services, the cost of infectious disease is 10 million dollars per life lost. Too many are sacrificed to save facilities the cost and burden of purchasing a 1-dollar N95 mask. Currently, many workers are safer and have better gear in an Appalachian welding shop than working in a local hospital. No one should have to take care of a patient with a respiratory pathogen without a well-fitted respirator or work in a poorly-ventilated building.
Thank you for this consideration,

Kevin Kavanagh, MD, MS

Health Watch USA

---

Letter from Disability Organizations

Dr. Mandy Cohen, Director CDC

RE: CDC/HICPAC's Plan to Weaken Guidance for Health Care Respiratory Protection and Infection Control

Dear Dr. Cohen:

We are writing to you as representatives of the disability community, which has borne the brunt the COVID-19 pandemic (Boswell et al, 2021)[7]. Over the course of the last three years, our organizations have fought for our community to have equitable access to ventilators, to vaccines and treatments, and for immunocompromised people with disabilities to be able to receive healthcare and participate in society without risking their lives due to COVID exposure.

We are writing to express serious concerns about the Healthcare Infection Control Practices Advisory Committee (HICPAC) proposed updates to the current CDC Isolation Precautions for Health Care Settings. We have reviewed the work group's presentation delivered at the June

[7] These data are from the UK, where they found 58% of those killed by COVID had disabilities, more than three times the disability share of the population. While similar data is not available for the U.S., there is little reason to think the situation was better here.

2023 HICPAC meeting. The recommendations do not ensure that the people we represent will be protected, as workers or patients, in health care settings going forward.

Many people with disabilities or chronic illness must regularly attend in-person appointments in various healthcare settings to receive ongoing specialist care, such as physical therapy, respiratory therapy or chemotherapy. Many such individuals are also at increased risk of severe illness or death from COVID-19 for reasons arising directly from their disabilities, whether as a direct physiological consequence of their conditions (e.g. those with Asthma or Cystic Fibrosis), reduced immune system function due to their condition (e.g. HIV/AIDS), reduced immune system function due to the side effects of treatment for their conditions (e.g. immunosuppressant drugs for Lupus or chemotherapy for cancer), or the long term consequences of Covid (e.g. organ damage and symptomatic long Covid).

Under the Americans with Disabilities Act, these patients have the right to receive care in a way that is accessible to them and meets needs arising from their disabilities. Providers going unmasked would lead to a disparate impact on disabled patients compared to non-disabled patients, both because the consequences for their health will be worse if they contract the virus, and because their underlying conditions require they make more frequent medical visits than non-disabled patients, increasing their likelihood of exposure. Patients themselves wearing masks is insufficient to mediate this risk, both because data show that one way masking can be fifty times less effective than two way masking at preventing infection of the masked individual (Bagheri et al., 2021), and because some disabled patients are unable to mask, either because of their underlying conditions (e.g. if they are ventilator users) or if they are undergoing treatment that is incompatible with masking (e.g. respiratory therapy).

The Biden Administration requires federal agencies to focus on issues of equity. For CDC, such issues should include a focus on ensuring that everyone – especially those at higher risk of infection – are protected in health care settings. According to the workgroup's June 2023 HICPAC presentation, the draft guidelines are designed to provide a minimum level of protection, not to protect vulnerable and high- risk groups. This approach ignores all we have learned during the COVID-19 pandemic about the disproportionate risks faced by many individuals and groups including those with existing health conditions and co-morbidities. Moreover, the guidelines ignore that people with disabilities have a right to reasonable accommodations under the Americans With Disabilities Act. In order to comply with the law, any individual with disabilities that would expose them to increased risk from COVID would have the right to request that any medical personnel who interact with them are masked, and the burden of proof would be on any provider refusing such a request to prove in court that the request was not reasonable.

We strongly urge you to open up the HICPAC process to include representatives from our community as well as from all stakeholders impacted by the HICPAC recommendations. All voices and perspectives need to be included, not just those of infectious disease professionals and hospitals. The guidelines must be designed to provide a high level of protection to <u>everyone, not a minimal level of protection to the general population.</u>

We have been informed that the CDC staff believes it is too early in the process for our involvement. It is never too early to hear from and include all potential stakeholders, particularly representatives of individuals at higher risk of exposure and adverse serious impacts from infection. The CDC Isolation Precautions are extremely important for ensuring that everyone's exposure to aerosol-transmissible diseases in all types of health care settings is kept to an

absolute minimum. It is not appropriate to leave the development and decisions about infection control recommendations up to a small group of individuals who operate in a closed, non-transparent process. And it is not appropriate or acceptable to ask us to wait until HICPAC is finished with its recommendations rather than including us as full partners in the development of the draft guidelines and decision-making. When this approach was taken with the development of Crisis Standards of Care, the result in many states were rules that actively devalued the lives of people with disabilities and deprioritized us for treatment. Many of our organizations mounted successful legal challenges and advocacy campaigns against these policies, and we would urge you not to put us in the position to have to do so again.

Yours sincerely,
Disability Policy Consortium
Disability Law Center
Disability Resource Center
Boston Center for Independent Living
Metrowest Center for Independent Living
Mental Health Legal Advisors Committee

---

Submitter's Information
Name: Seifer Almasy
Organization: Member of the public
Topic Addressed: Practice of healthcare infection prevention and control

Written Testimony
COVID remains a significant health threat, with 1 in 10 infections leaving people with long-term health impacts. The unchecked prevalence of COVID-19 and other airborne illnesses within our healthcare facilities makes healthcare visits dangerous for everyone, especially higher-risk populations such as immunocompromised people, older adults, and people with disabilities.

This situation personally impacts me because I do not want to risk long-term health impacts while attending routine healthcare appointments. I am deeply concerned that a long-term health impact will take away access to my livelihood and hobbies. Unfortunately, I have experienced skepticism, denial, and hostility while advocating for my own safety to healthcare providers. Hours of phone calls, emails, and research regarding the infection control policies for my local healthcare providers conclude with no assurance that providers will wear masks to protect me. At times, it has been up to me to educate my healthcare providers on the importance of infection control. It should not be up to any patient to plead for their own safety.

Most hospitals in my state were protecting patients from COVID with universal masking protections from the start of the pandemic, but essentially all of the hospitals in the state withdrew these protections abruptly this spring. Reinstating universal masking would help ensure that we leave no one behind in accessing healthcare. It would also create safer workplaces for our healthcare workers.

Therefore, CDC/HICPAC must take action to protect patients, healthcare workers, and visitors to healthcare facilities. CDC/HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens. Additionally, CDC/HICPAC must maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections. Also, the CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach. Finally, CDC/HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

---

Baggy Blues are barely better than bareback breathswapping; while surgical masks may help a little, they are NOT sufficient to control the spread of COVID.

Unless you wish to deliberately CONTINUE to be complicit in stochastic eugenics against just about EVERY marginalized class in America, you will do everything within your power to require N95 or higher quality respirators in ALL healthcare settings, and as many other settings as possible, particularly focused on places such as grocery stores & pharmacies where those who are at the highest risk NEED to go on a regular basis, and have just as much right to be, SAFELY, as the bigoted anti-mask bullies and the cowards they intimidate into joining their side for fear of dirty looks or sarcastic questions.

Disabled people, BIPOC, LGBTQIA+, women, low income, housing insecure/unhoused, the elderly, and more underprivileged classes are all more likely to be disabled/further-disabled or killed if infected by this virus. Many within these groups are ALSO more likely to be forced into contact with many people, such as working in service jobs, and less able to afford to pay for masks on their own, and so more likely to become infected. When the government mandates masking in those locations, that obligates the employers to provide appropriate respirators, rather than further burden workers who may be trying to survive on an already insufficient wage.

Large corporations already DO spend great sums of money on protecting their executives against COVID, while they resist being forced to do the bare minimum to protect the workers who generate almost all the value & profit their shareholders exploit.

Your actions will answer before the whole world, which are more important to the CDC - inflating the profits of a few rich people, or protecting the health & lives of the American people?

Harry R. Burger

---

Name: Paul Hennessy No Affiliation Public Comment 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 comment:

HICPAC should not issue guidelines based on assertions they know to be false. N95s are more effective than surgical masks. Everyone who doesn't believe that should resign or be fired for

knowingly endangering the people they claim to serve. Issue guidelines based on the truth: that N95s are significantly more effective at preventing infection by airborne pathogens than surgical masks are, or get out of the way of the people who actually care whether healthcare workers and patients live or die.

Please put in place commonsense guidance that affirms airborne transmission as an essential component of infection control and precautions. Protection from infectious aerosols must be provided for both healthcare workers and for patients. I am an immunocompromised and otherwise disabled patient who has been highly affected by a lack of infection control in healthcare; at present, I am unable to access my healthcare because masks are no longer required. When masks were still required, our family had to advocate extensively for our providers to wear N95s during appointments and procedures.

Please ensure that stakeholders are incorporated in these discussions, including disabled people and healthcare workers, and please ensure that all discussions are transparent and focus on protection from infectious aerosols. Please put in place requirements for healthcare workers and patients to wear respirators in order to provide safe healthcare that patients can access.

Best,

Ardis Smith

Sherwood, OR

Patient

---

To Whom It May Concern,

I am Angel Smith. I am an independent clean air advocate. I work as a medical case manager for HIV/AIDS patients, and I am deeply concerned about insufficient safety and protection protocols regarding COVID-19. Inadequate safety protocols threaten the health and lives of my clients and anyone who is vulnerable to severe complications from COVID-19.
Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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, Angel Smith

---

August 21, 2023

Dear HICPAC Isolation Precautions Workgroup Members,

We are writing on behalf of the National Emerging Special Pathogens Training & Education Center (NETEC) Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) workgroups to provide comments on the HICPAC draft proposed recommendations for updating the CDC Isolation & Transmission-based Precautions Guidelines. NETEC was established in 2016 in response to the Ebola outbreak in West Africa. NETEC is tasked with building and enhancing special pathogen preparedness for healthcare workers and healthcare facilities in the United States. Two workgroups, the Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) workgroups, of NETEC are tasked with supporting technical support, training and education for special pathogens and are composed of multi-disciplinary subject matter experts.

The NETEC IPC and PPE workgroups reviewed the proposed draft changes to CDC Isolation & Transmission-based Precautions Guidelines [outlined in the June 8, 2023 workgroup presentation to HICPAC] from a special pathogen and biocontainment unit level care perspective. While our special interest is the care of patients with high-consequence infectious diseases, we acknowledge the significant impact and implications of these guidelines on healthcare facilities and emergency medical services (EMS) as a whole. The comments below summarize the questions, impacts, and proposed solutions to ameliorate the challenges identified.

The CDC Isolation & Transmission-based Precautions Guidelines have not undergone a significant overhaul since 2007. Modifications were made for emerging infectious disease outbreaks, including Ebola and Mpox, over the past 16 years. These updates were necessary to address gaps in current guidance to support healthcare workers and patient protection as new scientific evidence became available. The following comments arising from our review are based on genuine concern and to understand and learn. This is due to the impact of the process of identification, isolation, and informing that so deeply influences the successful performance of biocontainment units.
The impacts of the proposed changes extend into many facets of healthcare, including:

- Education and training
    - The proposed precaution categories (i.e., air and touch) are different than the existing precaution categories. This will require re-education on the fundamentals of

infection prevention and control practices. A terminology change occurred for universal precautions to standard precautions decades ago, and the dated terminology is still used in practice today. It is possible to reeducate adult learners to new precautions, though the time and resources to implement the changes will be immense.

o The change in Middle Eastern Respiratory Syndrome (MERS) precautions, including the removal of using an airborne isolation infection room (AIIR), does not align with transmission experiences in the healthcare setting.[1]

- Electronic Medical Records (EMR)

o The current precaution categories are built into EMRs for workflows and alerts. These workflows and alerts support decision-making by healthcare workers and ensure appropriate safety measures are flagged for healthcare worker and patient safety. Changes to the categories would require an overhaul of these integrated workflows and alerts. This could be hundreds of person-hours per facility.

- Finances

o Changes require time, with people and systems implementing change. This change management will place financial burden on organizations.

- Unclear or changed guidance could lead to low confidence among healthcare workers

o The COVID-19 experience highlighted the challenge with changing guidance on healthcare worker confidence.[2] Changes should be carefully considered, with a diverse group of partners, to ensure an effective rollout and uptake. This requires buy-in and awareness from partners responsible for implementation. Confusion and low confidence in the new guidelines could lead to low adherence and misunderstanding of the changes.

We recognize the time and effort contributed by the workgroup to develop the draft proposed guideline changes. We are very much in support of updating the CDC Isolation & Transmission-based Precautions Guidelines to meet the needs of healthcare facing 21st century threats. Unclear guidance or recommendations that are not adequately health protective would increase the likelihood that government, healthcare organizations and the workforce are unprepared for the next emerging pathogen.

The following are recommendations, and we are happy to contribute to next steps to address and resolve questions and concerns for the proposed changes:

- Expand the development, formal review and voting process for the proposed changes to the CDC Isolation & Transmission-based Precautions Guidelines by including additional stakeholders.
- Inform and share the proposed changes to the CDC Isolation & Transmission-based Precautions Guidelines with a larger audience of partners and stakeholders to increase awareness.
- Initiate a thorough feedback process from partners across the United States. Invite representation from a diverse group of stakeholders including community members to be involved in the review process.
- Provide definitions for new terms and categories used in the proposed changes. This will help ensure understanding.

We support and affirm the need for regular review and modifications to the CDC Isolation & Transmission- based Precautions Guidelines to respond to emerging special pathogens as these threats pose significant safety risks to healthcare workers, our patients, and to public health. This is an important matter deserving of the attention from the CDC HICPAC Isolation Precautions Guideline workgroup. NETEC and the IPC workgroup are dedicated to training and educating healthcare workers on special pathogens. We would be happy to partner with the CDC HICPAC

Isolation Precautions Guideline workgroup to meet the needs of frontline healthcare workers and healthcare partners.

Thank you for your time and consideration,
IPC & PPE Workgroups from NETEC

[1] Zhang, AR., Shi, WQ., Liu, K. *et al.* Epidemiology and evolution of Middle East respiratory syndrome coronavirus, 2012–2020. *Infect Dis Poverty* **10**, 66 (2021). https://doi.org/10.1186/s40249-021-00853-0
[2] Hoernke, K., Djellouli, N., Andrews, et al. (2021). Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal. *BMJ open*, *11*(1), e046199.
August 21, 2023

---

Name: Paul Hennessy
Organizaitional Affilaition: None
Topic: CDC/HICPAC ventilation and airesol transmission standards

The CDC/HICPAC does not acknowledge the importance and function of core control measures for infectious aerosols.

Wearing respirators and having ventilated, clean indoor air and air filtration reduces transmission of not just Covid, but also RSV, Flu, common cold, and more. Any future airborne illnesses or pandemics will also be helpless against ventilation and air filtration. Ventilation protects the vaccinated and unvaccinated alike. We cannot risk death, disablement, or even disruption when a simple answer is right in front of us.

There are currently NO recommendations on ventilation, which is obserd. The proposed use of airborne infection isolation rooms, or other approaches to isolation is way too limited. Ventilation works against all variants of covid, which is extremely transmissible and airborne. Ventilation and air filtraiton also helps workers be more alert which improves quality of work. The benefits are tremendous.

On top of that, your Work Group on the Isolation Percuations only recommends the bare minimum of protection and allows health care workers to create infection control plan. This is unacceptable because in the past, it allowed employers to avoid protecting employees because they didn't want to spend more money. Health is more important than profit, and if workers aren't healthy, profits will suffer.

I also urge the HICPAC/CDC to increase transparency in public engagement, because of situations like this. We deserve input on protecting ourselves from airborne infectious disease. The current process is flawed and closed off.

---

My name is Liv Grace. I am 36 and physically disabled as well as chronically ill. I have a number of autoimmune diseases including lupus and I already live with many of the conditions associated with Long COVID such as POTS, lung disease, and kidney disease. Additionally, I am immunodeficient. That's on top of the immunosuppression from my lupus medication. I am also a cancer survivor.

People often comment that I live with so much illness and they say "how hard that must be." But what is many times more difficult is being unable to safely access medical care.

Last December, I caught RSV from my infusion center because my nurse, who knew she was exposed to RAV, refused to wear an N95. That turned into pneumonia. Two weeks after recovering and returning to my infusions, I caught COVID there (a few days before my birthday at the end of February… so that s as two months of recovery time). I then caught COVID a second time while getting necessary post-COVID bloodwork in April, barely after recovering from February's infection.

I have not gotten medical care since April because of the reality that I WILL get sick again as long as medical providers refuse to practice respiratory hygiene.

I attempted many times to implement ADA accommodations that would allow me to wait in my car rather than waiting rooms and would require medical staff to wear an N95 while treating me. Over and over again, medical establishments refused. My appeals were rejected. I was told that it was "impossible" to accommodate my needs as a high risk, severely immunocompromised person.

I am still recovering from back-to-back COVID. I now suffer from increased kidney issues and new heart issues. I had to start taking a blood thinner and a statin to reduce my risk for a catastrophic cardiovascular events.

Without medical care, my health will deteriorate to the point of needing hospitalization where I will have even more exposure to unmasked staff. This is a catch-22. Either access care and catch COVID and other dangerous-to-me infections to the point of further endangering my life, or do not get care and… endanger my life.

This is eugenics. I am Jewish and I see the writing on the wall. The  history of not only of the Holocaust, but many genocides - including the ongoing genocide of Indigenous people - target disabled people first.

I am literally begging for something to be done.

Liv Lavender Grace

---

To whom it may concern,

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.

Additionally, 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.

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.

Sincerely, Jessi Presley-Grusin

---

I urge CDC/HICPAC to understand how their proposals would harm health care workers and patients.

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

---

Hello secretariat,

I would like to express my confusion and disappointment at the present state of the pandemic and the CDC’s lack of effort to adequately communicate the dangers of COVID-19. As the Center is undoubtedly aware, the emergent research on the effects of COVID-19 on the immune system—including long-term activation of CD4+ T cells—and on the vascular system—damaging the endothelium—points to alarming ramifications for any infected persons. The impact of Long COVID on 10-20% of those infected poses an even greater threat, especially as the chances of post-infection sequelae increase with each infection. Given this knowledge, one would expect the country’s leading public health agency to be doing everything in their power to educate the public on these dangers. One would expect the CDC to urge US citizens to take effective precautions at work, in school, and in their personal lives. Yet here we stand, facing yet another wave of infections without mask mandates and with only our most vulnerable and informed populations even aware of the risk we face.

The previous director of your agency recently claimed the job of public health is “to strike an appropriate balance between protecting the health of all those who live in the United States while minimizing the disruption to the normal functioning of society.” While this characterization hand-waves away thousands of preventable deaths, I believe the CDC is failing to balance either of these two sides. In the wake of mass death and mass disability, future decades will look back upon this moment and identify the inadequacy of this agency in protecting our citizens as one of the greatest failures of our history.

There is still time. I beg of you: take what we now know, take what we will know, and educate. Tell the public what risks they face beyond the initial infection. Work with the FDA to inform people of the waning efficacy of vaccines and the importance of boosters. Advise a return to masking with high-quality respirators—the most effective mitigation measure we have—for all

indoor spaces. Implement air filtration per your own agency's standards wherever possible, especially in public schools, and incentivize private businesses and schools to upgrade their air filtration as well.

We are still learning just how bad things are, but we can take what we now know and try to prevent things from getting worse. Sincerely, Riley Pratt

Do you remember when we all regarded health care workers as heroes for working through the worst of the COVID-19 pandemic? I surely do. I went on my porch and applauded my two neighbors when they came home from work. Our lives hung in the balance. We needed every one of those heroes.

And we still do. They deserve regulations that will protect them as they care for all of us, especially the hundreds of people still dying from COVID. For critical resources like our health care professionals, "good enough" is not good enough. I urge you to protect them like your life depends on them — because it just might.

Caroline Swartz

---

Dear HICPAC,

Thank you for fully considering the science in setting protective guidelines to prevent airborne covid transmission in healthcare settings.

I was recently taken to the emergency room for post-covid symptoms and so very concerned that my attending doctor was not wearing a mask. In an emergency room! I worry for his colleagues, patients and family.

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.

I will not be comfortable when any of my loved ones visit or work in health care settings until protections are restored and improved. Please follow the science if transmission.

Thank you so much,

Carol Poliak

---

To Whom it May Concern:

As a disabled person, it has become increasingly challenging to advocate for my grandmother who is living in a nursing facility. I was notified last week that she had a cough, and came to find out days later that they did not test her for COVID "because she does not have a fever." Apparently the facility no longer has a policy around COVID testing, and is relying on outdated state guidelines regardless of the fact that New York state and many states in the country are currently experiencing a surge. My requests as an advocate on behalf of my grandmother are not respected, and I am often in a vulnerable position, being high risk, entering a nursing facility with zero mask or testing requirements. Medical staff in the facility don't bother wearing N95s or even surgical masks (which we know are not effective), they act like COVID doesn't exist, and therefore, my advocacy efforts on behalf of my grandmother, are futile at best, and endangering my life at worst.

It is incredibly negligent of the CDC and HICPAC with its refusal to acknowledge or implement measures to mitigate aerosol transmission. You all continuously fail 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.

Given that the residents of nursing facilities (and other carceral institutions such as prisons) are not able to leave at will, if at all, it is the responsibility of an institution and its staff to do the most it can to protect these vulnerable people with zero autonomy regarding the level of protections they have access to. These institutions will rely on state and CDC guidelines that are outdated, and now HICPAC is moving to implement even fewer protections and guidance. Stop being negligent. People are xxx dying. Shame on you all for being complicit in organized abandonment.

--

Best,

Ngozi Alston (they/she)

---

Subject: Recognizing aerosol transmission to ensure healthcare worker and patient safety

To whom it may concern:

I am writing to urge the Healthcare Infection Control Practices Advisory Committee to fully recognize aerosol transmission of pathogens to protect healthcare workers and patients. Incidentally, I am writing on day nine of my first Covid infection. I wouldn't have been capable of this in days one through eight, as I (a previously healthy 38-year-old) have been unable to do much more than sleep since I tested positive. Now that I have experienced this virus firsthand, I am much better able to understand the ongoing severe shortage of healthcare workers the US is currently facing (https://www.cnn.com/2023/05/16/health/health-care-worker-shortage/index.html).

I understand, further, that the Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (using the words "air" and "touch"),

which fails to fully recognize the science on aerosol transmission and the role that inhalation plays when transmitting aerosolized pathogens. I urge you to reconsider. These categories are not sufficient for communicating the risks associated with healthcare-related infections. What's more, the CDC / HICPAC's "air" transmission category doesn't recognize the important role of inhalation. The CDC / HICPAC is also continuing to recommend the use of surgical masks, which do not provide respiratory protection against inhalation of infectious aerosols.

I also urge you 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.

As they stand, the Work Group's proposals weaken protections for healthcare personnel (and patients), despite everything we have learned during the ongoing Covid-19 pandemic.

Sincerely,

Brenna Lemieux

---

As a member of the community who is high-risk because of common variable immune deficiency and multiple sclerosis, I am begging you to recognize that SARS-COV-2 is spread by aerosol transmission, much of which occurs asymptomatically, and do what is necessary to protect us.

**Please make transparent, evidence-based, universal guidelines that protect us all from asymptomatic aerosol transmission of covid.** There is no excuse for nosocomial spread, especially when our most vulnerable people absolutely require medical attention. Respirators are effective and widely available, as are HEPA filters.

Your choices matter not just to patients, but also to healthcare workers. Lack of appropriate PPE hurts practitioners of healthcare as well as their patients. This illness causes brain damage, and we need doctors, nurses, and admin staff to maintain their cognitive abilities. We should be protecting them as well.

We still don't know what the long-term effects of covid infection are on otherwise healthy people. We should not be abandoning the precautionary principle.

Please help us stay safe from this pathogen.
Sincerely,
Rachael R. Shapiro Majka

---

I am writing to submit comments for the CDC's August 22, 2023 Healthcare Infection Control Practices Advisory Committee (HICPAC) meeting. I am an infectious disease physician-scientist with over 25 years of clinical experience, an Associate Professor of Medicine at Harvard Medical School, and a Fellow of the Infectious Diseases Society of America.

I urge the HICPAC to correct its review on COVID infection control measures to reflect the science of aerosol transmission through inhalation and to establish the highest infection prevention protocols for any proposed “transmission by air” category. These protocols should include frequent testing, proper ventilation, air cleaning/purifying technology, isolation, and fitted N95 respirators.

I further suggest that HICPAC increase the transparency and accountability of its decision-making process by including patient advocates, aerosol scientists, healthcare personnel (medical providers as well as other frontline workers such as cleaning crews), union representatives, and occupational safety and health experts in its review process.

With regards,

Regina LaRocque, MD MPH FIDSA FISTM
Global Enterics Laboratory
Division of Infectious Diseases
Massachusetts General Hospital

---

Dear HICPAC,

I am writing to you as a concerned member of the public who deserves to feel safe seeking healthcare. I'm a mom, a teacher, and a daughter who, like all Americans, deserves to seek medical treatment without the risk of becoming infected with a preventable illness.

Recently, I had to take my mother to the emergency room. Turns out she had pneumonia, but we didn't know that yet. All we knew then was that she was having difficulty breathing and her blood oxygen was low. We also knew that her kidney function was such that she was ineligible for paxlovid. With her heart problems, we knew that any respiratory infection -- especially covid -- could be deadly.

**I cannot tell you how terrifying it was to be with her in a busy emergency room with unmasked people** who were surely infected with covid and another respiratory illnesses. Even though our lives literally depended on it, we felt awkward asking doctors and nurses to mask -- after all, we were at their mercy.

HICPAC knows about countless bloodborne illnesses and encourages universal precautions to prevent the spread of bloodborne pathogens. We have single-use gloves, we don't reuse needles, we sanitize surfaces. We know covid and other diseases are airborne. It's time we implement strong infection-control policies that reflect that.

When we know better, we can do better. **I join the People's CDC in asking HICPAC TO create concise control guidelines that recognize transmission characteristics of SARS-CoV-2**.

Sincerely, Mary Laura Calhoun

---

Sir or madam:

I am submitting comments regarding the upcoming vote on the proposed CDC guidelines on preventing infection transmission in healthcare.

Prior to becoming disabled by an unknown flu-like virus, I was a medical and academic librarian. I am highly familiar with evidence-based medicine and policy development as well as literature reviews. I am frankly appalled that the CDC is considering recommending surgical masks—which only protect against droplets—for the prevention of transmission of an airborne virus. Fit-tested N95 respirators are the only effective mask to prevent transmission of biosafety level 3

airborne pathogens. Would the CDC recommend that healthcare providers wear a surgical mask while caring for a patient with active tuberculosis?

As a person who was disabled by a post-viral illness, I am acutely aware of how damaging viral infections can be. SARS-CoV-2 has been proven to cause multisystemic disease and severe disability in addition to death. Vaccines can reduce the severity of an acute COVID infection, but do not reduce the likelihood of developing Long COVID.

I now have to risk infection with SARS-CoV-2 every time I need medical care. I am now high risk due to my post-viral illness. Anyone with Long COVID is also high risk—and that's up to 30% of those who are infected with SARS-CoV-2—even if their infection was asymptomatic, even if they did not have a PCR test, even if their state is no longer reporting to the CDC.

Reinfection with SARS-CoV-2 is known to increase the severity of long-term health complications ranging from neurological disorders to cardiovascular disease to cancer. Even if you are unwilling to put protections in place to help prevent transmission to patients, isn't in the best interest of all healthcare providers to prevent transmission among staff? Staffing shortages are at a crisis level in areas and will only increase as COVID cases rise.

Please act to protect the public and the healthcare providers who are exposed daily.

Thank you,

Dana Haff, MLS, MS, MAT

---

My name is Amanda Finley, long COVID advocate, COVID-19 Long-Haulers Discussion Group.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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, Amanda Finley

---

August 21, 2022
Public comment to CDC/HICPAC

JD Davids, co-director, Strategies for High Impact / Long COVID

Strategies for High Impact (S4HI) was founded by disabled and chronically ill leaders in health equity advocacy and policy, disability justice and inclusion, strategic communications and network-building. Among other roles, S4HI and our national Long COVID Justice (LCJ) Network links people with Long COVID, including our founders, staff and volunteers, with information, support and opportunities for advocacy.

Our members have much at stake in the HICPAC's process to develop updates to the 2007 Isolation. Many are newly or more deeply disabled and chronically ill, and must rely upon a medical care system that has never instituted or dismantled basic protections on airborne disease transmission such as universal high quality masking. We see significant research findings showing ongoing risk of new onset Long COVID or worsened Long COVID from COVID-19 reinfection, yet we rely on systems of care that may put us at risk of reinfection.

Thus, we are deeply concerned that this guidance development 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.

**The Work Group's proposals ultimately weaken protections for health care personnel even though the pandemic has underlined the importance of strong protections for health care personnel and patients.**

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. We need significant errors in the new draft recommended categories to be fixed. Further, we are concerned that 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.

We understand that HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting 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. We do not feel this is appropriate, and believe what's most needed is updated guidance that is **clear and explicit** about precautions 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.

For these reasons, our network urges HICPAC and CDC to slow down and commit to a transparent, clear and accountable process to effectively engage these experts in developing drafts. Until this time, 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 close to this degree.

Thank you,
JD Davids on behalf of Strategies for High Impact and Long COVID Justice

---

Brian Stan
Organization: No affiliation

To whom it may concern,
My name is Brian Stan and I am 30 years old and am passionate about health and advocating for basic human rights. The COVID-19 pandemic is one that upturned the lives of billions.

I remain deeply concerned about how politicians have taken a public health crisis out of the hands of scientists and health professionals and into the hands of their corporate interests. They have done everything in their power to minimize the truth and instead to put profits ahead of people. I did everything "right" throughout the pandemic - masking, every available dose of vaccines, avoiding crowded indoor spaces, and yet I still got sick - likely through an outdated building hvac system, though it's hard to pinpoint.

If I'd been sick for merely a week and then gotten better, I may not have been so vocal, but I was sick for months. The shortness of breath, chest pains, and brain fog absolutely took over my life. In that span of time I went from exercising daily to barely being able to go for a slow walk around my neighborhood.

I find it extremely troubling that masks are no longer required in health care settings and on public transit. Both are locations where people who don't have to luxury to "put the pandemic behind them" frequent and put themselves at risk. There's still so much we don't know about the coronavirus. I find myself drawing a comparison to chicken pox and shingles manifesting decades later.

Not acknowledging the aerosol transmission is a major disservice to the health and well-being of society. If politicians don't care, perhaps they will start caring when their corporate interests aren't returning the same level of profits due to their workforce being unable to work and/or perform.

Best Regards, Brian

Hello,

My name is Nicolette Mansour. I am advocating for real infection control in health care, in particular **airborne** transmission of pathogens/viruses.

My email is in regard to tomorrow's meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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 SARS Covid 2 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 inside all hospitals, including hospitals with dental facilities. Universal N95 use needs to be utilized by all healthcare workers, and all patients. It would be preferable if all patients would be provided KN95 and/or N95 while inside any part of a medical center, including hospitals which have dental facilities. Not all patients have the money to buy high quality respirators.

Only continuous respirator 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 have 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, Nicolette Mansour, Clean Air Advocate

Janine Schaults

Clean air advocate

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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, Janine Schaults

---

Contact information: Brenda Gibbs

Affiliation - consumer and patient

I understand the Healthcare Infection Control Practices Advisory Committee (HICPAC) is meeting tomorrow to discuss masking recommendations for healthcare practitioners. I am writing to urge you to at the very least give patients the right to ask their medical providers to wear high quality masks and for medical providers to be required to comply. As a person who is immunecompromised, it has been exceedingly difficult to be safe at medical appointments, and it creates an incentive to avoid medical appointments as much as possible. With great dismay, I have experienced being treated as a patient with no rights when it comes to asking medical providers to mask up. I frankly don't understand why a medical professional wouldn't want to automatically mask up in the presence of a patient with an N95 mask on, no questions ask. They should want to protect their patients as much as they possibly can. We wouldn't expect doctors to be able to choose between washing their hands and using sterile equipment, would we? Why do medical professionals feel they have the right to potentially breathe COVID

into the air around their patients, especially those who are vulnerable, and then expect that the patient has no right to request that the provider put a mask on.

Just recently, I had a medical professional (a dentist) call me rude for asking her to mask up and told me I could get another dentist if I wanted to. She felt the pandemic was over and that because she was vaccinated and had no symptoms of COVID, I was wrong to ask her to put a mask on. She wore one during the procedure but she was already in the room potentially breathing out COVID as an asymptomatic carrier, so that her soon to be unmasked patient could breathe in COVID and become ill.

So, I urge you to stand up for patients and to make sure that medical professionals are doing all they can to protect their patients. Further, the masks used should be high quality masks rather than surgical masks. Surgical masks don't cut it for COVID. They do not seal around the face, and they can and do easily fall down below the nose. I have seen too many instances of the surgical mask being used below the nose, or when it has fallen below the nose, and the provider just leaves it there, and that makes the surgical mask worthless for protecting patients. On the other hand, an N95 mask seals better, and it doesn't fall down below the nose.

---

Topic: Aerosol transmission

My primary reason for commenting is the status of staff and patient protection from Covid-19, a virus that is transmitted primarily by aerosols. I will not be citing sources here since I believe that this scientific evidence is widely known at this point in the pandemic.

PPE and specifically N95 masks, when worn properly, offer significant protection from aerosol transmission of viruses and other pathogens. Yet over the past year, the CDC guidance has been to allow individual providers to choose whether and how they protect patients and staff. I have heard from many people in healthcare settings that the result of this "masks optional" approach has been that staff do not wear masks and patients have been told that the Administration cannot require mask wearing (due to the CDC guidance).

What this means for patients such as myself, an older high risk individual, is that the very places where they seek healthcare are the places where they are most likely to be exposed to contagions since infectious people also seek healthcare in these places. It is nonsensical to expect vulnerable individuals thus to navigate such a system without spreading infection to them. This seems to be the very opposite of health "care", much less infection "control". As you know, Covid-19 frequently is asymptomatic and spreads (via aerosols) even among the vaccinated.

Further, I personally know multiple family members who entered the hospital without Covid but acquired it during their stay as inpatients. Not only high quality masking but also improved ventilation (HEPA filtering, high flow rates, etc.) is still needed and apparently lacking. Your agency can do better. Lastly, of course I must mention that healthcare staff are similarly vulnerable and deserve better working conditions, which then also provide better infection control for patients, in a win-win.

I urge you to consider this experience from a private citizen and to do more to incorporate the detailed input of experts in the field. From where I observe, it seems to me that the CDC has fallen prey to letting toxic anti-public health politics dictate our response to a novel virus that has and continues to slay millions around the globe. I am trained as a scientist, teach in a university,

and am a former hospital administrator.  I beg you to follow the science rather than the lowest whims of the uneducated (in public health) masses. A policy that makes control "optional" is no better than no policy at all.

Thank you for considering my comments.

Respectfully, Joyce M. Shelleman, PhD

---

To Whom It May Concern,

My name is Cathleen Fromm. I am a former public school teacher and full time at-home parent of three children and also the primary caregiver for my youngest child, whose diagnoses include Down syndrome, autism, congenital heart disease, and moderate/severe hearing loss. While not diagnosed with a specific immunodeficiency, his immune system is compromised by Down syndrome. Of note, in 2018 he was hospitalized and in the PICU for mycoplasma pneumonia for 3.5 months, during which he received mechanical ventilation for 6.5 weeks. He checks multiple boxes for being at risk for a poor outcome from even a single covid infection, never mind multiple reinfections and associated post-covid sequelae.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I agree with the 900 experts who wrote this letter to the CDC director:
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 declared that they are not RPE.
It has long been established that RPE is needed for protection against both short and long range airborne pathogens, which, the WHO has acknowledged, includes SARS-CoV-2.

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

Note here that the CDC says that "SURGICAL MASKS ARE NOT RESPIRATORY PROTECTION"

https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

Respirator use should be considered another universal precaution used by health care providers. To protect against airborne pathogens, respirators need to be worn continuously, by not just health care providers, but everyone who enters a hospital or health care facility from the time of entry until they exit.

Only continuous respiratory usage prevents transmission, as shown in the continuous arm of MacIntyre et al (2013).
https://pubmed.ncbi.nlm.nih.gov/23413265/

In other RCTs, donning and doffing of N95 respirators occurred within 6 feet or less of patients. This clearly invalidates the results of any test of effectiveness against airborne pathogens and thus, should not be included in your review.

Indeed, SARS-CoV-2 is a BSL-3 pathogen. Given that hospitals and health care facilities lack the biosecurity, infection control engineering, equipment and protocols of a BSL-3 facility, and given the ubiquity of SARS-CoV-2 infection in the general population, mandating respirator use while inside a hospital or health care facility should be considered the very minimum of level of infection control practices.

For children like my son, who is at high risk of a poor outcome from covid infection, cannot afford to add long covid to his list of health care challenges, cannot tolerate wearing his own mask, and who must visit hospitals and other health care providers frequently, the source control provided by universal respirator use is essential.

Universal respirator use will also reduce my own risk of infection. While I don't share the same degree of risk as my son, I do have some increased risk, not the least of which being my age. My son will need life-long, 24/7 care and as his primary caregiver, I must protect myself from both acute covid infection and the risk of long covid.

While I am sharing my personal circumstances here, my situation is far from rare. At least half of all Americans are at high risk and/or living with and/or caring for someone with at least one condition that places them at high risk of a poor outcome from acute infection. And, of course, we are all at significant risk of long covid/post-acute sequelae.

Universal use of respirators to protect patients in all health care settings is essential.

Thank you,

Cathleen Fromm
Bethesda, Maryland

---

Hi,

I am Elizabeth Hutton, 435 West Nittany Avenue, State College, PA 16801, a private citizen.

There should be universal respirator usage in hospitals. I recently had a colonoscopy and in the pre-operation and the recovery room, none of the

nurses were wearing masks. The only person wearing a mask was the doctor who wore a **surgical mask**, not even an N95! I was at risk unnecessarily.

I have heart disease and I am 70 years old. Thankfully I did not get Covid 19.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

Here the CDC says that "SURGICAL MASKS ARE NOT RESPIRATORY PROTECTION"

https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

Please require N95 respirators in all health care settings, but especially in hospitals and doctors' offices!

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, Elizabeth Hutton

---

Good evening,

I am the father of a three year old son who was born in May 2020, and have another son due this Sept. When my older son was born, having masks in the hospital and doctors offices was a huge help since he could not mask until he was two. However, with my younger son coming any day now, I'm upset that we have to take additional risks with masks no longer required in hospitals and healthcare facilities. Knowing that women who were recently pregnant and babies under 1 year old are incredibly at risk from a COVID-19 infection, I ask that at your August 22, 2023 meeting (https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac), you recommend that hospitals and healthcare facilities once again require masks for all providers, patients, and visitors. We cannot put vulnerable people at risk when then need medical care of any type.

I agree completely 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

I also want to emphasize that surgical masks are NOT RPE. The CDC's NIOSH has repeatedly said that they are not RPE, which is needed for airborne diseases like COVID-19. 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 have 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.

Please, for the sake of my family's health and that of all Americans, especially the most vulnerable among us, I request that you act in the interest of public health, safety, and increased confidence that healthcare in America can be grounded in scientific reality rather than flawed public opinion.

Sincerely,

William Schultz

---

**Date:** August 21, 2023

**To:** Healthcare Infection Control Advisory Committee

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

**Platitudes don't protect people.**

The safety of patients and healthcare workers must always come first when considering changes to guidelines, actions should always seek to improve healthcare quality.

Contending that baggy blue surgical masks offer equivalent protection when compared to an N95 is completely fallacious, flies in the face of sound aerosol science and physics itself. **Form, fit and capacity to filter fine aerosols is the measure of superior PPE.** All healthcare settings must adopt guidelines that stop infection, chopping chains of transmission is paramount.

COVID is Airborne, near and far transmission creates ample opportunity for patients and staff to be exposed without adequate PPE. Weakening masking and infection control guidance will have a dramatic impact on health care workers, patients, visitors, their families and the community at large.

There's no logical reason for these dilutions & from a moral and ethical standpoint such a move is completely indefensible. Surely sick and vulnerable patients should be able to **access care without further harm**, care in a setting that doesn't add to the burden of disease by exposing everyone to a range of airborne pathogens.

The preposterousness of the current proposal to downgrade protection, in the face of an **ongoing mass disabling event**, that has claimed **millions of lives**, is quite simply off the charts. Immediate death from COVID isn't the only outcome, "mild" symptoms during the acute phase are the tip of the iceberg, **COVID is the comorbidity for Long COVID.** COVID is a cardiovascular disease that afflicts numerous organs and systems, is Neuroinvasive, airborne spread must be contained. N95 Masks are the first line of defense.

Undoubtedly HAIS will increase if Healthcare workers don 2nd rate PPE. CDC, Centre for Disease Control, clearly not fulfilling its overarching function if you press forward with an infection mandate.

Well aware HICPAC and the CDC have all the relevant information to make an informed evidence-based decision, the only question that remains, will the HICPAC & the CDC grow a backbone moving forward to protect healthcare workers and citizens, or should we all expect to eat plague?

In closing, given the CDC Director is a Presidential Appointee, it behooves Biden in the midst of an election run up to press forward with a policy that promotes **Eugenics** in Public Health.

Marie Tattersall **Human Rights Advocate – Independent**

I am an internist and medical oncologist (Linda D. Green MD) in Maryland. I have addressed the issue of health care safety in the past but feel that this is a timely juncture to reiterate my concerns regarding hospital infection control. My family and I have been very involved with worker and patient safety throughout the COVID 19 pandemic. One daughter has worked as a hospitalist, another has supported transit workers in ATU 689 including paratransit operators, and the third has worked in New Orleans doing outreach on testing and vaccination campaigns in New Orleans. At this point we understand much about COVID 19 and its variants and have learned that testing, vaccinations, treatments such as Paxlovid, quarantining, masking with N95 masks and ventilation are levels of protection and treatment that can limit morbidity and mortality. The airborne nature of COVID 19 means that transmission in health care settings including hospitals, nursing homes, clinics and pharmacies can be limited by staff and patients wearing masks at the level of N95. PCR and NAAT testing of patients on admission and for elective procedures can decrease in hospital exposures to staff and other patients. Ventilation design can be evaluated and upgraded to maintain air quality that decreases risk of infection. All of these measures need to be employed in health care where patient care is involved. Ventilation and masking can further protect against other airborne diseases besides COVID 19 and upgrade the quality of medical care for all patients and staff. CDC guidance on these matters is critical to direct health care institutions. Just as blood borne illnesses like HIV and Hepatitis C have led to safer practices throughout the medical care system so too can we modernize our current practices for airborne illnesses. The Joint Commission has been largely absent from hospital surveillance on these issues but can incorporate them if the CDC provides leadership. I have been inspired by sections of the disability community who sought safe locations for their health care but have often not been able to seek care due to fear of COVID 19

risks by providers and institutions who have not stepped up their requirements for ventilation, masking and distancing. But their struggles can be all of ours as we see long covid effects as well as acute illness that impacts jobs and families. I am in agreement with the following more specific statements:

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 aeros0ls. 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.

Linda D. Green MD (Licensed in Maryland), NPI 1114005097

Affiliations: COVID SAFE MARYLAND, PANENDIT, APHA

---

To HICPAC

As an infectious disease physician, and medical director of infection control at Cottage Health, I am strongly opposed to removing N95 masks and PAPR's as the standard for prevention of aerosolized infectious diseases in healthcare settings. Properly worn, and fit tested, the N95 masks provide an added measure of safety for HCW's.

Thank you, David Fisk, MD, FIDSA

---

To the CDC and HICPAC Committee Members:
I am Pamela MacKay, Beverly, MA, a retired registered nurse and former medical risk management analyst.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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, Pamela MacKay

---

Dear HICPAC Members:

please find my comment for your 8/22/23 meeting on infection prevention and control guidelines pasted in below. My affiliation is Associate Professor of Pediatrics, Harvard Medical School.

Thank you very much for considering my comment.

Sincerely,

Julia Koehler, MD

It is profoundly puzzling that HICPAC meetings have remained closed and opaque to the many stakeholders and scientists who have important expertise and perspectives to contribute. Why would HICPAC, in the face of numerous inquiries and a letter from National Nurses United signed by 900 health professionals, insist on this secrecy and lack of transparency?

One cannot help but conclude that HICPAC has pre-determined to rewrite infection control requirements in ways that minimize medical facilities' expenditures, rather than in ways that maximize protection of patients and safety of healthcare personnel. This disturbing appearance is ineluctable, given the apparent intention to diminish current airborne precautions standards

for those infections known to be transmitted by aerosol exposure, including SARS-CoV-2. I strongly hope to convince myself that the answer to the following question is, no: are HICPAC members truly basing their decision processes on the fact that N95s cost more than surgical masks, and an airborne precautions room is more costly to maintain than a standard hospital room?

There are three principles in medical ethics to which the physicians on HICPAC are bound. Non-maleficence requires that medical practitioners seek to avert harm from patients. Beneficence requires that they undertake strenuous efforts to promote health and survival of patients. Justice requires that they seek the well-being of all regardless of income, ethnicity, gender and other characteristics. The proposed guidelines, as far as they have become known, apparently violate all three ethical principles.

Risking serious infections of hospitalized patients, and those in outpatient settings and care facilities, by not requiring use of measures known to avert such infections, violates the principle of non-maleficence. An appearance of prioritizing economic considerations of medical facilities over protecting patients from illness, disability and death similarly violates non-maleficence. Failing to pro-actively seek out the lessons from the COVID-19 pandemic regarding aerosol transmission and its prevention, from the foremost experts in these fields, violates the principle on beneficence. Failure to make explicit, the profound injustice of the pandemic in which Latino, Black and Native Americans died at shockingly higher rates than white Americans, and state as a goal of the new guidelines that these injustices will be stopped going forward, violates the principle of justice.

In addition to the uncounted hundreds thousands of patients who were sickened by nosocomial COVID, I would like to ask that CDC leadership and HICPAC keep at top of mind, the thousands of healthcare workers who died of COVID-19 in the US over the past 3 ½ years. Most of these deaths would not have occurred with sufficient PPE and adherence to known principles of ventilation and air filtration. COVID transmission occurred from patients to healthcare workers and between patients when examined rigorously. The death rate was harsh and likely undercounted among low-salaried staff like CNAs, housekeeping and cafeteria staff. RNs were more affected than MDs. Ignoring the sacrifice of these colleagues of ours disrespects their memory. The only way to pay them the homage they are due, is to ensure that no healthcare staff are infected and sickened in the workplace going forward.

I would like to add a personal note. The high risk of SARS-CoV-2 transmission in medical facilities has harmed my parents, whom I have had to counsel to avoid seeking care for their medical conditions. Of course I am just one of millions afraid for their vulnerable loved ones. Will HICPAC really decide to make unsafe medical facilities the norm for them, for the coming years and decades?

---

Please do not weaken current infection-control measures in healthcare.

And don't put forth unscientific new guidelines that state that surgical masks prevent airborne infections.

This just isn't based in reality, and it will erase decades of scientific gains in healthcare. It will also kill patients and healthcare workers.

The evidence shows that while respirators are highly effective in protecting against airborne infections, surgical masks are not.

I am immunocompromised and these changes would make healthcare incredibly dangerous for me.

Sincerely,

Elizabeth Zambelli

---

Hello,

My name is Elizabeth Idris. I'm a resident of Los Angeles, California, and I'm a disabled, immunocompromised person. As such, how we work to prevent infection matters greatly to me. Whether we are using the right tools for the job is quite literally life and death for me, on a day to day basis.

I am writing to you today to ask, to plead, to insist really, that you keep aerosol-transmitted/airborne disease at front of mind when you are creating infectious disease control guidelines and practices. One of the greatest risks everyone in this country faces day in and day out is the risk of catching COVID-19 - some estimates place our weekly COVID-19 cases at 5.5 million, if we had the proper testing and reporting apparatuses still in place. COVID-19 is spread through aerosols, it is an airborne illness. It is one that directly damages the immune system, and all major organs. It leads to disability in as many as 1 in 10 cases. It is so imperative that we are working to prevent as many cases as we can.

So please. Consider clean air (MERV13+, HEPA filters, the new ASHRAE standard of 3.5 air changes or more per hour) and masking guidance and even mandates when you are drafting your guidance. We MUST keep COVID-19, and other airborne illnesses, in the forefront of our mind if we are to keep people safe.

Thank you so much.
Elizabeth Idris

---

I am Elizabeth Arthur, LMFT, Evanston IL.

We need universal N95 or better respirator usage in all hospitals. People shouldn't have to worry about getting sick or even sicker while they are just trying to access medical care. We need to prevent transmission of respiratory viruses in the same way that we have previously enacted procedures like hand-washing/sanitizing to successfully prevent the spread of disease.  Currently, we are not doing enough. We need universal respirator use in hospitals.

Thank you.

Elizabeth Arthur

---

To HICPAC,

“First, do no harm.” Weakening infection control practices while COVID-19 is still widely circulating is the exact opposite of what HICPAC should be doing right now. It’s backwards, you should be strengthening them. N95 respirators should become as standard as gloves. I know

it's not popular, and the "optics are bad," but we need to adapt healthcare to the new reality of a serious airborne virus that continues to disable and kill. Adaption is hard fought:

Ignaz Semmelweis was ridiculed for suggesting doctors wash their hands to reduce infections in patients.

John Snow had to fight to convince people fecal contaminated water was spreading cholera.

HIV activists had to protest for years before the government took it seriously & educated the public on risk reduction.

And I will keep speaking out about COVID-19 because I watched it kill my mom in January 2022. My dad & daughter have health issues after their "mild" infections. I have not been infected (as far as I know) and I have been wearing an N95 everywhere since April 2020. I dread the thought of anyone in my family needing to go to a hospital because of the risk of acquiring COVID-19. I wonder if my dad will make it through the coming winter.

Please, do not weaken airborne infection control in healthcare. Living with COVID-19 shouldn't mean pretending it's 2019. It should mean doing everything you can to reduce the spread, especially among healthcare providers and vulnerable patients.

Thank you,

Melanie Thomas of Canton, Ohio-concerned citizen

ps-The attached picture is my dad saying goodbye to his wife of 52 years before the doctors removed life support. She was fully vaccinated & had multiple risk factors but nothing imminently life threatening. Please don't contribute to more heartbreak for my family or others.

---

Dear HICPAC Members and Staff,

Please see the attached letter signed by 45 organizations, which collectively represent nearly 6 million people, and nearly 11,000 individuals regarding HICPAC's draft proposed updates to the Isolation Precautions guidance. We look forward to your response.

Best,

Jane Thomason, Lead Industrial Hygienist, Health and Safety Division, National Nurses United

---

August 21, 2023
Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC)
Centers for Disease Control and Prevention
Dr. Alexander J. Kallen
Designated Federal Officer for HICPAC
Chief, Prevention and Response Branch
National Center for Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

Dr. Michael Bell
Deputy Director Division of Healthcare Quality Promotion Centers
for Disease Control and Prevention

RE: HICPAC and the CDC Must Fully Recognize Aerosol Transmission and Protect Health Care Workers and Patients

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee (HICPAC):

We, the undersigned individuals and organizations, recognize the pivotal role you play in setting guidance that shapes infection control and prevention practices in hospitals, nursing homes, and other health care settings across the nation and around the world.

**We urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:**

Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:[i]

Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.[ii]

Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.[iii]

Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient

health due to staffing concerns.

Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the *minimum* level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.[iv]

The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

**CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.**

We are concerned about the lack of transparency in your process to update the CDC's guidance document, *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* (last updated in 2007). Changes to this guidance will impact health care workers,

patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

Name: Annalisa Schaefer

Organization: The World Health Network (WHN)

Topic: Healthcare Infection Control Practices Advisory Committee (HICPAC) meeting on 8/22/23

Thank you for the opportunity to share my thoughts on this important matter. I hope this will be entered into the record. My formal educational background is not in science, but like many I owe my life to it. In 2015 I had a life-threatening kidney infection and was saved by medical science. Unfortunately one of my kidneys is all but destroyed so I am immunocompromised. From reading early 2020 news reports I came to understand that due to this I'm at high risk for severe disease and death from covid-19. Therefore I've been keeping up to date reading about it and I am continuing to take layers of precautions to avoid it.

My layers of precautions have evolved as improved information has been made available, from cloth masks and 6 foot distancing in 2020 to N95 respirators and HEPA filters in 2022.

It is crucial that the CDC and HICPAC guidelines are up to date and shaped by incorporating input from a multidisciplinary set of scientific experts. Anything less is irresponsible. Prevention of viral spread is a complex task and there is no shame, only pride, in recruiting a variety of specialties to share in this important work. It is practically and morally correct to do everything possible to get this right. So much of the trauma and loss of 2020 was fueled by people not knowing what protections would work, worrying that effective protection was impossible, or taking what they thought were good precautions and getting sick anyway. So much suffering resulted from uncertainty, lack of information, and untrue information.

As the saying goes, "When we know better, we do better."

I call upon this body to recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols. Establish the highest infection prevention protocols for any proposed “transmission by air” category. Ensure that updated guidance includes the use of multiple control measures (the Swiss cheese model) that have been shown to effectively prevent transmission of infectious aerosols. These include proper ventilation, air cleaning/filtering technology, isolation, respiratory protection, and other personal protective equipment (PPE). Further, I want to urge HICPAC and CDC to incorporate a wider variety of experts in developing drafts during the update process. These experts should include engineers, industrial hygienists, occupational health nurses, aerosol scientists, and experts in respiratory protection. We should not be listening closest to MBAs and economists when it comes to health, safety, and science. I’ll close by sharing that despite my tight-fitting N95 respirator, I am reluctant to seek healthcare because so few medical providers are masking. The ones that do almost always wear loose-fitting surgical masks. Two way masking with NIOSH approved respirators is far safer and more effective. Why am I concerned about catching covid in healthcare settings? Because I understand it is common now in 2023 and also I’ve witnessed the devastation myself. My parents got sick in March 2022 due to one-way masking in a medical setting. They weren’t leaving their home for any other outings besides medical care due to being high risk themselves, so they got sick from their hospital. They both developed horrific secondary infections. My dad was in and out of the hospital for a month. His Parkinson’s symptoms have gotten way worse since his illness; he has never been the same. People shouldn’t have to face preventable infectious disease, unnecessary suffering, permanent impairment, and loss of quality of life when seeking healthcare. Thank you for understanding the import of this.

---

Hello

I am a preschool teacher who has been in the classroom through covid. We wore masks for almost 2 years. I am asking that at your upcoming or just past meeting of 8/22 you adjust the recommendations and policies to reflect the latest science on aerosol spread of pathogens.

Science has learned much about the spread of covid, but policies have not adapted. I could list the out of date rules we have at work that do little to mitigate the spread of covid.

Thank you

Mathew Smith, Denver

---

Hello,

I am Dian Barber, Bedford, TX,  Independent Clean Air Advocate.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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

---

Hello,

My name is Gina Ruth and I am concerned about the CDC’s irresponsible proposed changes in guidelines.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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
I do want to emphasize that 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

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, Gina

---

Hello,

Any weakening of infection control practices is of disservice to patients, health care workers, and their respective families.

Knowledge evolves and as such, best practices must too. SARS- CoV-2 has clearly highlighted the role played by aerosolized transmission at a household, community, and in-facility (e.g. hospitals, nursing homes, jails, etc.) level.

The CDC has lost a tremendous amount of credibility since the onset of the pandemic. A weakening of infection control practices will only further contribute to a loss of respect and trust in the CDC as it will evidently harm patients, health care workers, and families.

Public health is not for sale. The CDC must stand up for the safety and wellbeing of all patients and health care workers.

Being infected while receiving/giving care is unacceptable. Making health care inaccessible to a significant portion of the population is unconscionable.

Ethics are a fundamental aspect of care.

It is more than time for the CDC to stand up for patients, health care workers, and their families.

Thank you for your attention.

Regards,

Caroline Blanchard
Naperville, IL

---

Good Day,

I am Phyllis Gould, Independent Clean Air Advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I want to emphasize that 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

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 and all health care facilities. 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, Phyllis Gould

---

Name: Annalisa Schaefer

Organization: The World Health Network (WHN)

Topic: Healthcare Infection Control Practices Advisory Committee (HICPAC) meeting on 8/22/23

Thank you for the opportunity to share my thoughts on this important matter. I hope this will be entered into the record. My formal educational background is not in science, but like many I owe my life to it. In 2015 I had a life-threatening kidney infection and was saved by medical science. Unfortunately one of my kidneys is all but destroyed so I am immunocompromised. From reading

early 2020 news reports I came to understand that due to this I'm at high risk for severe disease and death from covid-19. Therefore I've been keeping up to date reading about it and I am continuing to take layers of precautions to avoid it.

My layers of precautions have evolved as improved information has been made available, from cloth masks and 6 foot distancing in 2020 to N95 respirators and HEPA filters in 2022.

It is crucial that the CDC and HICPAC guidelines are up to date and shaped by incorporating input from a multidisciplinary set of scientific experts. Anything less is irresponsible. Prevention of viral spread is a complex task and there is no shame, only pride, in recruiting a variety of specialties to share in this important work. It is practically and morally correct to do everything possible to get this right. So much of the trauma and loss of 2020 was fueled by people not knowing what protections would work, worrying that effective protection was impossible, or taking what they thought were good precautions and getting sick anyway. So much suffering resulted from uncertainty, lack of information, and untrue information.

As the saying goes, "When we know better, we do better."

I call upon this body to recognize aerosol transmission through inhalation of SARS-CoV-2 and other infectious aerosols. Establish the highest infection prevention protocols for any proposed "transmission by air" category. Ensure that updated guidance includes the use of multiple control measures (the Swiss cheese model) that have been shown to effectively prevent transmission of infectious aerosols. These include proper ventilation, air cleaning/filtering technology, isolation, respiratory protection, and other personal protective equipment (PPE).

Further, I want to urge HICPAC and CDC to incorporate a wider variety of experts in developing drafts during the update process. These experts should include engineers, industrial hygienists, occupational health nurses, aerosol scientists, and experts in respiratory protection. We should not be listening closest to MBAs and economists when it comes to health, safety, and science.

I'll close by sharing that despite my tight-fitting N95 respirator, I am reluctant to seek healthcare because so few medical providers are masking. The ones that do almost always wear loose-fitting surgical masks. Two way masking with NIOSH approved respirators is far safer and more effective. Why am I concerned about catching covid in healthcare settings? Because I understand it is common now in 2023 and also I've witnessed the devastation myself. My parents got sick in March 2022 due to one-way masking in a medical setting. They weren't leaving their home for any other outings besides medical care due to being high risk themselves, so they got sick from their hospital. They both developed horrific secondary infections. My dad was in and out of the hospital for a month. His Parkinson's symptoms have gotten way worse since his illness; he has never been the same. People shouldn't have to face preventable infectious disease, unnecessary suffering, permanent impairment, and loss of quality of life when seeking healthcare. Thank you for understanding the import of this.

---

To the HICPAC committee members,

I am a California physician and data scientist concerned about possible weakening of infection control practices in US healthcare.

I 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

I do want to emphasize that 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

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,

Dana Ludwig, M.D.,

Berkeley, CA

---

Hello!

I am severely disabled with ME/CFS, so I may not be able to attend the meeting in person tomorrow, but I wanted to submit my comments for the official record.

I am asking the committee to PLEASE require staff at hospitals, dr offices, and other medical facilities and settings to wear appropriate PPE - and that means N95s or better, not surgical masks - at all times.

We are still in a pandemic, and the majority of people who go to those places for care are vulnerable to COVID and its long-term effects (which include long covid, organ damage, strokes, and death).

As for me, as someone who is already housebound and mostly bedbound from a post-viral illness, I cannot afford to lose even an ounce more of function. My immune system is unpredictable, which makes me more susceptible to covid, and my entire body is so ill and so sensitive that any illness at all could mean I go from someone who lies in bed all day but can feed herself to someone who has to be fed by a tube. **one COVID infection** could change my life - and the life of my family who take care of me - forever.

For this reason, it is of vital importance that the doctors, nurses, and staff I encounter at dr appointments wear masks. And because they often don't, and neither do the other people in the waiting room, I avoid necessary appointments for fear of getting COVID. I have blurry vision I

can't treat (and so I can't read). I have gum pain, and tooth pain, because I'm afraid to go to a dentist (where it's especially important they wear masks because I can't). I have back pain that could be solved by a physical therapist, but it's too risky for me to go to their office. I am in constant pain because of a lack of medical PPE.

And that's to say nothing of the preventative tests I'm missing. I haven't seen a gynecologist in a year. I've missed mammograms. Even flu shots. I avoid all medical centers unless something is completely urgent, because - as places where sick people go and no one wears (safe) masks - they're the most dangerous places for me to be. So I have slept through nights wondering if I'm having heart attacks, strokes, or am going blind, because I am afraid to risk COVID.

Making medical facilities less safe for people like me has a *profound* impact on our health, well-being, and ability to improve our own situations. I beg you to consider us. After all, medical professionals are in the business of helping and protecting the sick, and ***that is us. Please help and protect us.***

Thank you for your consideration and your time. If you have any questions, please feel free to contact me.

Sincerely,

Molly Freedenberg, 45, Camarillo, California

---

To Whom it should concern at the HICPAC:

Tanya Meyer

Concerned Advocate for safe air in health care

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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
I do want to emphasize that surgical masks are NOT Respiratory Protection Equipment (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

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, health care facilities, and long term care facilities.

Only continuous respiratory usage prevents transmission, as shown in the continuous arm of MacIntyre et al (2013).
https://pubmed.ncbi.nlm.nih.gov/23413265/

This was also shown this year in a great piece in Scientific American highlighting all the industry & other research that has shown that using respirators work to reduce viral/bacterial spread & reduce harm to the wearer- and ends with this sobering observation and guidance

"..Medical policy makers failed to learn the lesson of the 2003 SARS-1 outbreak, exposed again in the current global pandemic: a novel pathogen requires a precautionary approach that includes airborne respiratory protections until proven otherwise… It is not too late to do better."

https://www.scientificamerican.com/article/masks-work-distorting-science-to-dispute-the-evidence-doesnt/

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 shouldn't be included in your reviews.
There are ways to make this less difficult for health care staff that can be worked out, the correct use of sip mask devices that allows staff to drink with straws during shifts to reduce donning & doffing & keep them hydrated. Making protein shakes available for health staff to keep balanced & ease of using masks.
Keeping health facilities comfortable, and cleaning the air regularly to minimize humidity so it is more comfortable for Respirator Mask wearers (and reducing viral/bacterial levels from rising).

Break rooms should be ventilated and/or have good filtration including hepa filters. There should also be paper bags available they can put their Respirator into if they will reuse (N95s can be worn 8hrs I believe & then rested for a few days & worn again if not soiled badly & put in paper bag & dated)

We know more now than we did years ago about how respirators worn correctly really do help reduce viral (and bacterial) spread.

And we will keep learning.

With rising rates of hospital acquired Covid, I think we can rely on this conference to inform the CDC to at the very least aim to prevent those working in and those seeking health care should be protected from contracting SARS Covid (or RSV, EV, Flu etc) while giving or receiving health care.

A recent study showing how Hospital acquired Covid led to preventable clots in Cancer patients is devastatingly clear-

https://www.cidrap.umn.edu/covid-19/covid-19-tied-dangerous-blood-clots-cancer-patients?fbclid=IwAR2Mtxim9Ufp2d4RYcXohNZmsD58xLK_7aMwQBNYBhfNeCQjYP4pE-OTwwU

There are always paths to do better. As we progress and there is more research, so we can do better. There is always time to learn more once we protect the cognitive functioning & health of Health professionals and patients.

This is a great piece about Masks in health care to consider that also highlights that we have been learning and noting that Respirators in Health care have reduced spread of illness & improved the health of both health staff and those who sought care.

We continue to learn

https://www.acpjournals.org/doi/10.7326/M23-1230

Thank you for your attention.

Tanya Meyer

---

Anything less than mandating and enforcing quality N95 or better respirators in all healthcare settings is institutional manslaughter of HCW and vulnerable patients. If hospitals will not set an example of how to behave, then who will? If we make people sicker instead of healthier, then what is modern medicine even still good for?

We also need testing of hospitalized patients and HCW, quarantine and isolation of 14 days minimum for all infected, post-acute health screenings and clear, honest public messaging: each COVID infection is another nail into your coffin, it damages all body systems and accelerates aging and degenerative processes, do not catch it and do not spread it. Masks, air purification, co2 monitoring, testing /isolation /quarantine /contact tracing and vaccination work. We can, and have to use and apply them all, and retake control of this plague.

Towards a Culture of Mask-wearing - WHN (https://whn.global/scientific/culture-of-mask-wearing/)

The Case for Keeping Masks Mandatory in Health Care - WHN (https://whn.global/scientific/the-case-for-keeping-masks-mandatory-in-health-care/)

Thanks

Spela Salamon, MD, Ph.D.

---

Hello,

My name is Lia Woodward, I'm an independent proponent of masking and clean air.

I'm in agreement with the 900 experts who wrote to the CDC with their criticisms.

We know that COVID 19 is an airborne disease and it requires appropriate infection control with N95 masks. We can't say "we have the tools" if we refuse to use them. Surgical masks are insufficient. It's so disingenuous to use the wrong masks and then suggests all masks don't work, or to suggest that all masks are the same. N95s protect the wearer and others. This is not controversial. Rolling back known hygienic practices that protect patients and workers in order to save money or play a political game is unacceptable. I had to visit an oncology office where no staff was masking at all because of the lifted mandates. Is an oncology office not where the vulnerable have to be? The vulnerable the CDC concedes are still vulnerable and at risk? Surely an oncology office is not what anyone had in mind with the back to normal policies, and yet these are the consequences.

People want to do the right thing, especially healthcare workers, but they need to be told what that is. Someone has to be the adult, the leader, the one who follows the science and handles the truth. You have that responsibility and it shouldn't fall on individual patients to explain airborne transmission to their doctors and nurses. It's outrageous.

N95 use, ventilation, and air filtration must be included in your reviews. Anything else is irresponsible and will get even more people disabled and killed. It's not too late to do the right thing.

Thank you,

Lia

---

To HICPAC,

Thank you for the opportunity to comment in written form as I cannot attend the zoom meeting.

In 2023 both my elderly parents (mother over 70 and father just turned 80) contracted Covid-19 for the first time following the lessened advice from the CDC. My father attended an outdoor wedding unmasked and ended up hospitalized (thankfully he did not need a ventilator and thankfully is now back at home). My mother went on a travel tour unmasked and thankfully was not hospitalized during her stint with the virus. Thankfully they were able to isolate from each other and not reinfect each other while living and caring for each other at home. However both continue to suffer fatigue of long Covid, now, more than 6 months later.

Please seriously listen to the science-based comments from the People's CDC.

**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."

Please stay well and stay safe and do your job to help us to stay well and stay safe, AB

---

How can the group that determines masking requirements for the CDC not once mentioned airborne, aerosol droplet, and 95 filter, SFP respirator nosocomial, etc? Why am I a software professional that seems to know more than your healthcare professionals? Why is nobody keeping up with studies are re-search? Why do we not have masks and Healthcare were most vulnerable patients are? Why do we have to risk getting more sick when trying to seek healthcare? Why not air on the side of caution, considering we are still learning the long-term systemic effects of Covid? Why were no aerosol engineers consulted during this decision process? Why are we letting a biosafety level three pathogen rip through the population multiple times a year? We know better now, why don't you?
Nicole Schiro

---

I was a federal employee and clinical neuropsychologist at Walter Reed Military Hospital in Bethesda, MD. I was infected with SARS-CoV-2 at work in August 2021, while seeing patients. I have been disabled by long COVID-19 (PASC) since that time. I was wearing a "baggy blue" surgical mask when I got sick. We were required to wear these surgical masks, and we were not allowed to wear N95 respirators. Please reconsider the flawed evidence review on N95 respirator and surgical mask effectiveness. It must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

Tara Staver, PsyD

Clinical Neuropsychologist

---

To whom it may concern:

As a breast cancer survivor who went through 15 months of treatments during the Covid pandemic, a mother of a disabled child, a daughter of a mother who was killed by COVID-19, and someone whose family utilizes healthcare settings much more than an average amount, I hope you will consider my comments carefully.

It is important to me that while you update the 2007 Isolation Precautions and gather data, you expand your list of organizations and types of professionals to include frontline healthcare workers, scientists with expertise in aerosols and respiratory protections, and patient safety advocates working with COVID precautions.

It is important to me that you update your procedures to allow transparent, published, public comments before releasing your first draft of guidelines. This blog (https://blogs.cdc.gov/safehealthcare/hicpac-invites-your-comments/) that was posted on August 15, 2022, with 5 comments, was/is not enough. Additionally, I urge you to make public your presentations and documents allowing for public oversight at every step of your process.

It is important to me that you do not loosen precaution recommendations in health care settings. Each job, task, and location must be considered when evaluating exposure and control measures. A written exposure control plan is needed to outline the hierarchy of controls.

It is important to me that the CDC and HICPAC update the list of infectious diseases to include those that can be transmitted via aerosols and inhalation. This also supports that fact that N95 masks are the best option in health care settings for both workers and patients. Surgical masks are not adequate for protection against infectious diseases that have aerosol transmission. As

your guidelines are updated, you must consider studies from labs and other non-health care settings that support respirator effectiveness.

It is important to me that you include data and mention of ventilation and air filtration in your precaution updates. This is another layer of protection for health care workers and patients that must be updated and standardized in each setting. Better air quality along with required N95 masking is the best way to protect health care workers and vulnerable and disproportionately harmed groups (the disabled, the poor, Black and Indigenous people, etc.)

Thank you for considering my comments and thank you for your work.

Sincerely,

Monica Allen, Member of the Pan End It! Organization

Former Legislative Outreach Central Team Lead for the Marked By Covid Organization

---

Mark Stewart

No organizational affiliation

Topic: The evidence review on N95 respirator and surgical mask effectiveness

My comment:

HICPAC should not issue guidelines based on assertions they know to be false. N95s are more effective than surgical masks. Everyone who doesn't believe that should resign or be fired for knowingly endangering the people they claim to serve. Issue guidelines based on the truth: that N95s are significantly more effective at preventing infection by airborne pathogens than surgical masks are, or get out of the way of the people who actually care whether healthcare workers and patients live or die.

---

Good Morning.

I am the founder and president of the COVID-19 Longhauler Advocacy Project, a grassroots, patient-led 501c3 non profit serving the long COVID community. I am also the cofounder of the long COVID alliance, serving on the NASEM long COVID US Government Definition committee, and serve as the chair for the Infection-Associated Chronic Conditions Patient Advocacy Coalition funded by CDC through the CDC Foundation. I am a long COVID patient myself, since March 2020, when infected working as a south Florida firefighter paramedic. I am also a single mom. I am now disabled from long COVID and it’s associated conditions.

Masking is the best way to prevent infection. NIH’s own data in recover showed vaccination does not prevent long COVID and there was a negligible 5% difference. 3/4 of the US has had COVID, all while 1 in 5 develop long COVID (over 50 million!). There is no cure for long COVID. There is no treatment for long COVID. The bureau of labor statistics shows that 4 million are out of the workforce due to long COVID and that’s 2022 numbers and documented cases only. The cost, for the same time frame, is $4 trillion annually.

A failure to mask will result in complete devastation of the US workforce and its economy. The number of children developing long COVID is also about 1 in 5. This is a major issue that demands more seriousness and we must focus on preventative measures, they are the only way to get us to solutions and ensure we prevent the collapse of the US. Healthcare systems are already crumbling, as are their staff (15% + of healthcare workers have long covid). ENCOURAGE MASKING and other prevention methods. Do NOT abandon them. Do NOT erode the trust left, if any, between the public and our health agencies.

Karyn Bishof

---

As our understanding of SARS-CoV-2 transmission evolves, it is imperative to explicitly acknowledge and emphasize the role of aerosol transmission through inhalation. Such recognition necessitates the establishment of the most stringent infection prevention protocols tailored for airborne transmission. It is paramount that our updated guidance synergistically combines multiple evidence-based control measures to thwart the spread of infectious aerosols. These measures encompass frequent testing regimes, the incorporation of efficient ventilation systems, the deployment of proven air cleaning and purifying technologies, timely isolation of affected individuals, comprehensive respiratory protection, and the diligent use of other personal protective equipment (PPE). By adopting such a multifaceted approach, we stand a better chance at safeguarding public health.

Caitlin Olson

---

I am writing regarding the draft proposed changes to infection prevention and control, including isolation precautions and personal protective equipment (PPE). As someone who has worked in healthcare for more than 30 years, I know these changes can be difficult and expensive to implement and yet are necessary to respond to changes in our understanding of transmission, changes to the PPE we have available, and to the evolving risks pathogens old and new present to our healthcare workforce, our patients, and our communities. I appreciate the effort from everyone at HICPAC that these proposals represent.

One of the myriad things that made the SARS-CoV-2 pandemic so difficult was the persistent, pervasive uncertainty. What protection do we need? Is what I am wearing enough? Is it really safe to wear this mask over and over again? Do I need to protect my eyes? Who is the source of truth? Who can I trust? Am I likely to get sick?

Unfortunately, we still have few answers to those questions. Much of the evidence used in the draft guidelines is, as one might expect mid-pandemic, limited, anecdotal, and reliant on personal recall for important data such as PPE compliance and exposures. Past studies comparing medical face masks to N95 respirators in effectiveness at preventing respiratory infections have had design and data constraints that limit their relevance. New studies are needed that include exposure monitoring and asymptomatic infections.

Studies have demonstrated the usefulness of source control masking to reduce the number of infectious particles emitted, and while useful, many of the interactions required in healthcare (obtaining nasal or throat swabs, performing oral care or dental procedures, assessing swallow) and the populations encountered (pediatrics, mental health, dementia) limit the usefulness of this tool. Similarly, a growing body of evidence demonstrates the reduction in potentially harmful

particles with ventilation, filtration, and decontaminating air treatments, which if fully implemented could reduce the risk exposure of HCWs but lies outside our ability to control.

Many of the articles cited reveal the challenges and discomfort of wearing PPE – fogging, heat, skin irritations, pressure sores, verbal intelligibility. Since the B.R.E.A.T.H.E studies from more than a decade ago, we know that current respiratory protective devices do not meet the needs of healthcare workers (HCW), cannot be worn for the length of time required, and impair one of the vital tenets of healthcare, communication. During the recent pandemic, HCWs were the victims of an unsecured and unreliable supply chain that created shortages and allowed non-protective counterfeit products to flourish. Further, workplace based Respiratory Protection Programs were either absent (as in long term care and dental facilities) or weakened (29 CFR 1910:134) at precisely the time HCWs needed protection the most. Many facilities remain without an adequate Respiratory Protection Program or have yet to reinstate annual fit testing as required.

We do not know what protections will be required for the next pathogen, but we know we need a better understanding of workplace risks, better ventilation and filtration to reduce our reliance on PPE, better PPE that can be used as indicated for the entirety of shifts and that does not compromise our ability to perform our jobs, and clearer guidance on risk, isolation, and protection.

My recommendations are:

1. **Robust research to quantify workplace risk for healthcare workers across the spectrum of care, and in the diverse locations and environments that make up the healthcare landscape (long term care, outpatient, dental/OMF, clinics, pediatrics, mental health) is needed immediately and should precede changes to recommended protective devices.**
2. Once exposure risks are better understood, a new set of PPE standards that address the risks identified and can form a platform for better PPE devices will be needed. HCW may need something more protective than a mask and less restrictive than an N95. We desperately need PPE that does not injure us or interfere with our jobs, that is reliable, and has been tested for compliance to these important standards.
3. While healthcare facilities may change policies on universal masking and visitation based on community infection levels, **the occupational risk to individual HCWs treating an infected patient is not dependent on any outside numbers or pandemic phase.**
4. The proposed stratifications of air precautions assert a protection to the wearer by masks without sufficient evidence and without an ability for end-users to determine what a “well-fitted” mask is. **We cannot retain a workforce we are unwilling to protect**. Until we know more about assigned protection factors in the healthcare workplace, we should err on the side of caution and recommend respiratory protection, driving the marketplace to create more usable products.
5. The metrics of risk assessment in patient care are complex. In order to adequately protect themselves and others, staff must understand all the factors in place that may increase or decrease their exposure risk. These include ventilation and filtration (or lack of), what tasks they may need to perform, how close to a patient they must be to perform these tasks, the time required, the transmission profile of the pathogens when they are known, and the actions and behaviors of the patient, resident, or client. Reducing this cognitive burden should be one role of IPC guidelines and isolation precautions. **Other**

**risk reduction mechanisms must be in place along the Hierarchy of Controls to build a safe work environment before PPE is called for.**

6. **We do not have evidence that HCW are able to correctly and consistently anticipate risk of exposure to infectious materials or sites, or to track contamination pathways.** This is a gap in infection prevention education that needs to be addressed by research and followed closely by enhanced education on transmission, contamination, and risk for HCWs at every level.
7. Ocular exposure to pathogens is a workplace risk and should be mitigated with proper eye protection. The pathway from eye to nasopharynx and the GI tract has been established with known pathogens. More research is needed to determine whether face shields offer adequate protection and whether some procedures, environments, or patient conditions warrant increased protection.

Jill Morgan

---

As a front-line food pantry worker making sure seniors and immunocompromised people were receiving groceries early in the pandemic before vaccines were available. I cannot stress the importance that N95 masks, air filtration & ventilation played in keeping me and my fellow workers safe. 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 fact that there are no recommendations on ventilation, particularly around air exchanges per hour is outrageous. You must act to prioritize protecting workers and patients with all the tools available.

Shae McParland-Parrilla

The Mutual Aid Network of Ypsilanti

---

Dear CDC:

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.

Thank you.

Sincerely,

Craig Clark

---

**Task, Time, Proximity, and Source**

While Standard precautions are predicated on a HCWs perception on correctly and consistently *anticipating exposure* to blood and other potentially infectious materials, including aerosols and small droplets, little evidence is available to suggest that this ability is actionable or achievable. The decisions made about a risk of exposure to any infectious material are ideally based on our

understanding of four variables: the tasks we will perform; the amount of time required in an environment, either for a given task or cumulatively over our shift; the proximity we will have to a known or potential source; and the actions, abilities, or nature of the source of infectious risks. Other variables to exposure risk in HCWs include HVAC ventilation patterns and filtration efficiency, the infectivity of a pathogen, and the susceptibility of themselves as a potential host. These important variables may not be obvious or knowable to HCWs.

Which tasks confer risk may not be readily apparent. While the phrase “aerosol generating procedures” is frequently referenced, current aerosol science has revealed how common and broadly aerosols are generated and dispersed. What makes AGPs potentially dangerous for HCWs is directly related to the required time and proximity, and the inability to apply or maintain source control.

Other common tasks, from bathing to specimen collection and wound care, can present risks due to similar profiles of time and proximity. During all of these activities, the actions and behaviors of patients and residents are difficult to predict and may magnify an existing risk. When someone with respiratory symptoms coughs, yells, cries, or sneezes, those close HCWs have potential exposure to splashes, sprays, droplets, and aerosols. Source control masks can substantially decrease but not eliminate this risk when a patient is able to tolerate them. Mucous membrane coverage and respiratory protection for HCWs during very close contact with symptomatic persons is the only protection effective at such close range, where even excellent air handling cannot prevent exposure. The risks associated with the proximity and intimacy required for many HCW tasks defy the mitigating effects offered by engineering controls and therefore require more diligent use of PPE.

HCW exposures during patient care tasks are not exclusively proximity dependent. Risk increases in proportion to the time spent within the care space. Well designed, implemented, and maintained ventilation and filtration systems can decrease significantly the risks faced by HCWs who can remain farther away from sources of infectious materials and can blunt the increased risk time spent in a patient care area presents. HCW understanding of ventilation, filtration, negative and positive pressure, and the influence these have on risk and protection is far from complete. These engineering factors, which may only be clear to administrative or operations personnel, impact relative risk and need to be included in risk assessment and protection equations.

The risks of HCW exposures may not ever be eliminated. Even when we understand the details of a task, the time it may take to accomplish, the closeness of contact required, the ability or inability of a patient to comply with and maintain source control, we remain unable to fully predict the behavior and situations of those we care for. Standardized guidance must emphasize the protection of the healthcare workforce as a primary goal. The obligation to protect workers from risks they encounter in the workplace is not lessened when similar risks may be encountered elsewhere. Initial risk assessments for work activities are an obligation of the employer, and workers should be educated about and protected from those risks whenever possible. Using the highest level of precautions may be necessary to ensure staff safety when a complete risk profile is not possible, as with new pathogens. When new information about pathogens or substances is established, guidance may change, but in the absence of certainty, the ethical and legal obligation we owe HCWs of all kinds is to protect them first.

**Routine Air Precautions:**

Masks have not previously been considered PPE devices as the intention in wearing was not *personal* protection but rather as source control for the sterile field, operating suite, or immune compromised individual. Routine Air Precautions appears to consider masks as protective of the wearer against infectious particles in the air. While masks materials may possess sufficient filtration qualities, the protection offered by a mask is subject to fit, for which we have no measurable or quantifiable standard (Total Inward Leak) for loose-fitting masks. End-users have

no way to assess the protection they might receive from a mask and thus to match their anticipated risk to the appropriate protective device. (Bischoff, Duncan, MacIntyre, Rengasamy)

**What compelling evidence is there against this statement from the Respiratory Protection Toolkit, updated in 2022?**

*However, facemasks by design do not seal tightly to the wearer's face. Therefore, they allow unfiltered air to easily flow around the sides of the facemask into the breathing zone and respiratory tract of the wearer. In addition, the materials used for facemasks are not regulated for their ability to filter particles and are known to vary greatly between models. This makes it possible for small particles to pass through or around the facemask and be inhaled by the wearer.*

*This is why they are not considered respiratory protection—facemasks do NOT provide the wearer with a reliable level of protection from inhaling smaller particles, including those emitted into the room air by a patient who is exhaling or coughing, or generated during certain medical procedures.*

**Novel Air Precautions:**

The hierarchy of controls should be applied rigorously and consistently, including the use of engineering and administrative controls to lessen the burden on PPE.

If an N95 is needed/recommended, other protective mechanisms (AIIR) should also be in place whenever possible. (Samet, Lindsley, Tellier). Recommendations should be made to prioritize interdisciplinary collaboration to assess a facility's infrastructure risk.

The inclusion of MERS in guidance not requiring AIIR is troublesome for a pathology with an estimated 9 – 34% CFR and a high likelihood of admittance to a biocontainment unit. (Kraft, Madad)

**Routine v. Novel Air Precautions:**

It is difficult to understand how the risk to the *individual* HCW wearing PPE differs on a day-to-day, patient-to-patient, or task-to-task level based upon the community (or national) outbreak burden. Community outbreak level-based guidance may be appropriate for community settings, such as schools, restaurants, and retail outlets, and may influence visitor policy and routine masking in healthcare facilities. **The risk associated with the care of an infectious patient within a healthcare facility is not based on disease prevalence.**

The Routine Air guidelines do not account for the increase in the bioburden, or the amount of potentially infectious material that would be dispersed in the air of an infected patient in a non-AIIR over time. While the burden may be greatest within a few feet of a patient's head, over time and without other engineering controls in place, an unprotected HCW who may spend minutes or hours in these patient rooms could be exposed to pathogenic dose of small particles. (See Bischoff, Duncan, Nguyen-Van-Tam, Tellier)

**Eyes**

Eyes present a risk of mucous membrane exposure to splashes, sprays, and small droplets, and may also be a receptive location for smaller particles of respiratory and GI pathogens. (Belser, Coroneo)

References

1. Belser JA, Rota PA, Tumpey TM. Ocular tropism of respiratory viruses. Microbiology and Molecular Biology Reviews: MMBR. 2013 Mar;77(1):144-156. DOI: 10.1128/mmbr.00058-12.

2. Bischoff, W. E., Swett, K., Leng, I., & Peters, T. R. (2013). Exposure to influenza virus aerosols during routine patient care. *The Journal of infectious diseases*, *207*(7), 1037-1046.

3. Bischoff, W. E., Reid, T., Russell, G. B., & Peters, T. R. (2011). Transocular entry of seasonal influenza–attenuated virus aerosols and the efficacy of N95 respirators, surgical masks, and eye protection in humans. *Journal of Infectious Diseases*, *204*(2), 193-199.

4. Coroneo MT. The eye as the discrete but defensible portal of coronavirus infection [published online ahead of print, 2020 May 21]. *Ocul Surf*. 2020; S1542-0124(20)30089-6. Doi: 10.1016/j.jtos.2020.05.0115

5. Duncan, S., Bodurtha, P., & Naqvi, S. (2020). N95 respirators, disposable procedure masks and reusable cloth face coverings: Total inward leakage and filtration efficiency of materials against aerosol. *medRxiv*, 2020-11.

6. Kraft, C. S., Kortepeter, M. G., Gordon, B., Sauer, L. M., Shenoy, E. S., Eiras, D. P., ... & Kratochvil, C. J. (2019). The special pathogens research network: enabling research readiness. *Health security*, *17*(1), 35-45.

7. Lindsley, W. G., Blachere, F. M., Thewlis, R. E., Vishnu, A., Davis, K. A., Cao, G., ... & Beezhold, D. H. (2010). Measurements of airborne influenza virus in aerosol particles from human coughs. *PloS one*, *5*(11), e15100.

8. MacIntyre, C. R., & Chughtai, A. A. (2020). A rapid systematic review of the efficacy of face masks and respirators against coronaviruses and other respiratory transmissible viruses for the community, healthcare workers and sick patients. *International journal of nursing studies*, *108*, 103629.

9. Madad, S. (2021). Preparing Frontline Hospitals for Dangerous Special Pathogens Beyond Ebola. *Health security*, *19*(2), 209-213.

10. Nguyen-Van-Tam, J. S., Killingley, B., Enstone, J., Hewitt, M., Pantelic, J., Grantham, M. L., ... & EMIT Consortium. (2020). Minimal transmission in an influenza A (H3N2) human challenge-transmission model within a controlled exposure environment. *PLoS pathogens*, *16*(7), e1008704.

11. Rengasamy, S., Eimer, B. C., & Szalajda, J. (2014). A quantitative assessment of the total inward leakage of NaCl aerosol representing submicron-size bioaerosol through N95 filtering facepiece respirators and surgical masks. *Journal of occupational and environmental hygiene*, *11*(6), 388-396.

12. Samet, J. M., Burke, T. A., Lakdawala, S. S., Lowe, J. J., Marr, L. C., Prather, K. A., ... & Volckens, J. (2021). SARS-CoV-2 indoor air transmission is a threat that can be addressed with science. *Proceedings of the National Academy of Sciences*, *118*(45), e2116155118.

13. Tellier, R. (2006). Review of aerosol transmission of influenza A virus. *Emerging infectious diseases*, *12*(11), 1657.

It's important to strengthen control of airborne diseases in healthcare with N95 rated respirators at all times. It will reduce absenteeism and, by reducing overall infection rates, cut the burden on the healthcare system.

Brooke Orosz, PhD

---

Hi,

I am Maureen Hickey, Independent Clean Air Advocate .
Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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.

In addition, given the likelihood that the latest multi-mutation, immune-escaping variant, BA.2.86, may well have evolved in an immuncompromised patient, it is even more crucial health care institutions to limit the spread of disease throughout their buildings to help slow down further variant mutuation.

Thank you, Maureen

---

I am Sara Cohen. I live in Pierce County Washington and am a parent, patient, loved one of a healthcare worker, and advocate for clean air and equitable access to safe healthcare.

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Sara

---

Hello,

Below is my question. It is modified from the placeholder question I previously submitted:

"As listed on Biobot's press release from February, their contract extension for National Wastewater Surveillance of Covid ended July 31st. It is now nearing the end of August, and the CDC has yet to announce who will be awarded the 5-yr NWSS contract for covid wastewater monitoring. Since that time, Biobot has dramatically slowed their wastewater tracking to 1x a week, and it appears that states like Nebraska are ending their publically available data programs. As we are entering the middle of an on-going covid wave, and as wastewater is our most reliable, least invasive public health monitoring system for disease. We the public deserve to know if there will be a gap in services if the contract will not be awarded to Biobot. My questions therefore are who has been awarded this contract? and what is the CDC doing to expand the NWSS network for more widespread, accurate, and timely monitoring of covid and other diseases?"

Sincerely,

Patrick Vaughan

---

Adopting this policy will endanger millions of workers and patients across the country. Airborne infectious diseases such as COVID-19 are transmitted in the air we all share, which is why wearing high-quality, face fitting respirators is important to prevent transmission, in combination with ventilation and other layers of protection (3). COVID-19 has already caused over 42,000 deaths this year (4), placing it among the top 10 killers in the US in 2023, and 15.8% of U.S. adults have experienced Long COVID (5), a condition that persists after initial recovery from a COVID infection. Similarly, other airborne diseases such as MERS or SARS could also lead to large numbers of hospitalizations and deaths, the 2015 MERS crisis led to 38 deaths among 186 diagnosed cases in South Korea, and the 2002-2004 SARS crisis led to 774 deaths among 8,000 diagnosed cases across several countries in Asia and Canada.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms (6), they may pass it to their coworkers or patients in maskless healthcare

settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages. The recommendations were based upon a widely-critiqued (7), flawed literature review. The guidance even contradicts the CDC's own data which demonstrated that continuous use of N95 and KN95 respirators cut the odds of infection by 83% compared to 66% with surgical masks (8). Nearly 900 experts and over 1000 members of the public have already signed an open letter urging the CDC to strengthen, rather than to weaken its infection control guidelines, and to open the process of infection control guidelines to include more stakeholders and interdisciplinary experts (9).

CDC/HICPAC decisions are made undemocratically and developed behind closed doors, without input from nurses unions, healthcare workers, patient, disability and elder advocacy groups or even independent aerosol experts, occupational safety professionals and industrial hygienists. In the last public meeting, CDC/HICPAC voted on a proposal before hearing public comment – an example of lack of inclusion. Even though CDC/HICPAC is part of a Federal agency, they have not made their draft protocols available to the public – unlike other CDC committees.

The American Hospital Association has explicitly declared that hospitals are facing a "crushing" financial crisis (11). Given this, I am concerned that the hospitals may be pursuing this short-sighted infection control approach to reduce their expenses by cutting fit-testing programs and limiting access to N95 respirators and other airborne protections. However, increasing rates of health worker COVID infections will further worker shortages and may lead to additional disabilities caused by Long COVID. Ultimately, infection control that ensures the highest protection of healthcare workers and patients based on evidence-based science, and integrates the input of stakeholders is a necessary approach.

References:
(1) Kalu IC, Henderson DK, Weber DJ, Haessler S. Back to the future: Redefining "universal precautions" to include masking for all patient encounters. Infect Control Hosp Epidemiol. Published online February 10, 2023:1-2. doi:10.1017/ice.2023.2
https://pubmed.ncbi.nlm.nih.gov/36762631/
(2) Isolation Precautions Guideline Workgroup - Co-Chairs: Michael Lin, MD, MPH and Sharon Wright, MD, MPH - HICPAC June 8, 2023
https://drive.google.com/file/d/14s40YHjuZxMQ_ZOx2qXIdsPDxD0641_b/view?usp=sharing
(3) EPA - Implementing a Layered Approach to Address COVID-19 in Public Indoor Spaces
https://www.epa.gov/coronavirus/implementing-layered-approach-address-covid-19-public-indoor-spaces
(4) COVID Data Tracker - Trends in United States COVID-19 Hospitalizations, Deaths, Emergency Department (ED) Visits, and Test Positivity by Geographic Area
https://covid.cdc.gov/covid-data-tracker/#trends_totaldeaths_select_00
(5) CDC - National Center for Health Statistics - Long COVID - Household Pulse Survey
https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm
(6) Johansson MA, Quandelacy TM, Kada S, Prasad PV, Steele M, Brooks JT, Slayton RB, Biggerstaff M, Butler JC. SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. JAMA Netw Open. 2021 Jan 4;4(1):e2035057. doi: 10.1001/jamanetworkopen.2020.35057. Erratum in: JAMA Netw Open. 2021 Feb 1;4(2):e211383. PMID: 33410879; PMCID: PMC7791354.

https://pubmed.ncbi.nlm.nih.gov/33410879/
(7) Why the CDC's New Mask Guideline Proposal May Actually Imperil Frontline Workers. "The decisions some of these public health people are making are not getting better. They're getting worse." by Katie MacBride, The Daily Beast, Updated Jul. 01, 2023 3:40PM EDT / Published Jun. 30, 2023 11:47PM EDT https://www.thedailybeast.com/new-cdc-mask-guidelines-may-actually-imperil-frontline-workers-experts-say
(8) Andrejko KL, Pry JM, Myers JF, et al. Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection — California, February–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:212–216. DOI: http://dx.doi.org/10.15585/mmwr.mm7106e1
(9) National Nurses United - Urge the CDC and HICPAC to fully recognize aerosol transmission and protect health care workers and patients https://www.nationalnursesunited.org/urge-the-cdc-and-hicpac-to-fully-recognize-aerosol-transmission
(10) CDC - Healthcare Infection Control Practices Advisory Committee (HICPAC) - Meeting Minutes https://www.cdc.gov/hicpac/minutes.html
(11) Becker's Healthcare - Congress can take action to help healthcare deal with 'crushing' financial challenges, AHA urges - by Nick Thomas - Tuesday, October 25th, 2022 https://www.beckershospitalreview.com/finance/congress-can-take-action-to-help-healthcare-deal-with-crushing-financial-challenges-aha-urges.html

Katherine Cunningham, MPH

---

Hi,

Hello, I'm Evan Berry (unaffiliated).

Concerning the meeting documented here: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac, I am in agreement with the sentiments expressed by the 900 experts who addressed the CDC director in this letter: https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf.

It is essential to acknowledge that surgical masks are distinct from respiratory protective equipment (RPE). The CDC's NIOSH has consistently stated that surgical masks do not qualify as RPE, and RPE is imperative for safeguarding against airborne diseases, as designated by the WHO for Covid, encompassing both short and long-range transmission (https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted).

Moreover, the CDC underscores in this document (https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf) that surgical masks are not respiratory protection. It is imperative to advocate for the universal utilization of respirators within hospitals, commencing from the moment individuals step into the parking lot until they depart. Continuous respiratory usage is the sole effective measure for preventing transmission, as demonstrated by the study by MacIntyre et al. (2013) (https://pubmed.ncbi.nlm.nih.gov/23413265/).

It is important to acknowledge that many other randomized controlled trials involve the donning and doffing of N95s within a 6-foot proximity to patients, which undermines the efficacy of testing

N95s against airborne diseases. These studies should be excluded from your assessments. Thank you for your consideration.

Sincerely, Evan

---

Dear committee-

I see that you are about to recommend to the CDC a reduction in the severity of controls against both aerosols like COVID-19 and multi-drug resistant infectious agents in health care settings, in your report to the CDC.

I'm shocked! Even before COVID, multi-drug resistant infections acquired in a health care setting were.a serious problem, and NOW hospitals suffer from understaffing everywhere- why would you recommend less caution?

And COVID-19, while certainly less of an emergency, is ticking back up again. In our family, we have two immunocompromised members. To protect them, we don't go in airports or on planes, to concerts or sports events where people are tightly packed, or indoors to restaurants. There is a great deal we don't do anymore because COVID is dangerous to them, and long COVID would be unbearable given what they already deal with.

I've been hospitalized WITH a hospital-acquired multi-drug resistant infection. That feels pretty dangerous!

We are, of course, not the only ones.

But we have to be able to enter health care settings! There is already lots of research available to show that surgical masks are not as protective as N-95s, but I've heard that your recommendations say they're just as good. And I can't understand at all pulling back on cautions against MRSA and others.

Please hear us!

Rev. Susan Gillespie

---

Submitter's Name: Daniel Hong

Org. affiliation: None (submitting as individual)

Topic being addressed: Updates to 2007 Isolation Precautions Guidance

PUBLIC COMMENT: 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. Please do not weaken masking protocols in health care settings due to insufficient review that would make patients, providers, and visitors all less safe. Thank you.

---

To HICPAC committee,

The currently proposed revisions to the CDC's isolation precautions standards would weaken protections for healthcare workers and put them at risk. The proposed guidance fails to incorporate the best and latest science on aerosol transmission, in particular failing to base recommendations on the well documented best practices that reduce the risk of aerosol transmission, specifically the use of N95 respirators (not surgical masks) and improved ventilation and filtration. The literature review on N95 respirator effectiveness was incomplete and appeared cherry picked. The guidance also lacks an updated list of diseases shown to be transmitted by aerosol transmission.

Until these errors are corrected, the 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.

Please protect our healthcare workers and strengthen, not weaken, infection control measures in healthcare settings.

Thank you,

-Robin Pelc, PhD

California State University Monterey Bay

---

To the CDC:

At this critical junction of the spread of covid, I am writing to encourage you to keep masks as a requirement in healthcare.

As a nurse and as a patient, this is needed to protect individuals in our society who cannot risk a covid - or other airborne disease - infection. Whether it's for my elderly aunt and uncle, or my friend who is just 90 days post stem cell transplant, or for myself as I deal with autoimmune issues, we need to continue to provide safe access to healthcare.

When I became a nurse, I resolved to support the patients who crossed my path to the best of my ability. That resolve has been tested! But I've always held to it. If you are unable to protect your patients from getting sicker by the wearing of a mask, then I am going to say you should fine another line of work. Keep healthcare safe. Keep patients feeling their best. Wear a mask.

Sincerely, Melissa Tobler

---

For the attention of the CDC's Healthcare Infection Control Practices Advisory Committee, on the topic of recommendations to be discussed publicly at the August meeting today, Tuesday, August 22nd.

I understand you are making no recommendations on ventilation.

In an era of aerially transmitted viruses and rapidly spreading wildfires, the importance of air quality to human health can no longer be ignored. Its omission from your guidelines is glaring. When smoking was found to promote lung cancer, rapid widespread bans were enacted in restaurants, on airplanes, and certainly in medical facilities. The threats we face today are no lesser.

Patients should not have to gamble with Long COVID in order to access healthcare in a professional setting. Shoppers should not have to gamble with Long COVID in order to buy

groceries. Please, consult the existing evidence on the effectiveness of air filtration and ventilation for preventing exposure to infectious aerosols. Revise your guidance to include some minimum acceptable level of ventilation for medical and public spaces.

Thank you for your time.

Sincerely,

Patricia M. Brent

Writing in my capacity as a private citizen / not organizationally affiliated

---

As a member of the community who is high-risk because of common variable immunodeficiency and a variety of health issues, I am begging you to recognize that SARS-COV-2 is spread by aerosol transmission, much of which occurs asymptomatically, and do what is necessary to protect us.

Please make transparent, evidence-based, universal guidelines that protect us all from asymptomatic aerosol transmission of covid. There is no excuse for nosocomial spread, especially when our most vulnerable people absolutely require medical attention. Respirators are effective and widely available, as are HEPA filters.

Your choices matter not just to patients, but also to healthcare workers. Lack of appropriate PPE hurts practitioners of healthcare as well as their patients. This illness causes brain damage, and we need doctors, nurses, and admin staff to maintain their cognitive abilities. We should be protecting them as well.

We still don't know what the long-term effects of covid infection are on otherwise healthy people. We should not be abandoning the precautionary principle.

Please help us stay safe from this pathogen

Leah

---

It's insane you'd entertain anything other than protecting patients from nosocomial infections. It's insane that my family can't safely access basic healthcare without risking COVID. You're healthcare professionals, not the politicians interested in the economy at the expense of people. You're supposed to be on our side!!!!

You would literally be helping them kill off the weaker and disadvantaged in service of the government. This is eugenics.

Sincerely

Kathryn Johnson

---

Hi,

I am Sophia Myers, Independent Clean Air Advocate.

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Sophia

---

Medical facilities should require both the medical staff and patients to wear proper N95 respirators, with the exception of those who have a legitimate medical reason not to. Allowing individuals into medical facilities without masks is a threat to the public's health and always has been, even before COVID-19. Many viruses can cause lasting damage to the body, so we need to focus on proactive preventative measures. The more recent threat of COVID-19 merely highlights the problematic practices of our medical community. We have yet to understand the full impact of COVID-19, but we do know it can be spread asymptomatically through aerosols and scientific research suggests contracting the virus can result in long COVID. The more individuals contracting the virus, the more it will continue to mutate, and possibly eliminate our ability to produce effective vaccines.

Going to see the doctor puts myself and my entire family at risk of contracting a severe illness or worse, according to the CDC's own website. I have several immunocompromised individuals in my family, including myself. I avoid all indoor public spaces, if possible, and always wear an N95 respirator if I must go indoors. I am very reluctant to enter a medical building where masking is not required, but what choice do I have?

If our own medical community cannot "follow the science" then how can we expect anyone else to? Medical professionals should not be in the business of spreading disease. We desperately need our medical professionals to mask up and lead by example when it comes to infection control.

Thank You,

Nicole Holman

---

Hello,

I am Julia Ingraham, Independent Clean Air Advocate.

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Julia Ingraham

---

Dear Committee,
Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I agree 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

And all others who understand the importance of this decision when it comes to healthcare worker health, the healthcare system sustainability, and patient health and well-being.

Surgical masks are NOT RPE. The CDC's own 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

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. And it should be done in a way that actually mitigates respiratory viruses.
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.
Like gloves as a universal precaution, N95 or better should be considered part and parcel of the HCW uniform. Thank you, Janet Fisher

---

Hello,

I am Julia Ingraham, Independent Clean Air Advocate.

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Julia Ingraham

---

Written Comments submitted to CDC-HICPAC 22 Aug 2023:

CDC must require healthcare workers to wear respirator masks (N95, P100, or better) as part of Standard Precautions.

The so-called "evidence review" presented at HICPAC recently was not fit for purpose and would have been given an F by any of my science teachers. It must be completely replaced.
It was missing the leading real-world study, Ferris, Ferris, Workman, which proved conclusively that respirator masks stop airborne infection and surgical masks don't.
https://aairds.com/background It included studies by Loeb including Loeb 2022, which has been completely debunked, and Loeb had an undisclosed conflict of interest, meaning all of his papers are untrustworthy. https://first10em.com/the-now-infamous-but-not-very-helpful-n95-trial-loeb-2022/
It was also missing the overwhelming NIOSH and lab evidence that respirators work far better than surgical masks.

My partner was infected by doctors wearing surgical masks. Twice.
I did not get infected because we used respirators at home.

I am a professional investor with over 30 years of experience in financial analysis.
Fully reusable P100 respirators with source control cost less than $40 per staff member per year.
HEPA filters cost less than $100 per exam room per year.
These would eliminate airborne infection. Detailed citations are at https://whn.global/doctors-should-not-infect-patients/ , which has been peer-reviewed.
The cost of not using respirators is far higher.
Staff and patients are being infected routinely.
One sick day for one nurse costs a hospital thousands.
Replacing one disabled nurse costs tens of thousands.
Disability payments and liability costs for one workplace-acquired infection costs hundreds of thousands.

The liability cost from one infected patient is similarly enormous.
But the reputation damage is even worse. Millions of Americans, including me and my entire family, are avoiding elective and routine medical care because the offices are not safe. This may be millions of dollars in lost revenue for a single hospital. If they start using respirator masks and HEPA filters, we will come back.

The financial choice: $40/worker and $100/room to use respirators and HEPA. Hundreds of millions of dollars in lost revenue and added costs to not do so.

It is clear, financially, that respirator masks (N95 or better such as P100) should be Standard Precautions.

Financially, there is never any reason to use anything less, and so healthcare offices should not be given any discretion or flexibility: they should be required to use respirator masks as Standard Precautions.
This will be profitable for the medical offices, the doctors, the nurses, the patients, and the American economy.
This is my professional opinion as an investor with over 30 years of experience in financial analysis.

Nathanael Nerode

---

I write as a concerned citizen at high risk from Covid-19, as I am elderly and have both COPD and emphysema.
My concern also extends to our nation's healthcare workers who are on the front lines battling this and other transmissible diseases in the workplace, as well as their patients.

It is absolutely outrageous that the CDC is proposing to weaken protections for healthcare workers, just as the detection of Covid-19 in wastewater levels is rising and two new variants of concern are circulating during a surge.
Equally egregious is their conclusion that plain surgical masks provide adequate protection, which ignores overwhelming scientific evidence to the contrary.
Also stunning is their failure to include ventilation, UV disinfection and HEPA filtration, as other essential measures to combat transmission.

If allowed to stand, these dangerous proposals will cause the deaths of some, and serious illness for others with possible devastating long-term consequences.
There is little discussion of the dangers of long Covid but the impact it is already having on both our workforce and healthcare system is significant and will only get worse.
The economic cost alone will be astronomical, not to mention the havoc it wreaks with people's lives.

The recent increase in travel as well as the heat and unhealthy air quality from the Canadian wildfires which drove mostly mask-less people inside, has probably contributed to the present surge.
I am worried about schools re-opening, as a recent report published in the *Journal of the American Medical Association,* found that 70.4 percent of infections in nearly 850,000 households sampled originated in childhood transmission.

Also extremely concerning is that a significant proportion of Covid-19 transmission is asymptomatic or pre-symptomatic, potentially as high as 60%, according to a 2021 *JAMA Network Open* modeling study; China figures indicate that four fifths of cases may be asymptomatic.
And various studies show that rapid antigen tests miss 90% of asymptomatic cases, especially when taken only once as opposed to serially over multiple days.
All the more reason for *everyone* to mask up.

In a *Forbes* article entitled *CDC Weighs Lower Infection Safety Precautions for Healthcare Workers* published yesterday, I read that National Nurses United submitted a FOIA request for the committee's evidence review in its entirety and the minutes from the last nine months of working group meetings.
These were denied, violating rules under the Federal Advisory Committees Act.
This lack of transparency is appalling and the proposed drastic changes to infection control put

us all at risk of acquiring Covid-9.

Lastly, we better pray that a new variant does not emerge that vaccinations and boosters do not protect us from, or we will be in serious trouble and you will have blood on your hands..

Susan Diederich

---

To: HICPAC

I am not an expert on infectious disease as SO many of the people who have responded quickly to the non- transparency of this process and quick turnaround for new guidelines.

Who are these people suggesting that non surgical masks work?....that ventilation isn't important....that room size and # of people in spaces is of no consequence?

Who is suggesting that consultation with the front-line workers who have suffered the most do not count?

Why would people holding the power to draft new guidelines NOT consult with all stakeholders in a transparent manner allowing time for input and feedback? Please answer these questions before new guidelines are adopted.

Connie Valentine

Resident of Allegany County MD

Community Volunteer

---

Dear HICPAC,

I am writing in disbelief that this is necessary.

Masking/wearing respirators in healthcare should so clearly be a part of universal basic precautions. That this is considered debatable is like debating handwashing or germ theory - beyond preposterous.

Rarely is there something that is so clear and well-supported by evidence and yet there is so much ignorance and disinformation on the subject that this is somehow framed as controversial.

In no uncertain terms - mask/respirator wearing should absolutely be the bare minimum standard in healthcare to protect healthcare workers and their patients from COVID and every other respiratory disease known and emerging.

There is no argument nor defense for any other choice.

Sincerely,
~ Scott Menor MS/PhD
CEO Roambotics, Inc.

---

Hello. Good afternoon.
My name is Mya, and I am an undergraduate student at Dartmouth College in Hanover, New Hampshire. I am someone who is worried about my life and other students' lives with the

upcoming fall term. Already as young adults, we have to worry about handling our finances and taking on new responsibilities in this chaotic world and on top of that, we have a multitude of classes to keep up with. So, the absolute last thing that we need to worry about is the possibility of something affecting our health. Especially when we go to get said health checked up. That is why I am here to say that masking needs to be required in healthcare settings. Healthcare workers need to wear high-quality masks in facilities, not a surgical mask, and if they do not have access to them, they need to be provided some at the entrances. And, it does not need to just be required in certain areas of a healthcare facility, but all over the premise as COVID is airborne and anyone can get infected from it within seconds. It is imperative that these policies along with other precautions are enforced especially with this ongoing surge that's mainly happening because of how less actions have been enforced and taken to mitigate COVID. The vaccines are not enough. I know people who are my age, and younger, that are vaccinated, yet they still got infected and now, simple tasks or activities that they were easily able to do themselves take so much of their physical, mental, and emotional energy. Some cannot even perform these tasks without the aid of another person and have Long COVID. I do not want to be a witness to more people deteriorate from this virus. Frankly, I do not want to hear of anyone, especially someone on my college campus, die from this virus when several preventative measures can be enforced. Thank you for listening.

---

Restore mask mandates in healthcare. People shouldn't have to risk infection (with ANY virus) now that we know the importance of masking. It's malpractice. You know that we are entering another wave and are honestly thinking of declaring blue masks equivalent to N95s? Ridiculous.

I'm Black and queer and in my late 30s and so is my partner. We both are college educated and serve our community by working in or adjacent to public transportation.

This presidential administration claims it cares about us, but one key way it could show that consistently is to extend the protections it uses at the White House to all of us, especially in public buildings. Respirators, MERS 13 and PCR testing should be available to all, especially at the hospital.

Both of us have had life threatening conditions and if it weren't for surgeries and medical care with proper PPE, we wouldn't be here and we wouldn't have a positive quality of life.

Please use the tools we have for everyone and stop enabling and cowering to corporate and conservative hateful cowards who don't believe all of humanity is worth saving.

Thank you,

Kristen Jeffers

---

Hello,

I am writing to encourage the CDC to issue broad mask mandates for public locations such as hospitals and schools. I am immune compromised and wear my own mask in all public indoor and crowded spaces. We know covid is airborne. This simple tool saves lives and gives disabled people like myself the ability to participate in society.

Thank you for your time.

---

Stop surrendering your medical knowledge. Stop cowing to billionaires. SARS2 is an airborne virus transmitted via aerosols. YOU KNOW THIS. Yet, no one says, “wear a mask indoors and outside when around other people.” It’s almost as if you have been bullied …or paid? Does the money in your bank accounts assuage your guilt for breaking your physicians oath to “do no harm”?

You all disgust me.

Stephanie Trump Marrero

---

We've known the science for years. COVID-19 is airborne, and the pandemic is not over. Not only do we need better filtration to clean air in healthcare facilities (and public indoor buildings in general), but we also need to continue wearing N95 (or better) respirators at a minimum to keep everyone safe!

People should not have to risk infection to get healthcare. We know one-way making is insufficient. Failing to require proper respirators in healthcare is a spectacular failure of "do no harm". Weakening existing guidelines is dangerous for everyone because we're all at risk of serious health complications from COVID-19, but it's an especially callous act of violence toward the immunocompromised.

It is imperative that we keep respirators in healthcare to save lives and keep everyone safe.\

Cyle Ferguson

---

The CDC has already lost all credibility with those who are following Covid closely, and now is about to become irrelevant if the draft infection control guidelines become final.

For 3.5 years I have been doing volunteer work for 13 doctors at 4 NYC academic medical centers. I read Covid studies daily, and have become especially interested in indoor air quality & airborne infection control. The proposals are horrifying. Surgical masks the equivalent of N 95s? No far UV, ventilation, filtration etc requirements? No references to the new ASHRE guidelines?

I have homozygotic Factor V Leiden and Type A blood, making me high risk for Covid infection and extremely high risk for severe complications due to Covid’s propensity for clotting. *If these guidelines are implemented, I will have to go abroad for medical treatment*, because America will have returned the days before Florence Nightingale. It’s terrifying and, quite frankly, beyond idiotic.

Anna Stern

Retired

---

Hello CDC,

We need more action from you on this ongoing pandemic. You have walked back so many protections for people and have actively downplayed safety precautions.

The ways to make up for these failures is to bring back masks in healthcare (n95 and better, surgical masks are not on the same level.) Make air filtration a bigger deal and make testing free and accessible.

Please consider deeply,
Robby

---

Please improve COVID-19 recommendations/procedures and continue to treat the pandemic for what it is; an ongoing massively disruptive event.

Stop putting profits and "the economy" over people; stop foisting the responsibility on the individual. Systemic problems require systemic solutions. There's too much blood on the CDC's hands already. Anthony Madia Jr.

---

Hello, I am a data scientist whose family, friends, and co-workers have been, and still are, affected by COVID and Long COVID. Infection control is imperative to mitigate the harmful effects of the ongoing pandemic as observed by numerous scientific studies and literature. I feel we need to rethink our approach here because:

- The Isolation Precautions Guidance Work Group's proposed updates on infectious disease transmission terminologies inadequately address aerosol transmission science and risk, potentially undermining healthcare protections amid the Covid-19 pandemic's lessons.
- The HICPAC's revision process for the 2007 Isolation Precautions guidance has overlooked crucial input from stakeholders such as frontline personnel, safety experts, and respiratory protection authorities, necessitating a more inclusive approach to drafting.

The approach taken by HICPAC in formulating revisions to the 2007 Isolation Precautions guidance has unfortunately overlooked the vital contributions of numerous critical stakeholders. These include frontline personnel and unions, proponents of patient safety, industrial hygienists, occupational health nurses, safety experts, engineers, aerosol specialists, and respiratory protection authorities. I strongly advocate for HICPAC and CDC to reconsider the pace and method of progression, allowing for a more inclusive and meaningful involvement of these experts during the drafting phase.

The Isolation Precautions Guidance Work Group has put forth revised terminology pertaining to the transmission of infectious diseases through methods such as "air" and "touch." However, their recognition of aerosol transmission and the significance of inhaling aerosolized pathogens remains incomplete. Substantive inaccuracies exist within the newly proposed classifications of transmission modes, namely "air" and "touch," particularly in the context of healthcare-associated infections. Although the CDC/HICPAC introduces the novel classification of "air" transmission, the critical aspect of inhalation is not adequately acknowledged, and their continued endorsement of surgical/medical masks is problematic as these do not offer sufficient respiratory protection against the inhalation of infectious aerosols. It is imperative also to revise the roster of infectious diseases currently categorized as spread through airborne or droplet routes, expanding it to encompass those capable of transmission via aerosols and inhalation. Regrettably, the suggestions from the Work Group have the unintended consequence of diminishing safeguards for healthcare personnel, despite the pivotal lessons underscored by the Covid-19 pandemic concerning the necessity for robust protections for both healthcare personnel and patients. Eric Sherlock

---

Dear HICPAC,

Thank you for today's public meeting; I watched on the zoom link. I am a concerned citizen and mathematician at Colorado State University, and I have analyzed some of the statistics around respiratory virus protection from a mathematical standpoint.

I am concerned that the studies done that conclude that N95 use was not better than surgical mask use for protection against respiratory virus transmission in hospitals were flawed and did not involve proper use of N95 respirators. I urge HICPAC and the CDC to fully recognize aerosol transmission of covid-19 and other respiratory viruses, and add properly-fitted N95 respirator use to the Standard Precautions taken throughout healthcare, especially given the endemic and persistent high level of spread of covid-19, and the propensity of asymptomatic spread.

Since the rampant spread of covid-19 poses a serious risk to many vulnerable hospitalized patients, I sincerely hope you consider stronger respiratory precautions such as N95 masks to be a standard part of the care routine for all patients in hospitals. If one is concerned about the communication that happens with facial expressions and lip-reading, there are now certified N95 masks available that have a clear plastic window on the front for viewing smiles, available through the Optrel company and others. Therefore, there is no reason for not going the N95 route since many studies have indeed shown that they are effective in preventing the spread of airborne respiratory viruses.

Thank you for your consideration.

Best,

Dr. Maria Gillespie

Department of Mathematics

Colorado State University

---

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I am Pris Sears, independent public health advocate.

I 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 appropriate protective equipment for preventing aerosol-based healthcare-associated infections such as Covid-19. We should be strengthening, not weakening protections in healthcare settings. HAI Covid-19 should NEVER happen. It is becoming more common and engaging with healthcare is becoming increasingly dangerous for both patient and provider.

Please acknowledge that Covid-19 is aerosol, not droplet, transmitted, and require appropriate PPE and air-cleaning procedures in all health-care settings.

thank you

Pris Sears

Because of misinformation about masks, I have been unable to receive important cancer screenings and other routine health care.

"Baggy blues" and bare faces aren't what patients and staff deserve. Properly fitting respirators protect everyone.

Infections like covid are dangerous not only for "vulnerable" people, but also because they convert healthy people into vulnerable people.

Infection control is how we slow the mutation of current threats and prevent new diseases from getting out of control. N95s or better should be required in all health care settings.

Rachel Harrison

Name: Jonathan Soper

Topic: The importance of recognizing aerosolized transmission

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.

Good afternoon,

Thank you for the HICPAC presentation today. It was quite informative.

During the discussion of EBP, Michael Lin mentioned that EBP would not be used for an individual with C auris but Contact precautions would apply.

According to the CDC implementation guidelines:

10. **Are Enhanced Barrier Precautions recommended for methicillin-resistant *Staphylococcus aureus* (MRSA) and other MDROs if the resident does not also have an indwelling medical device or wound?**
While Enhanced Barrier Precautions were initially intended for those colonized with or at risk for colonization with novel or targeted MDROS, CDC's updated guidance now provide facilities and jurisdictions the flexibility to implement Enhanced Barrier Precautions for residents colonized or infected with any epidemiologically important MDRO. For this reason, facilities may consider Enhanced Barrier Precautions for more common MDROs such as MRSA. If implemented, Enhanced Barrier Precautions for residents with known MRSA colonization should be utilized in the same manner as Enhanced Barrier Precautions for novel or targeted MDROs and should not replace other interventions targeted at preventing invasive MRSA infection and transmission.

Examples of MDROs targeted by CDC include:

- Pan-resistant organisms,
- Carbapenemase-producing carbapenem-resistant Enterobacterales,
- Carbapenemase-producing carbapenem-resistant *Pseudomonas*,
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and
- ***Candida auris***

Please provide clarification.

Thank you,

Kathy

Kathryn Cusano RN, BS, CIC
Supervising Nurse Consultant
Connecticut Department of Public Health
Healthcare Associated Infections/ Antimicrobial Resistance Program

---

Hi,

I am Allison Taylor from Seattle, WA, a Registered Nurse and mother of a child with a high-risk medical condition.

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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 have 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,

Allison Taylor, RN

---

Please do not water down current masking guidelines—such as saying blue masks are sufficient when N95s are clearly superior. Also strengthen recommendations for air filtering in public environments.

The public realizes COVID is surging again yet we get little information. I'm reminded of the disaster a few years ago re: Purdue Pharma. Government medical advisors must maintain public trust. Please listen to all experts in this issue.

Cynthia Erb, retired

---

I am commenting today to express my strong desire for mask requirements to come back to healthcare settings. High quality N95 respirators should be required for those working directly with patients. The evidence review on N95 respirator and surgical mask effectiveness was flawed, and it must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. The evidence review used, 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.

This is critical not just for patients, but for the health care workers as well. Significant numbers of healthcare workers have been lost due to death and also to long Covid. Repeat Covid infections are going to increase the number of health care workers who are impacted by long Covid, and it will contribute significantly to ever increasing staffing shortages. Additionally, doctors and nurses are critical sources of information for the public. When high quality masks are no longer being used by these health care providers, it sends dangerous and incorrect messages to the public, including those who are vulnerable from death or other poor outcomes from Covid-19 infections. When health care providers do not wear high quality masks around patients, the messages they are sending is that, one, Covid-19 isn't of concern and two, that high quality masks do not help prevent transmission. Both of these messages are categorically

false, incredibly dangerous, and they cause incalculable harm to our communities. Our health care providers need to be leading by example to help protect the most vulnerable among us.

I know several people who have acquired Covid-19 while in the hospital since mask mandates were removed, both as patients and as visitors. One person in her early 40s who acquired Covid-19 while visiting her father in the hospital now has heart problems, which her new cardiologist attributes to her hospital acquired Covid-19 infection. Others I know are avoiding obtaining health care, even though they need it very much, because the risk of acquiring Covid-19 while receiving care is too great. No one should feel like it is too risky for them to receive health care, because providers will not wear high quality masks. A third person I know had both of their parents living in a long-term care facility. Both acquired Covid-19 after the mask mandate was dropped, and no improvements to ventilation or filtration were implemented in the facility. This person's father ended up dying due to his Covid infection. His death was preventable and he did not deserve to die how and when he did, because others wouldn't wear masks.

The final area that I would like to address is the failure 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,

Allison Bernaldez

---

Dear advisory committee,

I'm writing to urge you to PLEASE require high-quality masks (minimum of KN95, N95 preferred) in health care settings. I had to go to the ER in April and was anxious the entire time because the health care workers weren't masked. Some of them wore saggy, baggy surgical masks that offer minimal protection against Covid. I had to remove my N95 for some testing and my anxiety went through the roof.

We go to the hospital and doctor offices because we have health issues, and we should NOT have to worry that we could be infected with a deadly, disabling virus.

This should be a no-brainer: Health care settings need to be safe places for patients. PLEASE require high-quality masks in health care settings!

Sincerely,

Tracy Abell

Lakewood, CO

---

Hi,

I am Hana Martinez, Independent Clean Air Advocate .

Regarding this meeting: https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Hana

---

Dear CDC,

We know you are capable of crafting guidelines that will protect patients, family and healthcare workers.

Now is your time to reinstate masking in healthcare settings.

Sincerely,

Kate Hall

Mother of a child with Long Covid

---

Masks are a vital protection! COVID is airborne. The idea of any healthcare provider not masking is mind-boggling. Erika Ensign

---

Strengthen mask mandates and precautions. Do not weaken them. Covid is changing, getting worse. What the f*ck are you doing? We need CDC to push for more institutional and personal responsibility, not less.

- concerned citizen Nate Spacek

As a high risk person with multiple conditions that overlap, the weakening of covid precautions has made accessing healthcare less safe. Within the last year I've had medical appointments rescheduled because of staff shortages when doctors or nurses were sick due to Covid and having high quality masks would have both made me safer when accessing care and helped preserve capacity to access care. With new variants and low booster rates amongst patients there are a lot of expanding risks and blunt controls like air quality configurations in HVAC and masking are still incredibly effective. In the same way we never got rid of hand washing in restaurants we should keep masks in healthcare as it is key for reducing germ spread during higher risk settings. --

Urvi Nagrani

Patient safety from preventable disease in healthcare settings should not be a matter of luck. The risk of contracting COVID-19 in a healthcare setting should not have to be part of a patient's calculation when determining the cost of health care.[1] COVID-19 is still a potentially deadly disease and post-COVID-19 conditions or "long Covid" is no longer rare,[2] and can significantly disrupt the patient's life and interfere with their ability to work.[3] Moreover, long Covid symptoms may linger even after two years according to a recent study published in Nature.[4] Masking, engineering controls, ventilation, UV disinfection, and HEPA filtration should be utilized to protect patients in these settings. Today, many healthcare providers have abandoned masking and depending on the patient's condition, masking may not be possible (e.g., while vomiting, during surgery, when needing supplemental oxygen or breathing therapy), which makes them more susceptible to contracting an airborne virus. It is also important to consider that not all masks provide equal protection, even according to the CDC (see graphics below). A failure to adequately control infection in healthcare settings will result in increased spread of SARS-CoV-2 and potentially delayed care for other health conditions.

[1] Kim SH, Kim T, Choi H, Shin TR, Sim YS. Clinical Outcome and Prognosis of a Nosocomial Outbreak of COVID-19. J Clin Med. 2023 Mar 15;12(6):2279. doi: 10.3390/jcm12062279. PMID: 36983280; PMCID: PMC10056618.

[2] Bull-Otterson L, Baca S, Saydah S, et al. Post–COVID Conditions Among Adult COVID-19 Survivors Aged 18–64 and ≥65 Years — United States, March 2020–November 2021. MMWR Morb Mortal Wkly Rep 2022;71:713–717. DOI: http://dx.doi.org/10.15585/mmwr.mm7121e1.

[3] Davis, H.E., McCorkell, L., Vogel, J.M. et al. Long COVID: major findings, mechanisms and recommendations. Nat Rev Microbiol 21, 133–146 (2023). https://doi.org/10.1038/s41579-022-00846-2.

[4] Bowe, B., Xie, Y. & Al-Aly, Z. Postacute sequelae of COVID-19 at 2 years. Nat Med (2023). https://doi.org/10.1038/s41591-023-02521-2.

Maya Wilson

A STATEMENT ON THE PROPOSED CHANGES TO PRECAUTIONS GUIDELINES

Dear esteemed members of HICPAC,

My name is Savannah Yurcek. I am a resident of California, and I am speaking for myself and have no affiliation with any organizations. As someone who suffers from a profound post-viral illness, I am writing to express my concerns about the HICPAC's proposed revisions to infection control guidelines.

For background, I became ill after contracting Epstein-Barr at 18 years old. For the past six years I have experienced my health deteriorating to the point of disability, and accumulated a multitude of diagnosed conditions commonly triggered by viral infections. My experience even inspired me to pursue a bachelor's degree in public health.

Since the pandemic started, I have experienced friends and acquaintances seeking me out for help at the first sign of long-covid symptoms. I have had to direct people to the extremely limited number of resources and medical providers knowledgeable about conditions like postural orthostatic tachycardia, myalgic encephalomyelitis, gastroparesis, migraine, and many others that we have seen manifest with long-covid. I have watched people in my community grieve the loss of their health and previous lifestyles the same way I have been forced to over the past six years.

Given that we do not currently have the technology to fully prevent or adequately treat long-covid, and that many still die from SARS-CoV-2 infection, I believe it is the duty of the CDC to use every method at its disposal to prevent infection from happening in the first place. This is especially crucial in healthcare settings, where vulnerable high-risk individuals face the decision of either risking infection to access essential care, or going without and risking disease progression and a lower quality of life. Many of us have felt abandoned and left to fend for ourselves.

I am deeply concerned by HICPAC's recent conclusions on infection control for a few reasons. First, I am troubled by the assertion that surgical masks are comparable to N95 masks at preventing infection from airborne viruses. There is overwhelming evidence that this is not the case, and I would get into that here if the CDC itself had not put out resources and infographics arguing the same point.

Second, I believe that HICPAC does the CDC a disservice by not exploring other methods for reducing airborne transmission that are supported by evidence. I urge HICPAC to work with aerosol physicists and other experts in airborne transmission, and consider their recommendations. For example, basic protocols for cleaning the air such as increased ventilation and the use of air purification devices with HEPA filters should be included in HICPAC's recommendations for reducing the spread of airborne viruses.

I believe that with common sense infection control methods such as the use of N95 masks and cleaning the air we can effectively reduce the risk to health care workers and their patients. I urge HICPAC to reconsider their conclusions and strongly recommend N95 masks and increased ventilation. In this case, prevention is the best medicine we have. Thank you.

---

Hi, I did get to speak and read this, wanted to provide the one page text with links to all research in place:

Hi, I am Shea O'Neil, WHN volunteer, a patient, disabled rights advocate, sole caretaker of one son, high risk person with disability. It is quite obvious that your last discussions did not inspire confidence amongst the public in your ability to, without bias, pass guidance and standards that will deal with the dreadful rise in infections in healthcare facilities.

It is really clear in wildfire smoke messaging that you wear N95 respirator masks– that surgical, cloth, and dust masks aren't going to cut it. You'd never, in peak wildfire times, amidst smoke, tell firefighters, vulnerable people, or even healthy people, "hey, you know what, I think we need

more real world studies, wear a surgical for now", or "actually, wildfires typically aren't all year long, so we will change the guidance to surgical instead." These things do not make sense– do not protect people!

The fact that in your past meeting notes you use widely-criticized mask studies (https://first10em.com/the-now-infamous-but-not-very-helpful-n95-trial-loeb-2022/), failed to mention any with continued use of n95s (https://www.atsjournals.org/doi/full/10.1164/rccm.201207-1164OC) in healthcare settings (many show N95s DO lower infections (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8635983/)), the fact that you highlighted mask discomfort and ignored long covid and how damaging and widespread its effects are... I don't know if this is ignorance, immorality, if it is conflict of interests and money, or psychological coping at play, but I'll tell you science and logic are not at the table and they need to be brought back. It is not complex, it is very simple and clear that n95s offer adequate protection from aerosols, that two-way protection is much better than one-way (https://www.pnas.org/doi/10.1073/pnas.2110117118), that hospitals are full of vulnerable populations, that doctors should not infect patients, and that healthcare is a human right. We need N95 respirator masks in healthcare facilities to protect both staff and patients. There are many reasons why:

- Studies show that more than half of transmission is from asymptomatic carriers (https://pubmed.ncbi.nlm.nih.gov/33410879/), and COVID-19 is airborne (https://www.nature.com/articles/s41564-021-01047-y) and highly contagious (https://www.ijidonline.com/article/S1201-9712%2823%2900109-1/fulltext).
- Hospital-acquired COVID-19 had a 10% mortality rate (https://ozsage.org/media_releases/immediate-action-is-needed-to-reduce-hospital-acquired-covid-19-infections-and-deaths/) ; For the past year, nearly a third of COVID-19 cases in hospitals in England were hospital-acquired (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/) .
- a 2023 JAMA study on Omicron Variants (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2801464) shows that hospital-acquired COVID-19 was associated with an approximately 1.5-fold higher risk of in-hospital all-cause mortality up to day 30 compared with influenza;
- and a 2023 JAMA cohort study (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807160?resultClick=1) shows COVID-19 infections make people's existing illnesses worse.
- Research (https://www.mdpi.com/1999-4915/13/4/604) on viral genomic sequences during a COVID-19 outbreak in a hospital demonstrated that healthcare workers were responsible for much of the spread in the hospital ward.
- Long COVID continues to cause severe long-term consequences for millions (https://www.nature.com/articles/s41579-022-00846-2); with one study finding that those that develop Long COVID have a 38% chance of further developing disability that prevents them from returning to work (https://www.mdpi.com/2077-0383/12/3/741), and another indicating that up to 27% of healthcare workers develop Long COVID (https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/abs/risk-factors-for-long-coronavirus-disease-2019-long-covid-among-healthcare-personnel-brazil-20202022/AA01F17E1C8A33C07457914E63AB3EEE)
- While reported acute-phase deaths (https://covid.cdc.gov/covid-data-tracker/#demographicsovertime) are down, COVID-19 continues to kill, and many patients in healthcare settings are high-risk for severe COVID-19

(https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html)
.

- Vaccines offer partial/temporary protection (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804451#:~:text=Conclusions%20and%20Relevance%20These%20findings,vaccination%20cycle%20and%20booster%20dose.) from acute effects, do not prevent infection/transmission (https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00768-4/fulltext), and booster uptake is low (https://covid.cdc.gov/covid-data-tracker/#vaccination-states-jurisdictions).
- Treatments at this time are limited and include only one monoclonal antibody treatment (https://www.covid19treatmentguidelines.nih.gov/about-the-guidelines/whats-new/) currently authorized for limited, acute uses.

Thank you,
Shea O'Neil

---

Citizen trying to help prevent more health and long Covid from a preventable disease

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

Why are we willfully exposing people to a deadly virus, in hospitals of all places?

Hospitals should be a safe space for patients, it should not be one of the main sources of Covid spread. I and millions of others are avoiding going into a hospital or medical setting that doesn't have basic Covid protections. Many of us have put off lab work & procedures. Every decision has to weigh the real risk of Covid versus the health issue.

Dropping of masking in hospitals in UK caused over 14,000 deaths from hospital-acquired Covid. Many hospitals have already tried it and had to revert to masking since not only a rise in patients but also staff getting Covid. This created a staff shortage.

The answer is clear. We need N95 masks in hospitals. Anything less or half measures like loose surgical masks will increase infections. Masking needs to cover the whole hospital not just pockets. Why do we need to repeat this deadly experiment again and again? Follow the science and don't try to make a shortcut.

Thank you,

Scott Squires, VES

---

**Public Comment from the National Union of Healthcare Workers to the Healthcare Infection Control Practices Advisory Committee**

**August 22, 2023**

My name is Jessica Early and I work on occupational and patient health and safety for the National Union of Healthcare Workers. I am also a nurse practitioner.

NUHW represents 17,000 healthcare workers in diverse roles from CNAs, RNs, MDs, PTs and therapists to EVS and dietary service workers in hospitals, nursing homes, and outpatient clinics

across California and in Hawaii. On behalf of our members, I urge the Advisory Committee to issue recommendations for the C*DC's* update to the *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, which strengthen the current guidance—not weaken it.

Over the past few months, you have heard from numerous experts in aerosol science, medicine, and occupational and public health and so instead of repeating these experts' explanations of what protections healthcare workers need, I will tell you why healthcare workers can't count on their employers to provide them.

When SARS-CoV-2 arrived in our members' already understaffed facilities, instead of maximizing ventilation and filtration, placing patients in airborne infection isolation rooms, and providing respiratory protection of, at minimum, an N95, our members were given surgical masks—which do not protect from infectious aerosols—and instructed to care for infected patients haphazardly roomed across their facilities. When our nursing home workers reported a case in their facility at the beginning of the week, by week's end almost all staff and patients were infected. Healthcare workers got infected, they spread Covid to their patients, they spread Covid to their families, some ended up in the ICU, some got long Covid, and tragically, some died.

The healthcare industry dismisses the failure to protect staff and patients as an inevitable result of operating during a crisis, but our members know what they endured was and is preventable. Our members have called for more staff and equipment for years, and an extensive body of aerosol science and occupational health and safety knowledge tells us exactly how to effectively prevent the spread of infectious aerosols from pathogens we have dealt with for decades, like tuberculosis, or novel pathogens.

But the pandemic clearly demonstrates that the healthcare industry will not employ best practices voluntarily. This industry does not need more flexibility and discretion. Instead, this industry—and the state and local agencies that regulate it—need strong national guidance grounded in aerosol science and the core tenets of occupational health and safety.

Throughout the pandemic, healthcare workers have been called heroes by their employers, by politicians, and by the press. But our members will tell you that they aren't looking for words of praise and they aren't looking to be unnecessarily exposed to pathogens whose transmission we can readily prevent.

Instead, our members want safe workplaces where their employers follow guidance that protects them as they do their critically important work. And they want a voice in the development of such guidance. Failing to provide this is a profound disservice to the millions of healthcare workers across this country who have already been forced to sacrifice far too much.

NUHW thanks HICPAC for this opportunity to comment.

---

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.

HICPAC and the CDC needs to provide clear, specific rules for health care providers to follow when dealing with infectious diseases especially those that are transmitted through the air. Most health care providers do not have access to the full range of expertise required to develop these protocols themselves. During the worst of Covid I heard many mistaken statements and

opinions from people who were otherwise very knowledgeable. Of course, I continue to hear these comments now that Covid is less of a threat. I also heard them when TB was surging in the late 80's and early 90's and during the SARS outbreak, during the swine flu epidemic and the MERS infections.

History has shown that when employers aren't given specifics, they do what is easy and cheap, not necessarily what works. Surgical masks are cheap. But unfortunately, as I pointed out in my 30 years of respiratory protection classes, they are only designed to keep surgeons from coughing, sneezing and spitting into their patients' wounds. Respirators, which cost more and require training and usually fitting, are designed to keep people from inhaling the bad stuff. Why, there is even a government agency (NIOSH) which tests, certifies and regulates respirators for that purpose. The FDA doesn't.

Unfortunately, I continue to see employers, including major health care companies, handing out surgical masks for protection against respirable hazards of all sorts.

Of course, effective ventilation is rarely thought of or implemented. That takes time, thought and money. Handing someone a fan and telling them to stick it in the window is quick, simple and cheap. Unfortunately, it is also not effective. Most people are not aware of the concepts of make up air, air change frequency and air short circuiting. These are not difficult concepts to understand, but leaving it up to employers to figure out is not a solution to infectious disease control.

Most employers are also unaware of the hierarchy of controls, the concept that hazard elimination and engineering controls are most effective way to protect folks and PPE is the least effective. But leave it up to employers and they will be handing out PPE every time. It is just a lot easier. It also takes the responsibility for controlling infectious diseases off the employer and dumps it, along with the blame for its failure, on the public/employee.

Some employers may have better ways to control the hazards of infectious diseases. Science is always showing us better ways of doing things. But those employers should be required to show their method works at least as well as the approved method first.

So, let's just tell employers how to control of these diseases.  Let's not leave up to the uninformed, the penny pinching, the lazy or QAnon.

Thank you

---

Dear HICPAC Secretariat,

The following is my submitted public comment for the August 22nd HICPAC meeting:

My name is Dr. Bernadette "bird" Bowen and I am a Visiting Assistant Professor, critical media ecologist, and content creator, here speaking on behalf of myself. The following are choice passages from the second volume of my memoir, out later this week (as of 8.22.23), detailing my experiences of the last four years as a late-in-life realized autistic person.

How does one describe the monotony of waking up for almost 1400 days, and during most of 'em, existing inside merely 800 square feet? There is -- no way -- I can describe years of this monotony.

Over the course of the last four years, personally and professionally (due to my research about sociosexual ecologies in this age), I have lost almost all hope in the ability to trust most health organizations and members of the public to take basic preventative measures to protect my health. How is a lifelong sexual violence survivor and researcher of the sexually violent U.S. ecology supposed to trust any possible partner amidst this public refusing to take basic health protections?

Some may think I should have unsafely gone in public unmasked around countless people. People that have overtly accepted and act like disabled people's lives don't matter anymore. As if I don't know that autists (Dx or not) are high risk for C19 due to our Very Long list of comorbidities.

If not that, other minimizers may think that I should have just gone outside to enjoy the color-paved racist eyesores of late-stage capitalist suburbia.

Most folks nowadays completely deny that a contagious cardiovascular disease continues to sicken, disable, and kill us because the CDC recommended a deadly new normal. It has been clear for years now that eugenics is coming from inside the CDC. Hence, their director, claiming it was "encouraging that only those with four or more comorbidities were dying of COVID" then.

It was inexcusable and not even true at that time.

Unless you've lived this, I don't think you can ever really get it. I don't think you understand the fact that there is no end in sight for anyone that has experienced any level of disability. Or knows about the prolonged damage this virus does. The newest research goes to show that this is a cardiovascular disease that can cause heart, and overarching harm, for upwards of years after the initial sickness. To ignore that is absurd. This envirusment reveals that the U.S. government doesn't give a single xxxx about disabled people.

Since it began, this country has been ableist, and that bias bleeds into every institution. It's the same reason I wasn't introduced into disability scholarship throughout my entire PhD. Because neoliberalism doesn't give a single xxxx about disabilities. That's also why the vast majority of discriminations mentioned today basically never xxxxing deal with disabilities to this day. And why institutions across the country have the nerve to claim COVID-19 is over, when it's not.

This is also why people ignore disability as if this ongoing pandemic that threatens, especially the most vulnerable people in our society, as if their lives don't xxxxing matter at all. As if all our lives don't matter. Because the CDC Director said our lives don't xxxxing matter. She said it's "really encouraging" that only we will die.

And then most folks literally ate it the xxxx up.

They've chosen to eat inside a Chilis over all our lives. Now institutions shave away hybrid options, despite 2020 showing they're possible.

Despite the many people groups who require reasonable accommodations to protect their lives.

Despite the countless people who have died.

Despite the countless new people who are now formally diagnosed with one/multiple disabilities.

Despite the countless people who to this day remain undiagnosed, but still live and struggle everyday, disabled because this system has failed them. Because this system is insufficient at best and dangerous at worst for most to get diagnoses.

The CDC's severely irresponsible messaging has made "safety at work" a thing of the pre-COVID-19 past for most people still forced into in person work, and for groups who are already the most systemically discriminated against, inside and outside of national workforces. Regardless of whatever intention they've claimed to have, their impact has catalyzed eugenics logics and COVID as an environmental racism and injustice issue.

They have exacerbated any and all loneliness crises, sexual violences, and nothing short of social death of those who are disenfranchised.

Because all those violences are made worse and compounded with transmission of this virus.

The only other choice available for those who are most historically and intentionally targeted by most any and all organizations in this country, is to deny C19 too. Only to then, disproportionately, become sick, disabled, and die from this virus.

For this reason, countless people are currently choosing in person social death as one feasible alternative for the ongoing risk of physical harm.

This is not a lifestyle anyone should ever be forced to live. It is nothing short of a new form of home-based solitary confinement for the crime of choosing to protect ourselves in an era where the CDC decided our lives are expendable to profit.

Need I remind everyone, lack of physical touch has numerous harms to our mental and physical health. And, yet the CDC's rampant health disinformation and miseducation of the public has ensured our most vulnerable experience this.

This is the sentence that many continue to serve for simply existing in bodies deemed expendable.

Yet, this is the result of the CDC's messaging that has misled the public to believe COVID-19 "is not an ongoing danger to their body-minds".

Again, despite the fact that C19 has been found to completely destabilize people's ability to work in a country that doesn't pay anyone actually livable disability benefits, since that, apparently, isn't a priority in comparison to the military budget.

At this point, it should be blatantly clear that the CDC has repeatedly made deeply inhumane and irresponsible choices. We cannot accept their deadly message about this cardiovascular disease.

Thank you for your assistance in this matter.

Healthy and well wishes,

Dr. bird

Bernadette “bird” Bowen, PhD (She/they/Dr.)
Editorial Assistant of *Explorations in Media Ecology*

Visiting Assistant Professor, Public Speaking
Department of Media, Journalism, & Film

---

Hello,

My name is Julia Patterson and I was in attendance at today's HICPAC Video Conference (August 22, 2023). I am not affiliated with an organization.

As I (and many others) were not able to give comments during the meeting, here is my comment:

I'm asking that HICPAC/CDC recommends N95 masks in healthcare settings. We know that Covid is aerosolized and that quality masking is a necessary mitigation step in the ongoing pandemic. As many other commenters noted, quality ventilation and filtration in healthcare settings are absolutely necessary. However, it's important to note that upgrading HVAC systems can take time and money. To mitigate the spread of viruses immediately, N95 masking is crucial.

I work and study full-time, and I quite literally cannot afford to get sick for two weeks. I find myself putting off routine and necessary doctor visits because I cannot afford to get sick. Choosing between my income and education or my health is not a fair choice. I'm also extremely concerned as Covid-19 is surging across the country. We know this from an increase in hospitalizations, rises in wastewater and test positivity data, and anecdotally from friends, family, and medical workers. We also know from the past three years of experience that respiratory illness rises during this time. I'm extremely concerned for my immunocompromised and elderly friends and family. I don't want my 87-year-old grandma to go to a routine doctor's visit and end up with any virus. Healthcare should be a place where people heal not become vectors. This is why quality masking with N95s is necessary.

Thank you, Julia Patterson

---

Is it true you are going to equate surgical and procedural masks with N95 respirators?

My trust in Public Health can't get any lower.

I am a cancer survivor that has many follow-up appointments and tests.

One-way N95 masking is not sufficient.

I do not have the luxury of fit testing.  It would be nice if you offered it, but that is another email.

One-way N95 is not the same as two-way N95.

I will be avoiding medical care. I don't want to die so the hospitals can save a couple of bucks on cheaper masks.

Please do better and mandate N95 respirators for all patient areas and interactions.

Valerie Hartmann

Placentia, CA

---

Hello,

Here is my comment that I prepared for the Aug. 22 HICPAC video conference:

Hello, I am commenting because at the present time visiting a hospital or doctor's office to obtain medical treatment requires me to risk my health to do so, in part due to CDC's deficient guidance and protocols in the area of protection from aerosolized transmission of SARS-CoV-2.

In order to make medical facilities safe places for all Americans to visit, CDC should advocate for standard and continuous usage of NIOSH-approved high-quality respirators—including N95s, elastomerics, and PAPRs—by all medical professionals.

Also, CDC should clearly state that surgical masks are not sufficient to protect us from aerosolized pathogens including SARS-CoV-2 that are now continuously spreading throughout the country, including asymptomatically. Surgical masks are not designed to provide a seal on the face, and thereby allow unfiltered air to easily enter one's airways as well as escape via the loose edges of the mask—this is why we need to draw a clear dividing line between N95 respirators (which represent the minimum in true aerosolized protection) and masks below that standard, which are insufficient for aerosolized protection.

Additionally, CDC should advocate for high standards of ventilation and air filtration, and make "cleaning the air" in all medical facilities its top priority for infectious disease control and prevention.

I want to thank you for opening up the session today for public comment—I greatly appreciate it, and I hope that you will continue to increase transparency and openness in this process in the future as well. Thank you.

Many thanks,

Shawn Sprague

---

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee (HICPAC):

We, the undersigned individuals and organizations, recognize the pivotal role you play in setting guidance that shapes infection control and prevention practices in hospitals, nursing homes, and other health care settings across the nation and around the world. We urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings: 1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens. HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including: • Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls. • Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections. • Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns. 2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections. N95

filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement. 3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach. 4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates. We are concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

Thank you

Jaymie-Rose Scrivner

---

Hi, my name is Michael Askren, and I am part of Action for Care Equity, an advocacy group that is currently fighting this exact battle for masking requirements in Los Angeles. I submitted my thoughts to the LA County Board of Supervisors, and with any luck, they will listen. But my reason for fighting so hard on this issue is simple: I have long COVID. I acquired it in 2020 and my condition has only declined since then, resulting in my personal disability. I can't tell you how disappointing it is to put the burden of this fight on the disabled and patient advocates when the science is absolutely crystal clear regarding the risks of COVID, the enduring damage that it can cause, and the grim reality that there are no treatments for it in sight. The CDC and the HICPAC could be loud in the dangers of this virus and the necessary precautions required to prevent infection, including well-fitted N95 respirators, ventilation, and patient isolation, but instead they choose to damage their reputation as a public health organization and risk millions of lives. It is nothing less than close-minded bigotry to continue to weaken infection guidance when COVID goes unchecked and and untracked in today's world. If you are not loud on the proper course of scientifically backed actions required to prevent infection, if you provide discretion to the greedy hospitals that prioritize profits over care, then you will have become nothing more than a death dealer to America and the rest of the world—a feared specter of ruthless and systemic brutality that hangs over the entire medical industrial complex. I wish you would reflect on that.

---

My name is Elise Pechter. I speak as a representative of the National Council for Occupational Safety and Health (National COSH) that fights for safe and healthy work conditions.[8] [9] I worked

[8] National Council for Occupational Safety and Health https://nationalcosh.org/

[9] https://nationalcosh.org/sites/default/files/documents/2021-02-national-agenda-worker-safety-and-health_0.pdf

for 35 years as an industrial hygienist for the Commonwealth of Massachusetts, investigating workplaces across many industries and recommending prevention.

Healthcare is the largest industry in Massachusetts, employing 566,000 persons, 16% of the workforce. The Occupational Health Surveillance Program[10] in the health department documented COVID's impact on healthcare workers,[11] including doctors, nurses, aides, technicians, custodians and others exposed to infectious agents transmitted to and from patients and healthcare personnel (as defined by the Council of State and Territorial Epidemiologists[12]).

Healthcare workers, compared to other workers, were twice as likely to report testing positive for COVID, worked longer hours, and were more likely to report a COVID death among a close contact. Over one third of healthcare workers respondents reported 15 or more days of poor mental health in the prior month.[4] People of color were disproportionately employed in low-paying, hazardous healthcare jobs that contributed to observed disparities in COVID-19; positive case rates among Black and Hispanic Massachusetts residents were more than three times higher than for white residents.[13]

The pandemic took a terrible toll on all healthcare workers. The failure to identify aerosol transmission of COVID exacerbated the epidemic and added to healthcare worker morbidity and mortality.[14] Both the World Health Organization and the CDC incorrectly identified droplets that traveled only 3-6 feet and the risk of touch as the leading transmission sources for over a

[10] https://www.mass.gov/orgs/occupational-health-surveillance-program

[11] Massachusetts Department of Public Health. COVID-19 Frontline Healthcare Worker Study: Legislative Report January 2023. https://www.mass.gov/doc/covid-19-frontline-healthcare-worker-study/download

[12] https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/positionstatement2020/Interim-20-ID-02_COVID-19.pdf

[13] Massachusetts Department of Public Health. DATA BRIEF - Characterizing Massachusetts Workers in Select COVID-19 Essential Services: Healthcare. February 2021. https://www.mass.gov/doc/characterizing-ma-workers-in-select-covid-19-essential-services-healthcare-workers/download (Accessed 22 August 2023).

[14] Molteni M. The 60-Year-Old Scientific Screwup That Helped Covid Kill. WIRED, May 13, 2021. https://www.wired.com/story/the-teeny-tiny-scientific-screwup-that-helped-covid-kill/ (Accessed 21 August 2023).

year;[15] they omitted the main airborne route of transmission, which increased the risk for healthcare workers.[16]

SARS-CoV-2 is transmitted as an aerosol, generated by coughing, speaking and just breathing.[17] Include infection controls. Aerosol science, ventilation engineering, industrial hygiene, respirator expertise, and the hierarchy of controls,[18] in addition to infectious disease, must be used to devise protection.

Protect patients and healthcare workers from infectious respiratory diseases— improve ventilation and filtration, provide airborne infection isolation rooms, maintain respiratory protection with NIOSH-approved N95 masks or better.[19] [20] [21]

These additions are essential to ensure patients and personnel are protected from aerosol transmission. In regards to the earlier discussion about standard precautions, these protections are unrelated to activity.

---

My name is Karina, and I'm a PhD student at Carnegie Mellon University (5000 Forbes Ave) in Pittsburgh, Pennsylvania. I would like to comment about universal use of respirators, isolation, and ventilation for infection control. As a grad student, I am worried about my ability to even get

---

[15] Jimenez, JL, Marr, LC, Randall, K, et al. What were the historical reasons for the resistance to recognizing airborne transmission during the COVID-19 pandemic? *Indoor Air*. 2022; 32:e13070. doi: 10.1111/ina.13070

[16] Klompas M, Rhee C. Optimizing and unifying infection control precautions for respiratory viral infections. *The Journal of Infectious Diseases*, Volume 226, Issue 2, 15 July 2022, Pages 191–194, https://doi.org/10.1093/infdis/jiac19

[17] Klompas M, Milton DK, Rhee C, Baker MA, Leekha S. Current insights into respiratory virus transmission and potential implications for infection control programs: A narrative review. *Ann Intern Med.* 2021 Dec;174(12):1710-1718. doi: 10.7326/M21-2780. Epub 2021 Nov 9. PMID: 34748374.

[18] Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Hierarchy of Controls. https://www.cdc.gov/niosh/topics/hierarchy/default.html

[19] Landry, S. A., Subedi, D., Barr, J. J., MacDonald, M. I., Dix, S., Kutey, D. M., Mansfield, D., Hamilton, G. S., Edwards, B. A., & Joosten, S. A. (2022). Fit-Tested N95 Masks Combined With Portable High-Efficiency Particulate Air Filtration Can Protect Against High Aerosolized Viral Loads Over Prolonged Periods at Close Range. *The Journal of Infectious Diseases*, *226*(2), 199-207. https://doi.org/10.1093/infdis/jiac195

[20] Rashid TU, Sharmeen S, Biswas S. Effectiveness of N95 Masks against SARS-CoV-2: Performance Efficiency, Concerns, and Future Directions. *J Chem Health Saf*. 2022 Jan 10;29(2):135-164. doi: 10.1021/acs.chas.1c00016. PMID: 37556270; PMCID: PMC8768005.

[21] Plachouras D, Kacelnik O, Rodríguez-Baño J, Birgand G, Borg MA, Kristensen B, Kubele J, Lyytikäinen O, Presterl E, Reilly J, Voss A, Zingg W, Suetens C, Monnet DL. Revisiting the personal protective equipment components of transmission-based precautions for the prevention of COVID-19 and other respiratory virus infections in healthcare. *Euro Surveill*. 2023 Aug;28(32):2200718. doi: 10.2807/1560-7917.ES.2023.28.32.2200718.

through my degree given the complete lack of COVID precautions ensured by the CDC and then reflected at my institution - COVID causes long-term vascular damage, heart damage, and brain damage. I'm especially appalled at the dropping of basic precautions in healthcare settings, making it unsafe for me to seek medical care. Despite never removing my mask outside my dorm room, I got COVID from my sinkmate because my undergraduate institution had a policy of forced infection after they got rid of isolation housing, and I have had debilitating fatigue, a chronic cough, chest pain, indigestion, and excruciating headaches every single day since the infection in March 2022. I haven't been able to get medical care because healthcare facilities have been unsafe, and every day, I have to go to class and work and choose between my health and my career. Several of my classmates also now have long COVID because their initial exposures were to completely asymptomatic people. The CDC needs to make it clear that healthcare workers must wear high-quality NIOSH-certified N95 or higher masks, mandate HEPA ventilation in all healthcare facilities according to ASHRAE standards, and strengthen its isolation guidance for COVID (10+ days with consecutive negative tests). The evidence review on N95 respirator and surgical mask effectiveness was flawed and needs to be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. I urge the HICPAC and CDC to open further meetings for public comment and take the most basic precautions against infection with an aerosolized, asymptomatically transmissible virus in healthcare facilities.

---

My name is Shimi Sharief and I am a public health physician. I am writing in reference to the presentation by the IP workgroup and also in part the pregnant healthcare workers workgroup.

I am writing today in partnership with NNU 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 early 2020 due to the unavailability and inconsistency of PPE recommendations, I was able to return for a year in 2021 to 2022 due to the added safety of patient cohorting and respirator availability.

I ended up having to leave it again due to the dismantling of those precautions, and am disappointed by the draft guidelines presented in June and which stand now for how to handle such airborne agents that are ubiquitous in healthcare settings and among chronically exposed staff and therefore exposing patients, causing chronic illness and ongoing health effects and disability especially with repeated reinfection. Similarly the guidance to remove the exclusion of pregnant healthcare workers from infectious agents harmful to the fetus is equally troubling. The goal of a meeting convened 16 years after the last set of guidelines should be to strengthen protections, not weaken them.

Sars-COV-2, continues to show high rates of airborne spread and asymptomatic transmission. Studies were presented at the last meeting comparing and creating a false equivalence in efficacy between N95 to surgical masks using a limited set of studies ripe with confounding and lack of consistency in periods of study, enforcement and rates of community transmission. Respirators are superior to surgical masks by definition for prevention of aerosolized infection. The ASTM guidelines for face masks such as surgical masks, moreover, is designed for a lower level of protection to the wearer and for source control especially with the models available in healthcare settings which do not guarantee a close fit against the wearer's face.

In partnership with NNU I would like to ask for the following:

1. The workgroup to Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens including the multiple infection control measures including ventilation, PPE, and safe staffing solutions. Similarly, protecting all healthcare workers including from other infectious agents should be the priority at the current time of strained healthcare workforce and reverting to a period of minimum crisis standards will be detrimental to the protection of our healthcare workers going forward.

2. There are no recommendations on ventilation and especially other approaches to isolation when use of airborne infection isolation rooms is not possible. In addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

3. 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.

4. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections and to include elastomeric and powered air purifying respirators which address concerns around skin breakdown, and comfort for long duration of wear. The general market for N95 respirators has also proliferated since 2020 with much more comfortable yet effective models available than ever before.

Thank you,

Shimi Sharief MD, MPH

---

Hello,

I was infected with SARS-2 in March 2020. Within the first 10 days I developed organ damage/dysfunction, neurological, GI, and rheumatological complications even while receiving treatment at a large Academic Center.
At month 8, I had a stroke. Since SARS-2 causes vascular damage this was not surprising. My vascular system is damaged. I still have 90 symptoms, similar to the acute stage. My team says this is viral persistence as I have not cleared the virus— nothing post viral about my symptoms.

I remain in quarantine for 3.5 years. No family or friends due to the exposure of being reinfected. I am unable to work. Unable to be productive member of society. Unable to seek safe medical care due to masking.

Opening my door to quickly bring in groceries is the extent of my activities.

The only time I leave my home is to access emergent medical care. All routine appointments and care are not possible due to the removal of masking mandates. 99% of my healthcare is with telemedicine.

During an emergent ENT appointment I was asked to briefly remove my mask so the physician could check my mouth and throat. I held my breath as long as possible, I then had to inhale.

Five days later I was sick with a covid infection because two weeks earlier mask mandates were dropped.

So, after spending three years in isolation and missing, four birthdays, Christmases, Thanksgivings, my elderly parents birthdays, I was infected in a medical setting. Criminal.

N95 masks or better must be mandated in health care. I cannot believe I must write to request this during the spread of a BSL-3 pathogen. We are beyond politeness and logic.

My life is over. Yes I will never return to high level competitive sports due to SARS-2, or my healthy body without illness or comorbidities. What you can do today is save others from ending up like me, disabled for life!

So far nothing has been done to protect, break the chain of transmission, and educate the public on the truth. 30 million people with Long Covid will no longer be quiet. The truth will be known.

Please step up- do your job.

Thank you,
Cynthia Carlomagno

---

As an immune-compromised person whose life was destroyed by a Covid infection three years ago, I'm writing in support of the following People's CDC recommendations regarding HICPAC's process & proposed changes:

- 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,

Emily Fraser

---

Re: aerosol transmission and respiratory protection

Alexander Kallen, MD, MPH

Chief, Prevention and Response Branch

National Center for Emerging and Zoonotic Infectious Disease,
Centers for Disease Control and Prevention

Dear HIPAC/CDC taskforce,

I am an occupational epidemiologist and I work closely with the American Public Health Association's Occupational Health and Safety section where we organize research and advocacy efforts to protect workers. I have worked in industry, academia, and in government for over 10 years conducting health and safety research. I am concerned with this revision of infection control practices for several reasons, but the most worrisome are the following:

1. How much of the health and safety of healthcare workers will be left up to employers.

We know from a long history in occupational health that employers tend to make safety decisions based on economic return. The recommended changes would likely put more healthcare workers at risk in an already mentally and physically demanding job.

2. This proposed guidance is missing is any recommendations for ventilation or source control.

An emphasis on the hierarchy of controls, including a job-specific, written exposure control plans is needed. Respiratory protection should be the very last-ditch effort to protect people and more upstream prevention is needed. Please do not leave wiggle-room in health and safety regulations.

3. As a published researcher that reviewed the prevalence of respiratory protection pre-pandemic, I am concerned about the research used as the foundation for this respiratory protection guidance.

Surgical masks do not give the same protection as an N95. The evidence review failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

In conclusion, I am requesting that more stakeholder input is included, especially from NIOSH's NPPTL, occupational health experts, as well as the intended end users of these policies. I also recommend reviewing this report about COVID-19 in frontline healthcare workers by the

Massachusetts Department of Public Health: https://www.mass.gov/doc/covid-19-frontline-healthcare-worker-study

Thanks,

Kerri Wizner, MPH, CPH

Concerned Citizen

---

RE: Public Comment, CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) -- Aug. 22, 2023. I would like to summarize some of the concerns we have regarding the proposed CDC recommendations for infection control. I feel there is a lack of will to implement needed strategies. This must stop or countless American lives will be lost. The CDC should not muster its scientific and political might to discredit aerosol science and thereby give facilities a pass to justify their lack of implementation of needed protections. The sole reliance on randomized controlled trials is ill-advised since their primary utility is in drug and therapeutic research. When this methodology is applied to public health, there are too many ethical concerns and biases created to rely on randomized control trials as the primary tool for guidance. This is the same tactic that science deniers and extremists have used to discredit masking. The path forward is clear. The prevention of spread for all respiratory pathogens should require N95 masks or PAPRs. Surgical masks do not prevent the spread of aerosolized pathogens. Aerosolizing procedures aerosolize all pathogens and are not required to spread airborne diseases. An airborne pathogen can be spread by talking and breathing. We must formulate healthcare strategies to protect the most vulnerable who seek care. This includes those who are immunosuppressed, have an autoimmune disease and those who have received transplants and seek care for unrelated illnesses. The CDC should make sure their recommendations protect these individuals and are in compliance with the ADA. The CDC should require reporting of healthcare acquisitions of all major pathogens and should estimate hospital acquisitions of SARS-CoV-2 by determining all hospital presentations which occurred after admission and then adjusting this data with community rates of asymptomatic infections. Finally, the CDC needs to focus on screening, decolonization, and knowing a patient's microbiome. In nursing home settings, Enhanced Barrier Precautions will not stop the spread of dangerous pathogens such as MRSA, CRE and *Candida auris*. EBP may even promote spread, by providing a false sense of security. A better strategy is screening and decolonization and if this fails, cohorting patients with compatible microbiomes. According to the United States Department of Human Services, the cost of infectious disease is 10 million dollars per life lost. Too many are sacrificed to save facilities the cost and burden of purchasing a 1-dollar N95 mask. Currently, many workers are safer and have better gear in an Appalachian welding shop than working in a local hospital. No one should have to take care of a patient with a respiratory pathogen without a well-fitted respirator or work in a poorly-ventilated building.
Thank you for this consideration,

Kevin Kavanagh, MD, MS Health Watch USA

---

I attended your recent zoom meeting and was surprised and very disappointed by how little time was reserved for public comment, given how much power your recommendations will have over the ability of individuals to protect themselves and their families.

I have spent most of the covid pandemic caring for my Mother in law, a medically vulnerable elderly woman dealing with dementia and stage 4 cancer. I have a family history of heart disease and diabetes. Given how dangerous covid is to medically vulnerable people, and given the increased risk of cognitive damage, dementia, heart disease, and other organ damage that can result from a covid infection, it is an extremely high priority to me to avoid getting infected.

I am in my 50s and with my family history it is important for me to make consistent appointments for things like colonoscopies, annual dermatologist, ob gyn, and cardiologist visits. Unfortunately, the
CDC's message around the airborne nature of covid and the importance of respirators, ventilation, and air filtration has been weak, incomplete, and deeply flawed. Because of this, it can be nearly impossible to find doctors and hospitals who are effectively protecting patients and staff from healthcare-acquired covid infections by using masks and air filters in their exam rooms. And so I am left, like so many other members of the public who are medically vulnerable or their caregivers, having to choose between preventive healthcare and covid protections.

While vaccines and pharmaceutical treatments are an important part of the public health toolbox against covid, they are not enough by themselves. Respirators, ventilation, and filtration are essential as well. I don't understand why your planned recommendations don't acknowledge that. Scientists who work with air quality and respirator effectiveness are consistently recommending n95 masks and HEPA filters. There is a huge body of evidence showing that they work to protect both the public and healthcare workers. Your recommendations need to reflect that.

Thank you for your time,
Elizabeth McCarthy Formoso

---

First we deserve to have safe healthcare.

I have spent the last 9 months in and out of the hospital. I have Lupus, cancer, AFIB! I need protection from the HCW, that don’t have a single care to prevent diseases.

You fail to acknowledge that so many illnesses are airborne. That we need a standard of care, to protect vulnerable patients like myself from COVID 19, the flu, RSV, even a cold! I’m fighting for my life here! I have rights too. I have spent thousands in for profit healthcare that doesn’t care! It’s insanity!

You should be proactive. First do no harm. What happened to that? Where is the transparency we need?

I’m tired of having no choice. No choice, but to acquire any HCW disease! None of the facilities or providers have cared. When I mask, I am treated like I’m crazy!

It’s ridiculous.

I want a healthy life. No disease, is acceptable. It’s not acceptable to say we have vaccines that do nothing to stop transmission. To accept a vascular virus is ok to contract! No!

No disease, that is preventable in large part, by mitigation, is acceptable.
Diane Herron

---

To Whom It May Concern:

It is IMPERATIVE for any health professional in any health setting to wear a high-grade mask (N95) to prevent the spread of this virulent covid virus which is disabling and killing people. Not only COVID but ANY airborne virus that serves as a threat to humankind.

Also, buildings must have supreme air ventilation to prevent this spread - hepa filters, cross ventilation, etc.

Does it make sense to go into a hospital, medical clinic or any medical setting and to get SICKER from when you were only going for an annual visit? Etc?

Also, ALL EMTs MUST wear N95s and other protective gear when they enter the home of a person in a medical emergency.

When the global pandemic was in full force in 2020 the local EMTs (here in Washington, DC) always had on not only masks but also protective gear on their feet when they entered my home to check on my 82-year-old mother. She fell twice in May 2023 and when the EMTS entered both times NO ONE was wearing any type of protective gear - no mask, no shoe covering.

Before May 2023 and when the EMTS came in May 2020 until February 2023 the EMTs had on masks and shoe coverings.

Make it a standard for EMTs to have on masks and protective gear on their shoes!!

Sincerely,

Jennifer R McZier - concerned citizen, caregiver to 82 year old mother
Washington, DC

---

Victoria Becker, RN, ANP
August 22, 2023
To the HICPAC Secretariat:
My name is Victoria Becker. I am a retired nurse practitioner. I worked in nursing for 35 in private hospitals, non-profit health care systems, and in 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 risks to myself and other health care workers.
For example, as a county home health nurse I was assigned to do “direct observed treatment” of a tuberculosis patient who I was initially told did not have active disease, and 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 for which I hadn’t been fit-tested. When I asked to be fit-tested the model they had provided failed the fit tested , and they told me to go ahead and use it anyway. Other nurses who had not been fit-tested were then assigned to do it.
Throughout my careers, infection control professionals have ignored the facts of how diseases are transmited 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 of other experts such as industrial hygienists, aerosol scientists and ventilation engineers.
A combination of arrogant infection control doctors and the construct of nurses as martyrs who sacrifice our own wellbeing to take care of others, results in a lack of protection for us, which has been really proven out with the current COVID crisis. Health care 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 things like 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 no precautions are taken. Neither health care workers nor patients are masked. There is no routine Covid testing. Health workers are told to report to work even if they have tested positive.
You appear to be working toward enshrining this lack of protection in your revised guidelines. Shame on you, whether you are from the public or private sector, for allowing financial concerns to place workers and patients at risk.
Sincerely,
Victoria Becker, RN, ANP

---

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.

Covid is not the flu. Covid is not RSV. A single "mild" or even asymptomatic covid infection has been shown to have lingering blood effects for a minimum of 6 months, and has demonstrated immune system impacts - decreasing ones T/B cell counts for between 8 months and a year after infection. Following an acute covid infection, autopsies have shown covid in the brain and spinal cord up to years after infection. Covid damages the brain, damages the blood vessels and heart, impacts the kidneys, the lungs, the gastrointestinal tract. All of this does not even consider the long term effects of long covid, which now appears to occur within 25%-33% of individuals. I repeat, covid is not "just a cold".

The current isolation recommendations for hospitals, schools, and general workers follows a 5 and 5 policy. Where you isolate at home for 5 days, and then you can go into work masked for 5 days. First we do not specify mask quality and fit. The recommendation should be for well-fit n95 quality masks. Ideally these would be provided by the employer (especially for healthcare workers and patients of a healthcare facility). We also know in the majority of cases that once symptoms appear, an individual can transmit virus for around 10 days (with a few days of transmission possible before symptoms appear).

By forcing employees and healthcare workers back into the hospital or their place of employment while still transmitting virus (masked only in a surgical mask at best), we are promoting the continued spread of covid. The 10 day recommendation should instead be on the conservative end, with 10 days of isolation and 5 days of continued in-person masking with an n95. Ideally back to work clearance would come with a PCR-negative test for healthcare workers.

Additionally, we must consider and revist ventilation improvement efforts, and hospital cleaning protocols for fomite/touch acquired transmission. As exists the HICPAC and CDC

recommendations in regards to covid are inadequate, and must be adjusted for the reality of the situation that we are in.

Thank you for your time.

---

Thank you, CDC & HICPAC committee. I'm Barry Hunt from Canada. I have 40 years experience developing national & international healthcare standards & developing engineered solutions to reduce exposure to pathogens through air, water & surfaces in healthcare.
I'd like to respectfully request the multi-disciplinary HICPAC team be expanded to include Subject Matter Experts in Public Health Engineering, including aerosol scientists, IAQ engineers & societies such as ASHRAE, airborne transmission experts & Engineered Infection Prevention advocates.
We are long overdue for a fundamental paradigm shift in healthcare to recognize the prominence of airborne transmission & dissemination - likely 10,000:1 more significant than touch for primary respiratory disease transmission and often a very significant component of non-respiratory transmission.
Fomites are important, especially as way stations that enable re-aerosolization leading to transmission by inhalation, oral-fecal ingestion, wound entry & touch.
Aerosols from sinks, showers, drains & toilets are significant sources of disease transmission, either in whole or in part due to airborne transmission.
It's a new world of HAIs & we need to pivot quickly. Virtually all pathogenic viruses, bacteria, molds, & yeasts need an 'airborne first' mitigation strategy in healthcare.
In addition to SARS2, we have continued worldwide increase in MDRO severity & exponential growth of exposure & infection by CPEs, Candida auris, etc, through the global hospital network.
We need to slow, delay & ultimately stop MDRO HAI exposure before it results in significant community spread.
**Contact Precautions** & **Enhanced Barrier Precautions** without respiratory protections have limited impact on aerosol transmission.
We need a respirator first policy for all HCWs who have contact with patients and clinical staff, including non-clinical staff such as EVS, Facilities Management, Nutrition Services, IT, AVS, etc. who enter clinical spaces. This needs to be accompanied by new respirator performance requirement standards to ensure more comfortable, easier-breathing respirators are available to HCWs.
In short, respirators should be part of **Standard Precautions** PPE and become as ubiquitous as glove use in healthcare.
"**Airborne Precautions**" should be reserved for rare Risk Group 4 diseases such as Hemorrhagic Fever diseases, and renamed "**Highly Pathogenic Isolation Precautions**" that would trigger use of AIIRs & PAPRs to prevent onward spread to hospital personnel and the general community.
Thank you.

---

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 (https://www.acpjournals.org/doi/10.7326/M23-1190) 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 (https://archive.is/QZdoe) 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

---

To: CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC)

Re: Ongoing COVID Management Decisions

I am writing to register my position on this important issue.

In my experience as a medical provider during COVID, I have learned that almost every business and organization will refer to CDC guidelines and use them to justify holding the line on infection control... or not. Recommendations by the CDC become the default, in most cases the minimum. Official guidance then, needs to be evidence-based and carefully considered, involving all stakeholders such as frontline personnel and their unions, patient safety advocates, and experts such as industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with expertise in aerosols, and experts in respiratory protection. Health care workers put their lives and well-being on the line, and trust that official guidance and protections in their work areas will help keep them safe.

The two largest concerns at this point, aside from the lack of transparency in the process so far, are around masking and ventilation requirements. Firstly, universal masking in healthcare is the rational, safe thing to do. The benefits to staff and patients are immense in terms of decreasing sick days and unnecessary infections. We want going to the doctor to be as safe and healthful an experience as possible; it doesn't make sense to ask already vulnerable populations to accrue an additional risk when seeking care.

Connected to that, not all masks are created equal. There is a longstanding body of respirator research that predates COVID, and many studies since that have demonstrated the power of high quality respirators like N95s. The evidence review comparing N95 respirator and surgical mask effectiveness that concluded there were no significant differences is flawed, prioritizing the findings of randomized controlled trials (which while often the gold standard are not the correct methodological choice for an equipment question), cherry-picking data to conclude there was no difference between N95 respirators and surgical masks, and omitting other applicable data and studies. Not only should universal masking in health care environments be recommended, but high quality respirators should go with.

The other, probably larger, half of the infection control piece is the importance of quality ventilation and core control measures for infectious aerosols. The large body of evidence on the importance of ventilation and air filtration paired with mask use for controlling worker exposure to infectious aerosols must be considered. There are currently no recommendations on ventilation aside from limited guidance on use of airborne infection isolation rooms (AIIRs), which should not be conflated with more general high quality ventilation methods. Without quality ventilation, masking alone is less effective.

While this topic can become quite dry, it is essential to remember that the decisions and recommendations made by HICPAC/CDC will be for many the only protections they can count on. This guidance will inform the chances between life and death, health and disability for every American that needs to breathe.

Thank you for your consideration--

Liam Clark, MD

General Neurologist, a diplomate of the American Board of Psychiatry and Neurology, Inc., a member Board of the American Board of Medical Specialties

Cheyenne Regional Medical Center

Dear HICPAC,

I was mortified when all mitigation efforts against Covid and other infectious diseases was rolled back in healthcare settings. As an immunocompromised person with additional risk factors for severe covid, this has changed my ability to get the medical attention I require. I no longer feel that I can be encapsulated with the general public while waiting for a doctor's visit, lab visit or even the pharmacy. My life and the life of my family has been put on hold due to Covid. I was used to taking some precautions prior to the pandemic, but Covid tightened my world and made it infinitely smaller. While I can't force the general public to do what is best, not only for themselves, but for all of the vulnerable people, I do believe that I am entitled to receive healthcare in the safest setting possible.

Please revoke this rollback of mitigation. I don't believe it is asking too much for medical professionals and those that require their attention, to mask and stay a distance away when feasible.

Thank You,

Teresa Alexander

Roseville, CA

---

We are a family still actively trying to avoid COVID infection here in San Diego despite zero mitigation support by local governments, and a terrifying decision by our local children's hospital (Rady) to remove mask mandates despite access needed by vulnerable young patients

We have remained COVID free with tremendous personal sacrifice & privilege. Our children will not be able to attend public schools & we've essentially lost our family network for doing what has been forced on us by CDC's loosening of public health measures, making this an untenable individual responsibility to protect ourselves in a community with limited knowledge about COVID risk & mechanism of spread

I ask that you strengthen infection control measures, not weaken, as we are seeing the effects of not implementing safeguards against COVID spread in healthcare systems & schools. At the very least, proper protocols should be updated in healthcare settings following current data… COVID is airborne. This simple fact must be honored & measures taken accordingly. N95 respirators in healthcare settings worn by staff & providers is the bare minimum in infection control.

Please stop dragging feet on this monumental pandemic that continues to devastate families & our future economy with guaranteed poor outcomes. All data represented proves multiple, unimpeded infections will not be a positive net effect for society.

Thank you for doing the bare minimum in infection control - controlling infections by actually implementing data driven solutions

- Cody Hsu
San Diego Resident & mom of 2 young children who should be given a future without multiple SARS-COV2 infections risking chronic outcomes

---

Im stage 4 cancer, being treated at MSK in Middletown NJ. I have to go for treatment every four weeks till i die and every time I arrive i have to beg for anyone to wear a mask. I do not see any hand washing or sanitizing. A snack bar with tables and chairs are smack in the middle of the waiting room. I have to dodge visitors and staff eating and leaving without any respect for patients waiting to be seen. Its so crowded with guests i have to stand.

What is the infection control guidelines? I bring my own mask and disinfecting wipes. What will it take to re-institute masks, N95 masks during the current and next surge of airborne diseases???

How can i have any trust in a healthcare system that does NOTHING to protect me from transmission. I cannot go out while being treated with chemo. It destroys my bone marrow and I can't fight infection. The administration and staff know this yet they do nothing to keep the surroundings germ free to protect me. Why do I bother trying to kill cancer cells if this neglect will kill me with some airborne virus?

Do the right thing. Institute masks and infection control. Make it mandatory or be fined or take away their license to treat very sick people. We are going backwards. Are surgeons even washing their hands anymore? FIX THIS MESS

THANKS

SUSAN LARCHUK

---

To whom it may concern: I would like to express, in the strongest possible terms, that the CDC not move forward with weakening masking and ventilation guidelines in health care settings.

This would negatively impact multiple populations, including health care workers, who have greater exposure to all kinds of infectious disease than the population at large, as well as medically vulnerable patients at all stages of life.

I am old enough to remember medicine before HIV/AIDS was well understood, and have been treated by professionals without gloves. Today, gloves and barrier protections are regarded as common sense measures that protect against bloodborne infection. It should be the same with masks and in fact it almost inevitably will be. Therefore, it is inhumane and irresponsible to put people in needless danger on the way to that improved standard.

It is unfortunate that some people have chosen to politicize this issue and harass health care professionals. But the science has been clear for many decades, as surgical protocols bear out. Masks work. They are cheap, simple to use, and easily mass produced. Please keep requiring this low effort measure to protect healthcare workers and patients.

Sincerely,

Angelle Haney Gullett

Studio City, California

---

I fully endorse and support the concerns and recommendations of the 900 experts who signed this letter to CDC Director Dr. Mandy Cohen:
https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

As a former healthcare facility administrator, I recognize the issues raised by the group and the pitfalls of an insular analysis of the risks associated with reducing protections for patients and healthcare professionals. As the recent coronavirus pandemic has demonstrated, competing business interests often dominate patient care, resulting in an irreversible failure of policy for the sake of profit or political favoritism.

Respiratory protection equipment is required for airborne diseases. Surgical masks are not repiratory protection equipment.

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

Thank you for your anticipated consideration of this comment.

Respectfully,

**Stephen Scapelliti, Esq.**

---

Dear HICPAC Committee,

I am a psychiatrist in private practice, and I am writing to implore that HICPAC and CDC *strengthen* infection control protocols in healthcare settings. I am the son of a mother with Parkinson's and a father at high risk for severe outcomes from any infection. Right now, their ability to get safe care is compromised, and I worry it will be further compromised.

We now understand, quite clearly, that aerosol transmission is the dominant mode of transmission of SARS-CoV-2 and many other pathogens. We also know what to do about this:

-increase ventilation

-filter the air

-disinfect the air with Germicidal UV light, i.e. 254nm UV light

-require healthcare workers to wear fit-tested respirators

It is absolutely feasible to all but eliminate transmission of respiratory pathogens in healthcare settings, and it is an act of gross negligence to pursue *any* other goal.

You, the committee, have the opportunity to either save the lives of both patients and healthcare workers, or directly cause preventable deaths. I hope that all on the committee will take this responsibility seriously.

Sincerely,

Thomas Finch MD MBA MSc

---

To whom it may concern:
I am writing to ask you to recognize that COVID is an airborne disease that has the potential to cause death and long-term harm, and as such, citizens should be protected from it to the fullest extent possible. This is especially important for high-risk, immunocompromised and disabled individuals. Safe health care is important for all of us to access, but it is especially important for these vulnerable populations. I urge you to recommend health care providers wear appropriate,

high-quality N95 or equivalent masks/respirators when in contact with patients. Failure to do so makes health care inaccessible or dangerous to many US citizens.
Thank you,
Lisa Jordan

---

My name is Lisa Brosseau. I am an industrial hygienist and research consultant with the University of Minnesota Center for Infectious Disease Research and Policy.

While I understand that the workgroup is following a standardized process for reviewing and recommending revisions to the 2007 Isolation Precautions guidelines, it is clear to me that the workgroup needs more expertise and input from scientists and other stakeholders in reconsidering these guidelines. The presentation from the workgroup in June and today's discussion about standard precautions highlight how much the workgroup is missing in terms of other perspectives and input.

The workgroup – and CDC – would benefit from a more open, inclusive and consultative process right now. Because you are missing some very important, key information and insights.

The historical perspective on standard precautions highlights how important it is to step outside of your comfort zone. The OSHA bloodborne pathogens standard revolutionized the management of blood and sharps in healthcare settings. The OSHA TB standard encouraged the development of CDC TB guidelines, which led to the development of respiratory protection programs and the use of respirators by more healthcare workers.

What we've learned from COVID-19 should not be treated as something unusual or unexpected for respiratory infectious diseases but as an opportunity to rethink the overall approach to aerosol-transmissible diseases.

COVID-19 highlighted the importance of considering transmission from asymptomatic and presymptomatic transmission. But SARS-CoV-2 is not the only respiratory infectious virus where pre- or asymptomatic transmission may be possible. What does this mean for standard precautions?

There are interventions, such as improved local exhaust ventilation and patient source control, that should be encompassed in the "standard practices" or "core practices" for aerosol-transmissible diseases.

While I applaud the work group in thinking more carefully about the "air" mode of transmission, you need to move beyond the far and close range and large vs. small particle definitions to encompass the full range of aerosol inhalation at all distances in shared spaces.

As you heard from many commenters today, the workgroup needs to carefully rethink the assessment of respirators vs. surgical masks. There is no science that supports the use of a surgical mask for its original purpose in limiting surgical wound infections or as personal protective equipment to prevent inhalation of infectious aerosols.

CDC and HICPAC have an opportunity right now to be innovative, creative, thoughtful and future thinking. I urge the committee and agency to consult widely right now with public health professionals about lessons learned and where we should be going next. A letter from 900 public health professionals calling for more transparency and consultation should be a sign that the committee is not going about things the right way. Why ignore us when involving us in your decisions would make the world better for all of us? That is the true meaning of public health.

Lisa M Brosseau, ScD, CIH

Professor (retired)

Research Consultant, University of Minnesota, CIDRAP

---

To whom it may concern,

It is well established that SARS-COV-2 is airborne. The Whitehouse is among the many organizations which acknowledges this.

It is also well known that SARS-COV-2 is causing mass disability in the population, even if immediate death has been reduced.

By reducing or removing mask mandates in healthcare, you are being negligent in your duties. Many people will die or be disabled as a result - not only in healthcare but across the country (and the world) due to your poor messaging and social queues.

The long-term financial impact of this will be unlike any the world has seen.

If you truly want America to be a world leader, you need to acknowledge airborne transmission, mandate masks, and change your messaging to protect people and the economy.

No one will benefit when there are more disabled persons than workers. We won't be able to fix the damage. There are no treatments, cures, or even effective vaccines to prevent transmission yet.

It's a global event - we can't just import people from elsewhere to fix the economy. The world is looking to you for their next steps!

Change course now before too many people are disabled by the virus and the economy collapses as a result.

Yours faithfully,

Rebecca

---

My name is Rachel Langer, and I am commenting on behalf of myself.

I urge HICPAC to require respirator masks in healthcare settings in order to protect healthcare workers and patients.

Respirator masks, not surgical masks, should be the baseline standard of care during an ongoing airborne pandemic. Not requiring masks, or recommending poorly fitted surgical masks, is negligence in this context.

US healthcare is experiencing critical staffing shortages—and this during a supposed lull in Covid cases, and ahead of a predicted surge in RSV, flu, and Covid this Fall and Winter.

I am fully in agreement with the more than 900 experts in infectious disease, public health, industrial hygiene, aerosol science and ventilation engineering, who recently signed a letter to Mandy Cohen, CDC director, explaining how the new draft guidelines weaken protections for healthcare workers. They state, "Surgical masks cannot be recommended to protect health care personnel against inhalation of infectious aerosols."

CDC/HICPAC inexplicably fails to acknowledge the large body of evidence on the effectiveness of **respirators over surgical masks** 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 family member was taken by ambulance to our large regional hospital in May. He presented with shortness of breath and very low blood oxygen and informed paramedics and ER staff that his spouse was sick with Covid in the home. He was not tested for Covid, he was not asked to mask, and he was not isolated from other patients or HCWs in the ER.

Would you have liked to have been unmasked in his vicinity? What about the healthcare workers and patients who could be exposed so easily in these entirely typical scenarios? HCWs face an increased risk of Long Covid due to their occupational exposure. How could failing to prevent transmission of viral aerosols impact those rates further?

HICPAC should move into the future by keeping what works for infection control, instead of leaving healthcare workers and patients with even less protection than it had in 2019.

---

August 22, 2023

Please accept these comments on behalf of Cal/OSHA, California's OSHA State Plan. These comments supplement our letter dated May 31, 2023, and the oral comments provided at today's meeting.

We are seriously concerned about the lack of transparency in the process of revising the 2007 Guideline for Isolation Precautions. Despite our request, we have not seen a draft of the proposed guidelines, we have not seen the minutes of working groups, and working group meetings have not been advertised or open to the public. There has not been an opportunity for robust public comment.

If we have learned nothing from the tremendous illness and loss of life during the past three years of the COVID crisis, it is how important it is that public health recommendations be clear and strong enough to protect both individual workers and patients, and the health care system as a whole. At various points in the pandemic we have seen massive personnel and equipment shortages that put lives at risk. As with Cal/OSHA, the CDC advisory process must include all stakeholders, including affected workers and their unions, and experts from various disciplines, and the process must be publicly transparent.

California OSHA has an Aerosol Transmissible Diseases standard, which requires that novel respiratory pathogens be considered "airborne" for the purpose of employee protection, including the use of respirators. But repeatedly employers failed to implement these requirements, and stated they were confused by CDC guidelines. This has resulted in a very resource intensive enforcement effort by Cal/OSHA to ensure at least minimum protections to the health care workforce. Insufficiently protected workers, and the facilities in which they work, have suffered unnecessarily, and many still do.

It is important that public health messaging be consistent, and that the CDC establish credibility if we are going to control communicable disease. Public health message consistency must be based on protecting workers and the public, and not be the result of demands for unquestioning loyalty to weak and unprotective guidelines.

We are a state OSHA program. We rely on NIOSH certified respirators to protect ourselves, and the workers of California. The CDC must not undermine respiratory protection regulation by making the false and misleading claim that there is no difference in protection between respirators, which are designed and independently certified to protect against inhalation of small particle aerosols, and surgical masks which can not, and do not even claim to, prevent inhalation of small particle aerosols. We do not rely on “randomized control trials” to require certified respirators for workers exposed to lead, asbestos and other harmful aerosols, and it would be unethical to do so.

Personal protective equipment, including respirators, is only part of reducing transmission in health facilities and other congregate environments. We saw COVID-19 blaze through health facilities and prisons because they lacked effective means of isolation, and they lacked comprehensive infection control programs. The little we have seen of the draft Guideline does not include a thorough discussion of isolation, which should include not only early identification and isolation of infected people, but appropriate patient placement, ventilation design, airborne infection isolation rooms, and investigation and follow-up for exposure incidents.

Thank you for your attention.

Sincerely,

Eric Berg, MPH

Deputy Chief of Health

Deborah Gold, MPH CIH

Research and Standards Health Unit

---

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee (HICPAC):

I am writing to urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

- Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
- Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
- Safe staffing is essential to effective infection control and prevention. Updated

CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

COVID continues to be a threat to people like me who are at high risk for complications, and a threat to everyone (yes even those fully vaccinated) for long-term health consequences and disability via Long COVID. Now is the time to move forward, not backwards, in infection control.

Tina Broder, MSW, MPH

---

Members of the Committee,

I can't believe that I have to point out that CDC stands for Centers for *Disease* Control; not Information Control. Please stop excluding experts and stakeholders from your meetings. Stop denying requests for evidence reviews and meeting minutes. Start listening to experts. Be proactive and transparent and seek input from experts in an array of related disciplines. Listen to comments from the public. Recognize airborne transmission of Covid-19 and **strengthen**, not weaken, masking guidance. Please don't rush through drastic changes to infection control and put patients, nurses and all frontline healthcare workers at risk of acquiring Covid-19 and any other airborne pathogens.

Thank you,

Thomas Lyles

Alexandria, Virginia

---

I am writing to urge policy makers to protect healthcare workers, patients, and the community from airborne transmitted diseases such as Covid-19. There are multiple mitigation strategies available, high quality masking, filtration, testing, and ventilation. Patients should not get sick from seeking healthcare. People should be able to have basic safety in their work environments for themselves as well as their family and community members.

We have lost so many lives, so many essential workers, etc because simple public health has been put in the back seat to other concerns.

You are in a leadership role. People being tired of taking precautions as well as habituation are understandable reasons for the drift in mitigation. However, the drift in precautions does not match up with the science.

Thank you for your consideration.

Elizabeth P. MacKenzie, Ph.D. (She/Her)

Licensed Psychologist

---

Covid-19 exposure risk analysis performed per recent doctor's visit, a 1-on-1 twenty minute encounter in an 8ft x10ft interior office. Maximum exposure time (MET) calculated for various mask options using standard ventilation conditions and spreadsheet taken from the PNAS reference below.

Results as follows:

(1) 2 N95 masks, MET 4.5 hours.

(2) 1 N95, 1 loose surgical mask, MET 1 hour.

(3) two loose surgical masks, MET 10 minutes.

This office visit scenario mimics encounters in hospital private or semi-private rooms. The benefits of higher quality masks are readily apparent.

Reference: Martin Z. Bazant and John W. M. Bush, Proceedings of the National Academy of Sciences PNAS (2021); "Beyond Six Feet: A Guideline to Limit Indoor Airborne Transmission of COVID-19". Detailed instructions are in the Supporting Information, SI Appendix, Section 7.

Dan

---

If anyone has had COVID-19 even one time, or any preexisting conditions that make one's immune system less capable, they could become disabled by COVID if re/infected, if they survive. Even a mild infection can result in Long Covid- and this can happen weeks, months, or years after "recovery", as the virus is becoming stronger and smarter. It's able to hide easily, and it can show up whenever. SARS 2 COVID-19 has been let loose by the government, by public health officials. It's absolutely alarming, the amount of people who don't care that the immunocompromised population, children, and elderly people are largely at risk for Long Covid

(which could be bedridden disability- yes even for children), or death. It's important to mention that *EVERYONE* is at risk for this, but especially the groups mentioned. Having SARS CoV 2 ONE TIME makes someone high risk according to the CDC. But even the CDC obviously, clearly ignores this. How will anyone ever take the CDC seriously again?!

Schools are allowing COVID-19 to run amuck, masks are viewed as anything other than what they actually are- disability preventing, life saving tools in regards to respiratory viruses. Viewed as an annoyance, when twenty eight years ago we did not have the kind of masks (specifically N95 respirators) we do today. We can easily avoid deadly respiratory illness with N95s, but most view this amazing piece of technology as "too much", or complain about the comfort when just one atrocity COVID can cause, is fluid persisting in the lungs- which truly sounds more uncomfortable?

The way that healthcare workers don't automatically keep respirators on is a public health FAILURE. People have incorrect opinions on the obvious data presented.

People would rather have their guilt relieved and their normal way of outward consumptive living more than anything. A lot of news articles offer this. Poorly understood data reported with the goal to lessen the "paranoia" or "worry" about a deadly airborne pandemic. The people who are still masking, testing, avoiding crowds are simply acting accordingly during a pandemic. But, you get ridiculed for that. And that is on the CDC and public health officials. This is going horrible so far.

There will be more and more preventable COVID infections and Long COVID sufferers and preventable deaths from SARS 2 as time goes by, imagine ten years from now where we'll be globally regarding our health?

SARS COV 2 IS ONCOGENIC

I'm personally at the point where I am not sure if I have Long Covid or not, as I've had a myriad of health issues prior to my first COVID infection in Dec 2020. After my second infection, in March 2021, my heart would feel like it was beating out of my chest when I was laying in bed, and I've had a high heart rate on and off since then. I understand that a lot of people have it worse, as there's many bedridden Long Covid patients, and they're in misery. Long Covid can cause ME/CFS which is already understudied and downplayed. Disability denied because Long Covid is not recognized as a disability, left unable to work, how can someone not be miserable? If Long Covid was more widely studied, and more symptoms were listed, I would feel more confident going to a doctor for diagnosis and treatment. At this point, I am staying away from medical facilities at all costs because possibly getting COVID-19 again at a hospital is absolutely hypocritical and heinous of what should happen at a medical facility. I wouldn't even expect most doctors to grasp the reality of COVID-19 alone. It is in everyone's best interest to avoid COVID-19 re/infection for financial, emotional, physical reasons. I want people to be able to qualify for the bare minimum, for disability, when they become disabled by a pandemic let run amuck by the country. Even though benefits on disability offer so little.

The downplaying of the current pandemic and Long Covid will end in more and more doctors not taking it seriously, so why would patients who don't currently consider SARS 2 as an actual threat, take Long Covid seriously- so many people are suffering effects of Long Covid but don't even know that they have viral persistence from an unknown amount of infections. With up to 60% of infections being asymptomatic, and the constant downplaying of the pandemic, it's easy

to assume that millions will have infections in the double digits in a few years, if that hasn't happened already.

So many will be disabled, and already disabled people have to do their best to avoid re/infection of COVID. A lot of already disabled people *need* to go to medical facilities to ensure survival, but risk COVID-infection that could lead to even more disability issues, or death. Some doctors are on video cheering as mask mandates were lifted. This pandemic has been handled absolutely horrifically so far, and ten years from now looks scary. If 65 million worldwide are estimated to be disabled at this point, and nothing is being done to prevent COVID-19 transmission on a governmental level, (oh besides INSIDE of governmental buildings, as the Pentagon just installed sanitizing UV-C lighting) what does the future look like? Most people refer to the "height of the pandemic" in the past, but we do not know the height of an event until the event is over. Pandemics usually end when another begins.

We are still just at the start of the COVID-19 pandemic, and the virus is *already* known to disable people, just over three years in. The majority are playing roulette with their lives, whether it ends in death or disablement. The government, public health officials, the CDC are responsible for the lack of information, and the allowing of chronic pandemic misinformation while they have guaranteed access to regular testing, antivirals, the kids of these officials go to schools that do not allow COVID-19 to run amuck, or at least not in the same way for the average person. Note how your Aug 23 conference was mostly people at home. (Saw you made the video private as well… interesting) Many of you were unable to acquire infection at work on Aug 22, because you have the privilege to be able to stay home and greatly lessen risk of infection. Properly wearing respirators prevents SARS 2 infection which prevents COVID 19 disease which could end in Long COVID.

It is absolute bare minimum for health care workers and for anyone in hospitals and health care facilities to want to lessen the spread of disease, and if they don't want to, it should be mandated. Preventable deaths and disability or further disability are on the line. Disabled people are already treated horribly in this country. Why add to that?

How many personal accounts with reliable data and points do you have to read until you step up and make a change?

Why do we have to convince you to properly do the job you're paid so much to do?!

How will you feel in 5, 10, 20 years if you ignore public comments like these?

You have already failed us. You have already failed the people who don't even know the extent of SARS 2. You have already failed the people who have died and will continue to die preventable deaths especially during this surge. You have already failed the millions suffering long covid, including those who don't even know it yet because of the chronic misinformation during this massive public health failure.

May as well start doing better now. Anna Liddy

---

Hello,

As a concerned member of the public, I join National Nurses United and the 900 experts in infectious disease, public health, industrial hygiene, aerosol science and ventilation engineering (https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts

_letter_background_combined_FINAL.pdf) in expressing my deep concern that the revised CDC/HICPAC guidelines will severely weaken protections for healthcare personnel exposed to infectious aerosols, including SARS-CoV-2. The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during the COVID-19 pandemic. In doing so, these guidelines fail to adequately protect both healthcare workers and patients.

Furthermore, 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. This is particularly important for vulnerable and immunocompromised patients who would be at significantly greater risk of contracting a healthcare-acquired infection under the revised CDC/HICPAC guidelines. The revised guidelines are weaker than existing CDC infection control guidelines, signaling a step back in the quality of healthcare. The draft recommendations, if adopted, will put healthcare personnel and patients at serious risk of harm from exposure to infectious aerosols. These revised guidelines are proposing a significant decrease in the minimum standards of care, which will set standards of healthcare back, instead of propelling us forward to a future of increased safety for healthcare workers and patients.

HICPAC must not rush through these drastic changes to infection control. Doing so will ultimately put patients and all frontline healthcare workers at increased risk of acquiring Covid-19, MDROs or new emerging pathogens during a time when the healthcare workforce is already in crisis.

Sincerely,
Khassaundra Whitehead

---

**Zenei Triunfo-Cortez, RN**

**President, National Nurses United**

My name is Zenei Triunfo-Cortez. I am a registered nurse and President for National Nurses United, the largest labor union and professional association for registered nurses in the US. I tried to provide these comments at the August 22, 2023 HICPAC meeting but, when I was called upon to speak, the Zoom meeting host did not unmute me.

Throughout the Committee's process, we have heard HICPAC members and CDC staff discuss the need for increased flexibility for health care employers around infection control. But I want to underline for you what increased flexibility will mean in practice.

We saw the CDC incorporate more flexibility into Covid infection control guidance early in the pandemic. Initially, in January 2020, the CDC's guidance clearly recommended N95 respirators and airborne infection isolation for patients with Covid. These are the measures that we need to start with for any novel pathogen—and that the science has underlined are essential for Covid.

But over the following months, the CDC weakened its guidance to create flexibility for our employers to avoid placing Covid-positive patients in airborne infection isolation. We saw our employers refuse nurses access to N95s—even when they had them in storage—because the CDC's guidance gave them the flexibility to do so.

As much as we told our employers—Covid is aerosol transmitted—they dismissed us and said they were following CDC guidance.

We saw our employers force nurses to return to work even when they were Covid-positive because CDC's guidance gave them flexibility to choose to do so.

This led to countless infections among health care workers and patients that could have been prevented.

Nurses are now leaving the bedside in high numbers because of the abandonment of our health and safety during the Covid pandemic. Nurses are no longer able or willing to risk their or their patients' safety.

Our employers create unsafe working conditions when they prioritize money over protecting staff and our patients—but it is the CDC that sets the standards our employers follow. The CDC has lost the trust of so many nurses across the country, and it is because of this flexible approach to Covid infection control.

If HICPAC incorporates a similar approach into the Isolation Precautions guidance, it will have disastrous impacts on patient and nurse safety. It will only worsen the staffing crisis in health care. And it will undermine the CDC's ability to reestablish trust with nurses and other health care workers.

As nurses, we are on the frontlines of health care—during a pandemic and every day. We are the ones who carry out many essential pieces of infection control. Our expertise is essential.

Delaying your vote is the right move. I urge you to use this extra time to engage and incorporate input from direct care nurses, NNU, and other experts and stakeholders. Thank you.

---

**Jane Thomason**

**Lead Industrial Hygienist, National Nurses United**

My name is Jane Thomason. I am a certified industrial hygienist with National Nurses United, the largest labor union and professional association for RNs in the US. NNU stands with more than 40 other organizations and nearly 11,000 individuals to urge HICPAC and the CDC to ensure the following elements are upheld in updates to the 2007 Isolation Precautions guidance:

1. **Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens:** HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including: (a) ventilation, including the use of negative pressure isolation, and other engineering controls; (b) respiratory and eye protection for healthcare workers providing care to patients with suspected or confirmed respiratory infections; and (c) safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for healthcare employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. **CDC and HICPAC should maintain and strengthen respiratory and other protections for healthcare workers caring for patients with suspected or confirmed respiratory infections.** N95 respirators represent the minimum level of respiratory protection available and are essential to protecting healthcare workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on healthcare infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

**3. The CDC must be clear and explicit on the precautions that are needed in situations where infectious pathogens are or may be present in healthcare settings; don't adopt a crisis standards approach.**

**4. CDC and HICPAC should engage with direct care healthcare workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.**

Other organizations in support of these points have or are planning to comment for themselves and also include labor unions, patient advocacy organizations, professional associations, and worker advocacy organizations.

We are concerned about the lack of transparency in your process to update the CDC's 2007 Isolation Precautions guidance document. The draft has not yet been posted, working group meetings are closed to the public, our FOIA request for the completed evidence review presented to HICPAC in June 2023 was denied.

Changes to this guidance will impact healthcare workers, patients, and communities in every state, but you have no clear mechanism to garner our input before the updates are finalized. Three minute comments are insufficient. I urge you to remedy these transparency issues in your process and to engage the wide range of stakeholders before the proposal is finalized and sent to the CDC.

---

August 21, 2023

The American Nurses Association would like to voice concern with the CDC's recently revised *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Nurses throughout the United States seek CDC guidance to determine what level of protection they need to keep themselves, their families, and their patients safe from the spread of infectious agents. During times of uncertainty, infection from novel agents, and emerging variants of such agents, nurses and healthcare employers need clear mandates to provide safe patient care, as well as to keep nurses and other healthcare workers safe during the provision of patient care. During the COVID-19 pandemic, nurses often reported that inconsistent guidelines resulted in nurses not feeling a sense of safety and security during patient care – for themselves and their patients.

By relaxing isolation precaution guidelines, especially those for respiratory pathogens, the CDC will place the lives of over 5 million nurses at risk of infection and the lives of their patients who may become infected through nosocomial transmission. Therefore, ANA strongly urges HICPAC and the CDC to reconsider the new recommendations for isolation precaution guidelines.

Nicole Anselme

Senior Policy Advisor

American Nurses Association

---

Hi,

I'm writing to submit my comment. I am a member of the public in Portland, Oregon. Thank you for the opportunity to comment on this. The CDC and HICPAC need to acknowledge that COVID is an airborne disease that transmits via infectious aerosols. We know respirators, ventilation, and air filtration protect healthcare workers and patients, yet no recommendations have been made by you about ventilation.

I have many immunocompromised family members and hate the idea that they're taking their lives in their hands every time they visit a healthcare setting. Hospitals should not be places where people get more sick. For the sake of vulnerable patients, improving ventilation and air filtration in healthcare settings should be on the CDC and HICPAC's to-do list.

Vulnerable patients deserve the most consideration, not the least. It goes along with "First, do no harm."

Thank you,

Marie Biondolillo

---

You're head-in-the-sand approach to your advice and recommendations cost you your credibility when it comes to Covid and it's myriad variants. Here we are, on the cusp of yet another of what will likely be endless waves (thanks in no small part to you) of illness, hospitalization, long-term disabilities, and death, and you are doing nothing but splashing. No mask recommendations, no social distancing recommendations, no word on a new round of vaccinations -- nothing. There isn't a single word about prevention measures on your website's Covid landing page.

That tagline? "CDC 24/7: Saving Lives, Protecting People"? What a load of

Sincerely,

Anjin Jaymes,

Trying to live Covid-free, in spite of you.

---

Dear HICPAC secretariat,

I write to comment on the proposed update to the guidelines for respiratory viruses, including SARS-CoV-2 (Isolation Precautions document).

**Background:** I am an aerosol scientist and have published many peer-reviewed papers on COVID-19 transmission. In particular we have shown that:

(a) COVID-19 superspreading events can be quantitatively explained by airborne transmission in shared room air (Peng et al., Env. Sci. Tech. 2022, https://doi.org/10.1021/acs.est.1c06531). To our knowledge there is no published analysis that has quantitatively shown the importance of any other mechanism of transmission for COVID-19 superspreading events. This is also true for the more general patterns of transmission (Greenhalgh et al., The Lancet, 2021: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00869-2/fulltext)

(b) "Droplet transmission," where expelled droplets fall to the ground close to the infected person is mostly a historical error, confusing gravity with dilution. Unfortunately the CDC has promoted this error for decades, which has only become obvious during the COVID-19 pandemic (Randall et al., J Royal Soc. Interface 2021: https://doi.org/10.1098/rsfs.2021.0049; Jimenez et al., Indoor Air, 2022a: https://doi.org/10.1111/ina.13070 and Jimenez et al., Indoor Air, 2002b https://doi.org/10.1111/ina.13025).

(c) It is likely that the transmission of most (if not all) respiratory viruses has an important or dominant component of airborne transmission (Wang et al., Science, 2021: https://science.sciencemag.org/cgi/doi/10.1126/science.abd9149)

Importantly, critical processes in transmission fall within the realm of aerosol science, including the generation, emission, dispersion, ventilation, filtering, and deposition of virus-containing particles. Thus the methods of modern physical science and engineering should be considered primary to the transmission problem. The "pyramid" approach of evidence-based medicine where only RCTs are considered strong evidence is NOT applicable to this problem. Applying those arbitrary EBM rules to other fields (where they are irrelevant) deprives this field from being informed by the advances of modern science.

**Problems:** With this background and scientific understanding, I would like to point out that the current draft proposed update of the Isolation Precautions documents has many problems including:

(1) The draft proposal was developed in a closed and non-transparent way. Researchers who have directly investigated airborne transmission of COVID-19 or other viruses were not included.

(2) Transmission via "air", as for the superspreading events that we investigated, requires the use of respirators such as N95, both for source control and as PPE. Surgical masks are not sufficient, as about half the air goes through the gaps without being filtered. Using surgical masks for COVID-19 and other airborne diseases would expose both healthcare workers and patients to dangerous infections. This science is extremely well established.

**Suggested Actions:** given the problems above, I suggest the following actions to rectify the situation:

(1) Invest effort in updating the scientific understanding of the dominant airborne transmission by HICPAC and the CDC, e.g. by engaging relevant experts and inviting them to serve in HICPAC. Acknowledge directly that the input of non-medical science, and its different paradigms of operation (where RCTs are a blunt tool, and much better tools are available) are essential to bring the fruits of modern science to bear on this problem.

(2) Revise the process to develop the draft guidelines, including experts on aerosols and PPE, ventilation engineers, industrial hygienists, and healthcare personnel. In particular include those scientists that have most directly investigated the airborne transmission of respiratory viruses.

(3) Change the process of updating the guidelines to make it open and transparent. All the meetings should be open, with transcripts and recordings posted, and with a substantial public comment period before a vote.

Regards,

Jose L. Jimenez

Distinguished Professor

University of Colorado-Boulder

My name is Tamar Salibian, I am an educator, media scholar, and immunocompromised individual living with multiple chronic conditions who acts as caregiver for my elderly mother who also has chronic health issues. I am concerned with the lack of transparency on COVID precaution strategies by individuals in positions of authority and by institutions. I have witnessed this with employers and businesses, and I am witnessing it with the CDC and HICPAC. I am also experiencing the burdens this lack of transparency ensures when scheduling appointments with providers. We are being locked out of safe care. It's unacceptable.

While watching today's [August 22] HICPAC meeting online, I kept thinking about how CDC/HICPAC's process has essentially been closed to public access or engagement. Why is that? HICPAC meeting presentations and documents that are used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Doesn't the public have a right to know what decisions (or omissions) – and for what purpose – are taking place? Also, the August 22 Zoom chat was disabled, and as I write this, the video recording of the meeting is unavailable because it has been made private online. The CDC acts as beacon and guidepost for many institutions. Do you want to know how many times I've seen "CDC guidance" being used as a reason for decisions that keep healthcare workers, patients, and the public unsafe? Given the broad public interest in CDC's guidance on infectious diseases, it's baffling just how closed the CDC/HICPAC is being regarding their processes and strategies. Closed, and dare I add, smug regarding the misuse of this position of power. Again, unacceptable. I urge CDC/HICPAC to employ an approach that is clear and explicit about the precautions needed to protect everyone from infectious diseases. Our lives and your reputation are at stake.

Equally as baffling as this lack of transparency is what appears to me (at this point) to be an intentional refusal to acknowledge the fact that COVID is airborne, and a rejection of [mention or promotion of] N95 respirators. CDC/HICPAC are actively obscuring the critical role of inhalation and continue to recommend use of surgical masks which do not provide respiratory protection against inhalation of infectious aerosols. The evidence review on N95 respirator and surgical mask effectiveness utilized flimsy, selective methods to conclude there was no difference between N95 respirators and surgical masks. I think we all know better by know, don't we? Except when the CDC affirms something (by omitting or obscuring other things), institutions, businesses, healthcare workers, and the public defer to this decree, keeping us all unsafe during this ongoing airborne pandemic. The evidence review on N95 respirators must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

Why is 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 not being considered? There are no recommendations on ventilation. It almost looks like CDC/HICPAC are forbidden to say "N95." Say it with me: Unacceptable. I urge CDC/HICPAC to adopt measures that employ more transparency and ensure safety for healthcare personnel – and ultimately, for everyone. Not only is this a public health issue, it is, as one public commenter

mentioned at the August 22 meeting, also a liability issue. The responsibility is yours. Do better. Thank you.

Tamar Salibian, PhD, MFA

---

I am a cancer patient with a suppressed immune system. From my point of view, it is insanely negligent of a government health agency to limit or prevent the very low quality (surgical masks, not N-95s) masking we have had in healthcare settings. I have been dismayed as health provider after health provider eliminates masking in their offices because of CDC advice. At a time when covid is increasing everywhere in the country, this is irresponsible. I personally wear an N95 mask everywhere in public. I feel so much safer when my providers are masked as well.

This agency is supposed to protect patients, not subject them to possible infection from all their providers. What's next? Eliminating handwashing before surgery? Preventing healthcare workers from wearing gloves and protective gear? Seems like the CDC's purpose is to take us all back to the middle ages when infection control was not an issue and people died constantly from poor hygiene. These guidelines put both healthcare workers and patients at risk and make our healthcare settings unsafe, especially hospitals. Please rethink.

Cheryl Wolfer

Lacey, WA

---

Please keep masks in healthcare and bring back strong covid restrictions, requirements and regulations. This weak policy you are trying to implement will only cause more harm than help. People are still getting sick and developing long covid and/or dying at a high rate, and we have already seen from repelling covid restrictions that the cases rose and more people got sick. As an immune compromised person who has to go to multiple doctors appointments I would feel better with you all going back to how it was in 2020. Please for once do your job and think about the greater good for all people. Making these decisions you and the government have done so far has made not harmed not help anybody no matter what they say.
Tyra Smith

---

My name is Karen Carnessali, Information Literacy and User Experience specialist at an R1 Research Institution, and I am writing to provide public comment on CDC/HICPAC's Draft Proposed Guidelines and Recommendations regarding Health Care Respiratory Protection and Infection Control. (https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac)

I am writing to urge HICPAC and the CDC to unequivocally recommend universal masking with at least as protective as N95 (or higher) in healthcare settings, as well as developing baseline ventilation standards in line with respiratory airborne virus protocols. It is imperative to provide clear and consistent enhancement of current guidelines, including improvement of respiratory protection and infection control for healthcare workers in health care settings. PPE and RPE (Respiratory protection equipment) is required for airborne diseases. **Surgical masks are not respiratory protection equipment**. Continuous use of N95 respirators is necessary and more efficacious than intermittent use of N95 or medical masks.

https://www.cmaj.ca/content/193/26/E1010.short

https://pubmed.ncbi.nlm.nih.gov/23413265/

https://www.acpjournals.org/doi/full/10.7326/L23-0076

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

HIPAC's draft proposal has been developed without input from those it impacts directly, such as frontline personnel, their unions and representatives, patient safety advocates, and other experts and scientists, or sounds data regarding HAI-COVID.

Healthcare-Acquired Infections have drastically increased since the start of the COVID pandemic. We know COVID is an airborne virus. This is not the time to be weakening protocols, guidance, or recommendations. Respiratory protection equipment (RPE) within PPE protocols should be clear, stringent, and consistent. This is particularly significant now, as healthcare settings continue to drop mask mandates, and RPE regimens, while COVID continues to circulate. To contribute to this public health crisis by loosening recommended standards that already didn't go far enough is not only negligent, but actively dangerous. The CDC has an opportunity to help correct the gaps in respiratory protection and infection control, rather than contribute to further exacerbating this public health crisis. On August 22nd, 2023, during public comment, we heard from those that have acquired HAI, as well as the perils of seeking care in a healthcare setting. All commentators attended the meeting, listened to HICPAC presentations, rationale and debrief Q and A following each segment. Public comments were unanimously against CDC/HICPAC's Plan to Weaken Guidance for Health Care Respiratory Protection and Infection. Patients deserve to be heard on this matter too. I hope you Listen to their experiences and do not damage or betray the public trust. I agree with and amplify over 900 experts who delivered and signed this letter to Dr. Mandy Cohen (CDC director):

The proposed revised CDC/HICPAC guidelines will severely weaken protections for health care personnel exposed to infectious aerosols, including SARS-CoV-2. The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during 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. They are weaker than existing CDC infection control guidelines. The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols.

https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Thank you,

Karen Carnessali

Syracuse, New York

---

Please do not water down infection control protections for medical workers. We know what works (ventilation + n95 masks, etc) and covid plus other infectious diseases are out there. It doesn't make sense to put our healthcare workers, and therefore, the rest of us in danger. It is dangerous and goes against everything we know. N95 masks are the new normal. We need to just accept it.

Please consider!  Thanks

Mary Weber

Topic: Removing infection control protections.

---

To Whom It May Concern (which is all of us),

I am writing to express how vital it is to PUBLIC HEALTH and DISEASE CONTROL (ring a bell) that the CDC take a brave, bold, science backed stand and call for reinstating masks in crowded indoor places especially health care and public schools. In addition, the CDC should explicity call for increased ventilation and filtration of indoor air.  The CDC must also clearly and explicitly state that surgical masks are inadequate and that N95s are the best/safest choice with KN95 being better than surgical but not as tight fitting as the N95. It would be nice if the CDC admitted the pandemic isn't over, there are new and different variants in the pipeline now, at least one causing quite a stir as having the potential to be another large wave similar to Omicron.

Why am I taking the time to send this email? I'm a teacher heading back into the classroom with students on Monday. I expect to possibly be the only one masked. I will also be the only one who has extensive knowledge about the importance to avoid infection and re-infections. How can we say we care about kids when we collectively are letting kids get repeatedly infected (leads to time off from school or worse staying there infected, infecting others, and not learning anyway because they don't feel well). The list of problems associated with post acute covid seems to only be increasing - kidney damage, increased rates of diabetes, immune system damage, heart/vascular damage, oncogenic possibilities, long covid and the long list of symptoms that go with that, blood clots, aneurysms, anosmia, increased risk or worsening of alzheimers, and more. Why would I risk getting that?

Because the CDC/FDA has also botched vaccine guidance (is there even any anymore?) - many think that vax and relax is the way to go even if their last "jab" was more than 6 mos or a year ago.  I'm at more than 18 months from my last shot - since they wane by month 3 or 4, I'm not even sure it'd help me at all. I am not going to get another MRNA. I would get a Novavax (sorry pfizer :( ) but since I did what I thought was right at the time and got a pfizer booster, without any explanation, I can now not get a Novavax currently. So we are all starting school, without any kind of booster.

Have you looked at excess deaths and spoken to insurance actuaries? disability claims? We can not just pretend and ignore our way out of this. The antimask movement is funded and promoted by entities that want to throw a monkey wrench into things and actively fight against things that are actually good for people and the planet, do not cater to them. Your job is supposed to be as a watchdog, a guiding light, a trusted source, a protector - please remember this no matter who the president is or whatever the political pressure is - do your job.

It is astonishing how ill informed and misinformed so many people are, do they all watch Fox News? I don't know. I read articles from trusted sources and I follow many scientists and doctors on Twitter. Please don't abandon us.  I would welcome everyone at school being masked again, windows open, air filters in every room. healthy people are better at teaching and learning. The masks are so much less of a burden than all the potential adverse health outcomes post acute covid.

Please do your job. And if your employees/experts aren't actually experts or doing their job and finding out current accurate science based info - fire them, hire real experts- listen to those immersed in the consequences of covid.

Sincerely,

Kerry Cesan

---

To Whom it May Concern:

I am a US citizen who lives in Texas. I have had a very difficult time accessing safe health care due to providers following erroneous CDC guidance saying that they don't have to mask with me. I am immune compromised. I deserve to receive safe healthcare without threat of contracting Covid while in a health care setting. It's unconscionable to think that providers can refuse to mask during what is still a pandemic. We know the risks associated with both acute and long Covid. The evidence is clear. I am asking the committee to do what is right for citizens, not businesses, and put our health care first. Masking in health care settings during a pandemic should be a non-negotiable. Please put human beings over profit. Please keep masks in health care settings.

Thank you.

Amy Drake

Houston, Texas

---

The government policy on masking is "personal responsibility", but that is not respected or sometimes even possible in health care.

My 59 year old husband caught Covid while wearing a quality respirator at an optometrist office. We are still highly cautious, so know that was where he got it. He was in a stuffy, closet-like exam room with unmasked tech and doctor for about an hour, where they diagnosed him with significant cataracts, especially in one eye. Although his acute case was mild, he developed atrial fibrillation in the weeks after his infection. Additionally, he has begun having fatigue, brain fog, and low oxygen issues. This may or may not be related to his infection.

Although it was almost a year ago (October 22), he has still not been able to get cataract surgery. The first place would not let him mask during the procedure. The second SAID they would allow him to, but then cancelled his surgery in the pre-op area when he wanted to wear a brand new, just opened n95 mask instead of a surgical mask from their open box. He is finally scheduled for surgery at a hospital in September and October. His vision has continued to quickly degrade, and he was told the cataract had progressed to a point where he may have complications with the removal.

We are very concerned that he will contract Covid again during the surgery, but going blind is also not an option. He is fully vaccinated and boosted, but that did not protect him from contracting it the last time, and I assume it won't this time. With his additional oxygen issues, he is at higher risk from the acute infection this time.

This is wrong, and a violation of our Constitutional rights of Life and Liberty. One way masking to protect one's health should be treated as a right, not a privilege. Medical and dental providers should be required to mask if a patient requests it. Having individuals attempting to secure

protections for themselves in a medical setting is not acceptable. There is too much of a power differential between patients and providers. Allowing providers to "decide for themselves" doesn't make any more sense than having hand washing be optional.

Please strengthen your masking recommendations. Covid is clearly still spreading and mutating, and lax policies only increase the damage to our entire society.

Sincerely,

Melinda Lindsay

---

I am writing in hopes that HICPAC will influence the CDC to bring masks back in healthcare settings. I have skipped every one of my doctor's appointments since the decision to remove them in healthcare settings happened. I am high risk, and have witnessed friends fall ill with long covid which could have been prevented had their healthcare providers worn masks, or required them in their offices. One of my friends has been suffering since spring. She can't even sit up straight a lot of the time. She absolutely did contract it at her doctor's office because she has been stringently careful, but needed to be seen for something.

My friend's husband died last week from cardiac arrest after DVT. He was perfectly healthy before contracting covid earlier this year.

My husband's uncle was in the hospital last week with a surgery-acquired infection. He is back in the hospital now and on a ventilator due to hospital-acquired covid. This could have been prevented. Aerosols are the main way covid spreads. We know this. We have known this for years. We also know about the number of studies which have pointed to this virus being very dangerous, and how it is causing sudden death in a lot of people within 6 months of recovering from the initial infection. We know that the initial infection may not even be the problem. It's nice that people recover quickly once vaccinated, but where are they in the long-term?

We also know that this newest variant is likely to be more dangerous than we have seen in a while, since it has the ability to evade our vaccines, including the ones available next month. I have seen speculation that the newest vaccines may be delayed as a result.

We know that it damages the immune system, the brain, heart, kidneys, liver, vascular, and digestive systems. We don't know the extent of this damage yet, because it is too new. Every new infection increases all of this, as well as the risk of long covid, but we also know it only takes one infection to end up with long covid.

It is too new to call covid a non-dangerous virus. It is frustrating that the media keeps downplaying it, and making it difficult for those of us who want to stay safe to do so, especially when more and more of our friends and family believe what they are told. I know most will not do the right thing without a mandate, which is extremely frustrating. I wish it weren't like this, but we have to do something. Rampant infection is not the answer. Masks are the only thing that work in keeping infection rates down. We have seen this demonstrated during mandates, and during mandate lifts, when infection rates rise again.

The idea that we don't need them in healthcare settings is so incredibly misguided, it makes me

question the intelligence of the people in charge of these decisions. Are they just ignoring the data and research? Please consider masks again. We absolutely need them. I am not the only high risk person who has been skipping appointments as a result of their disappearance.

Heather Bartleson,
Portland, Oregon

---

To whom it may concern:

I am a disabled woman who is in congestive heart failure, has had open heart surgery and has severe asthma. I have been incredibly careful during this pandemic to the point of not leaving my house other than to buy supplies.

I had to take a family member to the hospital in January for critical surgery, and despite wearing a mask at every moment in the hospital and spending the time she was in the OR waiting in my car, I still got covid because not one other person in the hospital was wearing a mask. It was a serious case, and my asthma is much worse than before. It took extreme effort to stay apart from my disabled mother (3 open heart surgeries, serious mobility issues etc) in our tiny house but thankfully she did not get sick.

Today we went to the foot doctor, and my mother preferred to wait in the car until her appointment time because they no longer mask. They tried to force her into the busy, unmasked waiting room multiple times despite her stating she would prefer to go directly into the private room at her appointment time. After going out to the car unmasked to bully her to go check in despite the fact that I was there to confirm her information, they then told her she "missed" her appointment time and would not be seen at all. The foot doctor preferred for a disabled 74 year old to suffer with her problems untreated rather than make a small accommodation for her being high risk.

Mask mandates in healthcare settings would have prevented both of these issues. The government cannot yield to bullies at the expense of disabled and high risk patients any longer. We DESERVE and DEMAND safety during critical and life saving appointments. Our lives are worth more than the selfish petty bitches and angry loud mouths who ignore and object to science based best practices. Politics must bend to scientific evidence, not the other way around.

Elizabeth Bohan

---

Please continue to recommend masks in healthcare settings. Access to safe health care is a human right. All people deserve safe healthcare, and deserve to leave the hospital or a medical clinic without geting sicker, and picking up additional infections. Continue to recommend masking in healthcare settings, and to focus on improved ventilation, HEPA filters, and other effective measures to lower risks in clincial settings.

HICPAC is a federal advisory committee appointed to give advice to the CDC and DHHS.

Thank you!

Meredith Reue

---

Dear HICPAC Leadership,

I am writing as a member of the public to urge you to update protocols to more effectively reduce transmission of COVID and other airborne viruses. I urge you to acknowledge that COVID is airborne. I further urge you to require or at least recommend that healthcare professionals were respirators when seeing patients.

People should not have to choose between seeking healthcare and avoiding COVID exposures. Patients should not have to ask their healthcare providers to mask. Healthcare providers should not be able to say they are complying with CDC guidelines in defending their decisions not to mask when the best science shows that proper masking reduces COVID infections. We should look beyond hospitalizations and deaths when determining whether the benefits of masking outweigh the costs.

Thank you for all the work you are doing and for considering this comment.

Sincerely, Brigitte Roth Tran, PhD

---

Why is so difficult to recommend that all HCWs wear respirators?

Why has the public health messaging to the public not emphasized the need for N95 or better respirators rather than a simple baggy blue surgical mask? Calling all face protection masks and not educating on the difference is a public health messaging fail.

Please do better. We are depending on you.

Lisa Pfost

---

22 August, 2023

Honorable members of HICPAC,

My name is Naomi Bar-Yam, thank you for this opportunity to add my voice and expertise regarding updating guidelines for isolation precautions. I am director emerita of Mothers' Milk Bank Northeast and past president of the Human Milk Banking Association of North America. I have worked in maternal and child health 35 years as a researcher, educator and advocate. Since 2006, my work has focused on our most vulnerable citizens, premature and sick babies.

Each day, parents and health care workers of many disciplines work tirelessly for the lives, growth and development of sick and premature babies, over 10% of births in the US. Some of these babies are born at less than a pound, as much as a can of corn in your pantry. Most are bigger, a whopping 3 or 4 pounds, quite a bit less than a bag of flour. *All* babies are born with immature immune systems, making them vulnerable to diseases in the environment. This is even more true of preterm babies, whose body systems and organs are not fully developed. It is well established that COVID can cause long term, irreversible organ and immune system damage. For example, COVID can cause lymphopenia, a depressed immune system, in immature and premature infants as well as adults.

Some babies spend weeks and even months in the hospital before they are strong enough to go home. Hospital NICUs work hard to protect babies from pathogens that have short and long term harmful effects, including death. We know that Covid and other viruses are airborne, and that surgical masks, most commonly used in hospitals, are not designed to protect against transmission of airborne pathogens. The numerous protections of the NICU are compromised if

providers, hospital staff and guests bring viruses from the outside and spread them in the NICU to one another and to the babies, because of ineffective masking.

Hospitals and other health care institutions look to CDC and HICPAC for strong leadership and guidelines that reflect cutting edge knowledge and research. The National Personal Protective Technology Laboratory at NIOSH, and the US Department of Labor's OSHA, and National Academies of Sciences Standing Committee on Personal Protective Equipment for Workplace Safety and Health committee have sound, well researched guidelines and scientific information on workplace safety precautions for airborne diseases. The information that they can provide, including recent research on airborne transmission and its mitigation, should be the foundation of HICPACs updated recommendations for hospitals and health care settings.

Thank you. Naomi Bar-Yam ACSW, Ph.D.

---

I urge you to keep high quality N95 respirators in all health care settings and hospitals.

Surgical masks are not nearly as efficient and are not sufficient to keep him safe.
Please do not equate N95's and surgical masks.

My father has kidney cancer and has to go to get tests and treatments as an outpatient.

It is vital for his health that health care workers be required to wear these high quality N95s around him.

Please require N95s for all health care workers.

Thank you

Climperis

---

To Whom It May Concern,

I beg of you to please keep masks in health care environments.

I am a mother of two amazing children and since the pandemic hit in 2020 we have taken Covid very seriously. We have worked steadfastly to avoid infection and every time we have had a glimmer of hope, where we believe the situation might become safer for us to venture out for standard health care, we have learned that we are still at incredible risk. I have to beg the dentists, orthodontists, pediatricians, dermatologists, radiologists, gynecologists to all wear a mask so I can safely take either my children or myself to an appointment. It is always heart-wrenching and nerve-wracking to be told that my care or my children's care matters less to them than a few minutes in a mask. I live with a traumatic brain injury and a case of Covid could alter the rest of my life in a very negative way. I would like to simply raise my children without fear that our medical team is going to infect us because they refuse to believe that Covid is airborne and feel completely justified in making the decision to refuse to wear a mask for our care.

In addition to these concerns, what if something catastrophic happens to my family? A car accident or tornado or some other disaster could put us in the hospital where we have no way to spend time researching who might wear a mask for a few minutes for our benefit (completely ignoring the fact that doctors and health care teams should never be spreaders of a disease). If we are forced to spend time in a hospital there is a huge concern that we leave with Covid. That should be completely unacceptable. Much of that risk could be avoided by asking the health

care workers to wear a proper respirator, for acting in a manner that shows we have learned from the pandemic and have improved how we treat people.

We have tools (N95 respirators) that can protect the population. This virus is dangerous. It has killed millions of people and maimed millions more. We are aware of how a SARS virus affects a population from the SARS-1 outbreak in the early 2000s, yet we seem to not be applying this info to our current situation. It feels reminiscent of the days of yore when Semmelweis recommended doctors wash their hands. Too many people suffered before deciding he was right. Patients deserve safe care. Hospital Acquired Infections are already a dangerous concern for people who need care, and rather than make inroads to a safer standard of care, the medical community is choosing bunk science and personal comfort over the fact that Covid is airborne and the people who need care in a medical environment are some of the most vulnerable to its dangers.

As a small business owner we have continued to require masks in our business. It keeps my customers and my staff safe. We are also spending money and time to make clean air (through Upper Room UV and a Dedicated Outside Air System and Corsi-Rosenthal boxes) a function of our business. This is the right approach to take for Covid and other respiratory diseases. I would expect businesses that are supposed to be places where sick people get well can do at least as much as a mom and pop business can for their customers.

People deserve safer health care than what is being provided right now, mask requirements could quickly change that. We have seen what happens when medical personnel are given the opportunity to choose on their own - they refuse, and they feel allowed to refuse. It is ableist and discriminatory. Mask wearing should be like wearing gloves or closed toes shoes, it is part of what is done to keep the environment safe for both workers and patients.

We are at the beginning of another COVID surge and I would ask medical professionals to consider what they are doing to stop the spread. What are they doing to improve health outcomes and to save lives?

Thank you,

Kristen Alexander

---

Hello. Please keep masks in healthcare. I no longer feel safe going to very necessary medical appointments since the mask mandates were removed from healthcare. It makes me have to weigh whether I really do “need” that appointment and if I don’t feel safe, I skip it. This will be very detrimental for the most vulnerable amongst us that need our protection from Covid and other illnesses. They already have so much to worry about with their conditions and do not need the added stress of having to ask medical staff to mask.

The Covid pandemic eradicated a strain of the flu due to precautions. If anything, we should learn from this pandemic and retain helpful tools such as masking. (Especially in healthcare)

Thanks,

Itzel Kibler

---

To Whom It May Concern,

I am writing to express my concern regarding the recent relaxation of mask guidelines in healthcare settings amidst the ongoing Covid-19 pandemic. As an immunocompromised individual, I strongly advocate for the reinstatement of mask usage as a critical safety measure to protect both patients and healthcare providers.

Undoubtedly, the healthcare industry has made significant strides in implementing safety protocols to mitigate the spread of Covid-19. Measures such as wearing gloves and adhering to proper hand hygiene have become integral components of ensuring patient safety. However, the effectiveness of these measures can be further augmented by the consistent use of masks.

As the CDC is well aware of, masks serve as a physical barrier against respiratory droplets that may carry the virus, preventing their release into the air and subsequent transmission. This is especially crucial in healthcare settings where patients, particularly those who are immunocompromised or have pre-existing conditions, are at heightened risk. The combination of mask usage alongside glove wearing and hand hygiene practices will provide a comprehensive defense against potential infection vectors.

The interconnectedness of healthcare environments necessitates a comprehensive approach to infection prevention. Just as wearing gloves and washing hands have become steadfast habits, mask usage should be similarly prioritized. The reimplementation of mask mandates will not only enhance patient safety but also protect the dedicated healthcare workforce, which continues to play an instrumental role in the battle against Covid-19.

I urge the CDC to reconsider its current stance on mask usage in healthcare settings and emphasize the importance of consistent and appropriate mask wearing. By doing so, we can collectively contribute to the reduction of Covid-19 transmission rates and further safeguard the health and well-being of patients and healthcare providers alike.

Thank you for your attention to this matter. I trust that the CDC will take into account the significant impact that reinforced mask usage can have on ensuring the safety of our healthcare environments. I look forward to a positive response and a continued commitment to public health.

Thank you,

--Maryssa Stumpf

---

I am a Professor of Anesthesiology and Laura Cheney Professor in Anesthesia Patient Safety at the University of Washington. I am a cardiothoracic anesthesiology subspecialist. I take care of patients who are immunosuppressed from cancer and organ transplantation. My patients are at high risk from airborne respiratory pathogens, including but not limited to SARS-CoV-2. I have worn an N-95 respirator continuously while at work since April 2020, regardless of constantly changing hospital mandates for or against respiratory protection and regardless of constantly changing CDC and WHO recommendations for or against respiratory protection. I continue to do so currently despite the fact that my academic medical center has discontinued its universal masking mandate. I am trying to protect my patients, my colleagues and myself.

We have had numerous patients who have recently acquired COVID-19 while hospitalized in our medical center, and some have died due to COVID-19. We also continue to struggle with severe staff shortages due to the general shortage of health care workers and health care

workers who are out sick with COVID-19. In the past week one of our cardiac surgeons was out with COVID-19.

I have spent considerable time reading the literature pertaining to transmission of airborne respiratory pathogens in the past few years, and have coauthored 4 peer reviewed articles published in major anesthesiology journals pertaining to protection of patients and health care workers. In my opinion, a return to pre-COVID practices with respect to routine respiratory protection is unacceptable. I agree with recent articles in the New England Journal of Medicine, Annals of Internal Medicine and Infection Control and Hospital Epidemiology supporting universal “masking” in health care facilities; “masking” equals respirators whenever possible.

I strongly urge the CDC to adopt a policy of universal respiratory protection as part of standard precautions, as described in general terms in the following articles—

Klompas M, Baker MA, Rhee C, Baden LR. Strategic Masking to Protect Patients from Respiratory Viral Infections. N Engl J Med 2023;389:4-6.

Palmore TN, Henderson DK. For Patient Safety, It Is Not Time to Take Off Masks in Health Care Settings. Ann Intern Med 2023;176:862-3.

Kalu IC, Henderson DK, Weber DJ, Haessler S. Back to the future: Redefining "universal precautions" to include masking for all patient encounters. Infect Control Hosp Epidemiol 2023;10.1017/ice.2023.2:1-2.

Chow EJ, Lynch JB, Zerr DM, Riedo FX, Fairchok M, Pergam SA, Baliga CS, Pauk J, Lewis J, Duchin JS: Lessons from the covid-19 pandemic: Updating our approach to masking in health care facilities. *Ann Intern Med* 2023; 10.7326/M23-1230

T. Andrew Bowdle MD, PhD, FASE
Professor of Anesthesiology and Pharmaceutics

Laura Cheney Professor in Anesthesia Patient Safety

---

Good evening HICPAC,

I am writing to you this evening to request that the video of today’s meeting and public comments be made available for watching. It was taken down merely hours after being made public. This is funded by our taxes and we, the public, have every right to view it.

I agree, as any aware person would, that N95s are the only option for health care workers to avoid spreading infection as well as protecting themselves. It is completely outrageous that as a patient, the entire burden is on me to educate health care workers on the ongoing pandemic of an airborne virus and how to mitigate and avoid infection.

HICPAC are and have proven they are out of their area of expertise regarding disease transmission of an airborne pathogen. Aerosol scientists would have kept the population far more safe had we listened to them more than 3 years ago. We need clean air and we need respirators. Covid is in fact airborne as you know.

My two young children, packed in Covid filled schools, have avoided infection with their well fitted N95 masks with the entire burden placed on them to educate their schools. Surely you understand the absurdity of the situation you are putting covid literate individuals, including

children in, while you lower infection safety precautions, during a Covid surge no less. How can they justify protecting themselves when you are quite literally encouraging infection in health care settings by lowering precautions? None of this makes sense to a rational and reasonable person.

This is nothing short of scandalous as we plea with you to protect our health. We need education campaigns across healthcare and the public. The public needs to know the dangers of infection that are well beyond the acute phase of the illness. The true horror of Covid, is the long term poor health consequences that even a mild initial infection can result in.

The failure of the CDC to inform the public on how to mitigate spread and protect their families is tragic. N95s prevent infection, especially if we are all wearing them. Let's follow science. We don't need to live in a perpetual state of disease spread of a disabling virus especially in health care settings and schools. This is not normal.

This needs to be fixed once and for all. Please do the right thing and protect our health from this novel virus. Our health is in your hands.

Nerissa Laing

Independent Clean Air advocate

Maryland

---

Hello. My name is Nicole Limpert, and I am a member of the public. Firstly, I would like to thank the people of the CDC, HICPAC, and the work group for your dedication to protecting the public's health. I have the utmost respect for people who devote their lives to the well-being of others.

Recently, however, I have been confused and disappointed with how the CDC has responded to the Covid-19 pandemic, specifically, in relation to the recent discontinuance of universal masking protocols in healthcare settings.

In December 2019, at the age of 44, I was diagnosed with breast cancer. I had mastectomy surgery and was undergoing radiation treatment when the pandemic was declared. I began wearing masks to all of my doctor appointments.

Since then I have had numerous medical appointments including surgery to remove my ovaries. I felt safe while visiting hospitals and clinics because everyone was wearing a mask. Unfortunately, this is no longer the case since the masking recommendation was lifted. None of the clerical or medical staff I have encountered during my appointments wear a mask. None have offered to wear a mask in my presence.

I survived cancer to now be at risk of contracting Covid and acquiring long Covid from the very places that are supposed to protect and provide care to me.

The data are clear about well-fitting N-95 masks. They work. The data are clear that Covid-19 is highly transmissible and it's airborne. I am at a loss to understand why this simple infection control device isn't universally required in healthcare settings. I feel abandoned by the CDC and by members of my care team.

The CDC website states that the, “CDC is the nation’s leading science-based, data-driven, service organization that protects the public’s health.” What happened to that focus? It certainly doesn’t ring true to me any longer. It seems as though the CDC has forgotten they are the Centers for Disease Control and **PREVENTION**.

I’m urging the CDC, HICPAC, and the work group to please recommend and reinstate universal masking in healthcare settings.

Thanks for your time.

Nicole Limpert

---

Lisa Foreman APRN-BC

Hello, my name is Lisa Foreman. I’m a nurse practitioner with over 20 years of clinical experience. I’m a member of Clean Air Crew. I’d like to address masking and mask studies in the context of airborne pathogen transmission and Covid-19 in particular. The available research on mask efficacy is often flawed and inaccurate due to choice of respirators with poor fit and low fit-test factors, confounders such as community exposure, and poor study design in which control and intervention groups are commingled. Randomized controlled trials are used for interventions such as medication effects that are not able to be directly measured. They are the wrong metric to use for decision-making on whether or what type of mask to be used in the context of airborne pathogen transmission. Determination of respirator function relies on the application of physics principles which were established decades and in some cases centuries ago. These include inertial impaction, diffusion, interception, and electrostatic attraction. It is now commonly accepted that the vast majority of airborne transmission occurs via a range of aerosol particle sizes and Not from droplets. Surgical masks are used for splash protection and are loose-fitting, therefore they are not appropriate for prevention of airborne pathogen transmission.

In the age of Covid-19 and a worsening nationwide nursing shortage, fit-tested respirators should be part of standard precautions for all people working in healthcare settings, especially in the absence of universal, regulated indoor air quality mitigations; they should also be required in all healthcare facilities. The evidence is mounting for Covid-19 damage to all organ systems, risk of long Covid, and persistent immunosuppression, and these are occurring in an increasing proportion of the population; therefore masking should not be left to individual facilities or tied to scant data on Covid-19 case levels. Current asymptomatic infections are now at least 40-50% of total infections, and patients who contract Covid-19 while hospitalized face a 10% mortality risk. Many patients cannot advocate for themselves: patients having surgery or dental procedures, babies, unconscious, altered mental status, or intubated. It is wholly and completely unethical to force them to assume a high mortality risk from a healthcare-acquired Covid infection. They need us to protect them, and we’re morally obligated to do so.

In closing, I’d like to stress that in healthcare settings, patients are always in a position of vulnerability due to the patient/provider dynamic. The cost of care should not outweigh the benefit of that care. Respirators and clean indoor air should be required in healthcare settings. Thank you.

---

My name is Karen Carnessali, Information Literacy and User Experience specialist at an R1 Research Institution, former Healthcare Worker, and I am writing to provide public comment on

CDC/HICPAC's Draft Proposed Guidelines and Recommendations regarding Health Care Respiratory Protection and Infection Control.
(https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac)

I am writing to urge HICPAC and the CDC to unequivocally recommend universal masking with at least as protective as N95 (or higher) in healthcare settings, as well as developing baseline ventilation standards in line with respiratory airborne virus protocols. It is imperative to provide clear and consistent enhancement of current guidelines, including improvement of respiratory protection and infection control for healthcare workers in health care settings. PPE and RPE (Respiratory protection equipment) is required for airborne diseases. **Surgical masks are not respiratory protection equipment**. Continuous use of N95 respirators is necessary and more efficacious than intermittent use of N95 or medical masks.

https://www.cmaj.ca/content/193/26/E1010.short

https://pubmed.ncbi.nlm.nih.gov/23413265/

https://www.acpjournals.org/doi/full/10.7326/L23-0076

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

HIPAC's draft proposal has been developed without input from those it impacts directly, such as frontline personnel, their unions and representatives, patient safety advocates, and other experts and scientists, or sounds data regarding HAI-COVID.

Healthcare-Acquired Infections have drastically increased since the start of the COVID pandemic. We know COVID is an airborne virus. This is not the time to be weakening protocols, guidance, or recommendations. Respiratory protection equipment (RPE) within PPE protocols should be clear, stringent, and consistent. This is particularly significant now, as healthcare settings continue to drop mask mandates, and RPE regimens, while COVID continues to circulate. To contribute to this public health crisis by loosening recommended standards that already didn't go far enough is not only negligent, but actively dangerous. The CDC has an opportunity to help correct the gaps in respiratory protection and infection control, rather than contribute to further exacerbating this public health crisis. On August 22nd, 2023, during public comment, we heard from those that have acquired HAI, as well as the perils of seeking care in a healthcare setting. All commentators attended the meeting, listened to HICPAC presentations, rationale and debrief Q and A following each segment. Public comments were unanimously against CDC/HICPAC's Plan to Weaken Guidance for Health Care Respiratory Protection and Infection. Patients deserve to be heard on this matter too. I hope you Listen to their experiences and do not damage or betray the public trust.

I agree with and amplify over 900 experts who delivered and signed this letter to Dr. Mandy Cohen (CDC director):

The proposed revised CDC/HICPAC guidelines will severely weaken protections for health care personnel exposed to infectious aerosols, including SARS-CoV-2. The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during 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. They are weaker than existing CDC infection control guidelines. The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols.

https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Thank you,

Karen Carnessali

Syracuse, New York

---

Hi,

My name is Yoshiteru Murakami. I am a California resident who lives in Los Angeles County, where mask requirement at medical facilities was dropped recently.

I am already seeing medical professionals not masking while we are in the middle of yet another Covid surge, and while 1 in 6 Covid infections is resulting in long Covid.

Now, I go to our medical appointments with the mindset that, if the medical provider refuses to wear a mask, we walk away from the appointments.

I believe every citizen in a civilized world has a right to safely access to medical care, and I believe medical facilities of all places should not be where we are afraid of contracting life threatening viruses from.

For these reasons, I demand CDC to once again reinstate mask requirement/recommendation in medical facilities in the United States.

Thank you.

Yoshiteru

---

Name: Danielle Peck
Affiliation: Patient in Michigan, no conflicts of interest to disclose
Topic: Transparency and public engagement, standard care measures

My comment:
My daughter is 2 years old and needs to make cardiologist visits at my local hospital. We are in the middle of a pandemic of a virus that is airborne and that has been proven to cause vascular damage. And yet, my local hospital system has dropped mask mandates. This choice to do away with an infection control measure for a virus transmitted by aerosols is baffling to me. Vulnerable patients, like my daughter, frequent the hospital. The decision to lower percautions puts them at risk. Babies and toddlers like my daughter, and other people who cannot mask, are at even greater risk.

What we have learned in this ongoing pandemic should help us strengthen infection control measures and make healthcare settings safer for everyone: we should increase our use of ventilation and implement the use of respirators as standard care. Instead, the Work Group's

proposals ultimately weaken protections for health care personnel and patients. That's unacceptable.

People who are at greatest risk of servere disease and complications use hospitals the most. These folks deserve to have a voice concerning safety where they seek care, and that's why I am writing today.

I urge the HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. So far, the process has been essentially closed to public access or engagement. 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 this process is so closed.

Patients deserve to have a voice in this process. And this patient is here to say: we all deserve stronger standard precautions that reflect the reality of aerosol transmission, including respirators and improved ventilation.

---

Hello,

I am writing to express my disappointment in the lack of guidance and support for respirator style mask usage in Healthcare settings. Respirators in Healthcare settings protect patients as well as Healthcare worker. We know that COVID-19 is spread through aerosols and still Healthcare settings do not require respirators. Patients are unable to seek care without putting themselves at risk for COVID-19 infections and long term complications from said COVID-19 infections. 1 in 10 infections results in Long Covid. The consequences of dropping precautions and guidelines for an ongoing pandemic are clear, and those consequences affect already marginalized groups the most (disabled people, people of color, low income people).

I, and many others, are begging the CDC and HICPAC to protects patients and Healthcare workers by including respirators as mandatory and necessary PPE in Healthcare settings. Please do your part in this ongoing pandemic to encourage control of disease spread. We know respirators style masks work to stop the spread of COVID-19 and other diseases. We know surgical masks are inadequate. Any mask is better than no mask, but why not recommend and require the highest quality mask proven to control disease transmission.

We are begging for your assistance.

Regards,

Ashley Barone

---

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing to provide a comment for the public HICPAC meeting that took place on August 22nd, 2023. I want to express the urgent need for enhanced measures in healthcare settings to prevent nosocomial infections, particularly through the implementation of universal respirator use (N95 or better) and HEPA-quality air filtration systems. As advocates for the control of healthcare-associated infections, you know very well that these measures are crucial to mitigating the spread of infections within healthcare environments, particularly airborne viruses such as SARS-CoV-2.

Nosocomial infections continue to pose a significant threat to both patients and healthcare workers, and their impact on patient outcomes, resource utilization, and healthcare costs cannot be overstated. Research has consistently shown that these infections are a major cause of morbidity and mortality, prolonging hospital stays and increasing the financial burden on healthcare systems. Given the evolving nature of SARS-CoV-2 and the impact of an infection on vulnerable people seeking healthcare, it is imperative that you provide guidance on comprehensive strategies to prevent the transmission of such infections.

Universal respirator use has proven to be a simple yet highly effective measure in reducing the spread of airborne infections. By requiring all healthcare personnel, patients, and visitors to wear high quality masks in healthcare settings, we can significantly decrease the dissemination of respiratory droplets containing infectious agents. This approach not only protects vulnerable patients but also safeguards the health of healthcare workers who are on the frontlines of patient care.

In addition to masking, investing in advanced air filtration systems is essential. The quality of indoor air in healthcare facilities directly impacts infection control. High-efficiency particulate air (HEPA) filtration systems can efficiently capture and remove airborne pathogens, thereby reducing the risk of airborne transmission. These systems can be particularly beneficial in areas with immunocompromised patients, such as intensive care units and surgical suites, where infection prevention is of paramount importance.

I strongly urge HICPAC to recommend the following actions to healthcare facilities across the nation:

Universal Masking: Implement a policy mandating universal respirator use for all individuals within healthcare facilities, including healthcare personnel, patients, and visitors. This should apply to all areas of the facility.

Advanced Air Filtration: Encourage healthcare facilities to assess and upgrade their air filtration systems to include HEPA filtration, especially in critical care areas and high-risk patient settings.

Guidance and Education: Provide comprehensive guidance on the proper use of respirators, including fitting, and appropriate disposal. Additionally, offer resources on selecting and maintaining effective air filtration systems.

Research and Development: Support ongoing research into innovative technologies and practices for infection prevention, including the development of more efficient air filtration solutions.

By championing these measures, HICPAC can play a pivotal role in improving patient safety and reducing the burden of healthcare-associated infections. Enhanced infection control practices will create safer healthcare environments for both patients and healthcare workers, will protect our healthcare system, and will reduce overall costs for hospitals and other healthcare providers.

Lastly, I want to note that I agree in full with the 900 experts who wrote to the CDC director in this letter. Please listen to experts in ventilation, aerosol science, and public health.

Thank you for your dedication to improving healthcare quality and safety. I look forward to the continued efforts of HICPAC in advancing infection control practices.

Max Feingold

Hello,

As a former healthy 31 y/o, (thanks Long COVID) I'm begging you to please recommend that the public start wearing masks - high quality - masks again.

Now is not the time to weaken mitigation protocols.

Thank you,
-Andrea Parra

As an immunocompromised individual who had the dubious honor of being an "essential" worker, let me state that what has been done to stop the spread of sars-cov-2 — a level-3 biohazard — has been abysmal, if not outright eugenicist. We have lost nearly 2 million peope (when we look at excess deaths) and millions more have been temporarily or permanently disabled. Millions more in the US have new health conditions, may of them serious. How can I, a vulnerable person, expect to escape unscathed when even previously healthy people are being sacrificed on the altar of "normalcy" for market imperatives? There are simple solutions: ventilation, air cleaning, masking (N95s or better), free and regular testing. Improved vaccines could be prioritized. Instead, we have doctors spreading SARS to patients and vice-versa; we have untold PASC and Long Covid; we have a labor force that has been diminished and which continues to be damaged by repeat infections of this terrible virus that can and frequently does cause harm to many organs and bodily systems. Some of us are still fighting, still protecting ourselves and each other, as we refuse to believe the lies and half-truths that have been promulgated by the highest offices. We demand protection not just in all medical settings (what has been allowed to happen is utterly depraved insanity), but clean air in all our public facilities, and real OSHA protections in our workplaces. We also demand free masks, free testing, public education, and more.

Lou Hines

Healthcare workers have a duty to care for patients. One-way masking violates this duty. It is not acceptable for healthcare workers to actively place vulnerable patients in harm's way all because they are simply accessing necessary healthcare.
We know that many healthcare workers have rolled back even *pre-pandemic* masking norms, which is unfathomable. There is NO excuse for healthcare workers not to return to masking to protect *all* of the patients under their care. Bring back sanity, bring back the health and care in healthcare, and bring back masking.

Best -
Shannon Brown

Please accept my written comments regarding HICPAC's Isolation Precautions Guideline Workgroup draft document (https://drive.google.com/file/d/14s40YHjuZxMQ_ZOx2qXIdsPDxD0641_b/view?pli=1) that was considered at Tuesday's meeting.

Although this draft document has a number of issues, I am especially concerned by the "Evidence Review" section on masks that "suggests no difference between N95s and surgical masks".

This conclusion is not supported by the majority of studies that demonstrate substantial benefits of N95 respirators over surgical masks in the control of airborne pathogens, and it is concerning that this draft report appears to have based its findings on a small number of poorly conducted studies that are at odds with well studied and accepted knowledge, including the conclusions of both the FDA (https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/face-masks-barrier-face-coverings-surgical-masks-and-respirators-covid-19) and CDC (https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm?s_cid=mm7106e1_w).

It is also concerning that under the section "Transmission-Based Precautions to Prevent Transmission by Air", there appears to be different guidance on whether a pathogen is routine (seasonal) vs. novel (pandemic-phase). This distinction is meaningless in the context of the pathogen, which transmits the same regardless of whether we define it as routine or novel. Indeed, under this definition, it seems we could readily move the very transmissible SARS-CoV-2 from "novel" to "routine" based on political considerations of where we are in the current pandemic, vs. the actual risk posed by the pathogen, and thereby reduce protections. This is inappropriate from an infection control perspective.

Four years into the current coronavirus pandemic and at a time when our healthcare workers and the healthcare system are under considerable strain, this is not a time to weaken infection control standards and put our healthcare workers at increased risk.

Please update this document to reflect the known benefit of N95 respirators over surgical masks, and to recommend their use for both routine and novel air precautions.

Thank you very much for your consideration of my comments.

Jonathan

Jonathan A. Miller

Ph.D. in Microbiology from University of Washington

---

Please require and provide respirators or better for all health care workers and patients given the ongoing COVID pandemic.

I have Long COVID which I acquired this year, as vaccinated as I could be, and I am avoiding necessary in person medical care for it and in general since my local health care providers dropped mask requirements.

I know many others, particularly other chronically ill and disabled people, are avoiding necessary in person medical care for the same reason.

Sophie Ciurlik Rittenbaum

---

As the nation's largest network of individuals bereaved by Covid-19, Marked By Covid recognizes the imperative of centering the expertise of those directly impacted by systemic decisions.

Frontline personnel, unions, patient advocates, healthcare providers, and aerosol and respiratory experts should take the lead in shaping updates to the 2007 Isolation Precaution guidance; however, HICPAC's process to develop updates 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 the CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

Furthermore, substantial evidence supports the integration of superior protective measures like N95 respirators, enhanced ventilation, and advanced air filtration into the revised guidance. 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.

Those of us who've lost loved ones to Covid-19 remain forever indebted to nurses and healthcare workers who courageously cared for our dying family members and continue to save countless lives. Our responsibility is to prioritize their well-being, prevent further Covid-19-related suffering, and protect families from the anguish of loss and Long Covid.

Kristin Urquiza, MPA
Co-Founder, Marked By Covid
San Francisco, CA

---

I am currently writing this comment at 31 weeks pregnant. I delivered my first child in the peak of the pandemic in 2020 before vaccines were available. During my 2020 delivery, my son had to receive care in the NICU. Now in 2023, with masks and respirators more readily available and peer-reviewed evidence supporting this practice in preventing the spread of this potentially deadly (or forever health limiting) pathogen, I approach another birthing experience in fear that the medical system will not protect my newborn from this pathogen due to negligence.

Additionally, as the spouse of a critical care RN who works directly with patients sick with this airborne pathogen, requiring the use of masks demonstrated to be effective against the spread of SARS-COV-2, protects healthcare workers and their families.

Thank you for your urgent actions on making masks required in hospitals.

Regards, Carolyn T. Chang, Ph.D.

---

To Whom it May Concern,

I hope this email finds you well. I am writing to express my concern at the CDC/HIPAC's upcoming decision about infection control guidance for hospitals. It has been proven time and again that COVID-19 and other pathogens spread via aerosols. It is also a fact that patients

have no choice but to seek out hospitals in the event of an emergency and the bare minimum of care is to protect the public from infection while in a hospital's care. Additionally, the exceedingly valuable and courageous hospital staff deserve protections for their own health to decrease burnout and undue risk.

My mother-in-law is a respiratory therapist with diabetes. Reducing infection control puts her at increased risk for negative outcomes from COVID-19.

My sister is expecting her third child this fall. Reducing infection control puts her at increased risk of an in hospital acquired case of COVID-19. Pregnant and postpartum people are at higher risk of adverse effects of COVID-19 (and many other respiratory illnesses).

My grandmother is in her 90's at an assisted living facility. She has no choice but to need care but is at higher risk of adverse effects of COVID-19. The example of the CDC/HIPAC directly affects her care.

This policy change affects real people. These individuals have names, families, hopes, and dreams. These individuals have families that care about them and want to spend as much time with them as possible and want them to thrive.

Reducing infection controls will kill people, it has a human cost. It is shameful that healthcare professionals care so little about people because I thought people were what healthcare was all about. I am writing because I am fearful for the well being of my loved ones and the loved ones across our country. We need to take better care of one another, not less.

I am begging you to please consider increasing infection controls and consider the very real human aspect of healthcare instead of the bottom line.

Thank you.

Sincerely,

Laura Barry

---

Dear CDC:

The information coming out of the HICPAC meeting  on Tuesday, August 22 is truly disturbing. At a time in which the US is going through yet another COVID-19 surge, where as many as 600,000 Americans are contracting new subvariants of Omicron on any given day over the past few weeks, you plan to lessen the guidelines for healthcare workers and facilities. Suggesting that the standard examination mask for nurses and doctors, the blue baggy masks as those the health professions call them, is ludicrous and would be laughable if death and long-term debilitating illness wasn't on the line. We might not know everything there is to know about COVID-19 and its many subvariants, but we do know that high-filtration masks like N95, KN95, and KF94 offer far greater protection than a standard medical examination mask provides. We also know that sufficient ventilation, UV disinfection and HEPA filtration also protect healthcare professionals and patients from this almost exclusively airborne pathogen.

Which is why your decision to lower the recommendations around protecting professions and patients from COVID-19 is dumb and deadly and callous beyond belief. Please do not follow through with this decision. We are already beginning to learn the long-term effects of denials around a pandemic and a pathogen that has not gone away. Your decision will effectively

condemn thousands more to a needless death, millions more to chronic health conditions that will shorten their lives and make the idea of "quality of life" meaningless. And if you go ahead with your decision, knowing all this, why in the universe should I trust the CDC to deal with any outbreak moving forward? You have mishandled this pandemic so much that the US might as well not have a CDC. At least correct this ludicrous decision.

Sincerely,

Donald Earl Collins, PhD

---

Dear committee members,

Please *don't* advise the CDC to lower masking standards. A surgical mask isn't an N95 — not even close.

Masking standards are already deeply inequitable and unsafe. Don't give the CDC cover to make them even worse.

Thank you,

Michael Shilling

Tacoma, WA

---

I would like to add a comment that I agree with each of the public comments made during the meeting that emphasize the essential importance of making clear, simple guidelines for covid precautions in health care settings. The reasons for these are simple enough that a 3rd grader would understand:

1) Frequently you do not choose when or how you arrive at a medical facility.

2) Everyone inside a healthcare facility has different problems that potentially spread to everyone else

3) The best controls are the ones that require zero effort or thought (e.g. air ventilation, air filtration. The next best are ones that require minimal individual effort i.e. mask requirements for everyone - with masks provided for everyone.

In addition I think that the process of continuous improvement is needed when both outbreaks and nosocomial infections occur. I am aware of very few hospitals that have robust continuous improvement processes in place. In the pharmaceutical industry it is required that such failures are investigated. FDA requires that changes are made to correct and prevent such failures even if they occurred at another facility and you could have known about the failure. Such is the case with covid. It is well known that covid is an airborne transmissible disease with rates of transmission similar to TB or measles (as published in leading scientific journals including Lancet, Science, Nature, JAMA) . It is also well known how to prevent and reduce airborne transmission of disease.

That the above is not recommended and mandated at all healthcare facilities would be understandable in early 2020, but in 2023 with everything known today it can only be a sign of willful ignorance and deliberate neglect.

Regards,

James Morris PhD

8-23-2023

Simply put, life since Covid has been perfectly awful for a 76 year old woman, who sadly made a very bad decision moving into a large building of 150 apartments over a decade ago. Most of the others living here, are science deniers and when the virus was at a worse peak than now - were not vaccinated and refused to mask. In my case having to use the elevator due to the floor I live on - I've had my masks literally fused to my face, trying to avoid infection.

Even when public health was providing masks and testing, those efforts came late and were fraught with issues - inaccurate tests, very poor record keeping (if there even was any) - and literally no enforcement in most cases... causing an old, immune compromised, or person with grave health issues to live in a constant state of fear and defensiveness. Some country.

As of August 2023 we now need reinforcement of mask mandates - bearing in mind having watched the process these four plus years, I fully realize the deniers have increased their herds, exponentially, to dangerous levels.

Bottom line - we spend Billions (likely Trillions) in support of wars - but we inadequately care for the health of citizens here, even in! a Pandemic.

Respectfully,

Ellen Fraser

I am one of the many immune compromised citizens of the US who does not have adequate access to healthcare because I cannot safely do it. The stress and mental anguish this causes is unacceptable. Medical facilities and staff are not requiring masks and frequently refuse to wear masks for us. I BEG you to please base your recommendations for CDC guidelines to be based on SCIENCE.
N95 Masks should be required and standard for all medical providers, staff, and patients in any medical or dental facility period. All Americans deserve to access healthcare safely and without the very real risk of being exposed to a deadly/disabling virus. PLEASE DO THE RIGHT THING FOR HUMANS!!
Brenda Welter

As a new-ish kidney transplant patient, I need to access medical care more often than ever before—and because mask mandates in healthcare have been removed, I am put in more danger than ever before. The healthcare system was my last refuge as a place to visit where I felt somewhat protected, and now even accessing essential care has been nearly impossible.

Studies as early as 2020 have shown that the COVID virus is airborne, and precautions should be taken regarding ventilation and air purification, masking, and of course, continuing the search for new and better vaccines or treatments. Instead, our public health has gone in the opposite direction, focusing on mitigations that have limited efficacy like hand washing and relying on the current vaccines, which are not sterilizing and quickly become obsolete as the virus continues to evolve and mutate.

COVID is not “just a cold.” As I’ve seen far too often, it not only kills people, it debilitates them—an issue I’m more concerned about at this point. I know of literally dozens of people with permanent new medical conditions attributed to COVID, either directly diagnosed by medical

professionals, or a reasonable conclusion, based on recent studies of COVID impact. This includes children, adults, seniors, people who were “healthy” and those who were not. It includes permanent damage to the cardiovascular system; new neurological issues like brain fog, sensory loss (including severe hearing loss in a young teen girl), and chronic fatigue; ongoing chronic respiratory issues; and chronic kidney disease.

How does relaxing guidelines square with the “do no harm” part of the Hippocratic oath? There are studies in countries that still log hospital-acquired cases of COVID that show that between 10 and 20 percent of those who do acquire COVID in the hospital die. It’s bad enough having to spend an hour or so in doctor’s offices, where I can still wear a mask and hope for the best. I am terrified that I will need to be hospitalized and will develop a secondary condition as a result.

Despite what the government officials say, we don’t “have the tools.” For people like me, Paxlovid has too many contraindications with medications I absolutely have to take. Access to remdesivir is limited. Evusheld no longer works against new variants. And the amount of “fight” that my immune system can put up is definitely in question, as many studies have shown that the vaccine, which has limited success for healthy Americans, has even less for immunocompromised people.

Using HEPA filters, Corsi-Rosenthal boxes, and high-quality, N95 masks has helped (so far) keep my family safe. They work, but they work best if everyone involved is using these tools—especially in places people can’t avoid like healthcare facilities.

Please do not relax the standards any further for healthcare facilities. I already see that even at my post-transplant clinic, some staff aren’t masking at all, despite the fact that the people who are there most often are on higher doses of immunosuppressants and especially at risk with COVID. We need to go back to what we know works: high quality N95 masks, ventilation upgrades, HEPA filters. Make it safer for us to get the healthcare we need.

Sincerely,

Lisa Milbrand

---

To: CDC HICPAC
From: Janine Ryan
Date: 2023-08-23
Subject: Strengthening Universal Precautions and Respirator Use in Medical Settings

Dear CDC HICPAC,

I am Janine Ryan, Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

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*

---

Hello all,

I would like to echo some of the points made by fellow community members. It is clear that current proposed guidelines are not adequate. Respirators work and are necessary to control the spread of diseases spread through aerosols, including but not limited to SARS-CoV-2,

influenza, RSV, pertussis, and tuberculosis. Surgical masks and one-way respirator use is not adequate, especially in a healthcare setting.

You've heard that many disabled people are delaying or forgoing necessary healthcare treatment, due to inadequate infection control. I am also one of these people. Further weakening of these guidelines will deal a devastating blow to the quality and reliability of US healthcare.

I would also like to note that the next generation is watching. I will be entering the healthcare field as a practitioner in 2024. I've seen how the proposed guidelines will not protect my future coworkers, my future patients, and my own health. Young healthcare workers will be looking to practice in different countries, myself included. Other healthcare workers will be disabled due to inadequate protection from toxic aerosols. Know that these effects will place a catastrophic blow on the American healthcare system, as it will be unable to keep up with our population that continues to age. We can expect the excess death rates to only get worse, as we are unable to care for our disabled population and actively disabling others through improper protection measures that facilitate the development of severe conditions, including those associated with Long Covid.

In context of Andes and Nipah Virus, HICPAC members agree that it's better to provide guidelines that err on the side of caution. HICPAC acknowledges that guidelines for treatment of patients with these viruses should include the use of N95 respirators or better. This should be the baseline protective measures taken across healthcare settings in order to actively combat, rather than assist, the spread of dangerous, debilitating diseases. The guidelines must be updated to reflect this.

Thank you.

Jamie Hunstad

---

Dear HICPAC,

I am writing to submit my public comment for the HICPAC Video Conference, since I was not able to provide my public comment live during the meeting. Here it is:

I want to strongly urge the CDC to provide the strongest possible protections for health care patients. This definitely includes mandating well-fitting, tightly sealed N95 respirators (NOT just surgical masks!!) for all staff, at all times, in all health care facilities. Health care facilities should also be mandated to take additional measures to reduce the spread of COVID in their facilities, such as installing high-quality ventilation and air purification systems. These measure must be MANDATORY, NOT optional!!

People undergoing health care procedures are some of the most vulnerable people on the planet, and they do not have the option to just stay home and not access their health care. Many have pre-existing conditions that make them especially vulnerable to COVID. Even those who aren't at particularly high risk for COVID are still at risk of death or permanent disability from long COVID. We must protect these patients, and it is deeply immoral and evil to fail to take very reasonable precautions such as mandating N95 respirators for health care staff.

Sincerely,

Katherine Carter

Seattle, WA

---

Good afternoon,

I stand with all of the people, patients and medical staff alike, who speak in favor of keeping high quality masks in our healthcare system. As a disabled person who has spent time in both the transplant floor and the ICU during the active and unchecked pandemic, I shouldn't have to ask medical staff to mask around me. Putting patients in the position of having to request our providers to wear masks puts our health and our access to healthcare at risk. We shouldn't have to be subjected to unnecessary exposure to contagious illnesses such as Covid that could further disable and kill us. Additionally, we are at the mercy of our medical providers and often experience repercussions for so much as disagreeing with our doctors treatment (or lack of treatment) suggestions. I've had more than one doctor treat me with complete disrespect and disregard for asking them to mask after major surgery when there was a mandatory mask mandate in the hospital. Could you imagine what it's like when there isn't a mask mandate? Disabled people have been secluded by society even more so during this ongoing pandemic, at the very least masks should be implemented permanently in medical settings. We are simply asking that the remainder of our health not be further compromised when we are seeking care.

Katia Tilman

---

Good Afternoon!

I am writing this email to make a written comment as it pertains to the August 22nd meeting for public comment and HICPAC's proposed infection control measure updates.

In particular, I am deeply concerned about the proposal to not require healthcare professionals working directly with COVID-19 patients to wear N95s, and require them instead to wear only surgical masks. N95s and surgical masks do not provide the same level of protection, and this sets a dangerous precedent for the spread of covid within healthcare settings specifically. Healthcare professionals need to be supplied with and required to wear high quality masks, and the CDC should recommend the public to wear N95's and KN95s if possible. Please fully recognize aerosol transmission!

According to the CDC's own website, cases are on the rise. Yet protections are being proposed to be weakened. This is not ok!

HICPAC's process to create updated guidelines has also not included enough diverse stakeholders, such as scientists with expertise in aerosols, patient safety advocates, and frontline personnel. The process of developing and updating guidelines as they relate to infection control should include diverse groups so that a full body of knowledge is available when making decisions that affect the safety of us all.

Thank you for your time.

Best,

Flannery French

---

Dear Sir or Madam:

My mother spent so much of her time when my sister and I were young to help us get the health care that we needed. Now, when she is elderly, she requires much care and has multiple medical conditions, all of which together mean that she cannot risk contracting Covid as it will risk her life. Her doctors have been very specific that if she were to contract Covid, it would be likely she would not survive. I am also immunocompromised and am at risk.

So we have changed our lifestyles so that we only go into buildings and non-ventilated areas wearing a respirator system – and we only do this for medical necessities. We have been able to find ways to keep safe in every area of our lives **except healthcare.** The only times we have to risk our lives and/or our long term health now is when we go to a doctor or medical appointment. It is an absolutely exhausting process to analyze the risk of whether or not a medical appointment is worth the risk of contracting Covid.

This SHOULD NOT have to happen. You have the ability to make these medical environments safer for all, patients and healthcare workers. The serious risks of Covid, both short and long term, are showing up in study after study, patient after patient.

We need the updated guidance to be clear and explicit about the precautions that are needed to protect healthcare workers and patients from not only Covid, but all infectious diseases. We need clear and concise and understandable messages to educate the public about the dangers of Covid and being disabled by Long Covid so that they can understand and support these protocols.

We need you to do everything in your power to protect the lives, physical and mental health of all of us, especially those that are at high risk. Please take a stand for healthcare workers and for those at risk now and those that may be at risk in the future. Please help us.

Sincerely,

Nancy Doherty

---

Dear HICPAC,

I'm writing today as a strong proponent of keeping respirators in healthcare.

Sars-CoV-2 is an airborne virus, meaning that it is expelled from people's lungs through their breath into the air and it stays in the air until it naturally decays or is acted upon by ventilation, filtration, or some type of radiation (UV at 222 nanomenters, for example) that removes it from the air or decays it. Other people breathe it in and become infected.

That means that we must have airborne preventions and protocols in place to counteract it.

Handwashing is great, especially for other pathogens, and it took society a while to learn that lesson also. (Perhaps you will recall Dr I. Semmelweis tried to change things as well so mothers would stop dying from fever after childbirth because the doctors delivering their babies didn't wash their hands after performing autopsies prior to delivery; they didn't want to face up to the enormity of it and Dr. Semmelweis lost everything and the doctors went on infecting and killing many.) So definitely keep handwashing, but do not think handwashing is sufficient to tackle an airborne threat such as Sars-CoV-2.

Healthcare settings need better ventilation, improved filtration, and the consistent and overall use of respirators by staff and visitors, and where possible the patients.

Respirators are not equivalent to surgical masks. The design is different and they may perform similarly but are not completely similar. Surgical masks provide mainly droplet protection and are well known for their lack of fit on the edges while respirators provide protection against airborne particles and even when not fit tested, will generally out-perform surgical masks. The more consistently we wear respirators, and don't cheat by sticking our noses out or some-such, the better the results. In the case, while perfect wearing would be wonderful, it is very powerful to have more people wearing respirators overall. (Perfect should not be the enemy of the good enough.)

As a person who works in a laboratory, I mask in a respirator. It isn't particularly expensive and it provides safety both for the samples I work on from me and safety to me from the samples. It also keeps me safe from my co-workers who don't mask in non-laboratory spaces. They're also out sick a lot more frequently than I have been for the past three years. Keeping respirators in healthcare will protect the workforce as well as the patients. The engineering of respirators is sound and as more people in a space wear them more competently, fewer airborne diseases—including Sars-CoV-2 which is highly transmissible—will be shared.

I share that I've been wearing a respirator at work for years as a way to say that I understand that they aren't quite as comfortable as being bare faced, but this is a job. Healthcare may be a calling, but it is also a job. It is a job with the responsibility and duty to not infect the patients coming in with other health care issues. Wearing a respirator all day can be done. Getting it fitted and wearing the right one for your face makes it a lot easier. Looking for a smile is not an excuse to expose a patient to an airborne virus. Those two things are not equal at all and it is time we become serious about our duties and responsibilities.

(I have to add, nobody is doing a lot of smiling anyway. The often used line may be "let's see your smile", but people aren't smiling. They are grumpy and overburdened and too busy. They are frowning. They are grimacing. In healthcare, I'd rather have a respirator-wearing person taking care of me competently than someone smiling at me while giving me Covid-19. If they aren't wearing a respirator and I see their "smile", that informs me about them. That is not a sincere smile; they are okay with giving people a dangerous viral infection.)

As a person who does use the healthcare system, although I have reduced my appointments as much as possible to limit my interaction, it has been alarming for the past several months to go to medical appointments where no one is wearing any kind of a mask. So far I've been able to keep myself safe because I'm wearing a respirator to these appointments and in general, asking staff to mask around me during the appointment.

But that places a heavy burden on me as a patient to ask and I have felt that burden. Sometimes I don't ask because I have concerns if I will get the same level of care if I ask for something that the doctors and nurses clearly aren't already doing. It would be so much better to have this policy come from the top down rather than from the patient. Education is also going to be needed so that the staff understands how Sars-CoV-2 is transmitted and why it is important that people are not infected.

Not being infected is the only way to not get Long Covid, it is the only way to stop the virus from mutating at an ever faster rate, and it the only way to stop the damage being done to the body by each infection.

Patients should not have to deal with their health issues on top of having to constantly ask health care staff to wear a respirator ("mask"). Stories abound about health care staff refusing to mask and then treating the patient poorly for asking.

In one instance for me, a nurse went so far as to pre-empt my asking with a swift "You don't mind if I don't wear a mask do you?" as we're walking down the hallway, me trailing after while I was in some medical distress at the moment.

Patients spend so much time trying to get care and if in medical distress, to get well. They should not have to be additionally burdened with trying to protect themselves from a very contagious airborne virus like Sars-CoV-2. I have a strong enough personality to tackle this most days, but I honestly should not even have to, it should be automatic. Safety shouldn't depend on if I have enough privilege that day to get my healthcare staff to accede to my request to not put me in danger from an airborne virus.

This past summer I had to access emergency room care. In my absolute distress at the time, it was too much to also ask the nurses to mask and I felt very vulnerable and unsafe, even though I was wearing a respirator to the best of my ability at the time. I went alone to the emergency department, leaving a family member that might have assisted me at home, so that they would not also be possibly exposed to Sars-CoV-2 during that time. These are the decisions and repercussions being made all the time by people seeking care; it is already happening and we are all the worse for it.

I've also had entire doctor appointments postponed because all but one of the entire staff was out with Covid-19.

Healthcare is one of the places where the patient cannot always protect themselves. They rely on those around them to do the protecting. It is absolutely incredible that this is not the foundation of making sure that patients are protected by having respirator use in healthcare as a basic principle.

We didn't know any better a few years ago, we know better now. There is no excuse for continued ignorance or not taking action on this new level of knowledge to protect health and lives.

Absolutely there is illness and death resulting from lack of proper respirator wearing in healthcare settings happening right now, and at a far higher level than there would be with universal respirator wearing.

Again, this is because Sars-CoV-2 is airborne. And because many infections are asymptomatic, hence transmission is happening even when a person has no signs that they are sick.

Vaccinations have been shown to help protect (to some degree) a person from severity of illness and from possibility of death, but the protection from vaccinations wane. Being vaccinated does not stop breakthrough infections and it does not stop forward transmission.

Since transmission to symptoms can take a few days to weeks, people don't see the transmission they are causing, so they believe it is not happening or that it is not causing

consequences. Downstream consequences are happening and they can lead to permanent health conditions, disability, and death. Sars-CoV-2 is making the population in general have poorer health overall.

To be clear:  Wearing of respirators is so important in health care settings for several reasons – 1) Sars-CoV-2 is airborne and hence the majority of transmission is from breathing in the virus, 2) a substantial amount of transmission happens in the pre-symptomatic and/or asymptomatic period, so people without any symptoms are making others sick, 3) being vaccinated doesn't stop breakthrough infections and it doesn't stop forward transmission, and 4) even with being vaccinated, Sars-CoV-2 is not a minor illness, it has significant impact on the body.

I'm not just concerned for myself, but for my family and friends, and for society overall. This is a watershed moment. Hospital acquired infections can be more easily stopped by a simple precaution: universal wearing of respirators.

Sincerely,

Tracey Canino

Vermont, USA

---

Dear members of CDC/HICPAC and Dr. Mandy Cohen,

As a patient who frequently accesses the US healthcare system, I join the other commenters from the August 22,2023, meeting in requesting that universal N95 masking in healthcare become standard in the same way that disposable gloves did due to HIV/AIDS, and hand-washing did generations earlier.

I am immunocompromised due to lupus and further immunosuppressed due to medications. Therefore, I am at high risk of severe COVID-19, of long COVID, and of an autoimmune flare caused by a COVID 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 in the event of COVID infection.

They and I have been refused N95 masking by our healthcare providers, despite our prior written request for reasonable accommodation per the ADA. We have even been yelled more than once by healthcare workers in medical offices for daring to request that they mask. Repeatedly we have been told, "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, and oncology.

This will not change without standardization from a higher authority like HICPAC. Self-advocacy is exhausting and time-consuming and has become traumatic. Yet attempting it remains necessary if we are to access healthcare safely. Almost weekly we face risk calculations: am I at greater risk of getting COVID from keeping this appointment, or am I at greater risk from forgoing or postponing this appointment because of COVID?

With TB and measles breaking out in pockets nationally and COVID continuing to surge in waves several times a year, with Dr Fauci stating that 59% of COVID transmission is asymptomatic, and furthermore with WHO urging nations not to downgrade precautions and

data collection, implementing N95 mask standards across the board seems a small step that would yield large benefits beyond the threat of COVID.

Universal masking in healthcare protects healthcare workers as well as patients. It protects those workers' and patients' families. The healthcare system is only as good as its workers, but the current absence of precautions is exposing workers to relentless repeated infections with a virus that causes long-term health problems in at least 10% of infections and remains the third leading cause of death worldwide.

The economy is also only as healthy as the available workforce. By protecting patients, medical offices and hospitals protect law enforcement, education, the supply chain, the legal system, the military, and in short every field of human endeavor needed to keep America strong and thriving.

Please protect America's healthcare system and human infrastructure by taking strong united action in this matter.

Thank you,

Christina Moore

---

I am a breast cancer survivor and my husband is a kidney cancer survivor on dialysis—we are both high risk and immune compromised related to COVID.

Please consider continuing to require high quality masking and source control in all healthcare facilities. Vulnerable people like us have to use them frequently and a lack of effective masking puts us in danger.

Please also set indoor air quality standards for healthcare facilities, ideally at least the equivalent of 12 air changes per hour. This would make these facilities safer for everyone and is critical for high risk immune compromised people like my husband and me. Nobody would complain about air quality standards and they would provide at least some level of protection for the vulnerable ( and really everyone).

Thank you for your consideration.

Karen Zack

---

Prince Frederick, MD

To Whom It May Concern,

I would strongly urge you to reconsider your recommendations. First and foremost, much of your "evidence" with regards to N95 versus Surgical masks is biased and problematic, to say the least. But even if that were not the case, the outcomes you are referencing are far less serious than the death and disabling of the patients and healthcare staff through COVID or Long COVID!!! Your first priority should be the health and safety of people. *Noli nocere* is part of the Hippocratic oath, but your guidelines will most certainly cause great harm. The same can be said with regards to clean air. It is imperative that patients have the absolute right to not be infected with serious pathogens in the hospital.

At the end of the day, your organization serves We the People, which includes We the Chronically Ill People, We the Disabled People, We the Elderly People, and so on and so froth.

Your recommendations should start from a place of equity and only then move forth from there. As it stands, your proposed recommendations are a travesty and a violation of our basic human rights.

Sincerely,

April Spratley, Ph.D.

Disabled/Chronically Ill person

---

I cannot believe you are going to completely ignore the science ... oh wait, yes I can.

Improving ventilation standards is the only way to mitigate risks from airborne contaminants other than wearing a well fitting N95 or equivalent mask.

Because we can no longer mandate mask wearing building standards must be improved, not left as is.

I work in healthcare. Currently I am the only worker masking in my facility (which is dreadful). So reducing mask recommendations to surgical masks and refusing to increase protections by improving air quality is just malfeasance on your part.

Christ on a stick. Stop kowtowing to corporate greed and do your jobs to protect the public.

Theresa Brennan-Hochstetler, MAC

---

**Jayda Jones, MPH**

**Randolph, MA**

**Massachusetts Coalition for Health Equity**

**Ensure Health Care Worker and Patient Protection from Aerosol Transmission**

My name is Jayda Jones and I have a 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 increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. The proposed guidance by HICPAC 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.

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 CDC,

I'm writing to protest the inadequacy of the proposed infection control guidelines. I am very concerned for my own safety, as well as the safety of others who are immunocompromised or experiencing significant health challenges. I hope the CDC will issue indoor air quality targets of 12 air changes per hour, as well as maintaining a N95-level source control mandate for health care facilities.

I was diagnosed with chordoma in January of this year and have been in health care facilities on at least a weekly basis since the end of December. At the beginning of this journey, all of the health care professionals I interacted with wore masks, though all but one wore only a surgical mask. Now, at the end of August, almost no one in health care facilities (including my neurosurgeon and radiation oncologists) wears a mask. In addition to my cancer diagnosis and my recent surgery, I have pre-existing health issues that mean I'm at greater risk from Covid. I will be immunocompromised during my radiation treatments. No one seems to care.

I spent 3 days in the hospital after my surgery. Even with a mask mandate in patient rooms, many of the nurses and techs who were responsible for my care wore their (surgical) masks incorrectly, putting me at greater risk. While I would love a standing N95 mask mandate in those settings and expect one at times of high airborne disease transmission, targeting indoor air quality standards is a more consistent and less intrusive way of protecting vulnerable patients. I will continue to wear a KN-95 or better when

I'm in public in all situations, but attentiveness to air quality (in particular, 12 air changes per hour) is a way to provide a basic level of protection for all people, regardless of whether they understand the ongoing threat that Covid poses to people seeking medical treatment. It is important to note, though, that source control during periods of significant transmission (like the coming wave) will be essential to minimizing infection. Surgical masks do not provide the protection of KN-95 or N95 and should not be equated with them.

It is within your purview to ensure that vulnerable people have greater protection against Covid. IAQ targets of 12 changes per hour or the equivalent HEPA filtration will help protect everyone from Covid and other airborne diseases. It's astounding to me that so little care has been taken to ensure public safety in an ongoing pandemic. You have the ability to correct course, and I hope you take it.

Sincerely,

Angela White, Ph.D.

Director of Special Collections, IUPUI University Library

---

Hello secretariat,

Topic: COVID-19

I would like to express my confusion and disappointment at the present state of the pandemic and the CDC and HICPAC's lack of effort to adequately communicate the dangers of COVID-19. As the Center is undoubtedly aware, the emergent research on the effects of COVID-19 on the immune system—including long-term activation of CD4+ T cells—and on the vascular system—damaging the endothelium—points to alarming ramifications for any infected persons. The impact of Long COVID on 10-20% of those infected poses an even greater threat, especially as the chances of post-infection sequelae increase with each infection. Given this knowledge, one would expect the country's leading public health agency to be doing everything in their power to educate the public on these dangers. One would expect the CDC and HICPAC to urge US citizens and healthcare providers to take effective precautions at work, in school, and in their personal lives. Yet here we stand, facing yet another wave of infections without mask mandates and with only our most vulnerable and informed populations even aware of the

risk we face, and HICPAC is poised to degrade what limited precautions we have left in healthcare settings.

The previous director of your agency recently claimed the job of public health is “to strike an appropriate balance between protecting the health of all those who live in the United States while minimizing the disruption to the normal functioning of society.” While this characterization hand-waves away thousands of preventable deaths, I believe the CDC is failing to balance either of these two sides. In the wake of mass death and mass disability, future decades will look back upon this moment and identify the inadequacy of this agency in protecting our citizens as one of the greatest failures of our history.

There is still time. I beg of you: take what we now know, take what we will know, and educate. Tell the public what risks they face beyond the initial infection. Work with the FDA to inform people of the waning efficacy of vaccines and the importance of boosters. Advise a return to masking with high-quality respirators—the most effective mitigation measure we have—for all indoor spaces, but especially in healthcare settings. Implement air filtration per your own agency’s standards wherever possible, especially in healthcare settings and public schools, and incentivize private businesses and schools to upgrade their air filtration as well.

We are still learning just how bad things are, but we can take what we now know and try to prevent things from getting worse.

Sincerely,

Riley Pratt

---

I am very disappointed in the CDC no longer requiring n95 masks in health care environments. Not only does it put health care workers at risk but it also puts patients at risk. Especially those patients with compromised immune systems.

Additionally not recommending better ventilation systems has the same problems.

I remember how at the beginning of the covid 19 pandemic the recommendations about maskng were very wrong.

Let's not repeat the mistakes of the past and please protect the health of American citizens.

Regards

Robert Kamsler

---

I have multiple risk factors for COVID-19, including nonallergic asthma that causes brain fog and heart rate spikes when not well enough treated. I’d likely survive COVID, but there’s a significant chance it would destroy the quality of life treatment has only recently given back to me. For the last three years—my entire twenties—I’ve been isolating, delaying my life goals and the volunteer work I used to do for campaigns to protect my health and the health of my vulnerable family members.

I can’t work or go to college or see my friends and partner. The only place I go is to medical appointments; without Indoor Air Quality targets, and with masking in medical settings ended, even those aren’t safe anymore, and I have to wear a P100 respirator to protect my health from the people who are supposed to care for it. Masks belong in healthcare; COVID-19 isn’t the only virus that travels by aerosol, and enormous amounts of evidence show that it *does* travel by

aerosol. Surgical masks *aren't* as good as N95s, despite the committee's cherry-picked studies. Indoor Air Quality standards would reduce transmission, protecting patients and healthcare workers alike.

I've said a lot of this before. I'll keep saying it until the CDC is willing to listen to what vulnerable patients have to say.

Iolanthe McCoy
Dover, NH

---

**Topic:** Regarding the August 22, 2023 HICPAC Meeting, CDC Weighs Lower Infection Safety Precautions For Healthcare Workers.

**Name:** Morgana Harp

**Affiliation:** Concerned US Citizen

**Date:** August 23, 2023 around 3:00pm Central Time

To whom it may concern,

I am an immunocompromised citizen with feedback for the CDC. This matter is of vital importance to me as my life, and the lives of my fellow citizens are on the line.

Please issue Indoor Air Quality targets for all healthcare facilities, including dental facilities. People are contracting Covid-19 in hospitals and medical facilities, and infecting their families. This includes dental facilities. Many folks in my position have been forced to put off dental work and live with painful, potentially deadly dental issues or risk catching Covid-19 or other communicable diseases.

Please consider requiring the use of source control (i.e. masks) in healthcare facilities for the safety of our most vulnerable populations. When I say masks here, I don't mean surgical masks, I mean n95/kn95 or better, worn properly.

Please discourage healthcare facilities from pressuring or forcing patients to remove their n95 masks and respirators or replace them with non-n95 surgical masks. I've been asked to remove my mask to take a photo for a patient portal, which is unnecessary. Despite the danger this poses to me personally, I don't feel comfortable saying no to my medical providers, as I am at risk of being "fired" as a patient and could be blacklisted by that provider. All of this pressure is put onto the party with the least amount of power in these situations.

As someone who has had occasional pressure sores from masking during summer, I recognize that masking is not always convenient or easy. But it is necessary for allowing people like me to safely access necessary health care and have equitable lives. I am so tired of having to put my life and health on the backburner because my safety is considered too inconvenient for those who aren't at high risk.

Thank you for your time and consideration,

Morgana Harp

Please keep n95 masks in healthcare settings. If I wear one while I workout at the gym, shop, attend weddings, etc… health care workers can wear too.

Plus from an infection control, quality, morality perspective, wearing n95 and protecting patients who have to be in hospital, is the right thing to do.
Best Wishes, Dianna Lord

Dear CDC,

I am an asthmatic kidney donor and mom to a child with FSGS (a kidney disease). I am asking you to set a new standard for the prevention of infectious airborne disease in healthcare settings by requiring N95 respirators for healthcare professionals in all healthcare settings at least during pandemics/epidemics of infectious airborne diseases like COVID19.

Those of us in the 'Covid-cautious community' have remained NOVIDs (never had COVID) or have had minimal infections because we've utilized the science available and we've taken action to filter our air through HEPA, N95, and MERV13.
We have learned that N95 respirators work to reduce or eliminate the spread of infectious airborne disease such as COVID and TB. We know that surgical masks are inferior to N95s. We know healthcare professionals deserve protection from infection. We won't go back to 2019. We won't behave like the colleagues of Semmelweis. We will embrace this quote from Maya Angelou "…when you know better, do better."

It is time for healthcare to consistently do the same and practice the concept of "Do No Harm." Both workers and patients deserve protection. It is time to instate an mask/respirator requirement in ALL healthcare settings, at least until indoor air quality standards dramatically improve in all healthcare settings, and at the very least recommend N95 respirators for healthcare workers. We clean our water, we clean our hands, healthcare workers clean their tools… now is the time to clean the air!

Please do the right thing and include N95 respirator as standard infectious disease control for healthcare workers in your guidelines.

Thank you for your time
Elaine Vigneault, Henderson, Nevada

I was very distressed to read the Isolation Precautions Guidelines Workgroup report. As SARS CoV-2 now ranks as the third most prolific cause of death in the US, I would have hoped that the report would have emphasized the necessity of preventing airborne transmission.

Surgical masks are not designed for that purpose, and are meant to block splashes and droplets. They are inferior to N95 mask respirators, and very inferior to elastomeric respirators, in blocking the types of aerosols that transmit SARS-CoV-2.

Some of the studies used in the review are so confounded as to be worthless. For instance, the Loeb Annals study failed to differentiate between infections while wearing the mask or respirator, and those that took place without protection.

Health Care workers and patients deserve the best protection available. Instead, with the current relaxation of mask and respirator protocols, we are seeing a wave of nosocomial SARS-CoV-2 infections. The CDC needs to lead on this topic by recommending the most effective means of preventing transmission.

Peter Crowley

---

Comment on New HICPAC draft guidelines:

As a patient with chronic medical issues, I am writing to urge the CDC to REJECT the new draft HICPAC guidelines insofar as they:

1. Do not recommend increasing air ventilation filtration and safety in healthcare facilities; and

2. Recommend advising that surgical masks are the equivalent of N-95s.

In the midst of the relentlessly ongoing pandemic, these draft regulations are taking us in precisely the wrong direction, and will increase the health risks for all of us seeking healthcare--as we must--to stay as well as we can.

Sincerely,

Ellen Dickstein Kominers
Maryland

---

Hello,

I have a CD4 count of 180 and require infusions of human immunoglobulin. I am also very successful in my career, and my ongoing treatments have allowed me to live a fairly normal and very productive life despite my condition.

For the last several years, my medical appointments have been conducted in a facility which has had strict masking requirements for patient health and safety. As of a few months ago, all masking requirements were dropped (to worse than pre 2020 protections). Many of the facility staff not only refuse to wear masks, but actively try and convince me to stop wearing mine, "because the CDC says you don't need to mask anymore."

In a word, this is *insanity.*

This is going on *at a world class infusion center,* nevermind more mundane medical care facilities that I might need to visit, such as a primary care provider, phlebotomist, dentist, etc.

1. Please *mandate* that health providers require use of N95 masks, for all occupants of medical facilities, at all times (except where physically impossible, e.g., on the face of a patient undergoing dental treatment).

2. Please work with competent air quality engineers to adopt and enforce indoor quality standards for medical facilities.

Very sincerely yours, Arre Jackson.

---

August 23, 2023
Healthcare Infection Control Practices Advisory Committee
Centers for Disease Control and Prevention, Department of Health and Human Services
1600 Clifton Road
Atlanta, GA 30329-4027
RE: CDC/HICPAC Draft Revision of *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*
Dear Members of the Healthcare Infection Control Practices Advisory Committee:
On behalf of the more than 200,000 members of the Nurses and Health Professionals division of the American Federation of Teachers, thank you for this opportunity to comment on the Healthcare Infection Control Practices Advisory Committee work group's efforts to update the 2007 *Isolation Precautions* guidance. We represent nurses, physicians, respiratory therapists and other technicians and staff in hospitals, home health agencies, corrections, congregate settings, long-term care facilities and schools. The new guidance will determine infection prevention and control practices in these and other healthcare settings for many years to come. It is critically important that the new guidance is accurate and reflects a complete understanding of the research to date on disease transmission and effective controls. Healthcare workers bore the greatest burden of our nation's lack of preparedness for the pandemic, working without adequate ventilation and respiratory protection from an aerosolized pathogen.1 We are gravely concerned that the process to develop the new guidance has been shrouded in secrecy, has excluded input from relevant experts and stakeholders, and was devoid of consideration of the large body of scientific literature. As a result, the guidance will almost certainly reduce protections for healthcare workers and patients.
**HICPAC's failure to allow input from a broad group of experts and stakeholders removes any semblance of transparency and opportunity for stakeholder input in the process to update guidance.**
Work group meetings are closed to the public and proceedings are not posted on the CDC website or in the federal docket. This is in contrast with other CDC advisory committees authorized under the Federal Advisory Committee Act, which post copies of presentations, committee minutes and recordings. Opportunities for the public to comment have been limited to three-minute speeches and brief written comments during meetings of the full committee, as well as limited presentations on the draft framework to committees within the National Academies of Sciences,
Our members' experiences, before, during and after the early stages of the COVID-19 pandemic, demonstrate that far too many employers already start at the "basement" when it comes to protecting their workforce. Healthcare workers have worked far too hard throughout the pandemic for crisis and contingency practices to continue. They are humans who need adequate infectious disease prevention and control protections so that they can do their jobs. Patients must
Engineering, and Medicine and healthcare unions. Representatives for HICPAC have asserted that stakeholders will be able to provide comments through a Federal Register notice once the full HICPAC committee has voted on the work group's recommendations and the draft has undergone CDC review. At that point, the draft will be largely complete and underlying assumptions in the framework will be hard to address. The CDC and HICPAC should ensure transparency by opening work group meetings to the public, creating a docket for work group reports and evidence considered, and posting presentations and transcripts or recordings of the HICPAC meetings to the HICPAC/CDC website in a timely manner.
HICPAC and the work group must seek and accept input from a broader array of experts, including aerosol scientists, ventilation engineers, industrial hygienists and respiratory protection experts so that the work group considers all applicable evidence. Most members of HICPAC

and the work group are infectious disease doctors and infection control professionals employed by large hospitals and academic medical centers. The input from these subject matter experts is important, but not complete. Infection control specialists' work is narrowly focused on and driven by financial concerns for the employer. Aerosol scientists, ventilation engineers, industrial hygienists and respiratory protection experts provide critical expertise on the physics of aerosolized pathogens and the effectiveness of isolation, ventilation and respirators. CDC staff from the National Personal Protective Technology Laboratory within the National Institute for Occupational Safety and Health are recognized experts in the effectiveness of respirators and other personal protective equipment. They should participate in the work group and contribute to the guidance. NIOSH experts on ventilation and staff from the Occupational Safety and Health Administration with expertise on the respiratory protection standard should also have opportunities to provide input.

HICPAC should increase opportunities for more stakeholders to engage through public meetings. Only a few patient safety advocates and nursing representatives currently participate in the work group. Frontline healthcare workers and their union representatives and patient/resident safety advocates have valuable insights on what happens in the workplace. The people most impacted by these decisions must have a larger voice in the development of the guidance.

**HICPAC must conduct a new literature review that includes all relevant research and studies.**

We are very concerned that the work group omitted a large body of scientific literature on the effectiveness of respiratory protection against aerosolized pathogens, creating a false conclusion that surgical masks are as protective as N95s. The review excluded a randomized controlled trial that found that continuous N95 respirator use significantly reduced the risk of respiratory virus transmission, while intermittent N95 use and surgical mask use did not.1 The work group review omitted multiple relevant studies conducted by the National Academies of Sciences, Engineering, and Medicine (NASEM) and the National Personal Protective Technology Laboratory. A HICPAC representative refused to provide the methodology the work group used to select some studies and exclude others when asked during a meeting of the NASEM Standing Committee on Personal Protective Equipment for Workplace Safety and Health. The practical result of this is a false equivalence between surgical masks and N95 respirators, which will result in healthcare workers being denied respiratory protection when they need it.

**The new guidance must provide effective protections for healthcare workers to protect patients and the workforce against aerosolized pathogens.**

The draft framework downgrades multiple sources of protection for healthcare workers by failing to incorporate the hierarchy of controls. Employers should be encouraged to implement the most effective protections first and to provide overlapping protections when any one control cannot completely eliminate the risk of exposure. Use of isolation, source control and ventilation are largely unaddressed in the draft framework, but the work group has proposed to limit the use of airborne infection isolation rooms for novel pathogens. This approach will be dangerous to patients and workers alike.

The new guidance would allow healthcare employers to provide a "basement" foundation for infection prevention and control to be built up as they deem necessary. That foundation would deny healthcare workers fit-tested, NIOSH-approved respirators for "seasonal" infections, including COVID-19 and influenza, but would allow them for "pandemic-phase" infections. There is no scientific basis for this distinction. Moreover, this concept appears to assume that all healthcare workers are equally healthy. Many healthcare workers work while immune-compromised and are at higher risk of complications from COVID-19, influenza and other dangerous pathogens. Patients will also be at higher risk for nosocomial infection.

Our members' experiences, before, during and after the early stages of the COVID-19 pandemic, demonstrate that far too many employers already start at the "basement" when it comes to protecting their workforce. Healthcare workers have worked far too hard throughout the pandemic for crisis and contingency practices to continue. They are humans who need adequate infectious disease prevention and control protections so that they can do their jobs. Patients must also be protected from a race to the bottom.
We urge the CDC, HICPAC and the work group to change course. The work of the committee must be made transparent. The work group should undertake a complete review of the literature of effective controls against aerosolized pathogens. Input from experts and stakeholders must be solicited and considered in order to draft an effective and protective update to the 2007 guidance.
Sincerely,
Kelly Nedrow
Senior Director | Health Issues

---

**To whom it may concern,**
**I am writing to urge the CDC to increase Indoor Air Quality (ventilation/filtration) targets for healthcare facilities and to require N95 masks in healthcare settings.**

I am disabled and chronically ill. My quality of life declined a year ago when I got COVID. I was wearing an N95 mask when I became infected. I believe that a mask mandate would have prevented my illness.
Long COVID caused me fatigue so extreme I could barely sit up to brush my teeth, brain fog that prevented me from reading, listening to music or writing for 6 months, and stomach issues that require enteral tube feeding. I know a third Covid infection would be disastrous for me.
I am asking CDC to issue Indoor Air Quality targets for all healthcare facilities including dental offices (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration).

And I am asking CDC to require high quality masks in healthcare facilities.
I am still being very cautious, so I am avoiding spaces without masks requirements. I am putting off needed medical care when the Covid rates are high because masks are not required in medical facilities. I am delaying replacing my feeding tube and would not go to an ER or urgent care if I had an emergency because those spaces are not safe for me.
It would be a game changer if healthcare facilities required cleaner air. Vulnerable people like me shouldn't have to seek medical care in places that could make us sick, and it would also protect healthcare workers and staff.

I am appalled that you are considering not increasing indoor air quality inside healthcare facilities; and claiming that surgical masks are just as good as N95s when the science clearly shows otherwise.
I don't want anyone else to suffer from Long Covid the way I have. It's been hell. It doesn't have to be this way. The CDC has the power to make a safer world for everyone.
Thanks for your consideration.
Katie Vhay

---

August 23, 2023
Healthcare Infection Control Practices Advisory Committee (HICPAC),
Centers for Disease Control and Prevention
Submitted via email at: hicpac@cdc.gov

Re: Update to Centers for Disease Control and Prevention (CDC) Guidance *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*

Dear Dr. Alexander J. Kallen, MD, MPH,
The American Nurses Association (ANA) submits this letter to the Committee for your consideration regarding your current work updating CDC's guidance *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.* ANA is the premier organization representing the interests of the nation's over 5 million registered nurses through its state and constituent member associations, organizational affiliates, and the individual members. ANA strongly urges the Committee to protect nurses and all healthcare professionals in the update to this guidance.

During the COVID-19 pandemic nurses consistently reported an insufficient supply of personal protective equipment (PPE), often resulting in the need to make their own PPE and/or reusing or decontaminating previously used PPE, which made them feel unsafe.[1] As we continue to face new SARS-CoV-2 variants and prepare for future pandemics, it is critical that healthcare employers have clear and specific protection mandates to avoid repeating these unsafe practices. For example, the Crisis and Contingency Standard allows too much flexibility for employers and leaves healthcare professionals without a predictable plan based on the best evidence-based guidelines.

The Committee and CDC must ensure that any updated guidance includes the highest standards to protect healthcare professionals. ANA urges guidance to include multiple control measures against all respiratory pathogens, especially in environments with suspected cases. Thank you for the opportunity to submit this letter. If you have any questions, please contact Tim Nanof, Vice President, Policy and Government Affairs, at tim.nanof@ana.org or (301) 628-5166. Sincerely,

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

1 American Nurses Association, *Pulse on the Nation's Nurses Survey Series*, Last Updated January 24, 2023, Available at: https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/survey-series-results/.

---

I am asthmatic and have congenital renal deficiency. Both greatly increase my risk of severe illness and/or long COVID. I also have a neurological condition that requires monthly monitoring. Since the declaration of the end of the public health emergency, I am being forced back into monthly in-person visits. I must take a ride share to regional rail, to the NY subway (two lines, plus waiting in stations), then walk to sit in a waiting room. No part of my trip to, nor the actual visit, is required to have any COVID prevention measures in place.

I am terrified of contracting COVID again.

The absolute least that the Centers for Disease Control and Prevention can do in this situation is to require 1. high-quality masking (KN94 equivalent or higher) for EVERYONE aged two and up and 2. proper air quality monitoring, ventilation, and filtration (minimum of twelve air changes per hour with HEPA or equivalent) in all healthcare facilities . This includes, but should not be

limited to: waiting and treatment areas in pharmacies, clinics, urgent care, labs/imaging offices, standard medical offices, and hospitals. Recommendations are not sufficient in either instance.

Everyone I am related to, and almost everyone I know, has at least one aspect of their body or life that makes COVID infection more likely and/or especially dangerous. Too many disabled people – myself included – already did not get the necessary medical care before COVID due to cost and other administrative barriers. COVID made it near impossible, even when there were accurate transmissions rates and mask mandates. I will fear for my life every month while visiting the only doctor I medically cannot live without seeing. I – and the entire disability community – are begging you to make it slightly easier to keep ourselves alive. The public health emergency is not actually over. Please institute these minimum masking and air quality monitoring and filtration requirements.

Lynda Sciattara

---

During the pandemic an imperfect attempt was made to clean indoor air, it was the start of a project I had hoped that over the years would improve and improve to become part of OSHA code. Will you take up this problem? clean air will reduce missed work/schools/help with climate air problems against asthma for example

thank you

Kerry

---

To Whom It SHOULD Concern,

I am commenting on the public meeting from August 22- the idea that we would relax infection control procedures in healthcare settings is preposterous and to propose such is negligence itself.

Surgical masks are not respirators. This is obvious. No other profession dealing with hazardous airborne material treats them as such. Lead mitigation, Asbestos mitigation, welding, metalworking, insulation installation, even woodworking all utilize respirators for protection- not surgical masks. A surgical mask at best prevents fluids from contacting a person's face.

Airborne diseases are rampant- ASHRAE has finally published standards for ventilation to reduce infection- HICPAC should be moving to enforce those in all healthcare settings, not reducing the current standards to let infectious disease rampage through our hospitals, nursing homes, and pediatrics offices. This will lead to a healthier society, less burden on healthcare systems and workers, and frankly, fewer unnecessary deaths. Every year, people die of preventable, airborne diseases in America, many of them acquired in healthcare settings. This is unacceptable- imagine if that statement was about the drinking water and cholera- it would be shocking. Ensuring the air is clean, and we don't collectively do the airborne equivalent of pooping in the well, should be a baseline expectation.

Why do we continue to tolerate 10,000 senior citizen deaths & 300 child deaths from RSV annually? 4600 deaths from flu? The continued, preventable nightmare that is Tuberculosis? Even the resurgence of measles and polio as anti-vaccine sentiment increases? We must do everything possible to avoid spreading these pathogens in our healthcare settings- people will

not seek healthcare if the hospital is where you go to catch something worse than what you have.

This is personal- my mother is a respiratory therapist- she already assumes enough risk in her job, needing to be regularly screened for TB exposure, and she spends every day up close and personal with those most impacted by respiratory diseases. The field is generally understaffed- everyone who can afford to retire has, some died during the terrible waves of the pandemic, and many others have quit to find new careers- putting them EVEN MORE at risk will only increase the flood of those fleeing these healthcare professions.

Change course. Live up to your charter. Work to control infection, not increase short term profitability at the cost of the sustainability and public perception of the healthcare system and lives.

Nathan Barry

---

Dear CDC,

As an immunocompromised mom of three with a severely immunocompromised sister for whom I also help with medical care, I am writing to strongly urge you to issue strong indoor Air Quality targets for all healthcare facilities that require increasing indoor air quality (including ventilation and filtration) for such facilities. For example, targets such as all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration. This is necessary for me and my family to safely access healthcare services in the ongoing COVID pandemic. Moreover, please consider science-backed guidance regarding the importance of source control--specifically, the importance of kn95 or n95 masks for healthcare workers providing significantly more protection both for patients and providers as compared to simple surgical masks.

Thank you for your time and attention.

Lisa Ehrlich,

Berkeley, California

---

I am disappointed HICPAC has not recommended simple clear guidance for preventing transmission of Covid-19.

Just this week multiple hospitals have re-instated mask mandates. Those hospitals understand mask wearing prevents spread of covid. The places who need advice to require high quality masks/respirators already understand it - because they are mandating this on their own.

What HICPAC can do to fill the gap is to recommend airborne precautions in all healthcare settings until covid is gone.

The tools at the building/infrastructure level are simple: Ventillation and air filtration. There are standards and regulatory groups including ISO, ASHRAE and FDA which already have excellent guidance on air quality and monitoring. Looking at those guidelines and adapting to healthcare settings is simple.
At the individual level we already know that N95 or better masks work for airborne disease spread. In addition, it is critical that facility owners/managers must be responsible and

accountable for mandating because individuals always will fail to comply at some level without clear simple assistance with complying.

Regards,

---

Press Office Health and Human Services,

On August 22nd, community members unanimously urged the CDC's HICPAC members to recognize airborne transmission of SARS-2 and to require airborne precautions that include respirators, ventilation, and filtration in healthcare settings.

Today, I am joining ActionCareEquity.org and these community members who spoke during CDC's HICPAC public comment to emphasize the urgency of recognizing airborne transmission and to require airborne precautions in healthcare settings to save lives, prevent growing rates of long covid, and create safer conditions to access healthcare.

Lives should not be harmed in healthcare settings, lives should be saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence. People are dying tragic deaths from hospital acquired infection of SARS-2 that could have been prevented with mask requirements. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses.

And 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 masks will help our healthcare workers stay safer and help address critical staffing shortages which is reducing the overall baseline of care and is leading to a healthcare collapse. In closing: You are the CDC, 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?

Act quickly, our health and lives are depending on the requirement of airborne precautions in healthcare settings.

Thank you.

Saajida Deen

---

I am an individual who is highly concerned about the lack of public health protections for vulnerable people who access health care in the United States. The pervasive lack of masking in
public settings has forced me and my family to remain on lock down and we have ceased to access health care because we do not want to catch an airborne virus. Preventing a communicable disease should be paramount in any healthcare setting, especially due to the simplicity of the prevention action.

Along with many experts, I am extremely concerned about revised CDC/HICPAC guidelines that will severely weaken protections for health care personnel and patients who are exposed to infectious aerosols, including SARS-CoV-2. It is my understanding that the draft recommendations fail to reflect what has been confirmed about aerosol transmission by

inhalation during 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 regulations are weaker than existing CDC infection control guidelines and if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols

**Critical Flaws in CDC/HICPAC's Draft Proposed Guidelines and Recommendations**
1. The draft proposal has been developed without input from many important stakeholders, including frontline personnel and unions, patient safety advocates, and other experts and scientists.
2. CDC/HICPAC's process is not transparent and 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 CDC advisory committees. 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. 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 continue to recommend use of surgical/medical masks, which do not provide respiratory protection against infectious aerosols. The CDC's own website cites the efficacy of respirators over surgical masks, "While all masks and respirators provide some level of protection, properly fitting respirators provide the highest level of protection. Wearing a highly protective mask or respirator may be most important for certain higher risk situations, or by some people at increased risk for severe disease." Therefore, CDC/HICPAC proposals update terminology but not personal protective equipment (PPE) recommendations and ultimately move backwards in protections for health care personnel.
4. CDC/HICPAC's proposed flexible approach to implementing precautions is likely to cause harm to health care personnel. A protective approach should include assessments that evaluate the level of exposure, select appropriate control measures and PPE for each job, task, and location, and result in a written exposure control plan using the hierarchy of controls.
5. 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 for controlling worker exposure to infectious aerosols have not been considered, and the proposed use of airborne infection isolation rooms (AIIRs) is significantly limited. Source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

I urge CDC, HICPAC, and the work group to take the following immediate actions to correct their
review and decision-making processes and recommendations:
1. Seek input on proposed changes during the development of the draft guidelines from the public and all key stakeholders, including:
a. Health care personnel and their representatives
b. Industrial hygienists, occupational health nurses, and safety professionals
c. Engineers, including those with expertise in ventilation design and operation
d. Research scientists, including those with expertise in aerosols and respiratory protection
e. Experts in respiratory protection, including scientists from NIOSH's National

Personal
a. Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health
b. Administration (OSHA).
2. Make the process for updating the guidelines fully open and transparent:
a. Open work group meetings to the public.
b. Post work group reports, all presentations to the workgroup and committee, and transcripts/recordings of the HICPAC meetings on the CDC/HICPAC website in a timely fashion.
c. As the recommendations are being developed and before finalization and voting by HICPAC, create a public docket on the development of the guidelines that includes this information, the draft guidelines, all scientific evidence used in the development of the guidelines and all written comments from the public.
HICPAC is chartered under the Federal Advisory Committee Act (FACA) and should operate with openness and full transparency.
3. Improve the CDC's and HICPAC's understanding and assessment of key scientific evidence by seeking input from scientific researchers and key stakeholders, including health care personnel and their unions, and by making those written reviews publicly available:
a. Fully recognize aerosol/inhalation transmission of SARS-CoV-2 and other infectious aerosols and describe in detail the proposed "air" transmission category.
b. Ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of infectious aerosols, including ventilation, isolation, respiratory protection, and other PPE.
c. Maintain and strengthen respiratory protection and other PPE as critical methods for preventing health care personnel inhalation of infectious aerosols.
4. 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 health care settings.

Do not use an approach that recommends only minimal protections for health care personnel and allows health care employers undefined broad discretion in creating and implementing their infection control and prevention plans. Such an approach was adopted by the CDC during the COVID-19 pandemic and enabled health care employers to provide inadequate protection based on cost considerations, instead of basing protections for health care personnel and patients on exposure assessments.
I ask you to please consider this question, "Why would a person wish to work in healthcare yet choose not to protect their colleagues and their patients from serious illness, unnecessary suffering, and in many cases, death?"
Please protect our limited supply of healthcare providers, along with America's patients, while promoting health equity by ensuring the most effective safety measures that are available.
Very Sincerely, Marilyn Wacks

---

Sheri Elgin

Member of public, no affiliations

Topic: impact of lack of clean air in healthcare and schools and lack of reporting data

If the CDC is going to abandon guidelines for clean air, masking in public spaces including hospitals and clinics, which I will never understand, then the very least they can do is prioritize

reporting and vaccinations so those of us impacted the most by these decisions can at least make informed decisions about when we need to be extra vigilant, or schedule medical tasks, going to the dentist and other higher risk activities.

I'm also crushed that there is not a greater importance placed on safer air options for our kids in school. We have two school aged kids and so while there are mitigations we can make in our daily lives, regardless of the increasing pressure not to, there are no ways to protect our kids. Buses are no longer safe so we have to drive them to school. In the PNW where it rains most days, the crowded hallways, lunchrooms and gymnasiums are unavoidable. If nothing else, the simple message that some families remain at risk and there is nothing wrong with encouraging masking at schools would be helpful. However, despite what appears to be an increase in Covid transmission – just as schools are starting up again, and at least a full month before vaccine boosters MIGHT be made available – the CDC messaging has continued to support the idea that 'back to normal' is an acceptable path through the next few years. This, despite the mounting evidence that Covid infection can debilitate even healthy individuals regardless of age, let alone leaving those of us 'at risk' to navigate our way through without any tools or support. Placing the burden of being 'the most likely vector in' on your kids is a horrible reality.

Feeling abandoned by what I believe to be the science based voices of reason – the ones who KNOW – is a harsh reality. I'm forced to believe that much of this comes down to either political pressure or lack of funding – or both. I wish you could help us to understand why we can't rely on one agency that should be in the position to advocate for cleaner air, for continued support of vaccines, for greater support for families that need to continue masking. If we are going to persist with the 'stick our head in the sand' approach, then at least give those of us who do not have that luxury the tools we need to make informed decisions. What happened to the reporting? Where is the data?

Thank you for your time and the opportunity to share our concerns.

Sheri Elgin

---

I am writing to ask the CDC to issue Indoor Air Quality targets for all healthcare facilities, specifically that all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration, with monitoring that those CADRs are met.

I am also asking that you require the use of source control (i.e. high quality masks, N95+) in healthcare facilities. Research is clear that as Covid is airborne, surgical masks are not nearly as effective as NIOSH approved N95+ respirators. As such, respirators should be worn by all, at all times, in healthcare facilities.

As an immunocompromised person, this is especially important to me and my family. At the same time, adopting these standards will help everyone and reduce the load on hospitals and the community in general in reducing the spread of Covid and other airborne pathogens.

Thank you,

R. Catania

Rhode Island

---

Dear Members of HICPAC,

I am writing to ask that the CDC:

1) issue Indoor Air Quality targets for all healthcare facilities to ensure the safety of patients and decrease the spread of SARS-CoV-2 in settings where people seek medical care, and 2) reconsider the proposed conflation of surgical masks with N95 respirators.

The U.S. health care system is mindful of hospital acquired infections: healthcare providers are expected to wash their hands before seeing patients – but we need to have similar standards for reducing the acquisition of respiratory infections in healthcare settings. Respectfully, it is absurd at best, and negligent at worst, that in 2023 patients are entering medical facilities for anything from life-saving surgeries to necessary preventative care and leaving with Covid-19.

I am chronically ill with several autoimmune/immune-related issues, the worst of which is a rare immune-mediated kidney disease. Getting sick, especially with respiratory infections, means trouble for, and sometimes permanent damage to, my kidneys, as well as further blows to my quality of life which I work extremely hard to maintain. I also have high-risk family members and friends. We find ourselves in a difficult position as individuals who frequently need to seek out medical care, but also suffer worse-than-average (sometimes dire) consequences should we acquire infections from the health care facility. **This predicament has worsened with initially Dr. Walensky, and now Dr. Cohen's, refusal to acknowledge that Covid-19 is airborne and the CDC's reluctance to endorse masking, truly leaving vulnerable patients on their own.**

Please don't make chronically ill, immunocompromised, and disabled citizens choose between seeking medical care and protecting what precious health they do have.

Please listen to our voices, please do your job, and prevent and control diseases through proven methods like air quality, and protect not only the vulnerable but the health of our nation as a whole.

Thank you for your time,

Hannah P. Wellman, Ph.D.

---

healthcare facilities should be required to require masks for all healthcare providers and workers, as well as patients. many patients are immunocompromised and risk catching covid or other viruses from unmasked doctors, nurses, and other patients. many disabled people avoid medical care for this reason.

bailey biggs

---

To Whom It May Concern:

Hello. When the mask mandates dropped in virtually every state, I knew going to get necessary healthcare was now going to be an issue. Healthcare has its own worrisome problems as people are worried about whether they have cancer or an autoimmune disease, etc.; this all comes with stress. They do not need the added stress of worrying about catching Covid or another illness while at the appointment. Please consider reinstating masks in healthcare. Please make them worn well and be high quality N95. Baggy surgical masks just aren't up to par. Please also consider making it standard for all healthcare facilities to upgrade their ventilation. Healthcare buildings should have the best quality standards in everything as they are the structures that should protect the vulnerable.

When everyone masked and cared about Covid, I went to all of my appointments with nothing on my mind but the issue at hand. I felt safe. I no longer feel safe.

Thanks,
Itzel Kibler
Avon, CT

---

My grandfather and mother both recently caught covid due to the lack of infection control measures in healthcare. They both wore high quality respirators to the appointment, while all of the staff they interacted with were completely unmasked.

The current lack of simple precautions in medical facilities harms staff, patients, and everyone they come into contact with.

Institutions neglecting to use the precautionary principle is unethical and has placed an impossible burden on individuals. When I have called providers to ask what precautions they are taking, they reply that they are not masking, or at best are only wearing 3-ply surgicals, and often cite CDC guidelines to justify this decision, which makes it so that patients cannot safely access care. So I have personally had to avoid routine medical care because healthcare facilities are dangerous places to be for anyone who does not want to give or get a broadly circulating, possibly fatal or disabling illness.

The CDC's guidelines should include required universal masking in healthcare with N95 respirators and PAPRs as a basic infection control measure to reduce the ongoing harms of covid and all other airborne illnesses. Adequate ventilation and air filtration, regular testing, screening and early identification, and isolation protocols are also baseline.

Lauryl Berger-Chun

---

My name is Elizabeth Suffern. I live in Olympia, WA. I am deeply concerned about the continued spread of COVID and the lack of strong precautions in healthcare settings to prevent the spread of airborne diseases. HICPAC has the power to greatly improve the safety of health care workers, patients, and communities with strong, science-based, and risk diminishing standards for infection control.

Please consult with scientists who specialize in reducing airborne disease transmission as well as the vulnerable populations that are affected by ineffective infection control. There is still much we do not understand about COVID, but what we do know is serious. COVID is likely compromising the health of everyone who contracts it and as such, we need to limit spread to the strongest degree in health care settings. 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.

Thank you for your time. Please accept my comments as part of the public record.

With appreciation,
Elizabeth Suffern

---

RE: Public comment from 8/22 meeting

Hello, my name is Andrea and I've been disabled by Long Covid and now suffer from hyperadrenergic POTS, ME/CFS and a messed up immune system my Rheumatologist has yet to give a name to. My 2 young children suffered with long covid symptoms for nearly a year after their infection, but have thankfully appeared to have recovered. My family cannot afford to catch covid and we've been forced to become reclusive in order to stay safe. It's very jarring to notice my doctor's office still has signs hanging all over the clinic claiming they mask to keep everyone safe with absolutely no masks in sight. It has been a fight to get virtual appointments and numerous health care providers have been huffy about my request for them to mask. Here in Minnesota most have passive aggressively put on a surgical mask as loose as possible allowing the mask to hang off their face which offers me no protections.

**I am pleading with every fiber of my being that HICPAC mandates N95 masks in healthcare settings to give disabled and immunocompromised people safer access.**

Please remember that roughly 10% of covid infections end in long covid and each infection can cause cumulative damage to your body & immune systems which don't typically hurt and aren't always obvious. We have no idea how many Americans are walking around with a weakened immune system or vascular damage including you the person reading this. What happens to you when your next infection leaves you unable to work like me? What happens when your body can't take another SARS infection and you're stuck trying to access healthcare in this maskless hellscape? Please for the love of whatever higher power you hold holy, wake up to the reality that repeated SARS-CoV-2 infections are not good for the population and should be avoided.

Thank you,
Andrea Tomasek

---

Hi. I am writing to submit my testimony for the record in the HICPAC meeting. I am disabled. Being disabled comes with a lot of doctors appointments, blood draws, various tests of all kinds. I also have two minor children and I am a solo mother. There is no father in their lives. They need dentists and doctors as well. If I get Covid, my condition will become much worse or I will die. There is no scenario by which I get Covid and am okay. I recognize that schools and other places will not use respirators. However, respirators in health care should be mandatory. I have no option but to see doctors. I shouldn't have to risk my life to do so.

The CDC is pretending like it doesn't know that Covid depletes T cells. It is pretending like it doesn't know Covid is a syncytial virus that fuses peoples' brain cells. It is sinful that a virus that does this kind of damage, and has a high rate of Long Covid, is being allowed to spread at hospitals and doctors' offices. We all need respirators required in medical settings. We shouldn't go to the ER for a broken leg and acquire a brain cell fusing, T cell depleting virus.

I know I have killed and harmed no one during this pandemic. None of you who ignore what Covid is and choose to allow it to spread in hospitals and doctors' offices can say the same thing. You should all be ashamed of yourselves. Right now, you can redeem yourselves and act prevent the spread of Covid in healthcare.

Require respirators. RESPIRATORS. Not baggie blues.

Thanks,
Jessica White
Baltimore, MD

---

To whom it may concern:

I am writing to you regarding infection control guidance for healthcare facilities. As a multiply disabled, chronically ill person taking immunosuppressive medication, I rely on CDC's recommendations to ensure healthcare facilities and providers prioritize my safety.
Now that we no longer have Community Transmission levels to inform personal risk assessment, I think it is vital that CDC issue Indoor Air Quality targets for all healthcare facilities. Please forgive me for not being more precise as to what IAQ recommendations I'd like to see. This is not my area of expertise. I know that other members of my community who are writing to you will have much more specific requests, and I trust their judgment. What I do know is that there is a dearth of information about infection control strategy at the facility level. I've spoken to practice coordinators, facilities managers, a dental director, and more individual providers that I can count, and the common thread in all these conversations is that they don't know what they're even allowed to do, much less what they ought to be doing, what's considered best practices, or what strategies might be useful in what scenarios. So, while I may not have the expertise to say what specific IAQ targets are necessary to minimize risk of airborne pathogen exposure, I can say with complete surety that healthcare facilities and providers have urgent need of clear guidance in this area.
Please include dental offices in these recommendations. A shocking number of dental clinics are under the impression that having the clinicians wear baggy procedure masks only while actively working in patients' mouths is sufficient Covid mitigation. In reality, many of these offices treat patients in open treatment bays, side by side, while performing procedures that specifically generate large amounts of aerosols, making this strategy hazardous to both patients and clinicians. Patients are obviously unable to wear PPE of any kind during dental treatment. The responsibility must lie with facilities to protect their patients, but in my experience, they do not. I have called more than 10 dental clinics in my area that accept Medicaid, and I found only one that had ANY airborne pathogen control strategies in place.
I would also like to see source control required for everyone in all healthcare facilities (including dental facilities) in both waiting and treatment areas (except when care necessitates removal). I understand that this is a big ask, so I have a related request: please make an extremely specific statement clarifying that facilities are free to use stronger safety measures than CDC's recommendations if they so choose. The one dental clinic I spoke to that does have some mitigation measures in place recently stopped requiring patients to wear masks, stating that the end of the Emergency Declaration in CA disallowed them from requiring masks in their clinics. What's more alarming is that this incorrect information was given to me by the dental director of a facility with several clinics in my city. A clear, unambiguous message from CDC could go a long way toward addressing these kinds of misconceptions.
I have a condition that requires regular MRIs, and even when most/all healthcare facilities required masks, the only kind that can be worn in an MRI suite are minimally protective procedure masks. I am overdue for an MRI of my brain because there is no safe way for an immunocompromised person to get an MRI until we make the air inside our healthcare facilities safe. I have had to delay a large amount of dental work for similar reasons. Every time I need any healthcare that can't be done entirely via telehealth, I have to do complex risk vs. potential reward/consequences analysis to determine how to proceed, and my health has suffered as a result. Part of that is because of delayed healthcare, but part is due to the stress of the constant risk assessment itself. I can't describe the weight that would lift away from my soul if I could simply trust that the places I must go for healthcare would have safe air.

With so little information available to both healthcare facilities and individuals, the only ethical and effective posture moving forward must be that of proactively protecting the health of everyone who must enter a healthcare facility. Please help those of us who must frequent healthcare facilities to be safer within them. We're counting on you.

Thank you for taking the time to read this,
Robin McClanahan
San Francisco, California

---

Hello.
My name is Rita Lewis. I'm a recently retired Registered Nurse. I worked for 15 years at CA Correctional Health Care Services at San Quentin State Prison and saw up close the mishandling of the pandemic as over 2000 inmate/patients contracted covid and 28 died. Staff infection and repeat infection counts were frightening. (List of staff deaths is attached, system wide.) It would be a shame to see this repeated. Evidence: https://www.cdcr.ca.gov/covid19/population-status-tracking/ and https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/
I am a senior and immunocompromised. I had an ongoing battle to get a reasonable accommodation to work from home. The system, despite the Governor's direction, minimized and continues to minimize the valuable option of teleworking. Most staff are afraid to even ask due to anticipated retaliation. You could do much to assert the ongoing value of this simple intervention.
The public desperately needs your direction, guidance, clarity and modeling of appropriate behaviors. The messaging from the CDC was often confusing, and still is. The modeling is even worse. The director COULD be modeling masking at this time. She posted a photo at the airport, unmasked. This influences our government. While grateful that President Biden was vaccinated and seems to have had minimal negative outcomes from his bout with Covid, it could have EASILY gone a different way. I, for one, would not be pleased if Biden had Long Covid brain fog or other permanent system damage and by default we ended up with President Kamala Harris. Congresswoman Barbara Lee seemed to be the only person on the Hill demonstrating consistent masking.
On August 22nd, community members unanimously urged the CDC's HICPAC members to recognize airborne transmission of SARS-2 and to require airborne precautions that include respirators, ventilation, UV light and filtration in healthcare settings. I would also advocate for remote work and alternative schedule options to minimize transmission, especially during a crisis.
We, recognize the pivotal role you play in setting guidance that shapes infection control and prevention practices in hospitals, nursing homes, and other health care settings across the nation and around the world.

I echo the NNU as we urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

• Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.

• Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on
health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. **The CDC must 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 present or may be present in health care settings**; don't adopt a crisis standards approach.

4. **CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.**

We are concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.
Act quickly, our health and lives are depending on the requirement of airborne precautions in healthcare settings.
Thank you.

Rita D. Lewis, RN (retired)

---

I'm writing to express my alarm over the fact that HICPAC is actually considering lowering the bar for infection control in the middle of an ongoing airborne pandemic.

As you must know, COVID continues to spread at an alarming pace, especially in hospitals. Hospitals should be doing everything in their power to reduce infection rates, which includes upgrading ventilation, testing every single person for COVID, not placing COVID positive patients in rooms with COVID negative patients, and requiring respirators for all healthcare workers.

Surgical masks are simply insufficient against COVID and should not be considered the equivalent of N95s. Their purpose is in their name--surgical, for surgery, intended to protect against bodily fluids. Airborne viruses can't be stopped with a surgical mask, whereas N95

respirators provide excellent protection that will slow the spread of COVID and other respiratory diseases.

It's astonishing that members of the public have to write emails like these to an advisory committee that should have the knowledge and expertise to make intelligent recommendations. I never in my life thought that the CDC/medical establishment would fail the general public in the ways that you have, but here we are.

Do better. Stop trying to kill people.

Tara Komar

---

Comments regarding air quality and masking at healthcare facilities:

Healthcare Infection Control Advisory Committee,

We continue to find ourselves in the middle of a pandemic, even if the emergency status has expired, and we should continue to act on it to prevent deaths and disability as much as possible.

Removing infection control protections, especially for airborne diseases, leaves immunocompromised, chronically ill, and disabled Americans even more abandoned, not just by society but by the institution that should prioritize public health over politics and comfort.

Surgical masks are **not** comparable to N95s. N95s have been a standard to efficiently filtrate airborne particles for years. Even the CDC's own guidelines support it - one cannot wish evidence and hard data away and pretend it does not exist. Aerosol transmission scientists, epidemiologists, and researchers agree that N95s and air quality improvements like HEPA filtration and ventilation are some of the best tools to protect healthcare workers and the general public, including vulnerable populations.

As a person with a chronic illness, I think long and hard about which medical appointments and procedures are worth risking getting COVID. It shouldn't be this way. Accessing treatment and medication in a safe environment should be everyone's priority.

I urge you to reconsider these guidelines that do not improve healthcare quality. On the contrary, they weaken public health, make seeking life-saving treatment even more dangerous, and allow for more death and disability from COVID-19 and other airborne diseases.

Thank you,

Kari Zamora

Seattle, WA

---

My name is Karen Carnessali, Information Literacy and User Experience specialist at an R1 Research Institution, former Healthcare Worker, and I am writing to provide public comment on CDC/HICPAC's Draft Proposed Guidelines and Recommendations regarding Health Care Respiratory Protection and Infection Control. (https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac)

I am writing to urge HICPAC and the CDC to unequivocally recommend universal masking with at least as protective as N95 (or higher) in healthcare settings, as well as developing baseline ventilation standards in line with respiratory airborne virus protocols. It is imperative to provide clear and consistent enhancement of current guidelines, including improvement of respiratory protection and infection control for healthcare workers in health care settings. PPE and RPE (Respiratory protection equipment) is required for airborne diseases. **Surgical masks are not respiratory protection equipment**. Continuous use of N95 respirators is necessary and more efficacious than intermittent use of N95 or medical masks.

https://www.cmaj.ca/content/193/26/E1010.short

https://pubmed.ncbi.nlm.nih.gov/23413265/

https://www.acpjournals.org/doi/full/10.7326/L23-0076

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

HIPAC's draft proposal has been developed without input from those it impacts directly, such as frontline personnel, their unions and representatives, patient safety advocates, and other experts and scientists, or sounds data regarding HAI-COVID.

Healthcare-Acquired Infections have drastically increased since the start of the COVID pandemic. We know COVID is an airborne virus. This is not the time to be weakening protocols, guidance, or recommendations. Respiratory protection equipment (RPE) within PPE protocols should be clear, stringent, and consistent. This is particularly significant now, as healthcare settings continue to drop mask mandates, and RPE regimens, while COVID continues to circulate. To contribute to this public health crisis by loosening recommended standards that already didn't go far enough is not only negligent, but actively dangerous. The CDC has an opportunity to help correct the gaps in respiratory protection and infection control, rather than contribute to further exacerbating this public health crisis. On August 22nd, 2023, during public comment, we heard from those that have acquired HAI, as well as the perils of seeking care in a healthcare setting. All commentators attended the meeting, listened to HICPAC presentations, rationale and debrief Q and A following each segment. Public comments were unanimously against CDC/HICPAC's Plan to Weaken Guidance for Health Care Respiratory Protection and Infection. Patients deserve to be heard on this matter too. I hope you Listen to their experiences and do not damage or betray the public trust.

I agree with and amplify over 900 experts who delivered and signed this letter to Dr. Mandy Cohen (CDC director):

The proposed revised CDC/HICPAC guidelines will severely weaken protections for health care personnel exposed to infectious aerosols, including SARS-CoV-2. The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during 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. They are weaker than existing CDC infection control guidelines. The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols.

https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Thank you,

Karen Carnessali

Syracuse, New York

---

Dear CDC,

I can't tell you how much I appreciate masking on the part of health care professionals. I wish they wore them all the time, even outside the treatment room, even the receptionist. Masking simply acknowledges the truth the covid is airborne, and that airborne precautions need to be taken. Every mask helps.

Regards,

Kelley Nielsen

Salem, OR

Retired

---

I am writing to once again urge you to increase indoor air quality standards for healthcare facilities and maintain requirements for true N95 masking rather than inferior substitutes.

Acute COVID infections continue to represent a real threat, particularly to some of the most vulnerable in our communities, including children, older adults, and those with existing medical vulnerabilities. And instead of having more treatments available as time goes on, we are experiencing the opposite phenomenon: COVID variants are evolving faster than we are developing new therapeutics.
Given the current complete lack of preventative measures,lack of testing infrastructure, and high transmissibility and immune evasion characteristics of the current variants, imagine how many people are waking up with what they think is a simple cold and going about their days– exposing young children, their classmates, grandparents, vulnerable coworkers, and others along the way. The odds of one person's cold becoming another's severe, acute infection have possibly never been higher. This is already hugely problematic in homes, schools, and dozens of public settings. **Please don't let healthcare settings become another place where people with existing medical conditions have to choose between receiving care and running the risk of a ruinous infection.**

All ofthat said, it is increasingly clear that acute COVID infections represent only a small fraction of COVID's total impact to our health. The latest comprehensive review of "Long COVID" published in Nature Reviews Microbiology Notes that frequency of Long COVID (a catchall term for post-acute health impacts stemming from the infection) is estimated at 10-30% of non-hospitalized cases, meaning that these impacts are present following even mild initial infections. Adverse outcomes following those mild infections include increased risk of stroke and other major cardiovascular events, pulmonary embolism, heart failure, a 40% increased risk of developing diabetes, along with a wide variety of other debilitating, long-term or permanent conditions. Neurologic issues following acute infection include increased risk of cognition and memory disorders, nervous system disorders, migraines,seizures, and impacts to hearing and

vision. Numerous studies have also identified COVID's harm to the immune system, causing immune dysregulation for a period of 8 months or longer. And, repeat infections have been shown to produce even worse outcomes, with the likelihood of cardiovascular dysfunction,diabetes, kidney disease, and neurological symptoms increasing with each subsequent reinfection.

With all of this in mind, I again ask you to advocate for the continuation of any and all policies to enhance ventilation requirements for improved indoor air quality and maintain or enhance masking standards in healthcare settings. These critical measures are the only way to ensure healthcare services can be provided safely and equitably.

Amelia Aboff Kominers

Somerville MA

---

Dear Center for Disease Control and Prevention (CDC) Officials:

I'm writing to you in response to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), which I understand is considering new infection control guidelines. I am deeply concerned by these guidelines, as they do not recommend increased or improve air filtration in healthcare settings and they claim that surgical masks are as good as N95 respirators, when all the evidence shows that N95 respirators are necessary to protect healthcare workers and patients from airborne diseases such as covid-19 and the flu. As we go into another covid surge, if we weaken infection control in healthcare settings, we are leaving people vulnerable to covid-19 infections and the risks of long covid, strokes, heart disease, and the many other long-term health risks associated with repeated covid-19 infections.

Instead of weakening infection control guidelines, I ask the CDC to implement safeguards in healthcare settings to ensure that vulnerable individuals are not risking their lives and health in medical settings. Specifically, the CDC should issue indoor air quality targets for all healthcare settings and should recommend source control measures, prioritizing N95 respirators, in healthcare facilities. These measures would ensure that those who are immunocompromised, elderly, or who have other health risks that make them vulnerable to covid-19 could safely visit their doctors and receive necessary medical care. For instance, my grandmother, who 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 time and consideration of this message.

Sincerely,

Merrill Miller
Silver Spring, Maryland

---

Hello,

My name is Mona Kanin. Professionally, I'm a literary agent, but for a number of years I worked as a freelance filmmaker on many projects for the National Institutes of Health, including those commissioned by Francis Collins when he was director of the Genome Institute.

So, I'm not scientifically naive. I hope you read the latest Forbes article on your decision making process as well as yesterday's piece in the Annals of Internal Medicine. Despite the cost, it is imperative that HCW wear test-fitted respirators rather than surgical masks. At one point, I called my local healthcare system and asked why they were dependent on surgical masks—the answer? They were buying them for $5 a piece (their bulk rate) when I, as a lay person, could buy one for a little over a $1. Rather than risk long term sequelae for those who care for us—as well as putting at risk our welfare (basic bio-ethics—do no harm), why not review procurement practices? Who's making those profits?

And, too, when did nosocomial infections become acceptable to anyone who practices 'good' medicine. We aren't you working to prevent all of these costly and harmful problems?

Also, why are you not following already established CDC guidelines for ventilated and filtered air. (I'm one of those people who carry a CO2 monitor with me when I visit physicians. I understand this does not provide an exact correlation, but it does indicate risk. Isn't it nice that there's a Canadian province which lends C02 readers to the public at public libraries? We need to do better.

Thank you for listening,

Mona Kanin

Egremont, Massachusetts

---

To Whom it May Concern,

I was recently made aware that the CDC's Healthcare Infection Control Practices Advisory Committee declared the following:

1) does not recommend increasing indoor air quality (i.e. ventilation and filtration) inside healthcare facilities; but

2) claims that surgical masks are just as good as N95s.

I implore you to retract these statements and instead encourage N95 masks in all healthcare facilities as well as issue indoor air quality targets for all healthcare facilities. I am an immunocompromised person living in the US that requires medical care for their ongoing health and well being and I would like to receive that care without the increased risk of contracting COVID-19. Thank you.

-Rachel Gersten

---

Hello CDC email reader,

I'm a Kanyen'kehá:ka (Mohawk) woman with an autoimmune disease and two physics degrees trying to figure out why society and the CDC have left me behind at the expense of their own health. I was sad that people were going to crowded indoor bars, but now I'm furious that those people go to healthcare facilities later that week unmasked and infectious.

Things that would make it safer for me to receive healthcare without risking my own health and therefore employment:

1. Please issue Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration). This would be great for reducing ALL respiratory illnesses, not just SARS-CoV-2, and would better our infrastructure for the future while creating domestic jobs. What is there to lose?

2. While we are all working on #1's Indoor Air Quality targets, please require source control for healthcare workers while interfacing with patients. This means that healthcare workers should be wearing an n95 mask while they are with any patient or non-healthcare worker. I should not have to argue with nurses about washing their hands or wearing a mask during my care.

3. Do not claim that surgical masks are as good as n95 masks; they are not equivalent in matters of respiratory diseases. A doctor may know more about the human body, but a physicist (like myself) is more qualified to interpret data about air flow and the filtration of particles.

I lose precious time during my many healthcare appointments with doctors who are tired and overworked and do not want to have this discussion with a patient. These rules from the CDC would make healthcare easier and safer for everyone.

Sincerely hoping you'll do some "Control and Prevention" for us all,

Summer Saraf

Ithaca, NY

---

Please advise healthcare facilities to wear masks.
Please.
Some of us find it frustrating and irresponsible on the part of CDC to not want to protect more people by advising mask wearing in HCF.
Thank you,
Carol Gambone

---

Hello,
As family member of multiple immunocompromised people and a patient recovering from a significant surgery in midsummer, living in an area where health care providers and allied staff no longer universally mask in health care settings, I ask that the CDC issue strong indoor air quality targets for all healthcare facilities including 12 air changes per hour or the HEPA filtration equivalent. These measures will provide some protection to me and my family where Covid-19 transmission rates are again on the rise.
~ Joanna M. Rives

---

I am deeply concerned with the proposed reduction of standards for universal precautions. We should not be scaling back our efforts as this pandemic rages on and infects millions possibly multiple times with worsening effects. I urge you to please keep the current standards. Masks work. High quality respirators work. Please do not contribute to more deaths and harm to our

healthcare system.  We are already struggling and we need help.  Please I am begging you do not further harm the American people.

Thank You,

Dan Brophy

---

Submitter's name :Ezra David Mattes
No organizational affiliation
Topic addressed: planned HICPAC revisions regarding infection control protections

Public comment: Long covid has disabled me. I am a twenty seven year old man who lived in perfect health prior to infection in September 2022. One week, I was working, powerlifting at the gym, and volunteering to help friends move furniture. The next week, I was bed-bound and barely able to lift more than five pounds without assistance. Since mask mandates have been lifted, I cannot visit most places without potentially being exposed to a rapidly mutating virus that could kill or further disable me if I am re-infected. I am learning which parts of my life I am able to release for my health and safety. It is necessary, however, as the barest minimum, that I be able to visit hospitals to receive ongoing care for this chronic condition. With HICPAC's planned revisions to water down infection control protections, particularly for aerosol transmission and multidrug-resistant organisms, hospital visits for myself and for millions of others disabled by long covid would become a death sentence. It is unconscionable to conclude that plain surgical masks are equivalent to N95s to prevent the spread of disease, when there is abundant evidence to the contrary. Patients deserve better, nurses and hospital staff deserve better, and everyone forced to "just live with" preventable disease deserves better.

---

I am a resident of Ireland and the UK but feel my comments are totally relevant to HICPAC’s proceedings given that:

a) HICPAC’s foundational guidance influences guidelines and practices around the world including here in the UK and Ireland.

b) I have many loved ones living in the USA and they are directly impacted by HICPAC’s proceedings

Speaking personally, I and my immediate family are being excluded from our ability to access healthcare services due to wholly inadequate infection control practices in healthcare settings. There seems to be almost no recognition that Covid continues to be a serious disease that is not just respiratory in nature but vascular also. It can affect all organs in the body and lead to serious (even fatal) complications such as premature strokes and heart attacks. And this is even before considering the potentially permanent life-limiting effects of Long Covid. Because of these inadequate practices, I and my family have been unable to attend regular check ups and screening procedures since the start of the pandemic. This is unacceptable given that the technology exists to render healthcare settings relatively safe. All it would take is proper recognition by HICPAC of the scientifically proven aerosol transmission route favoured by Covid. Once this is recognized, then effective infection control measures would include the mandated / recommended use of N95 masks by all healthcare professionals and patients, proper ventilation, adequate filtration (e.g. HEPA, negative pressure) and even sterilization (e.g. UV) of the air within healthcare settings. This would set an example to the world and maybe,

just maybe, lead to a situation where I, my family and my loved ones can once again access healthcare in relative safety.

Yours faithfully

Tim Finch

---

I have concerns that your new covid recommendations are insufficient. Air quality standards must be maintained at adequate levels (i.e. there must be 12 air changes per hour, or an equivalent level of HEPA filtration) to help keep indoor spaces safe for the most vulnerable among us.

What's more, it is grossly inaccurate to say that blue surgical masks are as effective as n95 masks. It is irresponsible and dangerous to mislead people in this way. We need proper masking (with adequate masks) in healthcare settings.

What further steps will be taken to protect citizens from this disease? Leaving it up to us individually is not working. We need decisive, effective action from those in power. So I ask again, what further steps will you take? At a minimum, keeping health care facilities safe via masking and improved air flow are paramount.

Thank you for your time and consideration.

Anne E. Wallick-Bauhof

Minneapolis, MN

---

The pandemic is not over and it has very much so been not over for over three years now for those of us who are disabled, like myself, and for our families.

It is physically impossible for me to “personal responsibility“ myself out of being high risk for complications from SARS-CoV-2 despite my vaccinations being as up-to-date as I can get them, due to having a damaged spinal cord on top of having multiple autoimmune conditions. I am already fighting with everything I have to be an effective parent to my 7 year old; any one of me, my baby, or my spouse finally losing the exhausting, protracted fight against not catching SARS-CoV-2 and gambling with Long Covid or a difficult acute case would be devastating for us.

Every month, I have to receive lidocaine infusions into my blood at an anesthesiologist’s pain clinic, on top of taking daily medication (I’ve recently switched to Pregabalin, after having lost more and more efficacy from 3x 1200mg daily Neurontin), in an attempt to control the blisteringly painful neuropathy I suffer from thanks to my spinal cord damage. As of this spring, the requirements for source control within this and other healthcare facilities had at last gone to the wayside. This has left me as often being the only masked individual within the building for over an hour. During once such visit, I overheard a nurse celebrating with another patient about seeing smiles again in the cubby next to mine, while in the exact same conversation she relayed a story about how a friend was left permanently disabled from post-viral syndrome following an infection from influenza. As I left that same appointment, I watched someone clearly symptomatic with something and coughing enter the building, unmasked, despite the posted signage that it IS required for those showing signs of illness. But now that the full unity of

requiring everyone is gone, there's no way anyone will risk the uncomfortable social interaction to enforce this new, laxer rule.

The only place I "got" to go to and speak face-to-face with others outside my household and felt even remotely safe still stepping foot inside has been taken away from me, too. Except I still have to go once a month. It's like reaching into a wood chipper to do maintenance and having no idea whether or not someone will come behind me no matter how safe I try to be and boot me in and kick it on.

It has been a huge blow, losing access to accurate, useful community transmission data. "Community levels" is a garbage, fake value that was shown to be truly useless when our local hospitals in Southwest Michigan were nearly buckling under the onslaught of SARS-CoV-2, RSV, and Influenza, ICU beds for children across the entire state were full, and we still had happy colors and numbers obscuring just how dire things were on the graphs. Knowingly rolling back safety precautions after lulling the larger population into a false sense of security, despite the very real threat that BA.2.86 could pose if it's spreading further than reduced testing can catch while the autumn vaccines target the XBB strains, is particularly unwise.

No one abled can truly comprehend how depressing and frankly demeaning this recurrent prioritization of returning to a fake normal over useful risk management has become after three and a half years. Even before SARS-CoV-2, healthcare settings have historically been vectors for further infection, whether it's colds from other patients in a waiting room or something more dangerous, such as MRSA, for those staying overnight at the hospital.

In one month's time, I will once more find myself undergoing such a hospital stay following a third surgery on my C2-T2 vertebral fusion to repair failing hardware. Catching any infection at all will be a threat to my recovery, but something likely to produce a strong cough or risk needing ventilation—like SARS-Cov-2—should be avoided at all possible costs. Unfortunately, I will be in a position where masking will frequently have to be interrupted for use of my incentive spirometer to reinflate my lungs following undergoing general anesthesia, multiple times an hour. I very literally cannot keep my KN95 on during my recovery; there is no choice of personal responsibility available here. I will be forced to rely on the safety precautions of others around me until my release. Continuing to reduce and compromise hospital safety is directly endangering my life.

Equivocating about mask efficacy and the idea that a surgical mask provides the same protection to those around us when ill as a KN95 is directly endangering my life.

Even in the event that we somehow, someday manage to completely erase the threat of SARS-CoV-2 infection, adequate source control was shown to be an effective measure to reduce danger and harm of various illnesses and I personally believe it should be reinstated permanently within healthcare facilities, to protect staff, patients, and caregivers alike, not chipped away at further and further.

But beyond source control and masking, we have tools that can go beyond the human measure of properly fitting PPE to reduce danger and infections.

Cleaning the air surrounding us.

We know that SARS-CoV-2 is airborne and spread through aerosolized particles hanging in the air. We have known for months upon months now. One of the single most effective tools we have to fight it is therefore cleaning the air itself, through improving filtration and ventilation, as well as establishing firm rules and guidelines to ensure the job is being done properly.

Yes, updating buildings will likely be costly.

So was switching from leaded gasoline.

It was still the right thing to do.

It is within your power to issue Indoor Air Quality targets for all healthcare facilities, requiring a minimum of 12 air changes per hour or an equivalent HEPA level of filtration.

This would save lives. Not could, would. This many lives down the drain into this, we could use the Win, to be honest.

I personally wish you could go a step further and issue similar and appropriate guidelines for school buildings. The number of messages we received from our child's school about school-wide dropping attendance due to illnesses during the 22-23 school year was honestly staggering when taking into account how many of these children will continue getting sick more often throughout their lives due to mistaken beliefs about SARS-CoV-2's danger posed to children. Many of them are now unknowingly disabled for life with post-viral issues they may not even recognize yet for what they are. The classrooms had filtration boxes, but no one on staff was able to provide me with information about Air Changes per Hour or the expected IAQ of any spaces within the school, even when I provided them with full formulas that only needed numbers plugged into them.

All my child's teacher could tell me was that she knew to come in and turn it on before all the kids arrive in the morning.

My child's KF94 mask can only do so much when they are the only one wearing one and they have to eat lunch with their peers. And have snacks. And drink water throughout the day.

Establishing IAQ targets for schools could go a long way.

Requiring them for all public buildings would be utterly transformative—for SARS-CoV-2, allergens, mold, dust, other illnesses, viruses, bacteria… countless people would benefit from having safer air in the places they're required to be for hours at a time.

But sometimes we can only influence so much, and healthcare facilities absolutely need to have them established, as our direst need. People are at their weakest and most vulnerable in these spaces, most in need of any protection we can give them.

And you're the ones in a position to do just that, instead of undermining public health by doing the exact opposite. Stop endangering lives and start working again to save them.

I desperately hope that you do.

Thank you for your time and consideration,
Kathryn Kehrer, Portage, MI

---

I see from the extremely low quality data (barely more than anecdote, really) you have chosen to use that you have proposed surgical masks are sufficient barriers when dealing with airborne infections.
We both know this is wrong, and likely to harm practitioners, as well as increase the iatrogenic spread of infectious disease to patients. Since we also both know that nosocomial infections are the single leading cause of fatal complications, and a rising cause of staff deaths and staff permanent disability, this suggestion based on such flawed data is not helpful.
What will help reduce nosocomial infections and reduce infections in hospital staff? Improved air system filtration and increased air changes per hour. Required use of N95 equivalent respirators. Commissioning improvements in respirators. You know, what you should have been doing for the last few years.
Your proposal is poor and based on fool's gold. Do better, please.

Constance Edwards
Boulder, CO.

---

As HIPAC has invited public comment on the proposed COVID guidelines for healthcare facilities, I am writing to ask you not to take such a catastrophic measure. As an immunocompromised person, I am already at risk in healthcare facilities without masking requirements, but I am not just concerned for myself. To endanger the healthcare providers and many workers in healthcare facilities is no better. I ask that the committee recommend improvements to indoor air quality and acknowledge that N95 masks are far more effective than surgical masks at blocking COVID-19.

Those of us who are immunocompromised have already seen our worlds get smaller as the guidelines moved on without us. To lose even the meager protections we are still afforded in the places where we receive necessary medical care is wrenching. Please do not go forward with these proposals.

Sincerely,

Dr. Kristen Hanley Cardozo

---

To the members of the Healthcare Infection Control Practices Advisory Committee,

As someone with multiple chronic illnesses and who appreciates the healthcare workers of our country, I am writing to voice my support for the CDC to set guidelines encouraging the improvement of the indoor air quality of our healthcare centers. This feels like a priority that we ought to have considered long ago but which the new COVID virus and its many mutations give us further incentive to pursue. Our nation could prevent so much acute and chronic illness, improve quality of life, prevent deaths, and additionally cut back on sick days and lost work, by providing better ventilation and filtration. I urge the CDC to suggest improved air quality standards for all healthcare facilities.

Also to this end of protecting human health, I support language in CDC guidance that encourages the use of N95 respirators or equivalent in healthcare centers. Well-fitting quality

masks protect both patients receiving care and our already overtaxed healthcare workers, without whom there *is* no healthcare in this country. Thank you.  Jaclyn Kusluch, Amston, Connecticut

---

From: Aaron Radney

Chairman of the N.D.G organization (Nerds Doing Good)

I write this message to strongly encourage you and your agency to not only halt but reverse course on your current action and prioritize both the lives of disabled, chronically ill, older Americans and simply those of us who would rather not contract a deadly virus whose long term knock on effects are still being charted. I've seen reports from HICPAC that not only are you considering new guidance that would not address issues of air quality or improve air circulation but that would argue for the equivalency of basic surgical masks to N95 rated ones. For an agency tasked with following the science this seems terribly unwise. The scientific consensus doesn't back this claim. Further, a failure to address air quality issues almost feels like dereliction of duty at this point. It's a tool the disabled community has been demanding for some time as well as providing hard data!

Furthermore, for an agency that has been struggling with legitimacy and communication for some time this is the kind of action that destroys credibility. The initial shift from downplaying the need for masks to a sudden shift early in the pandemic was damaging enough. But after all this time of saying "trust the science" and now turning on that would be disastrous. Especially after a CDC conference turned into a Covid 19 super spreader event. Covid is airborne. That is not in dispute. To ignore tools we can use to limit an airborne pathogen (air filtering and high quality sealing masks) feels akin to ignoring the idea of gravity because the truth is inconvenient. If you are as has been claimed numerous times, "following the science" I hope the guidelines that frankly, ignore it, are not implemented. Failure to turn back here puts more people at risk of infection, disability and death.

---

To Whom It May Concern:

We are now in our third year of the COVID-19 pandemic, which despite assurances to the contrary has not "ended" or "gone away" but is still very much a part of our daily lives. Vaccinations and boosters have greatly helped reduce the severity of COVID-19 infections, but they have failed to prevent continued widespread transmission within our communities. Certified N95 and P100 masks and respirators and enhanced interior ventilation and air filtration, however, have helped to reduce transmission of COVID-19. It therefore makes no sense to recommend against wearing N95 masks, especially in healthcare facilities where patients with ongoing COVID-19 infections and patients with other diseases and conditions that might put them at risk for severe COVID-19 complications are likely to comingle. To be clear, I believe recommending only surgical masks over N95s and not recommending enhanced indoor air quality (ventilation and filtration) will lead to an increase in otherwise preventable deaths and chronic COVID-19 complications. While these measures may have their own minor annoyances, these do not outweigh the clear and life-saving benefits they provide.

Thank you,

Kwang Ketcham

San Francisco, CA

Hi. I'm writing to encourage you to recommend and work towards having high indoor air quality standards and targets in healthcare facilities. I'm addition, to acknowledge that surgical masks do not provide as much protection as an n95 or equivalent and require source control with masks wearing in those settings. There are many disabled, chronically I'll, older, and immune compromised folks who are at increased risk when seeking even routine healthcare because of this. This would make things safer for everyone. Thank you

---

To whom it may concern,

I am a healthcare worker and I am deeply distressed and disturbed by the proposals from the recent HICPAC meeting to update infection control guidance. Specifically, the lack of any action on standards for ventilation and filtration to improve indoor air quality. Improved air filtration not only curtails the spread of Covid-19 and other airborne diseases, it also protects against wildfire smoke, airborne pollutants, and other contaminants, improving health and productivity. By not proposing any standards for filtration, the committee fails to take action to prevent future pandemics and protect against the effects of climate change. Similarly, by equating surgical masks with high quality ventilators like N95s, the committee's recommendations break from well-established scientific fact and will make healthcare setting more prone to infections and outbreaks.

Please reconsider these proposals and create new standards that reflect the science around air quality.

Thank you,

Daniel Farnitano

---

To whom it may concern,

I am deeply disturbed to learn that the CDC is considering issuing guidance that is not in the public's best interest regarding improved ventilation in hospitals. Infectious airborne diseases like RSV, influenza and COVID are a persistent threat to all Americans, but what truly unnerves me is the idea of young children having to undergo chemotherapy in buildings that aren't safe for them. Imagine being the parent of an immunocompromised child and knowing that your child is at risk for getting seriously ill or dying from an infectious disease every time they go for life saving treatment. For sick children, healthcare providers and all Americans, please reconsider. It is imperative that hospitals upgrade ventilation systems to improve air quality and meet the challenges of this moment in history. Please issue guidance for improved indoor air quality and help keep the American people safe.

Sincerely,

Megan Yociss

Richardson, TX

---

Honestly, you hid the meeting when people brought up concerns. We have all been reading science for almost 4 years now. Who do you think you are kidding? You are killing!

Many people I know personally went into hospital for treatments or scans and caught SARS-CoV-2. I myself test prior to visiting my Dr., and/or scans. I bring individual wrapped N95s and they refuse to wear them. This would be Geisinger in PA.

Because I explained to my Physician why I would like her to mask, no more 6 month visits. She has moved me to yearly. I have pre-existing conditions that put me at high risk. By reading my chart and medication she knows this. Yet, no mask.

Even though I am high risk and 64 I am not allowed another booster. My last was September of 2022. I have lost 8 family members. I live in an apartment building. I have air purifiers, Merv 13 in my HVAC and I mask before leaving my apartment. Including while outside.

Why? Because SARS-CoV-2 is AIRBORNE! Not droplet! Please stop this Malarkey and stop killing people. You are giving long covid to our children. It is not respiratory, it is vascular!

You pathetic people don't work in person. Yet minimum wage people that serve you daily can not afford such luxury.

Please just tell people the truth instead of hiding behind it.

Jeanmarie Coyne

Scranton, PA.

---

Isolation Precaution Guidelines -- Deborah Socolar, MPH

I'm an active member of multiple national and local organizations concerned about COVID prevention and about access to health care, but speak only for myself in these comments.

1) Having strong standard protective protocols for airborne infection is crucial for access to care and for health equity. Both as a health policy professional and as a Long COVID patient for 2 and a half years, I believe that I and other people should be able to seek health care without risk of infection or re-infection because we confront skimpy or absent protections. Measures to reduce airborne infections now should routinely be used, with N95 (or better) respirators a standard part of care just as hand-washing is routinely expected. With most COVID transmission occurring asymptomatically, routine masking is essential source control.

2) So I'm appalled that the slides on draft guidelines that HICPAC released in June bizarrely fail to stress core measures to control infectious aerosols, and to protect health care workers, patients, and our communities. In those materials AND your 8/22/23 meeting discussions, HICPAC is clearly ignoring vast evidence that respirators are effective, that 2-way masking is superior and vital, and that massive improvements in ventilation and expanded use of HEPA/MERV air filters are essential across all health care settings -- from hospitals, nursing homes, and physicians' and dentists' offices to physical therapy centers, adult day health programs, and pharmacies. Notably, your materials had no recommendations on ventilation and scant mention of airborne infection isolation rooms or other means of isolation.

3) I'll now focus on a point that hasn't gotten much attention in other public comments that I've seen. Your Slide 19 in the June material suggested that mask/respirator use could potentially be only in "a part of a facility" that serves patients "at risk for more severe outcomes." Such

selective targeting, however, is NOT viable, not sufficiently protective, especially because so much transmission is from asymptomatic people and because many tests have false negatives.

It should be obvious that many individuals at high risk for varied reasons may be patients or staff in a service labeled as serving "low-risk" people. For example, a patient in an eye clinic or dermatology office may be an unvaccinated infant, immunocompromised, or getting cancer treatment. The burden must not be on them to ask staff and patients around them to put on a (good) mask, to turn on air filters, etc.

Neither I nor other patients and workers should have to choose between forgoing care or danger
*because infected staff or patients around us go unmasked or use ineffective surgical masks, or
*because there's poor ventilation and air filtering in doctors' offices, waiting rooms, elevators, etc., or
* because people unmask in corridors and elevators, or
*because an inpatient's roommate wasn't tested on admission and routinely thereafter.
Calling for respirator use only in "high risk" areas would be absurdly illogical and irresponsible.

4) Finally, you must end the secrecy and narrowness of HICPAC/ CDC's discussion of a guideline update. Failing to seek insights from patients and from experts in many essential fields is outrageously negligent. You obviously need input from OSHA and NIOSH, as well as from health care workers and their unions, industrial hygienists, occupational health professionals, engineers with expertise on ventilation, scientists with expertise on aerosols and respiratory protection, and groups representing immune compromised and disabled patients, among others. And your proceedings should be wide open.

I hope your members were shaken to the core by the devastating critiques in the few public comments allowed in your August 22, 2023 meeting, and that you radically change your approach to this process. Thank you.

---

My name is Maria La Place, San Francisco CA

First and foremost, I refer you to the publication, in November of 2022, in Nature of the study, A Multi-National Delphi Consensus to End the COVID-19 Public Health Threat: "a diverse, multidisciplinary panel of 386 academic, health, non-governmental organization, government and other experts in COVID-19 response from 112 countries and territories to recommend specific actions to end this persistent global threat to public health. The panel developed a set of 41 consensus statements and 57 recommendations to governments, health systems, industry and other key stakeholders across six domains: communication; health systems; vaccination; prevention; treatment and care; and inequities. In the wake of nearly three years of fragmented global and national responses, it is instructive to note that **three of the highest-ranked recommendations call for the adoption of whole-of-society and whole-of-government approaches1, while maintaining proven prevention measures using a vaccines-plus approach2 that employs a range of public health and financial support measures to complement vaccination.** Other recommendations with at least 99% combined agreement advise governments and other stakeholders to improve communication, rebuild public trust and engage communities3 in the management of pandemic responses. The findings of the study, which have been further endorsed by 184 organizations globally, include points of unanimous agreement, as well as six recommendations with >5% disagreement, that provide health and

social policy actions to address inadequacies in the pandemic response and help to bring this public health threat to an end."

The CDC has clearly ignored all of these recommendations and by its inaction is contributing to the spread of COVID-19 and the continuation of the pandemic, leading to the unnecessary death and disabling of millions of Americans.

Since the appointment of Rochelle Walensky by Pres. Biden on Jan. 20, 2021 up until the present day, the CDC has abdicated its role as the top public health institution in America and begun a concerted coverup of the true dimensions of the outbreak, to the extent that it has stopped gathering accurate data on number of infections; number of hospitalizations and number of icu hospitalizations.

Further it has not gathered data on the incidence and symptoms of Long Covid and the exact number of people disabled by it, thereby impeding those individuals' ability to be granted Social Security Disability benefits and condemning them to poverty.

It has obfuscated the impact of even mild infection on all bodily organs, including permanent disruption of the immune system, microclots in all organs, and sudden death within two months of infection.

But what is most shocking of all, the CDC in the midst of a pandemic then removed all mitigations, allowing new, more infectious and immune-evasive variants to multiply freely and ever-changingly. In complete contradiction to its earlier conclusions, and a mountain of reputable, peer-reviewed scientific evidence, the CDC declared that this respiratory virus was not spread by airborne aerosol transmission, but recommended hand-washing as a means to stop infection. Now apparently it recommends surgical masks which have been proved by dozens of scientific studies to have no benefit in stopping virus transmission, instead of the gold standard and the ONLY known mitigation to prevent the spread of a disease that continues to kill and disable, the N95 mask. The Delphi Consensus specifically recommends the mandatory use of N95 masking as one the most important measures to stop the pandemic.

And it compounds this criminal dereliction of duty by removing the requirement for N95 masking in health care settings. It truly beggars belief. Individuals at their most vulnerable are condemned to expose themselves to a virus that can kill or disable them.

Naturally since all this sociopathic behavior is clearly in contradiction to all know scientific evidence, the CDC has shrouded itself in mystery and silence, because if we saw the business and big money interests behind their behavior their corruption would be evident to all.

When the full history of this pandemic is written, the CDC since January 2021 will be seen as criminally colluding with anti-scientific interests, actively lying to the American public by commission and omission and enabling wholesale death and disability. As a Democrat it pains me to say that the Biden CDC is infinitely worse than the Trump CDC.

---

Hello,

I understand that the CDC is considering new infection control guidance. I ask that CDC consider increasing airflow quality and N-95 usage in hospitals and healthcare settings. When I

enter a healthcare facility, I should not worry about jeopardizing my health or others' health to get care. Airflow and N-95s will help decrease flu, Covid, RSV, and colds. It seems like the less infections going around would mean less disease, which would be a great thing. You are the Centers for Disease Control and Prevention, please provide guidance like it.

Thank you for your time.

---

Jacob Sherwood

The weakening of airborne illness precautions

Torrington, CT

I am a concerned member of the public and Frontline worker

N95 masks need to be standard as a precaution for covid and airborne illness protection as well as air filtration. The CDC cannot weaken already weakened precautions for airborne illnesses such as covid 19. Please reconsider your course of action I beg of you. Lives are on the line. Thank you for your time and consideration.

---

My name is Tamar Salibian, I am an educator, media scholar, and immunocompromised individual living with multiple chronic conditions who acts as caregiver for my elderly mother who also has chronic health issues. I am concerned with the lack of transparency on COVID precaution strategies by individuals in positions of authority and by institutions. I have witnessed this with employers and businesses, and I am witnessing it with the CDC and HICPAC. I am also experiencing the burdens this lack of transparency ensures when scheduling appointments with providers. We are being locked out of safe care. It's unacceptable.

While watching the August 22 HICPAC meeting online, I kept thinking about how CDC/HICPAC's process has essentially been closed to public access or engagement. Why is that? HICPAC meeting presentations and documents that are used to make recommendations to the CDC are not posted publicly, in contrast to other federal advisory committees including those at the CDC. Doesn't the public have a right to know what decisions (or omissions) – and for what purpose – are taking place? Also, the August 22 meeting chat was disabled, and as I write this [on August 22, 2022], the video recording of the meeting is unavailable because it has been made private online. The CDC acts as beacon and guidepost for many institutions. Do you want to know how many times I've seen "CDC guidance" being used as a reason for decisions that keep healthcare workers, patients, and the public unsafe? Given the broad public interest in CDC's guidance on infectious diseases, it's baffling just how closed the CDC/HICPAC is being regarding their processes and strategies. Closed, and dare I add, smug regarding the misuse of this position of power. Again, unacceptable. I urge CDC/HICPAC to employ an approach that is clear and explicit about the precautions needed to protect everyone from infectious diseases. Our lives and your reputation are at stake.

Equally as baffling as this lack of transparency is what appears to me (at this point) to be an intentional refusal to acknowledge the fact that COVID is airborne, and a rejection of [mention or promotion of] N95 respirators. CDC/HICPAC are actively obscuring the critical role of inhalation and continue to recommend use of surgical masks which do not provide respiratory protection against inhalation of infectious aerosols. The evidence review on N95 respirator and surgical mask effectiveness utilized flimsy, selective methods to conclude there was no difference between N95 respirators and surgical masks. I think we all know better by know, don't we?

Except when the CDC affirms something (by omitting or obscuring other things), institutions, businesses, health care workers, and the public defer to this decree, keeping us all unsafe during this ongoing airborne pandemic. The evidence review on N95 respirators must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

Why is 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 not being considered? There are no recommendations on ventilation. It almost looks like CDC/HICPAC are forbidden to say “N95.” Say it with me: Unacceptable. I urge CDC/HICPAC to adopt measures that employ more transparency and ensure safety for health care personnel – and ultimately, for everyone. Not only is this a public health issue, it is, as one public commenter mentioned at the August 22 meeting, also a liability issue. The responsibility is yours. Do better. Thank you.

Tamar Salibian, PhD, MFA

---

Hello,

I am writing to comment on the proposed weakening of airborne virus protections in healthcare settings.

Healthcare is something that we all have to access at some point in our lives, and for most of us, at least a couple of times a year. Covid 19 (and other airborne pathogens such as the flu and measles) remain dangerous and disabling risks to public and individual health.

It should go without saying that peoples health should be protected, especially when they are potentially in a medically vulnerable state. Medical facilities should have MORE protections added (high quality masking requirements, high powered air purification systems, enhanced sanitation), not fewer. These things are vital for protecting vulnerable patients. Additionally, medical staff should have enhanced ppe requirements and options to protect their health in their workplace.

PPE IS the new reality for keeping people safe. Everyone is looking to you to lead the way and tell us what is safe. Adequate PPE (n95 respirators and similar) is a primary way to mitigate the risk of Covid 19 transmission. Thank you, Kassi Grunder, MAPJ, San Diego, CA

To whom it may concern,

I am writing to share my perspective and requests as a public comment. I wish that you would:

- **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.

James West

---

As an informed citizen, I am absolutely appalled that a key organization is primed to make such a disastrous recommendation based on the flimsiest of evidence. Surgical masks are NOT in any way shape or form equivalent to N95 respirators. The science is nearly indisputable. Please don't put healthcare professionals and their patients at greater risk. Please DO NOT move forward with this recommendation!

Nikki Thomas
Brooklyn, NY

---

Dear CDC,

I am a physician who has been on the frontline throughout this covid pandemic. I take care of pregnant people and their unborn children. The ONLY way I have kept my family safe is through strong infection prevention with excellent PPE. This is not a manner of opinion. The evidence is outstanding that ventilator level PPE matters. If infection prevention is relegated only to hospital administration level decisions and we in the rooms with covid patients will almost certainly quit en masse. I know that I will. We are already facing a physician and health care worker shortage. Forcing repeated infections by gutting recommendations for the provision of PPE flies in the face of science and human decency.

The CDC has already largely failed us by failing to follow the science and endorsing the near-universal infection with a virus that we still only have 3.5 years worth of data on. Please do not continue down this road of slavish devotion to the financial sector rather than considering the true human cost of your decisions.

M. Koskelo, MD, PhD

---

Hello HIPAC,

I am writing to urge you maintain or strengthen infection control in hospitals and health care facilities rather then weaken them. Surgical masks are not adequate to protect patients or health-care workers from respiratory diseases. Do not make the poor trade of maybe short-term cost savings for hospitals administrators at health care workers and patients expense for long-term health ramifications for the public. This decision will likely also contribute to

increased  health care worker shortages due to increases death and disability of workers due to lack of protections. Show some care and actually have policies that control not spread disease .

Megan Jirschele

Hello,

As a public health student, I am concerned that the meeting two days ago was privated and no longer made available. It's really disappointing to see HICPAC have such a lack of transparency and advocate for weaker infection controls in a time when greater ones are fundamental to controlling the spread of disease. With the current COVID-19 surge, this shift in policy would severely limit the ability of millions to adequately access healthcare.

Policies need to be developed with the input of impacted stakeholders, such as health workers and patients. I am concerned that the CDC will soon profoundly weaken its Infection Control guidance which could place health workers and patients at risk of short- and long-term harm and even death from infectious diseases. Universal masking is a simple measure to reduce the risk of infectious disease transmission that has been implemented broadly in healthcare settings for the last three years. HICPAC should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators. (1) Instead, in June 2023, the CDC HICPAC Isolation Precautions workgroup formally proposed changing CDC guidance to recommend health workers wear loose-fitting surgical masks (2), which are less effective with airborne infectious diseases, to care for patients with COVID and other infectious diseases such as Middle East Respiratory Syndrome (MERS) or Severe Acute Respiratory Syndrome (SARS), rather than fit-tested N95 respirators or more protective equipment, which are much more effective with airborne diseases.

Adopting this policy will endanger millions of workers and patients across the country. Airborne infectious diseases such as COVID-19 are transmitted in the air we all share, which is why wearing high-quality, face fitting respirators is important to prevent transmission, in combination with ventilation and other layers of protection (3). COVID-19 has already caused over 42,000 deaths this year (4), placing it among the top 10 killers in the US in 2023, and 15.8% of U.S. adults have experienced Long COVID (5), a condition that persists after initial recovery from a COVID infection. Similarly, other airborne diseases such as MERS or SARS could also lead to large numbers of hospitalizations and deaths, the 2015 MERS crisis led to 38 deaths among 186 diagnosed cases in South Korea, and the 2002-2004 SARS crisis led to 774 deaths among 8,000 diagnosed cases across several countries in Asia and Canada.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms (6), they may pass it to their coworkers or patients in maskless healthcare settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages.

The recommendations were based upon a widely-critiqued (7), flawed literature review. The guidance even contradicts the CDC's own data which demonstrated that continuous use of N95 and KN95 respirators cut the odds of infection by 83% compared to 66% with surgical masks (8). Nearly 900 experts and over 1000 members of the public have already signed an open letter urging the CDC to strengthen, rather than to weaken its infection control guidelines, and to open the process of infection control guidelines to include more stakeholders and interdisciplinary experts (9).

CDC/HICPAC decisions are made undemocratically and developed behind closed doors, without input from nurses unions, healthcare workers, patient, disability and elder advocacy groups or even independent aerosol experts, occupational safety professionals and industrial hygienists. In the last public meeting, CDC/HICPAC voted on a proposal before hearing public comment – an example of lack of inclusion. Even though CDC/HICPAC is part of a Federal agency, they have not made their draft protocols available to the public – unlike other CDC committees. We only have access to a barebones powerpoint from CDC/HICPAC's last meeting on June 8-9 2023, which outlines the proposed changes (2). The meeting notes are not made available in a timely manner, and are still not available from the June meeting (10). The HICPAC committee is packed with representatives from the hospital industry, and lacks procedures for meaningful public input.

The American Hospital Association has explicitly declared that hospitals are facing a "crushing" financial crisis (11). Given this, I am concerned that the hospitals may be pursuing this short-sighted infection control approach to reduce their expenses by cutting fit-testing programs and limiting access to N95 respirators and other airborne protections. However, increasing rates of health worker COVID infections will further worker shortages and may lead to additional disabilities caused by Long COVID. Ultimately, infection control that ensures the highest protection of healthcare workers and patients based on evidence-based science, and integrates the input of stakeholders is a necessary approach.

References:

(1) Kalu IC, Henderson DK, Weber DJ, Haessler S. Back to the future: Redefining "universal precautions" to include masking for all patient encounters. Infect Control Hosp Epidemiol. Published online February 10, 2023:1-2. doi:10.1017/ice.2023.2 https://pubmed.ncbi.nlm.nih.gov/36762631/

(2) Isolation Precautions Guideline Workgroup - Co-Chairs: Michael Lin, MD, MPH and Sharon Wright, MD, MPH - HICPAC June 8, 2023 https://drive.google.com/file/d/14s40YHjuZxMQ_ZOx2qXIdsPDxD0641_b/view?usp=sharing

(3) EPA - Implementing a Layered Approach to Address COVID-19 in Public Indoor Spaces https://www.epa.gov/coronavirus/implementing-layered-approach-address-covid-19-public-indoor-spaces

(4) COVID Data Tracker - Trends in United States COVID-19 Hospitalizations, Deaths, Emergency Department (ED) Visits, and Test Positivity by Geographic Area https://covid.cdc.gov/covid-data-tracker/#trends_totaldeaths_select_00

(5) CDC - National Center for Health Statistics - Long COVID - Household Pulse Survey https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

(6) Johansson MA, Quandelacy TM, Kada S, Prasad PV, Steele M, Brooks JT, Slayton RB, Biggerstaff M, Butler JC. SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. JAMA Netw Open. 2021 Jan 4;4(1):e2035057. doi: 10.1001/jamanetworkopen.2020.35057. Erratum in: JAMA Netw Open. 2021 Feb 1;4(2):e211383. PMID: 33410879; PMCID: PMC7791354. https://pubmed.ncbi.nlm.nih.gov/33410879/

(7) Why the CDC's New Mask Guideline Proposal May Actually Imperil Frontline Workers. "The decisions some of these public health people are making are not getting better. They're getting worse." by Katie MacBride, The Daily Beast, Updated Jul. 01, 2023 3:40PM EDT / Published Jun. 30, 2023 11:47PM EDT https://www.thedailybeast.com/new-cdc-mask-guidelines-may-actually-imperil-frontline-workers-experts-say

(8) Andrejko KL, Pry JM, Myers JF, et al. Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection — California, February–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:212–216.
DOI: http://dx.doi.org/10.15585/mmwr.mm7106e1

(9) National Nurses United - Urge the CDC and HICPAC to fully recognize aerosol transmission and protect health care workers and patients https://www.nationalnursesunited.org/urge-the-cdc-and-hicpac-to-fully-recognize-aerosol-transmission

(10) CDC - Healthcare Infection Control Practices Advisory Committee (HICPAC) - Meeting Minutes https://www.cdc.gov/hicpac/minutes.html

(11) Becker's Healthcare - Congress can take action to help healthcare deal with 'crushing' financial challenges, AHA urges - by Nick Thomas - Tuesday, October 25th, 2022 https://www.beckershospitalreview.com/finance/congress-can-take-action-to-help-healthcare-deal-with-crushing-financial-challenges-aha-urges.html

Linda Yu

---

Hello,

My name is Kevin Alarcon, and I have no organizational affiliation except as a general member of the public.

I am writing to express my surprise and disappointment about the proposed changes by HICPAC to the CDC on infection control in healthcare settings. I am terrified to think about how many infectious diseases will be spread by these watered down protections that HICPAC is suggesting. Healthcare workers and patients deserve the highest levels of protection, so plain surgical masks should not be the standard when N95s are needed to prevent the spread of infectious aerosols. Healthcare workers and patients deserve to have access to high quality PPE and proper air ventilation to protect them.

HICPAC needs to consult with experts in aerosol transmission, ventilation, occupational health and worker protections, as well as representatives of healthcare workers.

I hope that HICPAC chooses to value human lives over cost-cutting measures.

Thank you.

---

To whom it may concern,

As a disabled person and caregiver for an immunocompromised family member, I am extremely concerned about the ongoing pandemic. My concern has increased as mitigation efforts have been lifted despite continued cases. While my family and I still wear our masks, we know one-way masking only goes so far. For me, something that would make a significant difference is for the CDC to issue Indoor Air Quality targets for all healthcare facilities. Whenever I know that a

space is keeping their indoor air clean, I feel much safer being there. This would also have positive benefits beyond just helping to keep people safer from covid and other illnesses, but also air pollution from things such as wildfire smoke as well. I also feel much safer, like I did at a doctor's appointment I had recently, when the provider wears the highest quality mask available to them.

We should be taking the lessons we've learned from the pandemic (which is still ongoing!) and use it to make decisions that keep us safe year round moving forward. High quality masks and improved indoor air quality are essential to implement.

Thank you.
Cassie Wilson

Boring, OR

No organizational affiliation

---

I have read the studies and it’s clear that an airborne virus isn’t going to go away on it’s own.

N95s are VERY effective against the virus. They need to be mandatory in all hospitals, schools, public transportation, and air planes at minimum but all indoors should include them as well.

HEPAs need to be the standard for all building codes for ventilation. These might one day actually make it possible for us to move past the disease. All buildings need to include HEPA in the hvac systems.

As you well know, we don’t have universal healthcare.

Covid 19 is a precursor to heart attacks, diabetes, dementia, chronic fatigue and many more illnesses. It harms T cells and makes people more susceptible to other sicknesses. You’re playing with people’s lives and you have blood on your hands by not making these things mandatory for over a year. The lack of messaging is extremely dangerous and you are leaving room for conspiracy theories to breed. Do better.
Risa Pedzewick

---

Hello my name is Shanna Washburn

Seattle, WA

I am a healthcare worker

Please update the current recommendations for airborne viral pathogens to reflect the large body of evidence that N95s and Air filtration are effective precautions and should be standard and universal in healthcare settings as well as other settings that are publicly controlled or exist in service of vulnerable populations including school-aged children.

Please update and maintain guidance that promotes infection mitigation at transmission via a multilayered "Swiss cheese" method of precaution taking.

Please update public guidance campaigns with the full extent of risks from covid and updated guidelines for preventing illness and transmission based on currently known transmission vectors (airborne, droplets, etc) and transmissibility (r0)

Thank you

---

Teryn Loebs

Airborne viral infection precautions

Denton TX

Member of the public

I urge you to redraft the airborne viral infection precautions for healthcare workers. Not only does this proposed draft fail to mention any air filtration of any kind, it conflates the effectiveness of surgical masks and N95s, which is simply scientifically inaccurate. The proposed guidelines will endanger our healthcare workers and patients alike. Change the guidelines.

---

My name is Cindy Boutelle, Albuquerque NM, and I am commenting on behalf of myself. I think HICPAC should require respirator masks in healthcare settings as the baseline standard of care during this ongoing airborne pandemic. Surgical masks aren't enough.

A recent letter signed by hundreds of infectious disease experts said, "Surgical masks cannot be recommended to protect health care personnel against inhalation of infectious aerosols." Why does the CDC/HICPAC disagree with this? Or why do they choose to ignore it? The topic of ventilation isn't even being brought up.

My best friend's family member was taken by ambulance to our large regional hospital in May. He presented with shortness of breath and very low blood oxygen and informed paramedics and ER staff that his spouse was sick with Covid in the home. He was not tested for Covid despite a request, he was not required to mask, and he then spent many hours in a crowded ER. What about the healthcare workers and patients who are being exposed and infected constantly in these entirely typical scenarios? Healthcare workers face an increased risk of Long Covid due to their occupational exposure. HICPAC should move into the future by keeping what works, not what's popular.

Thank you for your consideration.

Cindy

---

I am a member of the public who has a lot of health problems with 2 high risk kids. We would like for you to keep n95 masking in healthcare settings and add good ventilation because we do not feel safe to be in any healthcare setting without these in place. I had to go to the ER in July and no one was masked but me. Covid is a SARS virus. Its airborne. Healthcare should keep masks in place because covid isn't going anywhere and high risk people need to have a safe place to seek care. The fact they got rid of masking is insane to me considering they know how bad covid is. Covid is a vascular disease which can cause problems months or years later, long after you have recovered from the initial infection and you certainly dont want repeat SARS infections. Please help keep people safe.

Thank you for listening

Lisa Staake, Monona Iowa

---

To the CDC:

As a community member with loved ones who work in hospitals or are patients who must spend significant time in them, I am writing with grave concerns and outrage regarding HICPAC's recent recommendations. Namely, the assertion that surgical masks are just as effective as N95s when it comes to protecting healthcare workers and patients. This confounds me. Didn't CDC publish the below just last year?

*bit.ly/MMWR7106*

COVID-19 is an *airborne* disease, one of many that can co-exist in hospitals. Rolling back crucial protections like N95 respirators means that you are putting healthcare workers and patients in harm's way. The study that was cherry-picked for HICPAC's recommendations is deeply flawed and must be dismissed. Even without a study, it's obvious that the stronger seals of N95s are more effective than baggy blues.

I would like to amplify the concerns from National Nurses United: "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."

Keep infection control measures in place!

Crystal Le

---

To all concerned,

I understand that it is under consideration to make a dangerous update to infection control policies for healthcare facilities. As one of millions of immunocompromised patients throughout the country and someone who just spent several hours with another immunocompromised family member at an emergency room yesterday, naturally I find this alarming and frustrating.

First, you are not recommending an increase in indoor air quality targets. I urge you to reconsider. Since we no longer have national mask mandates or really any other protective measures, and with my autoimmune liver condition (AIH) it’s pretty much guaranteed that if I get COVID I’ll end up first on a ventilator and then dead, I’d like to think we can do the bare minimum to keep me and others like me safe. On top of that, it costs the healthcare industry less if I keep breathing on my own and stay home - now multiply that savings by millions.

Second, it doesn’t matter if you write it into the rules, we all know the science shows that surgical masks do not provide the same level of protection as N95s or KN95s. Gaslighting is gaslighting even if it’s written into policy. Since masks are no longer mandated, let’s make sure that the people willing to wear them are wearing the safer ones. I do.

The immunocompromised are not a small, fringe group. We are a much larger segment of the population than many realize, and all we are asking for is literally the bare minimum in public and healthcare facility safety measures. We take every precaution we can ourselves and need at least *some* support from our government health officials.

Please reconsider these two measures. Require air quality targets and N95s for healthcare facilities.

Thank you,

Scot Robnett

Bartlett, IL

---

To whom this concerns,

Revoking masking in healthcare settings is incredibly negligent. There are many people that don't have the luxury to get sick such as immunocompromised, high risk people and infants. I am a mother to two high risk children, if they get any illness it's immediate hospitalization no question. We don't have an option to just not go to medical facilities. My toddler can mask but even she knows the doctors should be masking when they examine her. My infant can't mask. My children can't get Covid-19 and long Covid they'd never leave the hospital. Doctors offices and hospitals should be the one safe place. If people don't want to mask at the store that's their choice I don't have to bring my children to the store but I do need to bring them to doctors. Places like this that are non options should be masking. Otherwise they're breaking their code of ethics the whole "do no harm" isn't valid when not masking in fit tested N95 masks that are proven to prevent illnesses aren't being worn because passing an illness can do harm to my children life long harm. Medical facilities should be the one place people should feel safe. Please mandate N95 masks in all medical facilities make them safe places for everyone especially those who don't have options but to access them. Please also make mask's mandatory for anyone entering a medical facility let's stop putting all the responsibility on those who don't have a choice but to be safe.

Thank you from a sincerely concerned mom.

---

To whom it may concern,

Hello, my name is Tessa Forte, a member of the public (address: 2653 W Coyle Ave. Chicago IL), and I am emailing to express my concern for the future of airborne virus mitigation in healthcare settings. Covid continues to cause irreparable harm, and it is well known that proper air filtration and usage of N95 respirators are necessary to negate further spread.

To lessen mitigations is to proclaim a lack of care, not only for immunocompromized/disabled citizens, but for the public as a whole. You need not be immunocompromized for Covid to have lasting effects and/or cause death.

I urge you to make the right call in regards to this topic, and I know my community stands with me.

Thank you for your time.

---

I am formally requesting that N95's be required in hospital and medical office settings. I am a retired social worker, 72, immune compromised, high risk and physically disabled. Covid is airborne. I maintained my Code of Ethics for decades. I have admired, observed and respected all medical decisions predicated upon "Do No Harm". Yet, when my rights to feel safe under the Do No Harm Principle are severely compromised with your planned decision to remove masking

with an airborne virus resulting in high hospital acquired Covid I am compelled to literally beg you to protect me from such a disastrous decision.
As a lowly social worker I dedicated decades of service to others. Please do Not ignore the science about the proven success of masking and vote to continue wearing in all hospital and medical settings. My remaining years and rights to not have them cut short due to unnecessary exposure to airborne infections after decades of serving others is in your hands. Please vote to continue masking in hospital and medical settings so that I can live out my remaining years without fear of exposure for simple preventative care. Thank you.

Judy Graham
Langhorne, PA

---

As we continue to navigate the challenges posed by the ongoing COVID-19 pandemic, I wish to draw your attention to the critical importance of implementing and upholding stringent respiratory virus protective measures within our healthcare community. The threat posed by COVID-19 and ‘long COVID’, particularly the long-term effects and potential for transmission, cannot be underestimated.

We have a moral and ethical duty to ensure the safety and well-being of both our vulnerable patients and invaluable healthcare professionals.

COVID-19 remains a persistent and evolving threat, with 'long COVID' presenting a clear reminder of the virus's enduring impact. The long-term health complications experienced by individuals who have seemingly recovered from the acute phase underscore the need for preventative strategies. Widespread use of N95 masks, along with enhanced air exchange and ventilation systems, represents a formidable defense against the transmission of respiratory illnesses, including COVID-19. The combination of these measures can significantly reduce the risk of both initial infection and subsequent transmission within our healthcare community.

Our healthcare professionals, including nurses, respiratory therapists, and doctors, are at the forefront of patient care. Their unwavering dedication places them in direct contact with various illnesses, making them particularly susceptible to viral exposure. By providing them with the highest level of protection, we not only safeguard their health but also ensure that our facility continues to function effectively during these challenging times. The well-being of our staff is intricately linked with the quality of care provided to our patients.

It is alarming to note that despite the visible threat posed by COVID-19, complacency and underestimation of the risks remain prevalent. We cannot afford to overlook the potential consequences of ignoring these dangers. By prioritizing the implementation of N95 masks and improved air exchange systems, we send a clear message that the health and safety of our patients and staff are paramount.

I urge you to consider these points and collaborate with relevant government officials and agencies to swiftly support these types of basic protective measures. It is imperative that we remain proactive in the face of the persistent threat from COVID-19. Let us lead by example and set a standard of excellence that ensures the continued well-being of all those entrusted to our care.
Thank you for your attention to this matter. Together, we can create an environment that exemplifies responsible and comprehensive healthcare practices.

Steven V. Joyal, MD

Hello, My name is Shelly Paul and I am a member of the public, I reside at 667 Ocean Ave in Brooklyn, NY. In 2020 I, like most of the reasonable population- looked to The CDC for guidance, quoted your findings and advice, and believed that you had our best interests and survival in mind.

That is no longer the case.

It has become increasingly obvious over time that your only concern is keeping the populace under control, making money, and systematically killing and disabling as many marginalized people as you can. That is the message you send when you treat this virus as if it is not the deadly, still very prevalent threat that it is. Most of my chronically ill and immunocompromised friends have literally STOPPED SEEKING MEDICAL TREATMENT due to the fact that medical staff has stopped wearing masks. That is abhorrent- shame on all of you. This “research” about mask usage is EMBARRASSING. Equating surgical masks to N95 respirators when dealing with airborne viruses is like saying sure, doctors should wash their hands- but bubble bath is just as effective as antibacterial soap.

You all have so much blood on your hands and instituting these guidelines will only cause it to turn from a drip to a flood. This is genocide and you will not get away with it. History will remember how you abandoned us- we will make sure of that.

Shame on you.

To the committee members:

Your proposal for mitigating COVID is ridiculous.  N-95 masks are a must and so is the use of air filtration and YOU know it.

It astounds me that people of science can be so nonsensical in their approach to a very dangerous virus.

Stop lying to the people of our country.  Stand on your oath of “do no harm “.  It is truly sad that you think this is debatable.

Barbara Marzette

Hi,

I am writing to express my disapproval of the proposed guidelines for transmission precautions for healthcare workers. These guidelines fail to mention air filtration of any kind, and erroneously equate the efficiency of surgical masks to that of N95 masks. This is grossly irresponsible and not in the interest of public safety. I hope you do not pass these proposed guidelines.
Regards,

Sophia

I was not given the opportunity to describe my concerns to  this meeting. Please find my comments regarding this issue. August 22, 2023

- My name is Andrew Streifel. I worked as a hospital environmental specialist for 50 years, at the University of Minnesota before my retirement in [2018]. My professional

experience has taken me to over 400 hospitals for environmental sources of infections, problem solving ventilation issues, design criteria for isolation and protective environment management issues, etc.. I have authored multiple guidance and reference documents on built environments of hospitals and health care settings. I worked with HICPAC to develop the environmental guidelines in [2003]. I continue to consult on various hospital issues.

- Currently, I see hospitals implementing unproven technology in air handling systems when trying to solve the problem of infectious disease transmission through the air. But these systems (like air ionizers) are not proven to work.
- The reality is that many hospitals fail to periodically ensure their existing ventilation systems work properly. Even top-notch institutions don't validate, don't make sure filters fit, etc. It happens way more often than you realize. A ventilation performance paper was published in June AJIC 2007
- It happens because I see hospital decision makers more concerned about money than protecting patients and staff. The impact of this is that patients get sick along with hospital workers.
- Ventilation is an essential part of infection control and prevention programs. Not just negative pressure rooms, but ventilation across the facility. You need to have a validated system that provides the necessary air change rate and appropriate pressures designed to clean and control of hospital air.
- There are other proven measures that hospitals could implement in terms of ventilation, like validating existing systems, self-closing doors, pressure, airflow direction and local exhaust hoods.
- Too often my consulting involves expert witness for lawsuits that investigate negligence due to lack of maintenance or untrained personnel working on vital ventilation. Because of lawyer client confidentiality such corrective guidance is often lost.
- There are extensive existing guidelines on ventilation that HICPAC should reference in updating its guidance on infection control, like the Facility Guidelines Institute. At U of MN, we wrote a MDH guide on temporary negative pressure isolation rooms during the pandemic preparation response that has been used as a reference around the world.
- It's concerning to me that HICPAC's proposals don't address the role of ventilation in hospital infection control. In my experience, ventilation is foundational to any infection control program. Without appropriate ventilation, patients and staff are at higher risk for infection.

Respectfully submitted

Andrew Streifel

Hospital Environment Specialist

---

Good morning,

I'm a concerned member of the public and I live. I want to leave a comment dissenting against the proposed guidelines for transmission precautions for healthcare workers, and demand that revised guidelines include the need for n95 masks when dealing with seasonal coronavirus as well as mentions of air filtration systems to keep our healthcare workers and the patients they are working with safe.

Thank you,

Jaden Baum

---

To whom it may concern,

My name is Steve Romenesko and I'm a two time liver transplant patient who's immunocompromised, frequently needs to go to the hospital, and is somebody who is at high risk for hospital acquired communicable illnesses. HICPAC's Work Group on the Isolation Precautions Guidance is doing work that terrifies me as a patient and makes me feel like HICPAC and the CDC do not have my best interest as a patient in mind. 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. This means that what you're working towards currently means a higher chance of death for me and people like me when we go to a hospital expecting care and time to get better and heal. 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. 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 and to take steps to ensure safety of patients, healthcare workers, and all stakeholders rather than put us at higher risk.

Thank you

Steve Romenesko

---

Hi there,

I am 34 years old, a mom and healthy but I am high risk for developing cancer. My aunt died from breast cancer in her 50s & my mother had it twice first diagnosed at 38 years old and again in her 50s, my brother just died in January of this year at 38 years old of terminal cancer. I did genetic testing and found that I have an increase risk of developing breast cancer and so I have to go and get MRIs done every year along with a mammogram along with follow ups to make sure that I catch any cancer that may develop early.

Because of my risk I looked into the risk of cancer after having COVID. I came across an article in The American Journal of Managed Care talking with an MD who is CEO of Carolina Blood and Cancer Care Associates told them in both the United States and overseas, they're seeing patients with rapidly progressing cancers of several types, such as breast cancer and renal cell carcinoma that is linked to a COVID infection. Among the patients there was even a 26 year old

with rapidly progressing triple-negative breast cancer after a COVID infection. (read more here: https://www.ajmc.com/view/kashyap-patel-md-sees-link-between-covid-19-and-cancer-progression-calls-for-more-biomarker-testing) Based off this information that means catching COVID even as a healthy 34 year old woman means it increases my risk of developing terminal breast cancer.

Thankfully I have avoided COVID so far. However in the Spring when mask mandates were lifted and I went to my high risk cancer specialist office, not a single person was wearing a mask even the nurses and doctors. What goes through my head is the risk I'm taking on of not only catching COVID but a new COVID variant at these offices especially among immunocompromised patients who as data is suggesting, that the weakened immune system may play a role in spurring mutations of current COVID variants and creating new variants. This is the theory around the origin of the new variant of concern you at the CDC are monitoring BA.2.86. (see https://fortune.com/well/2023/08/18/ba286-bax-highly-mutated-covid-omicron-strain-detected-united-states-pirola-pi-rho-world-health-organization/)

So I'm entering into a cancer specialist office, who sees immunocompromised patients, completely unmasked, exposing themselves and their other patients such as myself to potentially new variants if that immunocompromised person has a persistent COVID infection. My doctors don't seem to be aware of the risk or link of cancer development from the spread of a COVID infection. They follow the CDC guidelines that do not require masks in their facility and do not seem to be keeping them up to date as to the risk of COVID is to those with cancer risk.

Therefore I ask the CDC to reinstate masking in medical facilities especially cancer offices where immunocompromised patients go. We are seeing new variants & increase risk of cancers from COVID, I along with others should be kept safe when going to appointments where there's an increase risk of exposure.

Thank you for your time,

Amber Freeman

---

Dear CDC HICPAC Team,

I hope this email finds you well. I am writing to express my concerns regarding the recently released draft of the update to transmission-based precaution guidelines in healthcare settings. While I appreciate the efforts made in addressing the evolving challenges posed by Covid-19, I have reservations regarding the equating of surgical masks with N95 masks in terms of protective efficacy.

Firstly, it is crucial to emphasize that N95 masks provide a higher level of filtration and a better fit, offering enhanced protection against airborne particles, including respiratory droplets carrying the virus. By equating surgical masks with N95 masks, we may inadvertently create a false sense of security among healthcare workers, potentially exposing them to increased risks of infection.

I strongly recommend that N95 masks be established as the standard for healthcare workers when dealing with Covid-19 patients or in high-risk situations. This will provide them with the utmost protection and contribute to minimizing the transmission of the virus within healthcare settings.

Additionally, I would like to bring to your attention the absence of air filtration standards in the draft update. Adequate air filtration is crucial in reducing the concentration of airborne contaminants and ensuring a safer environment for both patients and healthcare personnel. I urge you to include specific guidelines regarding air filtration systems, ensuring their proper maintenance and regular assessment, to minimize the risk of viral transmission via aerosols.

In light of the evolving understanding of Covid-19 transmission, it is vital that our guidelines reflect the most up-to-date scientific evidence. By addressing these concerns and incorporating N95 masks as the standard and air filtration standards into the final guidelines, we can better protect the healthcare workforce and patients alike.

Thank you for your attention to this matter. I appreciate your ongoing dedication to public health and the well-being of our communities. I am eagerly looking forward to the revised guidelines that incorporate these important considerations.

Sincerely,

Raegan Schultz

Member of the Public

Saginaw, MI

---

I heard you want to drop Covid adequate air filtration requirements in healthcare facilities and also state that surgical masks are the equivalent to n95's?
As scientists you know that last bit is wrong. The first bit is wrong because no one can choose whether or not to be in a healthcare facility. Not staff, not patients. Long covid is common and not only a threat to the healthcare system because we do not have the capacity to care for the newly disabled and have no cure or treatment in sight but also to healthcare staff who we are unable to replace. The disrespect and potential for harm to medical workers alone from this is staggering. Hospitals are also a significant source of community spread, and although others exist (schools, prisons, nursing homes, etc) that we are also not making safe for people forced to be there it does not mean we should ignore public safety in one place we can get the public on board to improve. Our hospitals should be a model for basic infection control, people mimic healthcare workers and environments re safety. I should not have to take Covid rates into consideration when pursuing healthcare. I should not have to be afraid for my parents and my uncle with cancer when they go to get needed treatment. I do not wish to accept rampant and unavoidable nosocomial infection as a given when I am rushed to the ER. We require hand washing in hospitals. We require gloves. We require masks for TB, a much less infectious illness. If we don't clean the air and don't have adequate masking in hospitals where do we have it? There is not one safe public place to breathe indoors in the United States as it is. It is ridiculously negligent to burn through our healthcare workers at minimum. I truly can't believe this is where we're at two highly lethal SARs viruses into this century. We have been lucky with this one so far. There is no guarantee we will stay lucky and losing healthcare staff while repeatedly infecting immunocompromised patients is really not the path to avoiding that risk in the future. We have the technology. It is inexpensive and easy to put into place. Why are we not doing it?

Emily Crowley, citizen
Brattleboro, VT

---

With the CDC, itself, noting that 1 in 5 people who experience acute COVID infections go on to develop long COVID, how is weakening isolation/infection controls helping anyone or anything—including the economy?

Please look everyone raising concerns to you in the eye and tell us you are okay with us becoming disabled or dying? Please look us in the eye and tell us it is okay that we are being forced to choose being risking infection to access healthcare or risking our health in other ways by avoiding getting healthcare.

This is not going to end well for anyone. Or for the economy for that matter.

You have the power to change this.

You have the power to truly educate the public on what exactly we are risking when we risk catching COVID. You have the power to push for cleaning the air and for making healthcare accessible by requiring masking in healthcare institutions.

You have the power to turn this around.

Please use that power.

Sincerely,

Maria
Maria Giffen-Castro
US Citizen and Voter
Hackensack, NJ

---

Dear HICPAC and CDC officials,

I am an HHS civilian employee at the FDA, and I urge the CDC and HICPAC to reconsider their guidance regarding infection control in healthcare settings. Recognizing and enforcing airborne precautions is vital for saving lives, reducing long COVID cases—for which we have no cure—and ensuring safer healthcare for all.

We are being forced to delay much needed medical visits due to the high likelihood of acquiring COVID-19 in hospitals and other healthcare settings. I have heard too many stories of patients going in for routine visits who are already at high risk for severe outcomes and then are infected and subsequently disabled from seeking healthcare.

In an ongoing airborne pandemic, mask mandates should be the minimum healthcare standard. Failure to institute these protections is negligence.

HICPAC must acknowledge the airborne nature of SARS-CoV-2 and implement measures like high-quality respirators, better air filtration, and ventilation. For example, a surgical mask does not offer the same protection as an N95 respirator, yet this is what

the potential guidance from HICPAC proposes. Also, CDC's isolation precautions guide global healthcare practices, so every word from HICPAC and the CDC matters.

Airborne precautions such as these are smart for business, too. They mean fewer sick days, fewer workers who are disabled by COVID-19 (and other airborne illnesses such as influenza and RSV), less strain on our already stretched healthcare system, and improved health outcomes. That's why we saw the leaders at the World Economic Forum in Davos take every available precaution to keep themselves safe.

Please act swiftly. High-quality respirators (e.g., N95 or P100), ventilation, and air filtration are desperately needed to protect patients and healthcare workers. Even with limited data, it’s clear that we are only in the beginning of a surge in COVID-19 cases, right when schools are back in session and when we have a constellation of concerning new variants (especially BA.2.86) circulating through the population unchecked. Worldwide hospitalizations are up by a staggering 80 percent. This is the worst possible time to water down guidelines. We are desperate for protection and deserve better.

CDC's duty is disease control—and doctors’ duty is to do no harm. Our lives depend on your decision-making. Thank you for considering my comment.

Sincerely,

Rachel Unger

Silver Spring, MD

---

Cassandra Christine Peck

Air Filtration/Minimum Mask Type in Healthcare Settings

Mountain Home, AR

Comment:

The new proposed guidelines for disease transmission between healthcare workers and also to patients is disturbing. Your new draft fails to mention any air filtration guidelines and also equates the efficacy of surgical masks to N95 masks. This is obviously not adequate nor is it factual. The general public as well as myself are against this.

Personally, as a disabled person with Pots, fibromyalgia, hypothyroidism, etc, I could be killed by these new proposed guidelines. Immunocompromised folks, as well as cancer patients are regular hospital/office patrons. What are they supposed to do, forgo treatments and checkups/scans?? Please reconsider your new drafted guidelines and keep the disabled in mind . We aren't worthless.

Thank you,

Cassandra Peck

---

Good morning,

My name is Jordan Parshall and I am a private citizen of Columbia, Missouri who supports the People's CDC.

I'm writing because the CDC is leaning toward weakening infection control with proposed changes, and I am strongly opposed to this for a number of reasons. As National Nurses United has stated, one of the main reasons is that the proposed changes to the 2007 Isolation Precautions guidance have not been thoroughly discussed with all relevant 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. National Nurses United lists 5 more important and relevant reasons, and I ask that all of these things be taken into consideration and that the newly proposed guidance not be put into effect. People's lives and our country's welfare are at stake.

Thank you,

Jordan Parshall

---

To whom this concerns,

Revoking masking in healthcare settings is incredibly negligent. There are many people that don't have the luxury to get sick such as immunocompromised, high risk people and infants. I am a mother to two high risk children, if they get any illness it's immediate hospitalization no question. We don't have an option to just not go to medical facilities. My toddler can mask but even she knows the doctors should be masking when they examine her. My infant can't mask. My children can't get Covid-19 and long Covid they'd never leave the hospital. Doctors offices and hospitals should be the one safe place. If people don't want to mask at the store that's their choice I don't have to bring my children to the store but I do need to bring them to doctors. Places like this that are non options should be masking. Otherwise they're breaking their code of ethics the whole "do no harm" isn't valid when not masking in fit tested N95 masks that are proven to prevent illnesses aren't being worn because passing an illness can do harm to my children life long harm. Medical facilities should be the one place people should feel safe. Please mandate N95 masks in all medical facilities make them safe places for everyone especially those who don't have options but to access them. Please also make mask's mandatory for anyone entering a medical facility let's stop putting all the responsibility on those who don't have a choice but to be safe.

Thank you from a sincerely concerned mom.
Jessica Vecchio of Connecticut

---

Hello,

My name is Mo Orbach. I have long COVID. I don't just lead with this statement because it's relevant- my condition has become the dominant obstacle and condition of my life. Before I caught COVID, I worked as a teacher, took walks often, and had a full and healthy social life. I masked everywhere, because I suspected what COVID would do to me, and I knew what it could mean for my loved ones. That means I had to leave my workplace for lunch. That means I have not been to the dentist for three years. Even with these precautions, I got sick. One-way masking is not and never has been enough to prevent viral spread.

My body is still suffering from new soreness, fatigue, and pain since my bout with COVID. A mounting body of evidence suggests that COVID attacks the body on multiple fronts, and I may not know the full impact of this disease even now. I tell this story because it is not unique. I am not in my 60s. I turned 25 a month ago. I did not contract COVID in 2020- I contracted a supposedly milder mutation, a more recent one, in January of **this year**. People of any age can be debilitated and disabled by this disease. Still. Now.

One of the few reasons I still exist in public is for healthcare. I now need the care of an endocrinologist, as I have been diagnosed with hypothyroidism (soon after my infection). I see a physical therapist to manage pain and soreness to the point where I can perform daily activities. I have an ENT doctor/allergist who helps with my respiratory symptoms. Attending the doctor is a nerve-wracking process; I, by necessity, walk into a space where patient masking is no longer mandated, where I am subjecting myself to possible or probable reinfection, which hopefully won't kill me, just further degrade my quality of life. The guidelines this committee has proposed ignore expert advice, and will only serve to prevent people like me from seeking medical care at all, or to endanger us in the spaces we most need protection.

The proposal of a more “flexible” approach to implementing precautions that recommends only minimal protections and allows health care employers full discretion to write infection control plans enables employers to refuse to provide necessary protection for patients and workers. This much has been demonstrated when the CDC adopted these protocols in 2020, based on cost considerations. Cost-cutting is not worth patient or provider lives.

I strongly 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.

This approach includes assessments that evaluate levels of exposure, select appropriate control measures (including PPE) for each job, task, and location, and result in a written, formalized, exposure control plan following the hierarchy of controls.

Please don't kill us,

Mo Orbach

---

I am writing to urge HICPAC to implement guidelines that recognize the risks of airborne transmission of Covid and other viruses, increase indoor air quality, and recommend respirators (such as N95s) over surgical masks.

I am a disabled parent of children who have chronic health conditions and disabilities; we are all at higher risk of severe Covid and Long Covid. One of my children cannot mask consistently due to his disability and cannot take personal responsibility for his own protection from viruses. He relies on others to help keep him safe. All of us have delayed and missed medical care because of concerns of being infected by Covid in medical facilities. Policies that ignore airborne transmission of pathogens and put the burdens of advocacy and protection solely on disabled people like ourselves have created barriers to our medical care.

Please make sure your infection control guidance protects families like mine from airborne viruses and makes medical facilities accessible and safe for everyone.

Kim-Loi Mergenthaler

Burlington, VT

Dear HICPAC members,

The CDC has an opportunity to put patients first and implement science-based infection control when updating the guidelines for infection control in healthcare settings.

I lost a family member to hospital-acquired COVID-19. Millions are dealing with long covid. This is no time to be weakening standards.

Please, change course and recommend *improvements* in defending against aerosol-transmitted diseases: respirators, better ventilation, UV disinfection, and HEPA filtration.

In your hands,

Anne Larcom

Private citizen

Champaign, IL

HICPAC has begun work to revise the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. I am concerned, based on work group presentations at the June 2023 HICPAC meeting, that the revised CDC/HICPAC guidelines will severely weaken protections for health care personnel exposed to infectious aerosols, including SARS-CoV-2. They do not adequately provide for the proper control measures – isolation, ventilation, and NIOSH-approved respirators – to protect against transmission of infectious aerosols. I urge you to fully recognize aerosol transmission in the upcoming revision to ensure patient and health care worker protection.

Signed

Matthew Glassman

Hamilton, NJ

Greetings,
I am writing to share my profound disgust with the proposed standards that equate surgical mask with the effectiveness of N 95s. This is a ludicrous proposal. There are many other faults with your proposed new guidelines. To think that my government, our government is looking at rising wastewater rates of Covid, increases in hospitalization, and, which surely will be an increase in excess deaths and things hey, we should craft a message that Covid is not airborne and a flimsy blue mask is all anybody needs if they want to wear it. Why mask are not required, excuse me, and 95s or more efficient masks, are not required in all healthcare settings not to mention public schools, etc. is a mystery that will befuddle historians till the end of time. I pray that you take heed of the many comments you have gotten that are science based, not based on the bottom line, and that come to your final vote of the full HICPAC board, does the right thing and mandates quality masking in all healthcare settings, all workplace settings, schools , and any other indoor environment where crowds will gather. As a bonus comment, I would be like to see a return to widespread and free quality testing. Finally, can we please get some work done on getting a nasal vaccine thaT NOT only prevent serious illness, but WILL actually block transmission.
Regards,

Joe Corey
Franklin, MA

---

To whom it may concern,

I'm writing to express my strong opposition to the potential weakening of masking requirements and infection control measures in healthcare. My mother is a recent survivor of breast cancer and our dear family friend is currently undergoing intense treatment for melanoma. It would be absolutely unacceptable if they contracted COVID during their hospital stays, as this would make their cancer battles exponentially more difficult. If the CDC weakens masking practices and infection control, they will be flagrantly contravening the Hippocratic oath to do no harm and will guarantee that patients get sicker when they go to healthcare centers for treatment.

I urge HICPAC in the strongest possible terms NOT to weaken the masking and infection control measures in healthcare!!!

Sincerely,
Kristina Warren
Providence, RI

---

**Comments of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO.CLC (USW) on the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) work to revise the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**

**August 23, 2023**

These comments are submitted on behalf of the more than 50,000 members of the health care sector in the USW. 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. Consequently, some health care employers avoided providing necessary protection for health care personnel and patients, based on cost considerations. Employers are responsible for infection control plans; they must be based on science.

We 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 must 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. HICPAC and the CDC must ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

***Ventilation Strategies:*** *The guidance must prioritize the implementation of ventilation systems designed to remove aerosolized viral particles and other pathogens from healthcare settings. This includes advocating for the utilization of negative pressure isolation rooms and other engineering controls. Proper ventilation is a fundamental component in preventing airborne*

*transmission, and its inclusion in the guidelines is crucial to the safety of healthcare workers and patients.*

***Personal Protective Equipment (PPE):*** *Healthcare workers at the frontlines of patient care must be equipped with adequate respiratory and eye protection when attending to patients with suspected or confirmed respiratory infections. The guidance must emphasize the importance of providing and consistently using PPE. This not only ensures the safety of the workforce but also reduces the risk of cross-contamination within healthcare settings.*

***Safe Staffing Considerations:*** *Staffing levels are the bedrock of effective infection control and prevention. The updated guidance must explicitly recognize the indispensable role of safe staffing in healthcare facilities. It must refrain from allowing healthcare employers to compromise essential protective measures due to staffing concerns. The well-being of both healthcare workers and patients should never be jeopardized due to inadequate staffing levels*.

We must maintain or enhance respiratory protection standards, given the recent shared experience during a global pandemic. Worker safety must always be a top priority, and any updates to guidance must be based on sound scientific evidence and expert consensus. Additionally, we promote the enactment of strong permanent infectious disease prevention standards in which the workers and their representatives have active and meaningful participation. Consequently, transparency in the decision-making process is crucial to gaining the trust of healthcare workers and labor organizations. The involvement of stakeholders, including representatives from labor organizations, in the review and update of guidelines can help ensure that the adopted standards are in the best interest of all parties involved. We urge HICPAC and the CDC to fully recognize aerosol transmission (inhalation of small infectious particles) to ensure health care worker and patient protection.

The USW advocates for maintaining stringent respiratory protection standards for healthcare workers, emphasizing transparency, stakeholder involvement, and a thorough evaluation of scientific evidence in any decision-making process related to updating isolation precautions.

Respectfully submitted, Juan A. Zuniga

Safety and Health Specialist

Health, Safety and Environment Department

United Steelworkers

Tamara Lefcowitz

International Coordinator

Health Care Workers Council

United Steelworkers

---

Fen Arson King

How you're deciding to ignore science and safety regarding SARS-COV-2

1460 Johnstown ln

Wheaton IL 60189

Dear CDC Team,

I hope this letter finds you well. I am writing to express my concern about the notion that we can simply ignore the threat posed by the SARS-CoV-2 virus. While I understand that there might be discussions about the future trajectory of this pandemic, I firmly believe that dismissing its significance would be a grave mistake. There are several compelling reasons why we must continue our efforts to combat this virus:

Public Health Impact: The COVID-19 pandemic has already demonstrated its potential to overwhelm healthcare systems, cause severe illness, and result in significant loss of life. Ignoring the virus would leave vulnerable populations exposed to the risk of infection, leading to more hospitalizations and fatalities.

Variants and Mutation: Viruses like SARS-CoV-2 can mutate over time, giving rise to new variants with potentially altered transmission rates, severity, or vaccine resistance. Ignoring the virus could allow new variants to emerge unchecked, potentially rendering current prevention and treatment strategies less effective.

Global Interconnectedness: In our interconnected world, diseases can spread rapidly across borders. Ignoring SARS-CoV-2 could lead to continued international transmission, affecting countries with varying levels of healthcare infrastructure and potentially causing new waves of infection even in regions that have achieved containment.

Long-Term Health Implications: Research has shown that even mild or asymptomatic cases of COVID-19 can result in long-term health issues, commonly referred to as "long COVID." Ignoring the virus would mean neglecting the health and well-being of those who may suffer from these persistent symptoms.

Economic and Social Disruption: The pandemic has had profound economic and social repercussions. Ignoring the virus could prolong the disruptions to businesses, education, travel, and overall societal functioning.

Vaccination Efforts: While vaccines have proven to be a crucial tool in controlling the spread of the virus, ignoring SARS-CoV-2 could hinder vaccination efforts. Vaccine hesitancy may increase, and booster shots or updated vaccines might be required to address new variants, all of which would be challenging if the virus is not taken seriously.

It is essential that we maintain a vigilant stance against SARS-CoV-2 and continue to prioritize public health measures, surveillance, testing, and research. By doing so, we can mitigate its impact, safeguard vulnerable populations, and work towards a future where the virus is under control.

I commend the CDC's tireless efforts in managing this pandemic and appreciate your dedication to the well-being of the nation. I strongly urge you to continue emphasizing the importance of addressing SARS-CoV-2 and to ensure that science-based decisions guide our approach to its containment.

Thank you for your attention to this matter. I am hopeful that together, we can overcome this global challenge and emerge stronger as a society.

Sincerely,

Fen Arson King

This is Rosana Mayer-Conroy

I am strongly against weakening the guidelines to protect hospital staff & patients against airborne infectious diseases.

Unless N95s and high quality air filtration become the norm, too many citizens as well as healthcare workers will become disabled by covid, something no one can afford.

The healthcare system is already dangerously strained as it is. Please do ypur job and actually commit to fighting disease.

---

Sara King

loosening guidelines on airborne pathogens like SARS-COV-2 is a mistake

Wheaton, IL

Member of the public

Dear CDC,

I hope this letter finds you. I am writing to express my deep concerns about the recent decisions to loosen guidelines pertaining to airborne pathogens, particularly in the context of SARS-CoV-2. While I understand the need for flexibility as new information emerges, relaxing guidelines at this juncture will be a mistake with severe consequences.

The COVID-19 pandemic has reminded us of the devastating impact that airborne pathogens can have on public health and safety. While progress has been made through vaccination efforts, it is important to acknowledge that the virus still poses a threat, especially with the emergence of new variants. And that almost none of the population in vaccinated. (Please remember that the point of vaccines is to obtain heard immunity by having enough people vaccinated.) Loosening guidelines will lead to increased transmission rates and put the entire population at risk.

Furthermore, recent research suggests that SARS-CoV-2 can remain airborne for extended periods, particularly in indoor settings with poor ventilation. The potential for aerosol transmission makes it imperative to maintain robust guidelines to prevent the virus's spread. By doing so, we can ensure the safety of healthcare workers, essential personnel, and the general population.

I urge the CDC to consider a cautious approach when revising guidelines related to airborne pathogens. As we strive to move beyond the pandemic, prioritizing public health and safety should remain paramount. Continuously monitoring and adapting guidelines based on the latest scientific evidence will help prevent potential outbreaks and protect our communities.

---

Hello,

My name is Faith Lyons and I live in Denver, CO. I work at Denver Health, a nonprofit hospital in the Denver metro area. I conduct public health research and I am concerned citizen with personal interest in keeping myself and my community safe.

I strongly disagree with the proposed airborne viral precautions as you have recently outlined. Use of N-95 masks and air filtration systems should be basic and standard practice across the board. I urge you to reconsider for the sake of everyone's safety, as COVID is still an ongoing health issue. These precautions protect us all.

Thank you,

Faith Lyons

---

Hello!

This email is for the secretariat of the Healthcare Infection Control Practices Advisory Committee regarding the proposed guidelines for transmission precautions for healthcare workers.

My name is Elizabeth, I'm a member of the public and a parent of two, a 9 year old boy and a 7 year old girl. With the upcoming start of school, we're doing what most families are doing - scheduling checkups, shopping for school supplies, and trying to get our summer sleep schedules back under control. I'm also doing what many other parents are doing; every morning I check my county's coronavirus wastewater monitoring data page, hoping that it will update more than once every couple of weeks, to see if I should risk taking them grocery shopping with me. If the charts say that levels are climbing, I'm hoping that I don't have to turn down any playdates or birthday party invites...the most painful part is that both of my kids *understand* why we have missed out on so many events.

I count myself lucky that we've had so few brushes with covid when most of our friends have had far worse experiences...but it's really not so much luck, as it is our strict adherence to proven risk mitigation. We don't do indoor shopping or gatherings without proper air filtration. We ALWAYS wear a kn95 or n95, never surgical masks or cloth masks. We take testing seriously and we constantly remind our friends and family about how these basic steps do so much to lower risk. However, there are some situations that are unavoidably risky, no matter what precautions I personally take.

Those checkups that I have to schedule...how can I be confident that my healthcare provider is doing all they can to keep us safe when we HAVE to share space with the people who are currently sick? Even if WE follow every step perfectly to protect ourselves, how can I relax if the hospital itself isn't doing everything to that end? How can I stop worrying about my friends who WORK in the healthcare industry who are seeing their coworkers not masking and can't do anything about it?

Please revise your guidelines to fit what is actually effective. Air filtration MUST be a priority with this airborne virus, it's known to be a powerful tool in lowering transmission. Surgical masks are completely ineffective in protecting against covid and the guidelines should reflect that as well. If the guidelines are updated to utilize effective strategies, we can make healthcare spaces safe for everyone! For the sake of my community and my family, I hope you'll listen to science and to the public.

Thank you so much for your time! Sincerely,

Elizabeth Seeger, concerned member of the public

Eau Claire, WI

Hello,

Please, for the sake of our community's health and well-being, keep the Covid precautions where they are now. Why lower the healthcare standards?? Who does thus actually benefit?

Thank you for your consideration,
Margaret King

Hello, I'm Courtney Shea, a member of the American public that the CDC is supposed to serve and protect.

Weakening airborne viral protections within healthcare settings is dangerous. We are YEARS into the COVID-19 pandemic. While deaths have decreased, long-COVID infections are on the rise as many precautions have been taken away from public settings.

We need to keep healthcare settings safe and equitable. Disabled and immunocompromised patients should be able to receive healthcare without risking their health/life further.

Please keep masks in healthcare; surgical masks do little prevent spread. Endless studies within recent times have proven the KN95 and N95s are the most effective at decreasing spread. Surgical masks just do not cut it anymore.

Air filtration is CRITICAL for healthcare settings. This should be standard period. It will only serve to protect healthcare workers and patients alike. We are in a healthcare crisis where there is not enough staffing.
We must protect the workers from becoming sick. Community care is the only way to ensure safety.

Thank you for your consideration,

***Courtney Shea***
**Sterling Heights, MI**

Hello, I'm Mark Smak, a member of the American public that the CDC is supposed to serve and protect.

Weakening airborne viral protections within healthcare settings is dangerous. We are YEARS into the COVID-19 pandemic. While deaths have decreased, long-COVID infections are on the rise as many precautions have been taken away from public settings.

We need to keep healthcare settings safe and equitable. Disabled and immunocompromised patients should be able to receive healthcare without risking their health/life further.

Please keep masks in healthcare; surgical masks do little prevent spread. Endless studies within recent times have proven the KN95 and N95s are the most effective at decreasing spread. Surgical masks just do not cut it anymore.

Air filtration is CRITICAL for healthcare settings. This should be standard period. It will only serve to protect healthcare workers and patients alike. We are in a healthcare crisis where there is not enough staffing.
We must protect the workers from becoming sick. Community care is the only way to ensure safety.

Thank you for your consideration,

***Mark Smak***
**Sterling Heights, MI**

---

Dear HICPAC Committee,

I am writing to urge the committee to recommend both increasing indoor air quality in healthcare facilities and to recommend (or better, require) masking with N95 masks.

Indoor air quality poses a risk to everyone, especially in healthcare facilities where people are coming in sick. Twelve air changes per hour (ACH) would hinder the spread of so many infectious diseases -- flu, measles, colds, and yes, Covid. Patients are coming in with these viruses, coughing and sneezing and exhaling aerosolized viral particles into the air, and then the clinician and the next patient in the room gets to breathe them all in. Increasing the ACH would prevent illness among staff and clinicians as well as patients, reducing the burden on healthcare facilities to pick up the slack for staff and clinicians out sick.

Surgical masks were meant to block large particle droplets, splashes, or sprays. Covid is none of those--it is spread via aerosol. Only N95 masks can adequately prevent the spread of aerosolized viral particles. Surgical masks, therefore, are completely inadequate for source control and leave patients vulnerable to infection from aerosolized viruses. Given that many people have asymptomatic but still contagious Covid infections, high quality masks must be recommended for all, and especially for providers seeing many patients, in healthcare facilities.

As a high-risk patient with chronic illness, I am avoiding getting the healthcare I need because I cannot risk acquiring a Covid infection at the doctor's office. When I've called and asked if staff and providers could be wearing high-quality masks for my appointments, the response was lukewarm at best. The only thing I can do to protect my health at this point is to not get the care needed for my health. As you can see, that's a nasty catch-22.
Please recommend increasing the safety of indoor air quality in healthcare facilities to twelve air changes per hour and wearing of N95 masks as source control. Please make it safe for disabled, immune compromised, and high risk patients to get the healthcare we need.

Sincerely,
Cat Stolz
Woburn, MA
No organization affiliation

---

Hello.

My name is Dominika and I am an Illinois resident. I am writing to provide feedback regarding the CDC's newly proposed infection control guidance for healthcare facilities.

I was disappointed to hear that the new guidelines under consideration do not include recommendations for improving indoor air quality. By not issuing Indoor Air Quality targets for all healthcare facilities, the CDC is leaving immunocompromised and chronically ill Americans much more vulnerable to life ruining and care interrupting airborne infections. If all healthcare facilities had ventilation of 12 air changes per hour or an equivalent level of HEPA filtration, patients could seek care with more confidence. They could seek care without worrying as much about a hospital acquired airborne infection derailing their care, causing complications, killing them, or saddling them with new long-term illness or disability. In a post-Covid world, we must keep up with the latest research and invest in long-term solutions that will keep patients safe from the ongoing threat of Covid-19 and other airborne pathogens.

Just as people had to fight for water sanitation to address waterborne diseases, we must now advocate for ventilation and air filtration to address the problem of airborne disease transmission. And just as we made great strides in disease prevention thanks to clean water, I believe that we can do the same with clean air. I hope that the CDC will take an active role in leading these efforts to improve air quality for all patients at American healthcare facilities, from the temporarily ill to the most vulnerable immunocompromised patients.

Sincerely,
Dominika Koziol
Des Plaines, Illinois
No org affiliation

---

My name is James Sackett, a normal citizen. I am writing regarding the recent proposed changes to the recommendations for transmission precautions of airborne viral infections in a health care setting. I strongly suggest air filtration and n95 masks remain in the recommendation. Surgical masks are ineffective to protect the wearer, who in this case is the uninfected party. Clearly the proposed changes are either politically motivated, or the result of corporate profit driven influence. The CDC decisions should be evidence based and motivated to prevent the spread of disease, not based one political or corporate biases. Please do your job.

James Sackett, member of the public.

Tucson, AZ

---

Members of HICPAC,

I urge you to reconsider your proposed weakening of infection protection standards.

Your proposal ignores the science of airborne virus transmission, flouts decades of advances in aerosol science, and dismisses advances in infection control that have been confirmed in the past three years of the pandemic. HICPAC should incorporate universal masking into standard precautions across healthcare settings and recommend the use of N95 respirators broadly.

Policies need to be developed with the input of impacted stakeholders, such as health workers and patients. I am concerned that the CDC will soon profoundly weaken its Infection Control guidance which could place health workers and patients at risk of short- and long-term harm and even death from infectious diseases. Universal masking is a simple measure to reduce the risk of infectious disease transmission that has been implemented broadly in healthcare settings

for the last three years. HICPAC should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators.
Sincerely, Evan Preston, Washington, DC
Hello HICPAC,

In accordance with the opportunity to provide written comment on the revision of the CDC's *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, please find below my message of individual support for the Nurses United points of feedback.

Personally, I think it's a bit of a misnomer to call the agency a Center for Disease "Control" if revised policies on disease transmission don't address the fact that COVID is airborne in aerosols. Inadequate ventilation and use of high quality respirators in healthcare settings, as currently outlined in the latest HICPAC plan, basically *guarantees* that the disease will be OUT of "control" in healthcare settings.

More specifically, 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 hope you will seriously reconsider this gap in the current proposal, for the sake of workers and patients all around the country.

While many people want to pretend we are "post COVID," the current wastewater data says otherwise.

Sincerely,
Lizzie

---

Hello,

Please do not lower safety precautions for healthcare workers. The fact that this is even being considered is abominable. COVID-19 has killed nearly 7 million people, and you want to lower safety precautions for the people who have worked endlessly to keep this virus at bay? And to do so without consulting respiratory experts, OSHA, or others with interests in this matter? How dare you. If these 'precautions' pass then the people who die will be your fault. Their deaths will be on your hands. Do not do this.

Anna Brenner

---

To Whom It May Concern,

As an immunocompromised individual I am deeply concerned by HICPAC's proposed guidance and the overall failure of the CDC to implement science based mitigation measures to control and track the spread of COVID-19 in our communities. You have the responsibility to make

healthcare settings accessible to ALL— especially medically vulnerable people. High quality masks must be required by all personnel and we must invest in proper ventilation.

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,
Mary Sullivan
State College, PA

---

After nearly four years of COVID, HICPAC should acknowledge we have insufficient infection control, and prepare guidance that limits harm done to patients in medical facilities. Why instead does this committee insist on weaking infection control guidance?

This committee cannot ignore the objective research demonstrating the airborne nature of SARS-COV2 and other viruses, and the documented prevalent issue of hospital acquired infections.

Having lived through the last four years of millions of deaths, hundreds of millions suffering long-term, medical care providers quitting in droves, facilities being understaffed from constantly sick staff members - how does this committee think that weakening infection control will serve to benefit patients or staff?

Patients seeking routine medical visits or care for other issues are leaving their doctor's office with COVID-19, putting them at extreme risk of heart, brain, lung, liver, and kidney issues, diabetes, blood clots, strokes, and immune system damage. How is this healing? How is this providing medical care? How are severely ill folks supposed to improve or seek care? How are cancer patients supposed to win their battles with their already drug-induced weakened immune systems?

Fit-tested N95 respirators need to be the bare minimum for all healthcare workers. Proper air filtration and ventilation is equally crucial. These are proven methods at reducing or eliminating virus-laden aerosols in the air.

Anything less than that contributes to the spread of deadly and disabling airborne pathogens. There is no excuse for this committee or the CDC to not acknowledge this information. Your duty is disease control, and medical providers take an oath to do no harm. Let's live by those duties and keep patients and our healthcare workers safe.

Thank you,
John Kowalski

---

Hello,

My name is Allison Criswell of Tacoma, WA. I have no affiliation but am acting as a member of the public, please consider this my public comment on this topic "Airborne Viral Precautions in Healthcare Workers".

On behalf of my community I am reaching out to tell you that I am extremely concerned about the proposed changes to the airborne viral precautions for Healthcare workers.

The lack of mention of any kind of air filtration and relaxed precautions surrounding KN95 masks is of extreme concern for not only our healthcare workers but vulnerable community members which are much more likely to be in a hospital setting to begin with.

Treating this as a common cold and doing the least possible to protect the public is reprehensible and this decision could literally kill people.

I dissent against this proposed draft as it would not be in the best interest of **all** Americans. Including each and every one of you on this committee.

Do the right thing. We implore you. We are watching.

Best,
Allison Criswell.

---

Hello,

My name is Julia Patterson. I live in Rutland VT. I am a member of the public.

I was in attendance at today's HICPAC Video Conference (August 22, 2023). I am not affiliated with an organization.

As I (and many others) were not able to give comments during the meeting, here is my comment:

I'm asking that HICPAC/CDC recommends N95 masks in healthcare settings. We know that Covid is aerosolized and that quality masking is a necessary mitigation step in the ongoing pandemic. As many other commenters noted, quality ventilation and filtration in healthcare settings are absolutely necessary. However, it's important to note that upgrading HVAC systems can take time and money. To mitigate the spread of viruses immediately, N95 masking is crucial.

I work and study full-time, and I quite literally cannot afford to get sick for two weeks. I find myself putting off routine and necessary doctor visits because I cannot afford to get sick. Choosing between my income and education or my health is not a fair choice. I'm also extremely concerned as Covid-19 is surging across the country. We know this from an increase in hospitalizations, rises in wastewater and test positivity data, and anecdotally from friends, family, and medical workers. We also know from the past three years of experience that respiratory illness rises during this time. I'm extremely concerned for my immunocompromised and elderly friends and family. I don't want my 87-year-old grandma to go to a routine doctor's visit and end up with any virus. Healthcare should be a place where people heal not become vectors. This is why quality masking with N95s is necessary.

Thank you,

Julia Patterson

My name is Kae Jackim and I am writing you to implore you to revise your proposed guidelines for transmission precautions for healthcare workers. There is zero mention of air filtration or N95 masks in these proposed guidelines and it is negligent at best not to include these as standards in the healthcare environments. Surgical masks are not effective enough in stopping the spread of Covid, it needs to be N95 masks or you aren't protecting the people at risk.
Without these basic and necessary tools to protect against Covid, people will be unable to receive medical care if they are immunocompromised or disabled. You would be striping away our basic human right to safe medical care by refusing to make N95 masks and air filtration standard. At risk populations and even those at less risk of contracting Covid deserve healthcare without the fear of catching a disabling virus that is still killing and disabling people to this day. This pandemic is not over and the negligent handling of Covid by the CDC has dissolved any confidence the public had in the CDC's ethics and trust. Your organization has become eugenic and ableist at best and as a member of the public I will not stand for it.
Do your job and protect Everyone. Make N95 masks and air filtration systems standard for healthcare environments.
Again my name is Kae Jackim and I am a member of the public commenting on your newly proposed guidelines for transmission precautions for healthcare workers. I live in Corvallis OR.

The public, myself included, has already pleaded with your committee to make these things happen. We are begging you to make this happen to keep us safe in healthcare settings.
Thank you for your time,
I will be looking forward to the next draft of guidelines for these critical and necessary revisions.
-Kae Jackim

**Anne Miller, Executive Director, Project N95, Brooklyn NY**
**Topic: Project N95 Statement Regarding the Healthcare Infection Control Advisory Committee (HICPAC) Updates to CDC Isolation Precautions Guidance**

Project N95 is a national nonprofit organization with the mission of equitable access to respiratory protection for all people: healthcare workers, patients, and the general community. We call for the following common sense, science-based changes to be made by HICPAC regarding its isolation precautions guidance to CDC:

1. HICPAC must rethink its approach to infection control in healthcare settings. Policies must be comprehensive, actionable, and grounded in science. Policies must be centered on the people they impact.
2. Policies must be made with transparency. The CDC has struggled through the pandemic to maintain trust as a public health leader. Transparency is an opportunity to start to regain that trust.
3. The HICPAC voting panel should be expanded to include experts in aerosol transmission, workplace safety, NIOSH, and health communication specialists.
4. HICPAC guidelines must acknowledge the fully airborne nature of COVID. Thus far, HICPAC acknowledges airborne spread is possible in limited situations, but has not yet declared COVID-19 to be a fully airborne pathogen requiring universal airborne precautions.
5. HICPAC guidance for worker protection in infectious settings must be multi-faceted and layered. The guidelines should include respirators, ventilation, isolation, germicidal UV, and others to reduce infection transmission.

6. Respirators (N95s or better) should remain an important mitigation measure to protect our healthcare workforce as well as patients, including those at high risk for severe disease.
7. Surgical masks do not provide protection from aerosols as demonstrated by the preponderance of the evidence.
8. Cost is no longer a barrier. N95 respirators are nearly as inexpensive as surgical masks now and can be acquired in large quantities at very low prices.
9. Preventing healthcare provider infection is vitally important in maintaining the capacity of an already severely strained healthcare system.
10. Maintain a *simple* approach in the updated guidance. Guidance should be clear and explicit about the precautions that are needed to protect healthcare personnel, staff, and patients from infectious diseases.
11. Patient advocacy should start with healthcare institutions. Infection prevention policies should not place the burden of advocating for patient safety on patients. Policies that require patients to request that their providers wear a mask are burdensome and reduce the amount of protection available to vulnerable patients.

--
Anne Miller
Executive Director
Project N95

---

Hello,

My name is David. I live in Denver, Colorado.

I am extremely disappointed in these proposed reductions in healthcare workplace precautions regarding COVID and other airborne pathogens. As someone who works in a laboratory in conjunction with multiple hospitals, these reductions in public safety would put several people at risk. Not only healthcare workers, but patients, laboratory workers such as myself, and their families.

Please consider the negative outcomes of these reductions in pathogen precaution on us, the American people, before deciding to proceed with them.

Have a good rest of your week,

David Ceja Galindo
Research Assistant at the University of Colorado - Anschutz.

---

Hello, my name is Katarina Schumann, I live in Austin Texas & I'm writing you today as a member of the public to voice my concerns over the new proposed HICPAC recommendations regarding COVID-19 precautions in healthcare.

Over the past three years we've seen a watering down of COVID precautions while people continue to become sick, disabled & die. Healthcare facilities should be one of the places that everyone can go to & feel safe, wether they're high risk for COVID or not. Lowering precautions in terms of air filtration & the quality of masks recommended will put more people in harms way.

Please do the right thing, thank you

- Katarina

I am a concerned citizen writing to the Secretariat to express my and my friends' and family's displeasure at the new HICPAC advice informing the new CDC guidelines on masking in healthcare environments. There is ample evidence that plain surgical masks **do not** provide an equivalent measure of protection as N95 masks and respirators, but rather much less.

As new, more lethal and transmissible SARS-CoV-2 strains spread across the world at frightening rates, HICPAC needs to seriously consider it's role in the future of American public health. Does HICPAC want to be directly responsible for the continued death and suffering at the hands of COVID-19 and Long Covid?

Or does HICPAC want to stand on the side of public health and truth, and advise the CDC to re-recommend the universal wearing of high-quality masks or N95 respirators in all healthcare environments, and not utilize faulty information and data to advise false recommendations?

I am asking that the HICPAC choose their advise to the CDC carefully, as it will affect each and every single person living in the United States for the rest of their lives. Do not take this responsibility lightly.

Sincerely,
Devin Padilla

Hello,

I am writing to comment on the new airborne precaution guidelines being proposed.

I do not support the HICPAC's proposed airborne infection precautions as the measures proposed are not supported by science and will result in death and disability in the public.

The proposal to use surgical masks instead of n95s for non-pandemic phase coronavirus is not appropriate. Because the end to the Public Health Emergency was declared 05/23, we are in a non-pandemic phase. So, this seems to permit surgical masks for caring for COVID infections when we know surgical masks are worse than N95s at preventing disease in the wearer. This will cause disease in workers. Research has shown that vaccine efficacy at producing antibodies and preventing serious disease decreases over time and we no longer have vaccine mandates. This will cause deaths in workers.

The proposed measures do not mention air filtration of any kind. Research has shown air filtration reduces transmission from patient to worker and patient to patient. This will cause deaths in patients.

Overall, this will compromise patient safety and further compromise the integrity of care for patients in this country.

I speak as a member of the public, but my opinions are informed by my experience working as a Health Science Specialist in a Federal hospital setting. I believe the federal government, through its power, sets the bare minimum standard of who will be protected and who won't. This is an issue of accountability. Evidence-based healthcare and safety practices are how it remains accountable to its citizens.

Sincerely,

Lisa Keacher
Minneapolis, MN

---

**Full Name:** Ms. Kathleen Volker
**Topic:** HICPAC August Meeting
**Address:** Chicago, IL
**Organization Affiliation:** Member of the General Public

To Whom It May Concern:

HICPAC's Work Group on the Isolation Precautions Guidance has proposed adopting a more "flexible" approach to implementing precautions that recommend only minimal protections and allows healthcare 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 healthcare employers to avoid providing the necessary protection for healthcare 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 needed to protect healthcare 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.
In closing, it is imperative that we keep masks/respirators in healthcare (ideally n95s, NOT surgical masks) and uphold higher standards of care for our healthcare settings to ensure that we are providing the best healthcare possible (i.e. updated filtration). People should not be exposed to more sickness and illness when they need healthcare the most, and we should be protecting those who currently work in the healthcare field.

All the best,
Kathleen

---

Hello. I am a member of the public who is concerned about infection control in hospitals. I attended the HICPAC meeting on Tuesday of this week and had a few comments subsequent to the meeting:

1. The slide listing the prodromal phase of Nipah virus: The prodromal phase exhibits "(fever, HA, myalgia, dizziness)". These symptoms are also quite common with sars-cov-2. For Nipah virus, the recommendation is the use of N95 respirators. Shouldn't N95 respirators be used to protect against Sars-cov-2 also? Will your average ER healthcare worker be able to distinguish the two viruses immediately? Shouldn't they be protected at least while diagnosis is occurring?

2. As Sars-cov-2 mutates, it may become more virulent. Are your decisions on respiratory protection based on the virulence of a virus? If so, shouldn't you mandate higher protection now as a preventative?

3. If you will be mandating N95 use in certain circumstances, might it not be more cost-effective and environmentally friendly to provide an elastomeric respirator for at least everyone in the ER who has patient contact until a diagnosis has been made?

Thank you for taking the time to read my email.
Martha Young

---

We're all afraid to go to the doctor or to have medical procedures because of the lack of mask mandates in healthcare and lack of ventilation, filtration, and UV treatment of air inside these buildings. We've had years to address this issue in medical care and in schools, but the CDC's lack of leadership in ventilation and filtration efforts and guidance is ensuring that many more people will have their health ruined by Covid19. Please do something to help us!

If this were the measles or TB you'd be advocating and mandating air controls and airborne infection protocols in healthcare and indoor settings.

It undermines the CDC authority to pretend this #1 vector of infection does not exist and to lean into washing hands and other easy but not effective control methods.

Please, please show some authority that makes sense in this deadly disease. Protect what's left of our healthcare professionals and help keep us all from long-term Covid health catastrophes.

Susan Farrell
Eugene OR

---

My name is Jaime Cleland, and I'm a resident of New York, speaking today as a private citizen. I want to encourage the committee today to adopt strong protections from airborne infections in health care settings.

I have been following news about Covid-19 around the world with great concern. In Okinawa, Japan, Dr. Hiroshi Yasuda reported this summer that emergency patients were unable to find care even after visiting seven or eight hospitals; he described the situation as a "medical collapse." This emergency in Japan followed the country's decision this spring to take fewer precautions against Covid. (https://twitter.com/Yash25571056/status/1676746698314616832) There are two parts to this crisis: the number of infected patients, and the lowered ability of the medical system to provide care. A recent report from the United Kingdom shows that doctors themselves are no longer able to work as they did before, due to continuing symptoms from their own Covid infections; many of these infections were acquired in their own workplace. (https://www.bma.org.uk/bma-media-centre/first-major-survey-of-doctors-with-long-covid-reveals-debilitating-impact-on-health-life-and-work-and-wider-implications-for-workforce-and-health-services)

With more and more sick patients, and fewer doctors and nurses, it is imperative that we do everything we can to prevent airborne infections in medical settings here in the United States. This includes steps such as N95 or better respirators, along with ventilation and HEPA air purification.

Reports from Australia show that more than one in ten people who acquired Covid during a hospital stay died of their infection. (https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html)

The risk of becoming infected in this way is leading me to delay health care for other conditions. I had surgery during the fall of 2020 and was grateful for the precautions taken by my medical team. In the summer of 2023, I am no longer comfortable visiting the doctor for routine or even

urgent care, let alone surgery, in an environment where patients and even doctors are unmasked.

Let's learn from what we can see about the pandemic around the world. I ask the committee to "first, do no harm" and to prevent the airborne spread of Covid in medical settings, for the protection of patients, workers, and the entire health care system, by adopting the highest standards of protection. Thank you for your consideration.

--
Jaime Cleland
Senior Acquisitions Editor
Office of Scholarly Communication
Modern Language Association

---

Jennifer Moraga

Topic airborne infection precautions for Healthcare workers
Fair Oaks, ca
Organization: member of the public

I am writing to express my dissent against changing the standard of use of n95 masks to surgical masks when dealing with those with covid.

I want to give you my personal experience. Since 2020 my work, a behavioral health hospital, had the rule of wearing masks at work and testing all patients that came in to make sure they did not have covid at that time. During this time I work a kn95 masks at work and most of the time when going out. I was vaccinated x4. I did not have a case of covid once in this time.

Fast forward to about a month or two ago and my work lessens protocols. We don't have to test patients before they arrive. Boom, we get a patient with covid on a unit with other patients that are highly compromised individuals. Still the masking guidelines are not more than a need for a surgical mask on the unit. Boom, I am exposed to 3 people in a short time that have covid. So I have to test. Boom, second test for covid and I have it.

I have never had covid and this is the worst I feel in 9 years. I try to tough it out cause I am too tired to get to the Dr on my own (my husband is a paraplegic and highly immunocompromised). I am isolating, but then symptoms get worse and I have to go into the drs and get on medication to help me.

Now I am sick, my husband is sick (both for the first time with covid), i have to go to the dr, and I am missing work for at least 10+ days all because mask precautions were lowered.

This is the consequence of the choice you would be making. Precautions are there for a reason, as a precautions. Do not lower the standards.

Thank you,
Jennifer Moraga

---

My name is Stacie Hipp, I’m a patient and member of the organizing group Pan End It!

This comment, delivered while experiencing a surge too many years into this ongoing pandemic, is directed at this committee's failures to address the control of infection from airborne pathogens.
Delaying medical care because you cannot afford to get sick at the doctor.
Combing through online directories of healthcare practices with far too few listings. Directories laboriously researched and put together by individuals and communities, detailing the various infection control measures each practice takes, or would be willing to take. If requested.
Countless phone calls, messages, emails asking, requesting, confirming the basic measures we know of to protect yourself from infectious disease. Known but not enacted.
Delay. Delay.
Seeing providers without any mitigations because that's all there is. One way masking because that's all there is.
Getting sick from a place you went to for care.
So much time spent seeking care and not receiving.
Work missed, pay missed, bills missed.
The ripple effects of continuous illness unmitigated.
This is our reality. This is what is happening. This is what must stop.
The lack of care or urgency on this issue demonstrated by this committee is disgusting and shameful. Grow up, accept reality, and be better.

---

My name is Zachary Jeans from Salisbury, NC. I am a member of the public. I am contacting this committee to strongly urge the rejection of the new airborne viral infection percautions. These percautions fail to mention any filtration standards as well as equatinf surgical masks with n95 masks. If anything these percautions should be taking airborne infections more seriously as school go back into session.

---

Dear HICPAC Committee Members:

It was disappointing that at the August 22, 2023 online HICPAC meeting, appropriate COVID-19 infection control precautions in healthcare settings were not discussed until the public input portion of the meeting.
COVID-19 is primarily an airborne virus that research has revealed is mainly transmissible via asymptomatic individuals. It remains a leading cause of death in this country and should therefore be an ongoing concern, given its unacceptably high baseline of infection and death. Infections in our country are trending upwards again, and as the CDC itself has shared, a new variant, BA.2.86 has arrived - a variant for which, Eric Topol of Scripps Institute says, the new fall vaccines will most likely be a poor match. While it remains to be seen whether the BA.2.86 variant will rise to "variant of concern" status, appropriate action must be taken to reduce the transmission of currently circulating variants and any others to come.

Health care settings - hospitals and nursing homes, especially - are places where the sickest among us must go for care. Research has proven that hospital-acquired COVID-19 infections are not inconsequential, again, infecting the sickest. All of us have a right to health equity, to seek well and sick care from medical professionals who wear high quality (KN95 or better) masks that protect patients (and themselves). Anything less is playing russian roulette with patient health.

Though the "emergency phase" may have been declared over by both our federal government and the WHO, COVID-19 is still a pandemic. I urge you to act in the health interest of patients over the financial interest of hospitals.

Decision makers at the CDC and hospital leadership level should apply the precautionary principle in their approach to personal protective equipment for healthcare workers, patients, and all who utilize healthcare spaces.

First, do no harm.

Sincerely,
Christine Zimmermann

---

My name is Kimberly Johnson-Muffley. I am an extremely concerned mom, wife, and citizen. Somewhere along the way, I feel that those who are supposed to stand for the health and well-being of all citizens stopped caring, particularly when it comes to Covid transmission. Today I ask that HIPCAC and the CDC prioritize the well-being of everyone and prioritize effective Covid prevention measures in healthcare settings (college campuses would be great too). As the Covid pandemic rages on (yes - it is NOT over), reducing proper protocols in healthcare settings puts everyone at risk. The last few years should have taught a valuable lesson, that proper masks prevent airborne transmission of infection. This is common sense.

HIPCAC's recommendation to the CDC should be to 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. It is not okay at any time, for anyone to be put intentionally at risk. Recently my son and I were asked why we wanted a dental hygienist AND the actual dentist to mask; unacceptable that it would even be allowable for anyone in a dental practice to loom over a patient's mouth unmasked. This horrific behavior intentionally put us in harm's way. This is dangerous and it must stop now. If you require N95s or higher for Hantavirus, documented airborne, why would you not for something as devastatingly harmful as Covid, also documented airborne?
I implore you to do the right thing and recommend that proper prevention measures be taken in ALL healthcare settings. It is up to YOU to prioritize our safety, and NOT be the reason that Covid continues to spread in healthcare settings.

Side note - it is equally as dangerous for colleges to be hiding outbreaks, all while proclaiming they follow CDC guidelines. The guidelines need to change, Colleges should be masking during this latest surge. Period. As a mom of a college student, I am outraged at the lack of protocols for positive students. The CDC needs to do better. Much better.

Kimberly Johnson-Muffley

---

I had an episode of a fib and ended up in Newton-Wellesley Hospital in the cardio unit. Cardio patients are at risk for all sorts of opportunistic diseases and are vulnerable. Hardly anyone was wearing a mask. I masked the whole time, including when I slept.

I felt very uncomfortable and I think that it's incredibly stupid, unfeeling, and uncaring of public health for hospitals to not mandate masks. I don't understand what the problem is. I don't understand why public health is not being paid attention to. It is not a big deal to wear a piece of cloth over your face. Covid is not over. I'm still afraid I caught something even though I was masked the whole time. And I would blame the department of public health and the Healey administration if I get sick. You could do something and you are not. You are shortsighted and

inconsiderate. I actually don't have enough bad adjectives to describe how I feel about the decision to not mandate masks in hospitals. I cannot believe that you are in charge of public health because you're not paying attention. You are like ostriches with your head in the sand hoping it goes away. It's not going away.

Karen Schlosberg
Natick, MA

---

Christine Hauber
Guidelines for HCWs
White Rock, NM
Member of the Public

N95 masks should be required for health care workers….not surgical masks.
Air filtration should be required as well. Stop the madness and follow the science!
Thank you for the opportunity to comment on your forthcoming recommendations to the CDC on infection control policy. The CDC is a world-renowned body and its policies influence many other countries' infection control authorities. I am a retired General Practitioner in the UK.

HICPAC's proposals are deeply flawed, for the following reasons:

1. There is failure to recognise airborne spread as the predominant route of transmission of SARS-CoV-2 and other pathogens, and therefore to recommend the necessary protections against this in healthcare, Testing of healthcare staff and patients is essential as is sufficient time off work for staff to fully recover.

2. There is overwhelming international scientific consensus that SARS-CoV-2 is primarily an airborne virus. A multinational Delphi consensus statement by nearly 400 experts published in Nature in November 2022, reaffirmed that *"SARS-CoV-2 is an airborne virus that presents the highest risk of transmission in indoor areas with poor ventilation."* [1] Superspreading, the hallmark of airborne transmission, is well known to have occurred in hospitals with other Coronaviruses (SARS1 and MERS). [2, 3] HICPAC has ignored this.

3. The membership of HICPAC is exclusively from the biomedical sciences. There are no ventilation engineers, aerosol scientists, occupational hygienists or other experts on respiratory protection. Cholera was not stopped by doctors, but by sanitation engineers. There are also no patient or community voices, for example from disability and clinically vulnerable groups.

4. The evidence base for HICPAC's recommendations is highly selective to ensure continuity of previous policy, i.e. droplet/AGP precautions. The studies relied upon are flawed and subject to trenchant criticism, including the recent Cochrane mask review. [4,5] HICPAC also ignores the widespread and decades-long use of respirators to protect workers in a range of other industries against inhaled airborne hazards.[6]

5. Like infection control in the UK, HICPAC fails to evidence its favoured droplet/AGP theory of transmission. Where is the evidence in support of droplet spread and risk from so-called aerosol generating procedures? In a meticulous historical analysis of disease transmission research, Jimenez et al found "no direct evidence for large droplets as the route of transmission of any disease." [7] Studies show no additional risk from AGPs, and far greater aerosol generation by ordinary respiratory activities such as coughing and talking.[8] So poor is the evidence base for AGPs that the Lancet recommended in 2021 abandoning the term altogether as it is

inaccurate and misleading.[9] Yet HICPAC continues to endorse AGPs in its policies.

6. A scientific approach to policy-making must also include review of existing practice. In the UK, at least 14,000 patients have died from hospital acquired Covid-19, and 70,000 or more are infected in hospitals each year.[10] 2,100 health and social care workers died from Covid-19 in the first two years of the pandemic,[11] and hundreds of thousands have acquired long Covid.[12] Nosocomial infection rates for Covid-19 are running at 30%.[13] Droplet-based precautions have been a disaster for infection control, yet this fails to prompt comment, let alone policy change.

7. Many people are now afraid to go to hospital, especially those who are clinically vulnerable, because healthcare is not safe. A survey by Clinically Vulnerable Families in the UK found that 91% of respondents said that they would or had delayed or cancelled healthcare appointments because of the lack of protections against Covid-19.[14] People are being deprived of essential medical care because your policies place them at risk.

Along with thousands of others I urge HICPAC to follow the science, and amend your policies to recommend airborne precautions as standard across healthcare as a matter of urgency.

Yours faithfully,

Dr Jonathan Fluxman
(retired General Practitioner, London UK)

References


1. https://www.nature.com/articles/s41586-022-05398-2/tables/3
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3322930/
3. https://www.sciencedirect.com/science/article/pii/S2210909915301004
4. https://www.forbes.com/sites/brucelee/2023/03/11/cochrane-says-review-does-not-show-that-face-masks-dont-work-against-covid-19/?s=09
5. https://www.acpjournals.org/doi/10.7326/M22-1966#_comments.
6. https://www.scientificamerican.com/article/masks-work-distorting-science-to-dispute-the-evidence-doesnt/
7. https://onlinelibrary.wiley.com/doi/10.1111/ina.13070
8. https://www.bristol.ac.uk/news/2021/february/aerator-study.html
9. https://www.thelancet.com/journals/d/article/PIIS2213-2600(21)00216-2/fulltext
10. https://www.mirror.co.uk/news/uk-news/we-need-better-over-14000-28046576
11. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14379deathsinvolvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to28february2022
12. https://hansard.parliament.uk/lords/2022-11-17/debates/E105F485-3B07-4020-AA3A-118870DCF534/LongCovid
13. https://twitter.com/LawtonTri/status/1605894547883573250
14. https://twitter.com/cv_cev/status/1581649326245576706?s=20


WRITTEN PUBLIC COMMENT ON DRAFT ISOLATION PRECAUTIONS GUIDELINE
[*note: these comments are my own and do not necessarily reflect the views of my employer*]

Thank you for the opportunity to submit these comments, which I was prepared to offer orally at the meeting yesterday (Aug. 22). Having listened to the unanimous and overwhelming litany of oral comments from experts, caregivers, and victims of lax infection control guidelines, I was tempted to refrain from adding to the fray, but, to be frank, I'm not

confident that the Committee is inclined to listen to reason, and so I offer these comments for the written record if the guidelines are later challenged. I acknowledge a lack of familiarity with your process (it does seem, as others have mentioned, to be less transparent than FACA committees I have served on or convened are supposed to be…), but I was amazed not to have heard anything in HICPAC's presentation yesterday about the firestorm you created with your June 8 pronouncements about respirators and masks. In the absence of any candor from HICPAC, I have to assume you are currently still wedded to these retrograde and unscientific fantasies. Sincere apologies if you have partially or totally moved off of the June position, but the act of giving a presentation that completely avoided this issue, one recently highlighted for your consideration in a letter signed by nearly 1000 experts and interested citizens, gives the impression of a haughty Committee, and it is partially responsible for the tone of my comments below.

So, I offer these comments from a vantage point I urge you to heed. If, somehow, you were not moved by the personal experiences of those whom the healthcare system has utterly failed, perhaps you will consider these complementary observations from one of the pioneers in developing modern methods of quantitative risk assessment for environmental and occupational disease, a Certified Industrial Hygienist for the past 25 years, and a professor of public health (Michigan), administrative law (Penn), public policy (Princeton) and medicine (Rutgers). These are admittedly not unique experiences. However, *I also write as the lead author of 29 CFR §1910.134, the federal OSHA Respiratory Protection Standard*. I was OSHA's chief rulemaking official in the Clinton administration, and later enforced all OSHA standards as its Regional Administrator in the Rocky Mountain states in the GW Bush administration.

Here are some abbreviated comments, as they basically urge you to completely scrap your June 8 recommendations about respirators, which would then trigger a belated discussion with experts, which I'm happy to participate in. Of course, I can provide more extensive references if you wish to continue this discussion in writing.

1. There is simply no doubt that N95 respirators are far superior to surgical masks, and that the latter should NEVER be used in preference to the former (unless there is a genuine shortage, and we ought to actually be taking steps to avoid that!). Their filter media are superior, and perhaps more importantly, all NIOSH-certified N95s attach to the face via two elastic straps, which provide far more of a seal to the face than earloops possibly can.
2. *All* of the controlled studies, using either human subjects or manikins, prove this point amply. I can provide a longer list, but see Clapp et al. (2020)—from inside the CDC!—showing that a procedure mask on average filtered out 39% of Covid-sized aerosol, while an N95 blocked 98%. See also Duncan et al. 2021, Andrejko et al. 2022, etc., etc. And, despite the cherry-picked list of inappropriate epidemiologic studies (see the next item), your "evidence review" staff person ignored outcome studies that *do* show significant signals that N95s can reduce infections and hospitalizations.
*3.* Your staff's inappropriate reliance on outcome studies, and ignorance of fundamental physical processes and exposure studies, is the problem here. *Epidemiologists, even PhD-level ones, should not be making national decisions about industrial hygiene!* Let me offer an analogy here. X-rays cause cancer—we have known this since the late 1800s. Lead aprons block X-rays (early 1900s). Therefore, a randomized controlled trial or a retrospective cohort study to look at cancer rates among patients given and not given lead aprons during imaging would be, to use a technical term, stupid. An RCT would take 40 years to conclude, during which time the doctrinaire gatekeepers of "systematic review" would be sitting back and accepting the harm from the status quo.

But more importantly, there is so much noise in these two signals that we might well not get a statistically significant result showing fewer cancers in the apron group, despite the guaranteed reduction in carcinogen exposure in this group. Genetics and environment are much more important in overall cancer risk than an occasional Xray, *but it is also true that needless exposure to X-rays is folly.* So it is simply unacceptable to claim that at the population level, people wearing N95s *sometimes* at work—and going about the rest of their (unmeasured!) lives masked, unmasked, or using useless masks, while exposed to (unmeasured!) more or less Covid than others—don't have fewer Covid infections than people who wear surgical masks *sometimes* at work! ***And yet, CDC seems poised to recommend dangerous surgical masks in many situations based on these misbegotten "studies" and an amateur review of them.***

4. There is another baseless objection to N95s, which I didn't see raised specifically in the June 8 materials, but which I need to debunk for the record. 29 CFR §1910.134 **already** anticipated a relaxed fit-testing and medical monitoring regime *when filtering-facepiece respirators are recommended and there is no OSHA PEL being protected against.* Employees in these situations merely need to be provided with a ½-page flyer explaining the pros and cons of respirator use. Therefore, all of the complaining from the "masks are tyranny" crowd about how "without quantitative fit testing, N95s don't work," and "OSHA-compliant respirator programs are expensive" is misguided in the extreme.

5. The "mask adverse events" review (Slide 32 of the June presentation) should be deleted and purged from memory. This is a "poster child" for observational epidemiology gone berserk. There is simply no physical or mechanistic reason why we would expect a piece of electrostatic filter medium and two rubber bands to cause adverse health effects—there is no "hypothesis generation" that justifies asking these unreliable questions. Yes, some people claim in hindsight to have experienced "discomfort" wearing N95s. Others claim to have experienced "shortness of breath" with them. Another analogy: in a survey of seat-belt users, compared to those who relied on putting a pillow on their lap while driving to "protect" them from hitting the windshield, some subjects surely would have reported some "discomfort" with the former modality. Would we ever pay attention to this obvious and trivial offsetting "harm" of the obvious lifesaving benefit? And perhaps some would claim that wearing a seat belt gave them bunions. Would we believe this? Pardon my cynicism, but this slide conjures up memories of the infamous (retracted) Walach et al. (2021) article, which somehow passed peer review even though the authors measured CO2 levels inside an N95 after exhalation, and didn't realize that the volume of fresh air that was about to be *inhaled* made any claims of "CO2 poisoning" ludicrous. The anti-mask charlatans don't deserve a pat on the back from our CDC.

In addition, I offer one process observation. HICPAC is far from the first "consensus process" group to fall into the vicious circle of myopia and echo-chamber conclusions—but the health of HCWs and the patients they serve is far too important to be left to an insular group. There is no shame in recognizing that complex multidisciplinary science-policy problems require broad expertise. As a public health scientist, I would never diagnose a patient; but as a CIH and an expert in quantitative risk assessment, I expect clinicians to take some interest in the insights my colleagues and I offer about how exposures, dose response relationships, risk-reduction measures, costs, and offsetting risks combine to make some policy recommendations sensible and others deplorable.

Please consider re-starting this process with the right people at the table. Attached to these comments is a 2021 article from *The Journal of Law, Medicine, & Ethics,* offering recommendations for how a similar consensus process could redeem itself by broadening

its membership. I leave it to others to reinforce the other main point of this paper—that it is offensive to claim ownership of a policy problem while excluding the perspectives of those gravely harmed by prior mistakes, or at best bringing them in for a “thank you for your views” session.

One of the public commenters the other day gave a much pithier version of these recommendations to HICPAC: “do better.” I’m confident that despite the vast disappointment with your work so far, there are many, many experts and first-person chroniclers of the harm done to date who would contribute to your work with energy, optimism, and respect.
Thanks again for the opportunity to attend the listening session and provide these postsession comments.
Adam M. Finkel, Sc.D., CIH

---

Dear members of the HICPAC committee,

My name is Heather Sue Rosen. I am writing as a Medical Sociologist and Postdoctoral Researcher at the New England Complex Systems Institute, the child of two Air Force Veterans, resident of the State of Georgia, a member of the World Health Network, and a disabled person with an autoimmune disease and over 15 years of experience with medical gaslighting related to complex chronic illness. Some of these chronic illnesses put me at higher risk of complications from COVID-19, like juvenile idiopathic arthritis, asthma, Ehlers danlos syndrome (EDS) type 3, and mast cell activation disorder (MCAS). Others, like Postural Orthostatic Tachycardia Syndrome (POTS), can arise after COVID-19 infection—many long COVID patients have POTS. We are already ill equipped to manage the onslaught of newly disabled patients with these illnesses which were, as recently as 2019, considered “rare,” with some going as far as to question whether they were “real”. Even now with a growing population of people who are aware of POTS, long COVID patients complain of long wait times for appointments only to arrive and be referred to a psychiatrist.

Allowing COVID-19 to spread unchecked in healthcare facilities exacerbates these difficulties for people with complex chronic illnesses seeking healthcare, as more people will become ill with long COVID, a risk that increases with each subsequent reinfection. Healthcare workers are at inherently higher risk for reinfection with inadequate PPE, and many have left the workforce. Many people with long COVID have also dropped out of the workforce, including healthcare workers, but also across industries. Without protection against COVID-19 infection in healthcare, we are creating a situation that contributes to ongoing worker shortages both in and outside of healthcare while increasing the population of patients needing, not just care, specialized care.

There are two main reasons it is not sufficient to limit respirator usage to certain areas of the hospital/clinic or certain contexts of interactions.

The first, and most important reason, is that SARS-CoV-2 is spread via infectious aerosols, which can linger in the air long after an infected person has left the space. Furthermore, surgical and procedural masks are insufficient protection against infectious aerosols. N95 or better respirator masks must be required in healthcare, and NOT limited to patient treatment areas. Patients must wait in the waiting room amongst other patients, some of whom may be infectious. They must also enter exam rooms shortly after other patients have left the space; COVID-19 may still be lingering in the exam room under these circumstances. Lastly, some types of healthcare are performed in communal spaces. For example, physical therapist’s

offices are often set up with several exam tables and various exercise equipment in one large open space. In my own visits to physical therapy since the lifting of mask mandates in healthcare, I have experienced hostility from clinic staff for wearing a mask and pushback from providers when I request they mask. I have had to file ADA accommodations to ensure my safety at routine healthcare appointments.

This leads me to reason number 2 that a universal mandate for N95 or better respirators in healthcare settings is the only truly safe policy for protecting patients from COVID-19, which is not only still present, but is currently surging in the United States.

While fighting for safe and appropriate healthcare is not new to me, it definitely does not make me smile to see so many others now forced to do the same. As a sociologist, I have researched how something called “cultural health capital” directly affects the level and speed of care for chronically ill patients. Cultural health capital comes from experience and proximity to healthcare, the idea being that the more experience and proximity you have, the better you will be able to advocate in a way that the physician accepts and therefore the better and speedier your care will be. Patients with illnesses like POTS are often given some deviant label, for example, when they are referred to psychiatry instead of being taken seriously, or when they are dismissed by all but the most specialized physicians, or when they have to advocate for their rights under the ADA to have their providers protect them from COVID-19. The deviant label tanks cultural health capital.

By failing to mandate N95 or better respirators in healthcare, we force patients to advocate for themselves in situations where they do not have the cultural health capital required to achieve the necessary outcome via advocating for themselves. I have a PhD, I am white, I am thin, and I have moved in elite circles to know how to carry myself as such—I have a lot of privilege for a patient with complex chronic illness, and yet, I am often not taken seriously until my spouse, a white man, gets involved. It is naive to assume all patients considered “high risk” for severe acute phase covid-19 will be able to successfully advocate for themselves so that their providers wear appropriate PPE during the exam, and that patients who achieve ADA accommodations are often still faced with a provider in a surgical or procedure mask instead of an N95 or better respirator is in opposition to aerosol science.

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 urge HICPAC to acknowledge the need for experts in other sciences, particularly aerosol science and social science, must be consulted regarding the draft guidelines for standard precautions. Healthcare is a human right, and health care providers took an oath to protect patients. I urge you to protect us. Thank you.

Heather Sue M. Rosen, PhD
*Postdoctoral Scholar*
New England Complex Systems Institute, World Health Network Initiative

---

David H. Halpert, MD
Attending Neurologist
Ithaca NY

As a neurologist trying to take best medical care of my patients, I strongly support masking in all hospitals and national ventilation standards for hospitals.

Over the past three years, I have seen a clear spike in young people having strokes - some of these stroke were in the subacute recovery from diagnosed COVID infection. In addition, I have seen patients come in with cognitive impairments following COVID. These worsening cognitive impairments have been in both patients who have preexisting dementia and some who had been fine prior to getting COVID.

Finally, immunosuppressants are used for many neurological diseases - perhaps most commonly multiple sclerosis. These patients may get worse complications than others if they get COVID. Many of these people try to limit their exposure and risk.

Hospitals where unmasked sick patients are coming in are riskier places to go to than the supermarket. And hospitals have a greater responsibility for keeping people who enter them healthy than other buildings. For the immunosuppressed patient and the elderly patient, concern about getting COVID at the hospital represents a barrier to basic health care.

As medical professionals, we should give opinions based on evidence and observation. Political considerations and decisions can follow. The evidence is overwhelming that masking and better ventilation reduces spread of COVID. Evidence also shows that reducing the spread of COVID reduces long-term risks for a growing list of severe health complications. Masking and improved ventilation should be mandated at all hospitals as part of standard precautions.

Thank you,
Dr Halpert

---

To whom it may concern,

My name is Kodey Stauffer and as a general member of the public with at-risk family members in the healthcare setting often, I aggressively advocate for the use of N-95 masks and strong air filtration systems in healthcare settings to care for those in the healthcare settings both as employees and patients. I live in Centennial Colorado

Sincerely,
Kodey Stauffer

---

Hello,

My name is **Julia Vulcan** and I live in **Somerville MA**. I am a member of the public and a research associate in biotech. I have a background in microbiology. I am concerned with the **unmitigated spread of COVID19**, as well as other airborne/aerosolized viruses.

In the new **proposed guidelines** for **transmission precautions** for **healthcare workers**, I would love to see the guidelines to **include** proper **air filtration systems** and do **not recommend surgical masks** only as a **mitigation method** against COVID infection. **N95's** should be **standard**.

I've worked in containment labs and the flow of air, as well as the quality of HEPA air filters, is very important. Indoor air quality has been shown to be a way of covid transmission (Zhao et. al.). Furthermore, "ventilation has been recognized as a solution for preventing transmission of the virus in aerosolized form" (Guyot. et. al.), although it should not be relied upon as the only solution. Please include proper air filtration systems in your guidelines.

Furthermore, equating surgical masks with N95 masks is not correct. As a rule of thumb, surgical masks protect others from yourself while N95 masks will protect you from others. Collins et. al. summarize that there are "statistically significant differences between N95 respirator versus surgical mask use to prevent influenza-like-illness" among other airborne viruses. Now, while Bartoszko et. al. suggest that "medical masks and N95 respirators offer similar protection against viral respiratory infection including coronavirus in healthcare workers during non–aerosol-generating care," their finding were published in 2020, during the height of lockdowns, when supply of good n95 masks were down and needed to be preserved for higher rist workers. A study Alkhalaf by stated that "According to this systematic review, N95 respirators provided better protection against COVID-19 infection compared to surgical masks." There needs to be standardized ways of measuring the protection against COVID19 infection, and N95 respirators appear to be a good solution, especially for healthcare workers, especially when caring for vulnerable and immune-compromised people.
In **summary**, please **include** in the new **guidelines ventilation systems** and **air filtrations systems**, as well as using **n95 respirators** in **medical settings** as a more effective way to **protect** both **healthcare workers** and **vulnerable patients**.

Thank you for your time,

Julia Vulcan

**Works Cited**

Alkhalaf A, Aljaroudi E, Al-Hulami M, Gaffar B, Almas K. Efficacy of Surgical Masks Versus N95 Respirators for the Prevention of COVID-19 in Dental Settings: A Systematic Review. Cureus. 2023 Apr 16;15(4):e37631. doi: 10.7759/cureus.37631. PMID: 37200654; PMCID: PMC10186565.
Bartoszko JJ, Farooqi MAM, Alhazzani W, Loeb M. Medical masks vs N95 respirators for preventing COVID-19 in healthcare workers: A systematic review and meta-analysis of randomized trials. Influenza Other Respir Viruses. 2020 Jul;14(4):365-373. doi: 10.1111/irv.12745. Epub 2020 Apr 21. PMID: 32246890; PMCID: PMC7298295.

Collins AP, Service BC, Gupta S, Mubarak N, Zeini IM, Osbahr DC, Romeo AA. N95 respirator and surgical mask effectiveness against respiratory viral illnesses in the healthcare setting: A systematic review and meta-analysis. J Am Coll Emerg Physicians Open. 2021 Oct 28;2(5):e12582. doi: 10.1002/emp2.12582. Erratum in: J Am Coll Emerg Physicians Open. 2023 Feb 05;4(1):e12894. PMID: 34746923; PMCID: PMC8552225.

Guyot G, Sayah S, Guernouti S, Mélois A. Role of ventilation on the transmission of viruses in buildings, from a single zone to a multizone approach. Indoor Air. 2022 Aug;32(8):e13097. doi: 10.1111/ina.13097. PMID: 36040282; PMCID: PMC9541182.

Zhao X, Liu S, Yin Y, Zhang TT, Chen Q. Airborne transmission of COVID-19 virus in enclosed spaces: An overview of research methods. Indoor Air. 2022 Jun;32(6):e13056. doi: 10.1111/ina.13056. PMID: 35762235; PMCID: PMC9349854.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9541182/

---

Hello, I watched the 8-22-23 HICPAC meeting online because I'm concerned about the effects of covid on the most vulnerable patients since the health emergency officially ended in May. I myself am not high-risk, but I have many friends and family who are. Most are elderly, but my

son is 33, otherwise healthy but still recovering from the effects of his second bout of covid 14 months ago. He was hit with severe brain fog and fatigue and has been unable to work since then. He's going to try puppy-sitting for 2 full days next week; he's hoping he can handle driving 45 minutes to and from the puppy's home. If successful, it will be the first time he's been able to earn any money since June of 2022.

Access to healthcare is important, right? So can't we find some way for extremely covid-sensitive patients to visit their doctor without putting their health in jeopardy? I was saddened to hear stories at. the meeting about ADA requests for masking, etc. that had been turned down by providers. This happened to my son as well. (He lives in Denver, CO.)

Grocery stores used to have early morning hours for seniors during the pandemic. Can't doctors offer something similar for their patients, especially since covid - as measured by hospitalizations and wastewater surveillance - is on the rise again?

To be clear, I'm not in favor of mask requirements for all. But I think there has to be some middle ground for patients with extra risk. After all, this is the sort of thing the ADA was set up to address, right? So please recommend precautions like well-fitting N95 masks and filtered or high-exchange-rate HVAC systems, at least in healthcare settings.

Please include my comments above in the minutes of the 8-22-23 meeting.

Thank you.

-- Margaret Henderson

---

Dear HICPAC,

My name is Tamra Fricke and I am writing to provide comment on the recent HICPAC meeting regarding updating standard airborne precautions.
My address is 9274 Creekside Circle, Pleasant Prairie, WI
I am a member of the public and previously worked on healthcare and hospice for 12 years.

I would strongly advise that the HICPAC reconsider their stance on their newly proposed standard precautions for airborne diseases. We NEED the standard precautions to be use of N95 respirators and a focus on proper air filtration and ventilation - these are the proven methods that best protect and mitigate airborne viruses.
If the committee cares at all about the lives and wellbeing of those in healthcare and anyone accessing healthcare services, the above is the only sensible choice.

Kind regards,
Tamra Fricke

---

Hello,
I am an occupational therapist who works in a hospital in rehab, acute care, ortho and ICU units. I also work in a skilled nursing home. I have seen first hand how hard Covid-19 has been on the staff and work in these buildings. It has taken an emotional and physical toll. I am also a person who happens to have a compromised immune system. I have felt less and less safe at work as restrictions have eased up in the hospital. I love my job and I love feeling like I can make a

difference in my patient's lives. However, I do wonder how much longer I will be able to work in this environment.

I URGE you not to weaken Isolation protocols. This will result in a loss of life, patients as well as staff. At some point, we have to start putting people's lives before profit. ALL people, including disabled people, should matter more than the cost of supplies. I ask that you reconsider making changes to isolation protocols. My ability to remain working depends on it.

Thank you,
Elizabeth B. Wagner

---

My name is Deborah Santor, and I dedicated over two decades of my life as a Physician Assistant at Johns Hopkins.

In my years of service, I held onto the belief that the core principle guiding healthcare was "Do No Harm." Yet, today, I find myself grappling with a reality where this very principle seems to be fading. The abandonment of mask mandates and the lack of testing for asymptomatic patients admitted to hospitals have created an environment of uncertainty and fear by letting covid run free in hospitals. Patients, at their most vulnerable moments, now face the harrowing choice of seeking essential medical care or risking exposure to COVID-19 and potential death due to a hospital acquired covid infection. Our brave healthcare workers, who have given so much, are now forced into situations where their safety is compromised daily. This is not just a deviation from our principles; it is a betrayal.

The policies that have allowed this situation are flawed and not based in science; they are morally indefensible and medically negligent.

Those who have played a part in shaping these policies should be ashamed.

Now, HICPAC has the opportunity to rectify this by enhancing the CDC's infection control guidelines. But distressingly, the draft guidelines seem to dilute, rather than strengthen, the existing measures.

I'd like to highlight a few concerning areas:

1. **Masking and Respiratory Protection:** The evidence review on the effectiveness of N95 respirators versus surgical masks is deeply flawed. The review prioritized the findings of randomized controlled trials and cherry-picked data to conclude there was no difference between N 95 respirators and surgical masks. This review urgently needs the insights of experts in respiratory protection, aerosol science, and occupational health.
2. **Aerosol Transmission Control:** The draft failed to consider the critical role of ventilation, air filtration, and source control for controlling worker and patient exposure to infectious aerosol.
3. **Flexibility in Precautions:** The proposed guidelines grant an alarming degree of undefined broad discretion to healthcare employers to create their infection control plans, potentially compromising the safety of both staff and patients.

I implore HICPAC and the CDC to pause, reflect, and open the doors for meaningful dialogue. Let's bring in scientists specializing in aerosols, respiratory protection experts, engineers, industrial hygienists, and most importantly, our frontline healthcare workers. Their collective wisdom can guide us towards guidelines that genuinely protect both healthcare workers and patients.
Thank you.

Deborah Santor

Hello
My name is Claire Gartner. I'm a concerned community member and student. I live in Baltimore Maryland. I strongly disapprove of the new proposed guidelines for transmission precautions for healthcare workers. We need to be encouraging the use of n95 masks not surgical masks as well as the importance of air filtration. Please don't put health care workers in danger.
Thank you
Claire Gartner

Greetings to the CDC, Re: HICPAC Meeting 8/22/23, regarding healthcare infection control.
From: Leah Kell, Melbourne, FL

I would like to share with you about my situation, and then make a request of your agency. I am writing from a patient's perspective, but please know the healthcare workers our country relies on are one infection away from possible long-term disability. It happened to me. I'm a 30-year-old who was studying to enter the healthcare field until I was disabled by a post-viral illness (POTS).

Due to my bedbound disabled condition, my medical team considers me highly vulnerable to severe outcomes from COVID-19. While trying to protect myself, I experienced a worsening of my disability in response my first booster shot, my first mRNA vaccine. Because I am not well enough to tolerate another downslide, unfortunately my vaccine protection is now out-of-date. With the loss of preventative alternatives like Evusheld, you can see I am in a difficult position.

I especially need medical care because of my complex health conditions, but I am uniquely vulnerable to poor outcomes in the case of contracting COVID-19, which is currently a risk of receiving medical care. I am asking the CDC to do all that is within its power to lower the risk of COVID-19 transmission in healthcare facilities.

1. I ask that the CDC issue indoor air quality targets for healthcare facilities that are evidence-based and strong enough to minimize the spread of COVID-19. This includes working with experts in aerosol transmission, ventilation, occupational health protections, and representatives of healthcare workers and patients. It means utilizing all the tools at our disposal such as improved ventilation, UV disinfection, HEPA filtration, and masking protocols.
2. I ask that the CDC recognizes its own conclusions that, compared to surgical masks, N95s provide superior protection against COVID-19's aerosol transmission.
3. I ask that the CDC recommend universal masking in healthcare facilities. If this is deemed infeasible, I ask the CDC require masking where most critical for infection control, and additionally offer guidance to healthcare facilities for the creation of dedicated days, times, or locations where universal masking is practiced to allow vulnerable patients like me equal access to healthcare.

If the CDC took these actions, my health and life would be improved. For fear of complications from COVID-19 infection, I have delayed medical procedures where I must remove my mask, such a GI motility test, a lip biopsy, a swallowing exam, and dental work. I know I and the healthcare system that serves me will face costs for delaying this care. The stress of constantly contemplating these risks is also taking its toll on my wellbeing.

I and so many ill, disabled, elderly, and immunocompromised Americans want to return to the

same "normal" as anyone else, and for us that must include a minimum level of safety in the healthcare facilities we so desperately need to use. We can move toward this goal if the CDC recommends meaningful indoor air quality targets and universal or targeted N95 masking in healthcare facilities. Thank you for considering the most vulnerable in your decision-making.

As a chronically ill citizen I am deeply concerned by the lack of precautions we have already dwindled down to. Getting rid of the few common sense practices we still have in place is the opposite direction from where we need to be heading. We are still living in a pandemic where spread and strains are steadily increasing because of the lack of care and precautions that have been recklessly encouraged by the CDC's terribly lax guidelines.
We need free universal, updated testing, & required masks in ALL healthcare settings, especially in covid and other infectious disease units. All buildings, but especially hospitals & healthcare facilities need better ventilation, & patients with infectious disease need to be quarantined from one another. People need the CDC to reinstate protections for workers, including the right to stay home until it is safe to re-enter the work space & set up support for those too disabled to return. The CDC should be ashamed of their terrible decision to let covid run out of control your lack of care is still resulting in unnecessary death and disability & you need to make amends now. Jess

I read with dismay that you are considering weakening your already unconscionably lax guidelines for preventing the spread of airborne diseases, including COVID-19, in health care settings.

I am a caregiver for people with immune disorders, who should not have to choose between obtaining health care and risking exposure to airborne diseases. It is your responsibility to protect them and all of us, and it's to your shame and discredit that you are ignoring their needs, their disabilities, and their deaths, to no purpose other than, apparently, making it cheaper to run health care facilities.

You should be ashamed for considering this, you should be ashamed for sleeping on aerosol transmission of COVID-19 and similar diseases for, well, the entirety of my adult life, you should be ashamed of flouting FACA, and you should be ashamed of pulling the Youtube video of the only hearing you've held available to the public, notably after a unanimous chorus of commenters pointed out the science you're ignoring and the horrific consequences of your abrogation of your responsibility to the health of the public. The fact that your working group has not included input from experts in aerosol transmission, healthcare worker groups, or disability advocates puts the lie to your claims that you're balancing the interests of stakeholders. That claim is only defensible if the only stakeholders whose interests you consider are our political elite, hospital owners, and yourselves.
Donald Ball

---

All it takes is looking at the science to know that COVID-19 is spread through aerosols. This is true of other pathogens and could very well be true of future pandemics too.

As an immunocompromised patient and healthcare advocate, it is hard for me to understand why the public health officials at HICPAC would not want to do everything they can to protect me and all people from unnecessary nosocomial infections.

I do not understand why this decision has gotten this far without transparency and input from the medically vulnerable such as myself.

I'm supposed to trust my doctors and my doctors are supposed to trust public health officials. But in order for that to work, public health decisions need to be grounded in science.

For now, I go to needed medical appointments with high-quality PPE. I am very privileged that I could afford to buy PAPR, which keeps me safe and alive. Most medically vulnerable people do not have the ability to do that and we all deserve to be safe. Yet my PAPR cannot keep me safe for all medical care and it certainly can't be worn during a hospitalization or surgery. I suffer with chronic pain and have had to indefinitely put off an elective surgery that would likely decrease my pain because the aerosol burden of viruses in hospitals is just too great a risk for someone with my chronic complex medical conditions. At some point, I'm sure I will have an unavoidable hospitalization. When that happens, I hope that the hospital will be a safe place with appropriate aerosol disease mitigation. If not, I would be at serious risk for additional permanent disability or death.

I ask you to be transparent in your process and take into account the best available science and the voices of your most vulnerable patients. I believe that when you do, you will come to the conclusion that high quality respirators and excellent air filtration are essential in preventing disease and deaths from aerosolized viruses.

Sincerely,
Debby Schwartz

---

Good afternoon,

My name is Hannah Sullivan, I live in Tyler TX, and I am a member of the public desperately trying to advocate for high quality masking in healthcare facilities.

I have a 3 year old son, and struggle every day with autoimmune issues brought on by pregnancy and high levels of pandemic stress the last three years.

I am desperately trying to get safe medical care to provide my son with a quality of life, but no longer feel safe doing so here in Texas where masking has become political and surrounded by public health misinformation.

Please, for people like me, alter the guidelines surrounding covid to be based on science and robust data that highlights the importance of disease mitigation.

I don't know when public health turned into a political debate, but EVERYONE DESERVES SAFE MEDICAL CARE. I understand that other aspects of life cannot be forced to require masking, but public health should be looking after the public's HEALTH!

Please listen to the disabled and immunocompromised community that are screaming from the rooftops, all for the simple request to be able to access safe medical care without worrying about bringing covid home to their families.

N95s SAVE LIVES!!

Hannah Sullivan

---

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. 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.
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

---

Hello,

As a scientific and governmental institution, weakening any kind of protocol that protects citizens from infections is ludicrous.

Thanks to COVID, we understand that many viral infections have a lot of serious and long-term consequences. However, we also know that they are relatively easy to prevent with high-quality masks (N95s) and air purification.

Take this moment to save millions of lives and the quality of life of millions more. Do your job and protect the citizens of the US by providing N95s, particularly in hospital settings and upgrading air purification in ALL public buildings, but particularly in hospitals and schools.

Thanks,
Ellen

---

Hello HICAP,

I am Aviera Mitchell located in Reading, PA, member of the public, and I'm reaching out for HICPAC written comments that are still being accepted until 08/25.

We should not be regressing in quality of care after this ongoing calamity of public health crisis by downgrading masking requirements. To say a surgical mask gives the same level of protection as a N95 or KF95, is absurd and allows for more disease and death to run rampant in our healthcare settings. We also need to be improving air ventilation in all buildings, but MOST CERTAINLY HEALTHCARE SETTING. We need to have air purifiers and open windows in healthcare settings for air flow. Please backtrack on this current guidance to prevent more death and disability of the masses of people young and old. It's outrageous that we have to tell you how to protect us because your corporate masters pay you enough to create guidance that allows for more suffering. The end times are happening and you all are trying to make it worse, why? You hate humanity so much you want to take us (all of humanity) to extinction? GET IN LINE ABOUT PUBIC HEALTH POLICY OR GUIDANCE THAT PROTECTS EVERYONE OR GET OUT OF THE WAY!

The CDC has a duty to control and prevent the spread of infectious disease. This includes establishing guidelines that adequately protect patients and health care workers from airborne diseases, such as SARS-CoV-2. Rather than weaken existing protections, the CDC should strengthen them, including promoting the use of well-fitted N95 (or better) respirators, HEPA air filtration, and sufficient ventilation as standard of care in all health care settings.
Patients have a right to safe health care, where they can be secure in the knowledge that they will not leave sicker than when they arrived. They and those that care for them should feel confident that they will not become disabled by a preventable illness. Anyone that enters a medical setting – whether a patient, provider, support staff, or visiting family – should know they are entering a space where health and safety are the top priority.
Sadly, no such security or confidence can currently be found in most health care spaces. Many of us have had to put off not only routine examinations, tests, and procedures but also more pressing medical needs due to the high level of risk from airborne diseases in such settings. It is a travesty that this situation has been allowed to occur and that neither “health” nor “care” are valued.
I would like to see the members of HICPAC recenter their focus on practical, evidence-based ways in which they can improve infection control (such as those noted above), and I urge them to recommend proper precautions against airborne illnesses as the standard across all health care settings.

Tracy Craig
Pittsburgh, PA

---

August 24, 2023, Public Comment to CDC/HICPAC from Roselie A. Bright, Sc.D., on August 22, 2023 meeting

1. I'm Roselie A. Bright, Sc.D. (Doctor of Science in Epidemiology from Harvard University). I recently retired after 31 years as an epidemiologist employed by the U.S. Food and Drug Administration (FDA). During my time at FDA I was involved with many Federal Advisory Committees by:
- preparing scientific background and presentations for the meeting,
- attending and listening to meeting presentations,
- analyzing guest speakers' and public oral and written comments, and incorporating them into final FDA work products.
Many public commenters were patients with experience relevant to the meeting topic. For decades, at least since the breast implant controversies in the early 1990s, patient representatives have been formal appointed members of FDA FACs for medical products. More recently, FDA decided to expand patient involvement in medical product regulatory decisions whether or not a FAC meeting was held. Information is at https://www.fda.gov/patients/learn-about-fda-patientengagement/
about-fda-patient-representative-program; as of today, this page is 5 years old. Clearly, FDA has been finding value in obtaining the patients' perspectives.
**HICPAC is clearly missing the benefits of patient input and should consult FDA to find out how to effectively include it,**
**and then include it as soon as possible.**
2. For all the FACs I was officially involved with, I never saw a page limit imposed on written public comments. For all the times I've submitted oral or written public comment as a private citizen, I never saw a page limit imposed on written public comments. I am appalled at the one page limit imposed for HICPAC public comments for the August 2023 meeting. One page might be enough for a superficial description of a patient's encounter with the healthcare system. It is not nearly enough for a professional essay with scientific references regarding any complicated topic, such as infection control. True transparency of the HICPAC decision making process will not impose any limits on written public comments.
**HICPAC must drop the page limit on written public comments.**
3. **I endorse all the specific comments that have been submitted by People's CDC, World Health Network, and National**
**Nurses United.**
4. In addition, it sounded like the new infection controls being discussed in the August 22nd meeting regarded "isolation". I suggest comprehensive airborne infection controls should be standard, core, and routine, for all (inpatient, outpatient, etc.) patient encounters, both to minimize infections of any type, and to improve the cognitive performance and healing progression for all the people involved. The minimum controls should include:
- Air cleaning, via ventilation, filtration, and Far UV-C,
- Universal N95 respirator use for all workers (not just patient contact), visitors, and all possible patients,
- All workers (not just patient contact) staying home on paid leave when symptomatic or testing positive for an airborne disease,
- Frequent testing of all people in healthcare facilities.
**All controls should be in place all the time, using a time-tested concept from patient safety that "layering" of individually**
**imperfect controls is necessary to strengthen overall control.** These controls are relatively inexpensive to implement, compared to the cost to the healthcare system and our general population of unnecessary healthcare-associated infections.
5. **HICPAC membership should include professional experts on all aspects of the built environment.** I didn't see any air engineers on the roster. You also need experts on water quality and surfaces. It has been well known that many infections spread via physical vectors (air, water, and surfaces).

Sincerely,
Roselie A. Bright, Sc.D.; retired; member of COVID Safe Maryland
Rockville, MD

---

Dear HICPAC,
Due to the ongoing pandemic and spread of COVID19, the CDC needs to implement universal masking in healthcare with N95s or better, recognize aerosol transmission, and keep citizens safe from not only potential death but long covid.

Long covid is real, disables people often to the point of putting them out of work, and happens often enough that we have to protect all people from it. It is also not fair to immuncompromised people to put the burden of masking solely on them, when one-way masking is significantly less effective than two-way.

Surgical masks are also not respirators and do not prevent spread of respiratory illnesses according to OSHA. Surgical masks are loose fitting disposable masks that do not provide a tight seal to protect the wearer or others against airborne diseases. They are not designed or certified to provide respiratory protection and cannot be the deciding factor between life and death or disability for a person, for an occupation where the motto is “do no harm”.
https://www.youtube.com/watch?v=ovSLAuY8ib8

Sincerely,
Julia Conger

---

Taylor Petersen
Rogers, AR

I am a member of the public and I am writing to you to speak against the newest proposed guidelines for COVID precautions in healthcare. Both N-95 masks and proper air filtration should be required in healthcare settings. Your suggestions are irresponsible and dangerous.

---

Dear Committee Members,

Given the ongoing transmission and spread of SARS-CoV2 and knowing that asymptomatic spread is possible, I urge you to recommend the use of N95 masks in all medical settings. This single guideline can dramatically reduce the risk of the most vulnerable members of our communities. Additionally, the continued use of N95 masks in medical settings reduces the risk of the general population and healthcare professionals of developing long COVID, the impacts of which are not even fully known yet.

Sincerely,
Michael Dvorscak
Wheaton, IL

---

I am writing to express my concerns regarding the ventilation systems in healthcare settings and to advocate for the implementation of better ventilation practices to ensure the safety and well-being of both healthcare workers and patients.
In light of the ongoing global health challenges, it has become increasingly evident that maintaining a safe environment in healthcare facilities is of paramount importance. While stringent hygiene practices and personal protective equipment have been crucial in mitigating

the spread of infections, there is a growing body of evidence suggesting that proper ventilation plays a significant role in reducing the risk of airborne transmission of pathogens.
Healthcare settings are often high-traffic areas where individuals with various illnesses come into close contact. Adequate ventilation is essential to dilute and remove potentially contaminated air, thus reducing the concentration of pathogens that may be present. Furthermore, proper ventilation can help control the dispersion of respiratory droplets that may contain infectious agents, contributing to a safer environment for all occupants.
I kindly urge the CDC to prioritize and promote the following measures to enhance ventilation in healthcare settings:

- **Assessment and Upgrades:** Encourage healthcare facilities to conduct comprehensive assessments of their ventilation systems. Implement necessary upgrades to ensure that the systems are up to date and capable of effectively circulating and filtering the air.
- **Guidelines and Standards:** Develop and disseminate clear guidelines and standards for ventilation in healthcare settings, taking into account factors such as air exchange rates, filtration efficiency, and the specific needs of different areas within a facility.
- **Training and Education:** Provide healthcare workers with training on the importance of proper ventilation and how to optimize ventilation systems based on the unique requirements of their respective areas.
- **Research and Innovation:** Invest in research to further understand the role of ventilation in preventing the spread of airborne pathogens. Support the development of innovative ventilation technologies that can be applied in healthcare settings.
- **Collaboration:** Collaborate with relevant stakeholders, including healthcare professionals, engineers, and architects, to develop holistic solutions that address ventilation challenges in a comprehensive manner.

By focusing on these initiatives, we can take significant steps towards creating safer healthcare environments that protect both the dedicated healthcare workforce and the vulnerable patients they serve. I believe that the CDC's leadership in advocating for improved ventilation practices will have a profound and positive impact on public health outcomes.
I am hopeful that, by working together, we can ensure that healthcare facilities across the nation prioritize the implementation of effective ventilation strategies.
Sincerely,
Gwyneth LaMarche

---

I hope this letter finds you in good health. I am writing as a concerned citizen to express my strong support for the adoption of N95 respirators as the standard for preventing COVID-19 transmission. Given the evolving nature of the pandemic and the emerging variants, I believe that it is imperative to consider every available measure to ensure the safety and well-being of the population.
The COVID-19 pandemic has demonstrated the importance of robust and effective preventive measures in limiting the spread of the virus. While masks have been widely acknowledged as a vital tool in reducing transmission, there is a growing body of evidence suggesting that N95 respirators offer a higher level of protection compared to other types of masks. The superior filtration capabilities of N95 respirators, which can block a significant portion of small airborne particles, make them a valuable asset in curbing the spread of the virus.
As we continue to navigate the challenges posed by COVID-19 and its variants, I believe that the CDC has a critical role to play in setting and promoting the highest standards of protection for the general population. By recommending N95 respirators as the standard, you would not only safeguard individuals but also contribute to the collective effort of controlling the pandemic more effectively.
In conclusion, I respectfully urge the CDC to evaluate the evidence supporting the use of N95 respirators and consider updating the guidelines to recommend their use as the standard for

COVID-19 prevention. By taking this step, the CDC would demonstrate its commitment to prioritizing public health and safety.
Thank you for your attention to this matter. I look forward to a safer and healthier future for all.
Sincerely, Gwyneth LaMarche

---

I am writing to express my strong support for the implementation of N95 respirators as the standard for preventing the spread of COVID-19. The ongoing pandemic has highlighted the importance of utilizing the most effective measures to safeguard public health, and I firmly believe that adopting N95 respirators as a requirement is a crucial step in achieving this goal.

N95 respirators have been proven to provide a higher level of filtration and protection compared to other types of masks. With the emergence of new variants of the virus, many of which are more transmissible, it is imperative that we take every possible precaution to limit its spread. By mandating the use of N95 respirators, we can significantly reduce the risk of transmission, not only among the general population but also among healthcare workers, first responders, and other essential personnel who are at the forefront of the battle against this virus.

The effectiveness of N95 respirators in preventing respiratory droplets containing viral particles from entering or leaving the mask wearer's respiratory system has been well-documented. These masks are designed to fit tightly and form a seal around the nose and mouth, minimizing the potential for airborne transmission. While cloth masks and surgical masks offer some level of protection, the higher filtration efficiency of N95 respirators makes them a superior choice for preventing the inhalation of fine particles and aerosols that may contain the virus.

Furthermore, the widespread availability of N95 respirators has increased over time, making them more accessible to the general population. This accessibility, combined with potential government support, could alleviate concerns about the affordability and availability of these masks.

I urge the CDC to consider the latest scientific evidence regarding the effectiveness of N95 respirators in preventing the transmission of COVID-19. By recommending or requiring N95 respirators as the standard for public use, the CDC would send a clear message about the seriousness of the situation and the agency's commitment to protecting the health and well-being of the population.

In conclusion, I respectfully request that the CDC take a proactive stance by advocating for N95 respirators as the standard for preventing the spread of COVID-19. Your leadership and guidance in this matter can make a significant difference in curbing the pandemic and saving lives.
Sincerely, Gwyneth LaMarche

---

Dear Dr. Cohen,

I write to extend my full endorsement of the concerns outlined in the recent letter from National Nurses United regarding the forthcoming changes to the CDC's Isolation Precautions guidance. As a mother and service industry professional, I share their concerns and underscore the gravity of this issue for the safety of healthcare personnel and the wider community.

The COVID-19 pandemic exposed vulnerabilities in our healthcare system, especially regarding protections for frontline healthcare workers. Any guidance modifications should not only be based on the current scientific consensus but also consider the real-world experiences of those

at the forefront of the healthcare system.

It is imperative that the CDC prioritizes:

1) Stakeholder Input: Engage frontline personnel, unions, scientists, and patient safety advocates from the outset.
2) Transparency: Ensure that the entire process is open to public scrutiny, as this impacts public health and safety.
3) Scientific Rigor: Accurately acknowledge and integrate current research, especially about aerosol transmission, into the new guidelines.
4) Clear Protocols: The guidance should unequivocally lay down the precautions to be taken in healthcare settings, ensuring the safety of both personnel and patients.
Dr. Cohen, the CDC has always been a beacon of scientific integrity and public health advocacy. I urge you to ensure that this tradition continues by giving due weightage to the concerns of our healthcare personnel. Their safety directly translates to the safety of the patients they serve.

Thank you for your consideration. I believe that under your leadership, the CDC can continue to uphold its mission to protect the health of our nation.

Kathy Angel

---

Dear Center for Disease Control and Prevention (CDC) Officials:

I'm writing to you in response to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), which I understand is considering new infection control guidelines. I am deeply concerned by these guidelines, as they do not recommend increased or improve air filtration in healthcare settings and they claim that surgical masks are as good as N95 respirators, when all the evidence shows that N95 respirators are necessary to protect healthcare workers and patients from airborne diseases such as covid-19 and the flu. As we go into another covid surge, if we weaken infection control in healthcare settings, we are leaving people vulnerable to covid-19 infections and the risks of long covid, strokes, heart disease, and the many other long-term health risks associated with repeated covid-19 infections.
Instead of weakening infection control guidelines, I ask the CDC to implement safeguards in healthcare settings to ensure that vulnerable individuals are not risking their lives and health in medical settings. Specifically, the CDC should issue indoor air quality targets for all healthcare settings and should recommend source control measures, prioritizing N95 respirators, in healthcare facilities. These measures would ensure that those who are immunocompromised, elderly, or who have other health risks that make them vulnerable to covid-19 could safely visit their doctors and receive necessary medical care. For instance, my grandmother, who 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 time and consideration of this message.
Sincerely,

Merrill Miller
Silver Spring, Maryland

**Re: HICPAC's Revision of CDC's 2007 Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**

The CDC's 5/7/2021 "Scientific Brief: SARS-CoV-2 Transmission" correctly states that COVID may be spread by infectious aerosols that can remain suspended in the air for hours, and their concentrations build up in enclosed, poorly ventilated spaces. Indeed, an infectious person exhaling virus indoors for more than just 15 minutes (for less transmissible 2021 variants) can infect others, even after they themselves have left the enclosed space. Effective control measures are listed as physical distancing, community use of well-fitting masks, adequate ventilation, and avoidance of crowded indoor spaces. (Surgical masks are incorrectly listed as well-fitting.)

Hospitals are currently places where few or none of these control measures are implemented. They are ideal breeding-grounds for air-borne illness, where the infectious and the vulnerable meet in close quarters. Desperate cancer patients receive immune-destroying chemotherapy, then are infected with COVID and RSV. Other immunocompromised patients, the elderly, the many who are at risk for severe COVID, and COVID longhaulers/PASC patients must decide whether to forgo needed healthcare to avoid infection. They are cast aside because it is politically popular to pretend the pandemic is over and their lives don't matter. This is a violation of the ADA and the ACA, and an affront to common decency.

It is little consolation to PASC patients like me that new, highly-transmissible variants are milder, when the bulk of the millions of U.S. PASC cases stem from asymptomatic or mild initial infection, and when each re-infection compounds the risk of new, horrific health problems. My months-long experience with PASC involved being bed-bound and barely able to move, while I gasped for air – a fate worse than death. I was re-infected in January with a miniscule (probably 1-minute) exposure while wearing an N-95 mask. So, I must avoid re-exposure.

My access to life-saving care is subject to the whim of the provider, whether they feel like wearing a mask. (No one should have this kind of power over another human being!) Also, PASC patients are not listed as a vulnerable group, so I have trouble obtaining vaccines. Every measure that could help us survive has been systematically yanked away. We account for 15% of the national labor shortage, yet we're portrayed as insignificant, while lax precautions create more of us daily. It's as if we're expected to just crawl away and die.

After the most devastating airborne pandemic and mass-disabling event in 100 years, HICPAC plans to weaken the precautions the CDC has deemed effective, and is pushing cheap, surgical masks. Even my N-95 didn't protect me. Vulnerable people need fit-tested, superior respirators and two-way masking that reduces virus levels *at the source*. The public must be made aware of this through widely-available educational materials.

The Cochrane study that supposedly equated N-95 and surgical masks was highly flawed (e.g. only 42.3% in the intervention arm wore masks!). Cochrane itself acknowledges these limitations in a 3/10/2023 statement/apology, and states the claim that masks don't work "is an

accurate and misleading interpretation." The study itself states these flaws "[hamper] drawing firm conclusions." Also, if people mask incorrectly "in the real world", it is time to step up education, not give up and throw away effective masks. Any industrial hygienist will tell you that the idea that floppy surgical masks protect against aerosols is a farce. Please enlist the help of people who know these things.

COVID cases are on the rise. The new, highly mutated BA2.86 variant is afoot in the U.S., and we have no idea how virulent it will be. What is your contingency plan?

Laura Cole
M.E.M. Biohazard Science, Duke University

---

Dear CDC,

I am writing 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

---

Written Statement to HICPAC Committee

Submitted By: Chelsea Kolander, BS, MPH/MSW

Member of the Public

San Jose, CA

Topic: Infection Control in Healthcare Settings

I am writing today as a Medical Social Worker and Public Health professional who has been working and volunteering in healthcare settings since 2001. I have worked through SARS-CoV-1, H1N1, and now SARS-CoV-2. Patient, staff, and visitor safety is paramount, and should take precedence in all decisions and proposals brought forth from this committee.

We know in healthcare settings, that clear guidance and updated, scientifically sound information is crucial for patient, staff, and visitor safety. Nosocomial infections are unacceptable, and patients who are positive for TB, COVID, and other airborne viruses must be adequately tested and isolated to prevent spread in the healthcare setting. Additionally, all staff, patients, and visitors must have and use high quality respirators such as N95s and elastomerics to protect their own health, and that of vulnerable patients who are immunocompromised,

undergoing infusions and treatments for cancer, testing, surgeries and procedures in which they cannot mask. It is unacceptable to leave safety up to the patient to ask their provider to wear a mask, when power dynamics are such that this request is far too often denied, leading many high risk patients to delay crucial medical care or not be able to access it at all without risking infection.

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 current proposals ultimately weaken protections for health care personnel. 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.

HICPAC and the CDC can and should do better, for public health, for our patients, staff, and visitors!

---

Please accept my comments below addressing the topic of the work of Healthcare Infection Control Practices Advisory Committee (HICPAC) to revise the CDC's "Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" last updated in 2007.

In July 2023, a group of nearly 900 public health experts sent a letter to the new CDC Director, Dr. Mandy Cohen, expressing concerns about the HICPAC/CDC's updates and process. I would like to echo these concerns as a citizen who is impacted by these decisions. It is a basic expectation that federal advisory committees consult with and address concerns of all stakeholders, and other federal advisory committees including those at the CDC already do this. I urge HICPAC/CDC to increase public engagement and overall transparency in the process of updating the 2007 Isolation Precautions guidance. The letter that was sent by those 900 experts has yet to be meaningfully responded to, and at the HICPAC meeting on August 22nd 2023 there was only a Zoom capacity of 500 people and roughly 30 minutes provided for public comment. It is clear that there are hundreds of expert stakeholders ready to be engaged in this process, and there need to be clear actions taken to meaningfully collect and incorporate their feedback.

Sincerely,

Adrienne Horne

Appleton, ME

---

To HICPAC,

Even people who are vaccinated, boosted young and healthy can become immune compromised in an instant when 1 in 20 COVID infections results in Long Covid. As a result, millions more Americans are immune compromised than were at the start of the pandemic. I am one of them. I have a human right to access medical care without being exposed to a disease that can disable me further. Yet here I am pleading for you to do something obvious to protect me: require N95 or better masks throughout the entire healthcare setting and filter our air.

People with Long Covid are on long wait lists to see specialists. When we finally get appointments we're often afraid to ask them to wear N95 masks lest they drop us in retaliation. I have asked for doctors to wear N95 masks, in order to accommodate my disability, and I'm usually refused despite the ADA. Some medical providers do not understand what airborne spread means. Other medical workers have told me they aren't allowed to wear N95 masks unless their hospital issues them to them.

Because COVID lingers in the air for hours, putting on a mask only at the patient's request does nothing to clear the viruses that linger from when healthcare workers didn't mask in that room before. This is how my friend's baby just got COVID while receiving his 1st COVID vaccination. Masks should be worn by all in waiting rooms, halls and elevators– anywhere patients go.

Like many, I'm now avoiding medical appointments as much as I can in order to protect my remaining health. I've spent hours upon hours researching which hospitals are still masking and calling hospitals and begging them to protect me and patients like me. I've had to put my migraine treatment on hold. If hospitals used proper HEPA air filtration and UV sterilization they could be accessible again. Installing those improvements takes time. But medical professionals could wear N95s and respirators today.

N95 masks can comfortable and accessible. When people complain about masks they are usually complaining about surgical masks that get caught in their mouths when they speak, stuck in nostrils and don't even filter air. Surgicals literally gape around your face. People will wear masks more when they are sturdy, comfortable and work like N95s do.

Act before your hospitals are forced to close during this surge. Who will treat us once so many doctors and nurses are out sick with COVID and even become too disabled to return to work?

Elana Levin

Member of Covid Advocacy Initiative

Brooklyn NY

---

Name: Vanessa Auritt

Topic: HICPAC Weakening Airborne Viral Infection Precautions in Healthcare Settings

Address: Philadelphia PA

Organization Affiliation: Member of Public, Public Health Professional

Comment:

As a Public Health Professional, I implore the committee to reconsider the decision to weaken airborne viral infection precautions in healthcare settings. With the knowledge and studies that has been gathered since March 2020 and the surplus of COVID-related deaths and people with

Long COVID, I am disturbed at the notion that this committee would not to everything in their power to protect healthcare and front line workers, and patients. Committee members, your actions make huge impacts. The decision to STRENGTHEN airborne viral infection precautions will be celebrated today and in history as a deeply important measure to protect people from COVID-19. COVID-19 numbers are exploding in the US as we continue to get more mutations of the virus. Please make the right decision. Thank you.

---

My husband is 81 and I am 70. According to a recent study, we are 20 times as likely to get reinfected if we get COVID even once. COVID is airborne and highly contagious, and new variants continue to emerge. Vaccines are not enough to prevent the spread, and there is a growing body of evidence that even those with mild cases can experience long term effects .Two simple, highly effective preventive strategies are improving indoor air quality and using 95 masks. It is simple common sense to apply these strategies and it shows a deliberate, callous disregard for the health and safety of vulnerable populations like the elderly and immunocompromised, as well as the currently healthy, to ignore and even active weaken these strategies.

You are educated scientists and you are needlessly condemning people to worse health and possible death. Why are you forcing my 81 year old husband to risk his health and possibly his life so he can get surgery that we've post poned for three years until it was safe? Now, we doubt that even the best hospitals will ever be safe for elderly patients like us.

I have to ask, in all sincerity, "Have you no dignity?"

Lou Rosenberg

Los Angeles, CA

---

It's simply unbelievable that in the middle of a continuing pandemic from an airborne pathogen, HICPAC is holding private closed door meetings to lower standards in healthcare settings and remove respirators, thereby lowering infection control standards. The only conclusion I can reach at this point is that your committee is prioritizing industry cost savings at the expense of patients' lives. For those who have cynically suspected that all decisions made by CDC leadership has been driven by interests of the economy over human lives, this latest decision seem to confirm their suspicions.

Reports from overseas hospitals, like this one from Australia (https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html), show how Sars-Cov-2 has killed 659 patients from hospital-acquired infections in Victoria, and that nearly 6,500 have caught Covid in hospitals (total state pop. of 6.6 million people) while being treated for something else. Given all the research that show improved ventilation, upgraded air filtration, along with N95 respirators can significantly reduce the spread of this airborne virus, it is a clear failure that health care systems have not addressed this situation in the past 3.5 years. Even worse, US's private healthcare system (profit over people) has given this country the dubious distinction of being the nation with the most excess mortality due to Covid in the developed world.

In light of all this, the fact that your committee is attempting to weaken the guidelines set forth in 2007 without input from aerosol scientists, occupational health experts, and other relevant scientist and experts is truly incomprehensible. The fact that you're doing this with industry

representatives behind closed doors, and refusing to circulate your working draft prior to voting is egregious. Furthermore, HICPAC's failure (refusal) to answer NNU's FACA request and redacting its FOIA response is illegal. Where is the transparency which is fundamental from a publicly funded health agency?

Many of us in the public attended the 22 August meeting, heard the facts presented by commenters who came ready with the latest research. There were many, many more experts waiting to have their turn to speak. Your committee limited the public comments to only the first 14 people. Then, a mere two hours after the meeting concluded, you removed the public video of the meeting, further serving to highlight the secretive and evasive manner in which this whole business has been conducted by this committee.

We, the public, are dismayed, alarmed, and worried by what we've seen so far. We hope that before the CDC votes on this issue in November, all of the problems noted so far will be addressed with transparence. We'll hope, but we also stand ready to fight this with legal challenges and all other means at our disposal.

Madhouse Muse

---

Name: Aron Winter

Address: Hannacroix, NY

Organizational Affiliation: Member of the Public

Hello and thank you for accepting my comment on the topic of precautions and mitigations for disease control in healthcare settings. I am the caretaker of my aunt, who is a heart attack survivor and also, recently, a kidney and ovarian cancer survivor. My aunt is now among the millions of people in America who are disabled and considered high risk when it comes to respiratory illnesses like COVID19. Since the removal of masks and precautions from healthcare settings, my aunt now further risks her health each time she must go anywhere, including oncology and pulmonary appointments. Healthcare settings now lack any safety precautions to protect people like my aunt from contracting respiratory illnesses while they receive treatment for other health concerns. It should be the most basic requirement of healthcare professionals to keep their patients safe by using well-fitting N95 respirators, especially when patients are faced with needing to remove their mask during appointments or procedures. In addition to NIOSH-approved respirators (which we know have been incredibly useful against the spread of COVID19), it should be a requirement that clean air be a priority in healthcare settings with the use of air cleaning machines and HEPA filters. This is a necessity to protect the millions of people in America who need medical care on a regular basis. The lives of the vulnerable are worth living and worth taking care of. They matter. They are people, just like you. And if I, a layman, can research and understand the importance of clean air and quality protections in healthcare settings, then, surely, well-educated people like those in HICPAC can, as well.

Thank you for your time

---

I am submitting my comment (below) addressing the topic of the Healthcare Infection Control Practices Advisory Committee (HICPAC) revising the CDC's "Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings," last updated in 2007.

It is my understanding that the Centers for Disease Control and Prevention (CDC) is endeavoring to weaken protections that prevent health care workers from being exposed to airborne pathogens at work. This is alarming to me, as someone who relies on health care workers for care. Not only do I want my family, neighbors and friends who are health care personnel to have their own health protected to the highest degree, I also, as a patient, do not want to be infected by an airborne pathogen as I'm seeking care at a healthcare facility and trying to heal.

Healthcare facilities must be places where the public can trust their health is valued at the highest degree. The revised CDC/HICPAC guidelines do not sufficiently protect healthcare workers or the public. The COVID-19 pandemic has demonstrated the risks of not taking proper precautions against infectious aerosols, and has also proved the importance of air ventilation and the right personal protective equipment (PPE) in keeping people safe, especially in busy indoor settings with many sick individuals (i.e. hospitals). It is not enough to simply talk about "air" transmission - the CDC/HICPAC must also specify that N95 masks and respirators, not surgical masks, are the standard for preventing infections from aerosols. It is not enough to allow hospitals to determine for themselves whether ventilation is adequate - there needs to be specific requirements for ventilation to ensure that this safety measure is in place for workers and patients alike. We have seen during the COVID-19 pandemic that when a "flexible" approach is taken, health care facilities use this leniency to allow workers to forgo effective PPE, putting others at risk, all while claiming to be safer than they really are. CDC/HICPAC guidelines must be clear, specific, and science-based if there is to be any assurance that health care facilities are safe places to work or seek care.

To relax protective protocols at this time would render healthcare facilities into spaces of disease and death, not health and healing. It is paramount that the CDC/HICPAC listen to the stakeholders, experts, scientists, and ordinary citizens like me who are asking that health care facilities have baseline safety requirements that put health and science-based protections over cost-saving measures. Every health care worker deserves this. Every patient who breathes air deserves this. Please protect us.

Claire Horne

Appleton, ME

---

To whom it may concern,

I have lost respect for so many in the medical profession during this pandemic that too many of you keep pretending is over. It's very hard to take my local public health officials seriously when they send their representatives to crowded indoor events without masks to give away preventative tools like condoms and Narcan, but not masks. Now your agency is considering further undermining public health by weakening your infection safety precautions for healthcare workers. Just when I thought I had no confidence left to lose, you've proven me wrong.

I have already seen what's happened as healthcare facilities no longer require masks, or rather I have received this information secondhand because I am doing my best to avoid these places now that doctors, nurses, and dentists aren't wearing masks anymore. I am 44 years old and this year I have been avoiding the type of preventative care a woman my age should get because I am afraid of contracting COVID at a routine appointment. I have given up so many things. I have put my life on hold because your poor public health communication has

encouraged everyone to relax masking requirements to the point where every commute to and from work on public transportation is a potential super-spreader event and every elevator in the buildings where I work and live is a vector of disease. Because your agency has done such a terrible job explaining the risks of COVID to the public, people in leadership positions keep making decisions that put their patients, employees, students, parishioners, visitors, and customers in harm's way. In addition, because of your confusing messaging, misinformation and conspiracy theories abound and there are still people who aren't aware that long COVID exists.

So many medical personnel are already afflicted with long-term health issues after getting infected with COVID early in the pandemic or multiple times. Not only would your proposed changes further undermine their quality of life, but at the rate things are going, I don't think they can take it any more and many of them will want to quit. Isn't there already enough of a shortage of qualified healthcare providers? What about the medical staff who are already high-risk? Should they be driven out of medical facilities just as high-risk patients have been? Is it unreasonable for them not to want to get infected with a new disease like COVID?

You should be ashamed of yourselves. What is your purpose? What diseases do you prevent? Who is calling the shots here, scientists with the best interests of humanity at heart or the authors and signers of the Great Barrington Declaration? Your agency went from providing the American public with updated information about the spread of COVID in our communities to posting the current useless map that only shows how many people are hospitalized with it, yet we are assured that all we need to do is look on your website to decide for ourselves what precautions to take. Whatever happened to the notion that an ounce of prevention is worth a pound of cure?

As an African-American, I am well aware of your agency's egregious malfeasance in the matter of the Tuskegee Syphilis Study and your COVID response feels like history repeating itself, as though this disease is just something to be studied as it runs rampant through an unprotected population. We need better tests, better vaccines, better treatments, better ventilation, and better communication from your agency about the importance of all these things. Our lives depend on it, our taxpayer dollars pay your salaries, and I am thoroughly disgusted with the way you have handled this dire situation.

Sincerely,

Tiffany Gholar

---

To the CDC,

My name is Tea and I am a trans, disabled, immunocompromised, Filipinx immigrant nurse working in an emergency department in a busy public hospital in so called new york city. I am emailing you today to shame you for proposing to weaken infection control in healthcare settings, and to demand that you listen to the science, not the corporations. Your plan to weaken protocols will lead to the ***easily preventable*** death and disablement of ***millions*** of people. You already have blood on your hands for bending to the will of the monopoly capitalists and weakening COVID safety guidance, but you will have even more blood on your hands unless you strengthen infection control protocols to follow the most up to date evidence regarding COVID safety. The study comparing the efficacy of N95 vs surgical masks, which you have cited to bolster your decision, is a flawed study that has been disproven by countless other

studies. This is unacceptable and will be met with resistance from the very people you claim to serve.

It is my duty to give high quality care to my patients and my community, and so following your weakened infection control protocol would do extensive harm to not only my patients, but also myself and my fellow healthcare workers and their families.

This move to cut costs will have significant long term effects on so many people that history will forever remember the CDC has the eugenicist lackey of the capitalist ruling class.

Do no harm, not as you are told by the capitalists.

Regards,

Tea

---

My name is Renee Shoop. I am a member of the public, a covid survivor, and my spouse is high risk. We wear N-95 or KN-94 masks EVERYWHERE. We do not rely upon surgical masks, which are not effective against covid.

My address is
Signal Mtn, TN

I formally request that you:

Please require adequate air ventilation and N-95 masks in ALL healthcare settings. High risk people are avoiding healthcare because of the dangers inherent to lax guidelines regarding covid and other airborne viruses in medical settings. It is insane that when I go to the doctor for long covid treatment, I have to ask the nurses to put on a mask.

Thank you,
Renee Shoop

---

we need masks in all healthcare situations. it's an crime that they had to stop wearing them, we are old and have to deal with doctors and hospitals a lot, a surgery last week with no mask wearing at the hospital. my husband was going to have to take his off for his procedure, but they assured me they would hang it on his IV stand, and of course they lost it, when he came around from anesthesia they gave him a crappy surgical mask. not the N95 that we wear.
syracuse NY just posted they are going back to requiring masks. make this country-wide, please!
jan mackay

---

Kate Ryan
Medford, MA
Topic: masks in health care

Nobody knows why autistic and developmentally disabled people get long covid and die of covid more. But we do. I am only 39 and I don’t want to die. Society doesn’t value disabled lives much though, it values the economy. I don’t contribute much to the economy but I contribute to my community and my family. The new CDC rules are not accurate about aerosol transmission. I am very medically complex. If I get covid and die I don’t want it to be from the hospital. You

need to require n95s in healthcare settings. You need to acknowledge the expertise of the disabled community.

I do NOT want to die but it seems like the CDC is okay with it.

That is all I have to say.

---

Hello,

My name is Em Rabelais, and I live in Chicago, Illinois.

Most important:

- The CDC ***must*** increase indoor air quality in healthcare facilities, and yet you are not. This is wrong, and you should correct this.
- Viruses are airborne and can float in the air of a room or hallway for hours; they travel like cigarette smoke does. Think about when you can smell the secondhand smoke of others--that's when you can also inhale the viruses they're shedding.
    - A medical/surgical facemask does not protect from airborne pathogens.
        - A medical/surgical facemask does not prevent spreading airborne pathogens.
    - A well-fitted N95+ respirator with a seal, identified via fit testing, does protect from airborne pathogens.
        - An unvented N95+ respirator with a seal does prevent spreading airborne pathogens.
- Immunocompromised people can die and will die and have died, because clinical staff have not worn N95+ respirators, either of their own volition or when patients ask them to.
    - ***Today, and in the future, the only way that immunocompromised people can safely access healthcare is to require 2-way masking with respirators***.
    - The world has changed. Clinicians and others in the clinic/hospital setting should always be wearing N95+ respirators.
        - ***This should be the new universal precautions.***

I am a nurse and health ethicist with expertise about clinician-patient power dynamics, especially in how clinicians are violent to patients, in interactions and communication. I also am disabled with several permanent, chronic conditions, and have been immunocompromised for a decade. My chronic conditions limit what I can do physically, and I use a cane to help me with stability. I do my best to minimize leaving my home, because, as an immunocompromised person, it is unsafe for me to be at most places I was able to be in before becoming immunocompromised, just over a decade ago. It is unsafe even when I am wearing an elastomeric half-mask with P100 filters. During the early pandemic, before national and local mask mandates were lifted, I felt safer than ever before when grocery shopping, going to a medical visit, or to the pharmacy. Now, since there are no more mask mandates or any other required anti-pandemic, anti-disease spread regulations, I try to only have virtual medical appointments. I have delayed several medical appointments and diagnostic procedures and treatments because participating in those would expose me to pathogens that would leave me further disabled or dead. It is quite possible that, if it were safe for me to have these treatments, then I very well might be able to work again. Yet, for now, it is not safe for me to be treated in a hospital setting.

I bring my Aranet 4 just about everywhere, because it is a CO2 monitor acting as a proxy for indoor air quality, and the potential density of airborne viruses. The lowest measure of CO2 is about 420ppm, which is what you'd find outdoors, generally. Between 1000-1400ppm heeds

caution, and above 1400ppm represents unsafe levels. Almost every clinic or hospital waiting room I have been in has had CO2 levels higher than 2000ppm (the highest were 3200 and 4300ppm). Examination rooms have ranged between 700-2500ppm. This is dangerous not just because of the level of carbon dioxide, but also because of the density of pathogens in the unfiltered air, including the cold virus, influenza, covid, and others.

I need to be able to access my health care in ways that are not going to make me more sick. I'm sure it would also be quite helpful for those working in healthcare to be able to work in an environment where the air is safe to breathe. I'm referring not just to physicians, nurses, and aides, but also to desk staff, schedulers, and all other nonclinical staff. The pandemic is not over, and because of the way government entities in the United States handled things, the pandemic will never be over. Masking for all people in clinical facilities should be permanent. I know that in this country that is apparently the highest of asks, even though the tools exist (N95+ respirators, fit testing). The tools and abilities also exist for ventilation and air filtration targets for healthcare facilities to work towards making clinical areas safe for patients.

I know that you can do this, but will you? I am scared about what my future might be.

Thank you for your attention,

**Em Rabelais, PhD, MBE, MS, MA, RN**
Interdependent Scholar, Consultant, and Artist
Chicago, IL

---

Name: Kaitlin Sundling, MD, PhD Organization: The People's CDC
Location: Madison, Wisconsin Dear HICPAC Committee Secretariat, Below is my public comment for the CDC's HICPAC August committee meeting, which was delivered orally via Zoom during the meeting on August 22. I have also recorded my comment which is available on Youtube: https://www.youtube.com/watch?v=Ht5VioGQjCs August 22, 2023

This is my public comment from today's CDC Healthcare Infection Control Practices Advisory Committee meeting.

My name is Kaitlin Sundling - I'm a physician, scientist, and pathologist in Wisconsin. I have no conflicts of interest to disclose. I'm a member of the People's CDC.

I am speaking today in support of universal masking in healthcare, ideally with broad use of well-fitting N95 or better respirators, as a new addition to standard precautions.

Now is the time to use what we've learned from HIV and bloodborne pathogens. Matching our understanding of the science of aerosol transmission to our precautions in healthcare allows us to work toward building public trust and destigmatizing aerosol transmitted infectious diseases, especially where asymptomatic transmission is common as with COVID.

Denying the well-proven science of N95 respirators would be a significant step backwards. There is no physical basis to support the idea that different aerosol pathogens travel different distances. Appropriate isolation for known or suspected aerosol pathogen infections of any kind including COVID MUST include N95 respirators at minimum and appropriate ventilation controls.

I wanted to share a couple of experiences where universal airborne precautions would have prevented exposure from my work as a pathologist and as medical director of a health professional training program.

While I was in my fellowship training at a well-known Boston hospital, I found out I had been exposed to tuberculosis when I had performed a small biopsy of a neck lymph node on a patient who, as far as we knew, lacked any symptoms or history that would have caused us to suspect the infection.
More recently, one of my students was also exposed to tuberculosis on a lung biopsy procedure where cancer had been the suspected diagnosis.

If we only protect ourselves against known or certain exposures, we put both patients and workers at risk. We need to expand, NOT reduce, the use of N95 or better respiratory protection including elastomeric respirators with source control and PAPRs in healthcare settings.

Lastly, we have a duty to protect our patients. I have had multiple people in my community ask if I, as a pathologist or laboratory-based clinician, can be their primary care provider. It is incredibly sad to me that so few of my fellow healthcare providers are wearing masks to protect themselves and their patients, and some are not even willing to mask upon request. Where providers are masking, our patients, including those who are immunocompromised, still face unmasked waiting rooms and other spaces with shared air. Should patients have to ask their surgeon to wear sterile gloves? Putting the burden of protection on patients is not an appropriate infection control approach.

In conclusion, I call on you, the CDC's HICPAC committee members, to recommend universal masking in healthcare, ideally with broad use of well-fitting N95 or better respirators, as a new addition to standard precautions

---

I immigrated to the United States less than three months ago and I am in the midst of navigating its health system: finding new primary care doctors and specialists to stay up to date on my health care. Even as an individual with advanced education degrees and a general understanding and interest in public health, this has been an unreasonably hard task. In addition, it has been even harder to find doctors and health facilities that take minimal precautions to address the transmission of SARS-CoV-2. I have a health condition that, although it minimally affects my daily life, puts me at a very high risk of vascular consequences from COVID.

There is more than enough evidence at this point that justify the need for measures to improve air quality in general, but specially in settings where persons with chronic illnesses and those immunocompromised, just to mention two groups. I am respectfully requesting the CDC to take all measures under its legal mandate to ensure indoor air quality in healthcare facilities following scientific evidence, including, but not limited to:

- Issue and enforce Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration)
- Require the use of N95 masks in all healthcare facilities.

First name: Juan Sebastian
Last name: Jaime Pardo
Address: Washington
No organizational affiliation

---

Dear Center for Disease Control and Prevention (CDC) Officials:

I'm writing to you in response to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), which I understand is considering new infection control guidelines. I am deeply concerned by these guidelines, as they do not recommend increased or improve air filtration in healthcare settings and they claim that surgical masks are as good as N95 respirators, when all the evidence shows that high quality air filtration is as necessary as are N95 respirators to protect healthcare workers and patients from airborne viruses such as covid-19, with strong benefits for controlling flu infections too. As covid mutates and new variants transmit predictably and continuously, we must strengthen the weak infection control guidelines in healthcare settings. We are leaving people in the dust who are especially vulnerable to covid-19 infections, and introducing to every worker, patient, and provider in in-person healthcare the risk of long covid, which increases with each subsequent infection.

Specifically, the CDC should issue indoor air quality targets for all healthcare settings and should recommend source control measures, prioritizing N95 respirators and air purification with HERV-13 filtration in healthcare facilities. These measures would ensure that those who are immunocompromised, elderly, or who have other health risks that make them vulnerable to covid-19 could safely visit their doctors and receive necessary medical care. Currently, high-risk populations who are aware of the risks between accessing necessary medical care and avoiding covid-19 infection make impossible choices, risking the documented exacerbation of pre-existing health problems by increased covid infections. Indoor air quality targets and source control measures prioritizing N95 respirators in healthcare settings would protect those who are vulnerable to covid-19.

Sincerely,

Mckenna LC Stratton
Rockville, MD

---

**Name:** Kelsey McEvoy
**Address:** Portland, OR
**Affiliation:** Pan End It!, disabled patient, and member of the public
**Topic being addressed:** Improve infectious disease measures in healthcare settings

August 24, 2023

Due to the CDC’s irresponsible and negligent response to the ongoing COVID-19 pandemic—including the agency’s unclear, inconsistent, and inaccurate messaging and guidance specifically regarding the use of well-fitting, high-quality respirators to control and reduce the transmission of COVID-19 in general and in healthcare settings in particular—disabled patients like myself are unable to safely access important and vital healthcare.

While some hospitals and healthcare settings have opted to recommend or require masking in certain areas of their facilities, patients must still access and travel through shared spaces—such as parking garages, waiting rooms, and elevators where masking is not recommended or required—to access specialized areas. Masking in only certain areas and one-way masking are not enough.

I am calling on you to align your guidance and public messaging with the science:

- Establish universal masking in healthcare settings—including medical, dental, and mental health spaces, including in schools, residential facilities, and jails/prisons—with N95 respirators as a minimum requirement for all staff, patients, and visitors.
- Provide explicit guidance to medical schools that masking using N95s or better should be standard in educational and training environments.
- Track hospital-acquired infections.
- Fully recognize aerosol inhalation/transmission of SAR-CoV-2 and other infectious aerosols and describe in detail the proposed "air" transmission category.
- Include the use of multiple concurrent controls that have been shown to effectively significantly reduce or prevent transmission of infectious aerosols, including ventilation, air filtration, isolation, testing, and respiratory protection and other PPE.
- Make HICPAC's planning, review, and voting processes transparent and collaborative, including stakeholders such as patients, personnel, and subject matter experts at each step.
- Formally recognize the lack of proper infection control measures as an equity issue, as Black, Native American, and disabled and chronically ill people are disproportionately impacted by COVID-19 and other infectious diseases.

The CDC is in a position to effect substantial and much-needed change to make healthcare—a universal human right—safer and accessible to all during the ongoing COVID-19 pandemic. That the CDC is even considering removing/reducing infectious diseases protections in healthcare settings is unconscionable. Do better.

-Kelsey McEvoy

---

I am Dr. Judy Stone, an infectious diseases physician and medical journalist.
I am very concerned about the process HICPAC used in making its proposed revisions to isolation guidelines. These are explained in greater detail in my two posts in Forbes this week on 8/21 (https://www.forbes.com/sites/judystone/2023/08/21/cdc-weighs-lower-infection-safety-precautions-for-healthcare-workers/?sh=772f778d7ba4), 8/25 (http://www.forbes.com/sites/judystone/2023/08/24/public-pushes-back-on-cdcs-plan-to-weaken-infection-control/).

My biggest concerns relate to:

- The clear appearance from the two HICPAC meetings (June and Aug 22) that **the public understands aerosol transmission better than the committee does.**

The CDC had previously noted that N95s are better than standard masks and are now backtracking.

- Your **flawed literature review, with cherry-picked data. There is ample data that N95s provide superior protection which was ignored.**
- **Lack of experts on HICPAC—specifically in the areas of** in respiratory protection, aerosol science, occupational health, and ventilation engineering.
- The need for **protection from asymptomatic transmission.**
- You are giving the appearance that the **guidelines are being weakened to protect employers and save money, and that the health and safety of patients and healthcare workers are of secondary concern. The drumbeat of "the pandemic is over" and the urgency of normal belies the truth.**
- **HCWs are refusing to mask and not accommodating patients. This is resulting in patients fearing to seek medical care,** further endangering their health by doing so.

This does not consider the power relationships between patients and HCWs. There MUST be universal masking when caring for patients. The disabled are considered disposable nuisances to hospital efficiency. This smacks of eugenics.

- HICPAC shows **no recognition of long Covid or toll of recurrent infections in designing their recommendations**
- **Lack of transparency and responsiveness—need for open meetings and notes in a timely fashion**
    - As an example, Jane Thomason, Lead Industrial Hygienist at National Nurses United, told me that they had submitted a FOIA request for the committee's evidence review in its entirety and the minutes from the last nine months of working group meetings. These were denied, then redacted.
    - Lack of substantive response to the expert's letter from Peg Seminario, et.al.
    - I agree with Rachel Weintraub who said, "Create a public docket on the development of the guidelines and include all meeting minutes draft guidelines, all scientific evidence used in the development of the guidelines, and also comments from the public. Inform the public in advance when there will be a vote" to "increase the openness and transparency of this process."
- The **appearance of conflicts of interest with avowed anti-maskers being on HICPAC.**

---

I comment in the hope that HICPAC will follow its ethical and legal responsibility to help reduce healthcare-acquired infections by strengthening guidelines for respirator use in healthcare settings. I was pleased to hear the discussion at the recent HICPAC meeting of proposed guidelines for Andes virus. In this discussion, it was clear that CDC experts understand the need for N95 respirators or better to prevent the spread of aerosolized diseases. At a time when hospitals are citing to a few deeply flawed and biased studies to support their profit-based refusals to provide proper respiratory equipment to their employees (for example, studies in which healthcare workers were primarily infected in the community, which is not a scientifically valid way to assess the efficacy of work PPE), it was good to hear this recognition of the well-established reality that N95 respirators or better are necessary to protect against airborne hazards, including tuberculosis, Andes virus, and other aerosolized diseases. It now falls to HICPAC to follow the science showing that Sars-CoV-2 is also an aerosolized virus, and to establish guidelines requiring adequate respiratory protection for this and other aerosolized viruses currently circulating in our communities and healthcare settings.

The inadequacy of current CDC guidelines to protect patients and medical staff against the transmission of airborne diseases such as COVID-19 and influenza has prevented my family from safely accessing medical care. Without even a basic mask mandate (much less the scientifically and ethically called for mandatory use of respirators to prevent the spread of airborne diseases), we have cancelled or put off medical appointments, concluding that our existing medical needs are less serious than the medical consequences we may experience if we are exposed to the SARS-CoV-2 virus by an unmasked patient or medical provider. When we have obtained necessary medical care, the lack of a mask/respirator mandate has made the experience both stressful and dangerous.

For instance, when I needed surgery earlier this month, I requested that all medical staff involved in my care wear masks in order to protect me while I was unable to keep my respirator on to protect myself (e.g., when I needed to swallow pills, and while I was in the post-op recovery room). Despite this request, however, few of the staff wore masks, and those who did wore surgical masks, which experts have long recognized to be far less effective than

respirators at preventing the spread of aerosolized diseases. I was also left in the post-op recovery room with an unmasked coughing patient, and my respirator was not placed back on me for several minutes despite my repeated pre-surgery requests that it be placed back on me as soon as possible after my oxygen mask was removed.

I should not need to beg medical staff to be protected from exposure to infectious diseases in a healthcare setting, and I should not have my requests for such protections ignored. I should not need to worry during my recovery period that I may have contracted an infectious disease while in a weakened state. HICPAC needs to fulfill its responsibility of preventing healthcare-acquired infections by recognizing the aerosolized transmission of serious diseases such as COVID-19, RSV, and influenza, and by implementing policies to prevent such airborne transmission, including mandatory respirator use in healthcare settings.

Sincerely,
Cindy Jones

---

To whom it may concern:

It is beyond comprehension why the CDC is considering new infection control guidance for healthcare facilities that does NOT recommend increasing indoor air quality (i.e. ventilation and filtration) inside healthcare facilities, but does claim that surgical masks are just as good as N95s.

Surgical masks are not as protective as N95s. There is a ton of solid research on this. Improving air quality with HEPA filtration and appropriate air changes per hour is an effective part of reducing the spread of not only COVID but flu and other airborne viruses. There is a ton of solid research on this.

I urge you to recommend the use of well-fitted N95s and HEPA air filtration in healthcare settings. To do otherwise is to endanger millions of people.

Sincerely,
Jacqueline Mittman

---

Hello,
Please increase requirements for mask usage in healthcare settings. Do not decrease them in any way.
I am not a healthcare professional, but I have family members who are doctors, nurses, and in other healthcare positions who have direct contact with patients. Some of my family work in hospitals, some work in doctor's offices, and some work in group home healthcare settings. I hear their stories and their concerns. Even if you believe that the danger of Covid is past, which it isn't, there are so many other threats to my family's health. They are exposed to Covid, RSV, flu, and many other viral and bacterial illnesses. Most of their patients are not wearing masks any more. Patients risk spreading their illnesses to each other in these settings, but also to the healthcare workers. And the reverse is true - workers to patients.
Beyond the obvious worry for the patients' and workers' health, this concerns all of us because we already are seriously understaffed across the nation in many healthcare settings. My personal physician told me she is struggling because there simply are not enough qualified healthcare staff. Imagine how much worse it can be when many of the staff are out for illness. Having patients and healthcare workers wear masks greatly reduces the risk of loss of

those workers due to illness. This was proven during the height of the pandemic. We have all seen the graphics put out by the CDC, the American Medical Association, universities, government agencies, and others. Masks work. They reduce risk. And they are especially helpful when both parties wear them.
My sister was recently hospitalized for a total of nine days over two stays. I was with her through the emergency room (twice), the ICU, and a small two-person hospital room (twice). And I have been with her on related doctors' visits. I wore my N95 but the majority of the healthcare workers were not masked. I was truly frightened - for myself, for my desperately ill sister, for the other patients, and for the healthcare workers. They still have not determined what caused her illness. They are talking about getting an infectious disease specialist involved. With that unknown risk, why weren't the hospital and office staff wearing masks?
She had three roommates during her stays. They all were very seriously ill and happened to be elderly. In those tiny and poorly ventilated rooms, they were exposed to my sister. In fact, we were all exposed to each other and who knows what illnesses, as the healthcare staff were caring for many very ill patients. We were told the hospital was full. I certainly saw the standing-room-only emergency room both times.
Why were the overwhelming majority of healthcare staff in the ER, in the ICU, in the main hospital, and in the doctors' offices not wearing masks for their protection and for the protection of the patients? It is a no-brainer - we know that people can be asymptomatic or be contagious before they show symptoms. Why are seriously ill patients being put at unnecessary risk? Why are we risking our already highly stressed healthcare workers and system? All that is needed to provide more protection is a simple mask.
Please increase requirements for mask usage in healthcare settings. Do not decrease them in any way.
Thank you,
Debra Wilson
St. Louis, MO

---

Hello,

I urge HICPAC and CDC to fully recognize aerosol transmission (inhalation of small infectious particles) to ensure health care worker and patient protection.
The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during 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. They are weaker than existing CDC infection control guidelines. The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols.

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.
Please change course and develop updated guidelines and recommendations, in consultation with key stakeholders, based on the full body of the scientific evidence and experience confirmed during the COVID-19 pandemic that will fully protect health care personnel against infectious aerosols.

Thank you,
Roberta Klug

---

My only question is why is it the people who are being effected by something out of their control also have to be bullied by a group of people making choices on their behalf? Every choice you make has no effect on your life but has a cast ripple in the lives of people around you. Try putting yourself in someone else's situation before making your choice. Unless the corporate money is already in your account.

Tyler Mengore

---

To the Secretary,

I am speaking as a public voting citizen of the US and a healthcare provider, my name is: Stephanie Sammarco, Edison, NJ

I am writing to address the future COVID and other viral infection precaution recommendations for healthcare settings that are to be decided and implemented in the near future. There is no mention of air filtration as one of the precautionary measures in the fight against the spread of COVID and other viral airborne illnesses. Yet, we know from countless peer reviewed studies, that this is the best way to prevent the spread of airborne viral illnesses, like COVID, which is currently on a major uptick in this country. Also, surgical masks are completely different from n95 or Kn95 masks and cannot be categorized as having similar protections. You all know that n95s are our best protection. You also know the public was unanimous in their dissent against the proposed draft of having surgical masks, instead of n95s, as the protocol for preventing COVID. Do you wish to collapse our hospitals and doctors' offices throughout this country? Do you wish to kill countless people with autoimmune diseases, cancer, heart disease or other underlying illnesses? I thought doctors took an oath to "first do no harm" to their patients. This includes protecting them from infection, using infection control measures that have been in place for at least the last 30 years, such as masking properly. Are we getting rid of washing our hands too? We have a new (novel) illness- COVID-19 and need to adjust accordingly. Why would you use antiquated recommendations for a new situation? Doesn't seem like a very intelligent decision to use a baseball playbook when we are playing basketball. Understand?

Is your motivation money instead of the lives of our American citizens? Do you wish the healthcare system to collapse in this country? Do you want people to die in this country because of bad or cowardly decision making? If you don't implement proper infection control

recommendations, that is what you all will be doing. The proper recommendation for COVID precautions in a healthcare setting should be proper air filtration systems along with requiring all healthcare providers in healthcare settings to wear at minimum a kn95 mask, nothing less.

I hope you take this seriously because you are playing with millions of people's lives all because people don't want to take the proper precautions to protect their fellow man. Do the right thing, you know what works.
Best, Stephanie

---

To whom it may concern:

Despite your evident distaste for engaging with facts, ethics, or scientific consensus, I am trying to encourage you to vote against the new transmission guidelines for healthcare workers. We know what works for reducing the spread of COVID-19: N95 masks and air filtration. Equating N95s with surgical masks and ignoring air filtration is inaccurate and misleading, increasing the risk of infection and death for people who are already vulnerable due to their exposure to the public (medical and hospital staff) and by the fact that they are hospitalized. Weakening guidelines when the pandemic is ongoing and when we know it is airborne is eugenics. You think you're invulnerable—you aren't. Good health and able bodies are not permanent or guaranteed. You behave with reckless disregard for the lives and welfare of the public you have sworn to serve when you refuse to act upon the knowledge you have and the clear consensus of the witnesses who spoke at this week's meeting.

Do better,

Victoria R. Hill
HICPAC Transmission Guidelines
Washington DC

---

Hello, my name is Sarah Canoy, and I heard you need my address, also. It is:
Hanford, CA

I am writing this comment to you as a member of the public. While the CDC is focused on their reputation and messaging, millions of people are unnecessarily dying and/or becoming disabled from COVID-19. This is PREVENTABLE, and you know it! The CDC needs to grow a backbone and simply cite the science. You are supposed to CONTROL disease and its spread. Instead, you let it rip throughout the United States without dare uttering the words "masks" or "vaccines."

You know what the right thing to do is, and yet keep your facts/knowledge/information locked up and unmasked-smiles out, so as to look better - again - for "messaging." It is cruel to people's lives, especially immune-compromised and elderly people. As it seems you need a reminder: they are PEOPLE. Human beings same as yourselves. If you know air quality, masking, and distancing is important for disease control, why are your practices "for me but not for thee"?

Do better. You are killing and disabling people. Don't be villains in the history books.

Sincerely,
Sarah Canoy

---

As a new public health professional, I am repulsed by the decision to adopt minimal protections and allow healthcare workers undefined broad discretion to create their infection control plans. It is apparent that saving money and political influence are the driving forces behind these decisions because anyone competent in public health and infection control measures would never consider these suggestions.
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 majorly 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 reviews 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.
How many more innocent people need to die because y'all are prioritizing political/social gain and economic benefits? Are the CEOs on HICPAC going to see patients when all their healthcare workers are disabled or dead? Probably not. Stop being negligent and look at the xxxxing data. Thank you for your time.
Brittany Walling, MPH, CHES
References: The People's CDC

---

Dear HICPAC Team,

I am writing to respectfully recommend the inclusion of comprehensive ventilation and masking guidelines for infectious diseases for the upcoming new guidelines. Given the ongoing global health challenges posed by infectious diseases, it is imperative to provide healthcare professionals and institutions with up-to-date and evidence-based guidance in these crucial areas.

The impact of proper ventilation and masking strategies on disease transmission cannot be understated. Recent research has highlighted the role of aerosol transmission in the spread of various infectious agents, including respiratory viruses, such as, SARS-CoV-2. Adequate

ventilation in healthcare settings plays a pivotal role in reducing the concentration of airborne contaminants, thereby minimizing the risk of cross-infection.

Similarly, the appropriate use of masks, especially respirators, has proven effective in preventing the inhalation of infectious particles. The guidelines should outline the different types of masks and their recommended usage based on the specific infectious agent, mode of transmission, and the risk profile of the individuals involved.

By integrating detailed recommendations for ventilation and masking into your guidelines, HICPAC can ensure that healthcare professionals, facilities, and public health organizations are safe for their workers and patients. This will not only enhance preparedness but also contribute to the overall containment of infectious diseases.

As a chronically ill person, seeking medical care has become an increased risk. I have to weigh my options between getting healthcare and the risk of catching SARS-CoV-2 or handling my health conditions at home without healthcare professionals. I have severe asthma that started in March 2020 that has not been relieved by rescue inhalers, preventative medications or steroids. Catching SARS-COV-2, would put me at risk of further lung damage, possibilty of not returning to the workforce or death. There are a plethora of Americans who are making this same choice due to lack of ventilation and masking surrounding SARS-CoV-2.

Thank you for your time. I eagerly anticipate the positive impact that comprehensive ventilation and masking guidelines could have on infectious disease management.

Sincerely,

Alicia Randall
Salem OR

---

I am submitting a public comment regarding proposed changes to the healthcare infection control guidelines by HICPAC. I feel that the new, relaxed guidelines are very problematic and are being made for economic and political reasons, not what is in the best interest of public health. The proposed changes could increase the risk of acquiring Covid-19, MDROs, or new emerging pathogens for both frontline healthcare workers and patients.

The claim that plain surgical masks are as effective as NIOSH-approved N95 respirators is contradicted by a preponderance of scientific evidence. The proposals also fail to include essential tools like ventilation, UV disinfection, and HEPA filtration. There is considerable research proving that the combination of clean, filtered air and two-way masking is effective in greatly minimizing the airborne transmission of Covid-19, and healthcare workers have taken the Hippocratic Oath to do no harm. The CDC, as the healthcare arm of the U.S. government, should be held to the same oath.

These new guidelines are especially concerning for immuno-compromised patients who either have to remove their masks for procedures or treatment or who are in close contact with technicians (ex., mammograms). No patients should have to choose between exposure or getting needed medical care. I have a 24-year-old daughter who had Covid in January 2020. Long Covid symptoms began soon after and have become progressively worse to the point she can no longer work. She cannot risk contracting Covid again, but needs to be able to attend necessary appointments without fear of becoming more ill. Exposing high-risk and immuno-compromised patients to Covid is both a moral and community failing that smacks of eugenics.

It’s also been proven that more infections per person increase the likelihood of Long Covid (approximately 1 in 10 infections leads to Long Covid), and this mass-disabling event will be a nearly insurmountable burden on our healthcare system.

The process of formulating the new guidelines lacks transparency and inclusion, with no consultation from healthcare worker representatives or experts in aerosol transmission, ventilation, occupational health, and worker protections. As you are aware, over 900 experts in various fields signed a letter opposing the new draft guidelines, asserting that they would weaken protections for healthcare workers, and there is a collective call from experts, industrial hygienists, and academics united in opposition, calling for a more transparent and thoughtful approach that includes public and expert input that prioritizes the safety of patients & healthcare workers.

Please center the most vulnerable, and understand the unequal & unfair power dynamics of an immuno-compromised patient having to repeatedly request healthcare personnel wear an N95 every time they enter the room. Healthcare is a human right and we, as a society, must protect the most vulnerable citizens, not treat them as if they are disposable. Anything less is eugenics!

Thank you.

Sarah Peters
CA
Private Citizen (not affiliated with any organization)

---

Jill Woodman, MSL, CCRP
Franklin Park, IL
No Org Affiliation
Public Comment:
As a chronically ill and immunocompromised patient, every time I go into a healthcare facility, I'm taking a gamble. In May of this year, that gamble didn't work out, and while trying to address a major health issue, I contracted COVID. I was forced to walk past someone who was visibly sick, coughing everywhere and not wearing a mask in a building that clearly doesn't have adequate ventilation. The toll this illness took on me is still visible today. I urge this committee to use science to dictate the protection of all patients, especially for those who are immunocompromised and/or high risk. There should be 12 air changes per hour or an equivalent level of HEPA filtration in all facilities and all spaces. Masking should be mandatory during peak transmission levels for all visitors and staff. I would also ask that you recommend and endorse the use of highly protective masks- surgical masks don't fit as well and even when worn, they don't offer the same protection.

Please don't doom many of us to having to gamble each time we need to seek medical care.

Thank you-
Jill Woodman

---

I am speaking today in my capacity as a political economist, a mother, and a member of The People’s CDC and Massachusetts Coalition for Health Equity. I also have Long COVID. Often, my symptoms interfere with my ability to work and to effectively care for my children. I live in Massachusetts where healthcare has become inaccessible since hospitals lifted their mask mandates in May. As Dr. Shenoy and Dr. Wright know, not one healthcare facility continues to

require masks (unlike much of the rest of the country), even as wastewater numbers and hospitalizations rise. We don't know why in no hospitals kept masks in Massachusetts – once a national leader in public health – because the meetings of the MADPH's Healthcare Associated Infections Technical Advisory Board, where these decisions are made, and on which Drs. Shenoy and Wright ostensibly serve, similarly are opaque and not open to the public. We do know however, that hospitals say that they are in a massive financial crisis, and that ventilation upgrades, fit-testing, and pre-procedure COVID testing, are expensive. Is HICPAC prioritizing hospital profits over our health?

Mass General Brigham, Dr. Shenoy's employer, has refused my multiple reasonable accommodations requests for masked care. My young children — one of whom is too young to mask — are currently behind on their vaccines, and I am unable to safely access care for Long COVID. In our advocacy work with Massachusetts Coalition for Health Equity, we've helped dozens in similar positions request reasonable accommodations for safe healthcare. The vast majority have been denied, in violation of our civil rights as protected by the ADA and Section 504 of the Rehabilitation Act. HICPAC's proposed guidelines will only worsen this situation.

The CDC currently advise immunocompromised people to: "avoid poorly ventilated or crowded indoor settings." Without masks, isolation, or ventilation standards, you are now saying that immunocompromised people should avoid care. And that's exactly what many are doing: members of our coalition are currently avoiding lifesaving care, to avoid the risks of unchecked aerosol transmission amidst a COVID surge. This is unacceptable, it is also likely illegal.

The decisions you make in these meetings have immediate impact on our daily lives, on our children's lives — on your children's lives (whether you would like to admit it). They are value judgements.

CDC HICPAC must recommend fit-tested N95 masks or better for healthcare workers, upgraded and enforceable ventilation standards, and universal masking in all healthcare settings. HICPAC must substantively include disability justice groups, healthcare unions, occupational safety, and aerosols scientists in your decision-making. Amidst what hospitals have called a "crushing financial crisis" HICPAC members who are hospital administrators must declare their financial conflicts of interest and recuse themselves accordingly.

Otherwise, you are making a judgement on the value of my life — saying its ok that I am exposed to harmful aerosol transmitted viruses, like measles, MERS, RSV, SARS-1 and COVID in healthcare — which I do not consent to.

I'd like to thank all the CDC staff who are pushing for better standards, and working to communicate risks to the public, especially those of you who continue to wear masks, those who publish MMWR's like "Perception of Local COVID-19 Transmission and Use of Preventive Behaviors" which showed people are willing to take measures to protect themselves and each other when they know transmission is high. Even your CDC data shows that if you were to communicate to the public the need to protect each other, they would. You still can do that, and you must. I also thank those of you CDC staff who have been quieter with your discomfort with this frightening status quo, because of peer-pressure to go along with the current, and against the science, or to keep your jobs — you are not alone.

Do the right thing.
Mary Jirmanus Saba
Malden, MA

Hello,

Thank you for reading and accepting my public comment regarding precautions for disease control in healthcare. As SARS-cov2 and other diseases continue to spread rapidly, it is critical that healthcare settings take research-based steps to reduce such spread.

I am immunocompromised due to a genetic autoimmune disease, and since the removal of masks in healthcare settings, have been unable to safely access critical health services. When I have advocated for myself and requested that my providers wear a mask for my safety, I have faced discrimination, harassment, and retaliation. It should not be up to individuals to ask their providers - who have a position of power over patients - to take research-based, logical hygiene measures such as wearing a respirator in an ongoing pandemic. I have also contracted a respiratory illness from a provider who refused to mask when treating me earlier this year. I am still suffering from the repercussions from this illness, have lost the ability to work due to my symptoms, and have faced enormous healthcare costs. I may face bankruptcy, and even homelessness in the future due to the provider's refusal to mask and the impact that has had on my health. As a professional in my mid-thirties, this is devastating.

I implore you to use your power to prioritize the mandated use of n95 respirators in healthcare settings and invest in infrastructure for clean air, such as HEPA filtration and other methods. These tools have been shown in an abundance of studies to dramatically reduce the spread of SARS-cov2 and other airborne infectious diseases.

To not mandate the use of these tools means the unnecessary death and disability of countless patients and healthcare workers.

To not mandate the use of these tools means our already overburdened healthcare system will become more and more overburdened.

To not mandate the use of these tools means you have blood on your hands.

The research is proven. The tools are available. It is up to you to use your power to mandate that they are put to use.

Thank you,
Martha Burwell

---

Hello,

I'm writing regarding the HICPAC meeting, 8/22/23, and specifically in support of the public comments offered during the meeting -- the many voices urging this committee to follow the science and protect both healthcare workers and patients by establishing robust standards for healthcare setting safety and PPE in light of airborne disease, and particularly in light of COVID-19.

Many officials and politicians – as well as corporations hoping not to be responsible for proper protections, or liable for failing to provide them – have urged a "return to normal," even as we continue to face distinctly abnormal conditions with an ongoing pandemic, caused by a virus that continues to mutate and evade our vaccines, prior immunity, and treatments. This virus continues to kill and disable people far beyond what we'd expect from a normal flu season, and

we are still learning about its wider and longer-term effects – on the cardiovascular system, the brain, the immune system, etc. Workers and patients should not be expected to risk their health and gamble with this virus simply in order to go to work or access healthcare.

We know that healthcare settings are uniquely high risk, bringing together those who are at increased risk of illness and severe illness, as well as healthcare workers who have long been notorious for going to work while sick. (I'm thinking, for example, of Julia E. Szymczak's "Health Care Worker Presenteeism: A Challenge for Patient Safety," a perspective from some years before the pandemic, in 2017.) The need to address nosocomial infections had long been clear and is now all the more urgent in an age of "living with COVID-19." I am alarmed that this committee would be entertaining the idea of rolling back, versus bolstering, protections.

I urge this committee not to forget the lessons of the past three and a half years. Not only are we not actually in a place to return to normal – i.e., we still see substantial spread of COVID-19 in our communities and around the world – but, even if we had been so lucky as to have our initial vaccines provide us with sterilizing and lasting immunity, we cannot now "unsee" what we have seen: the way we previously thought about respiratory illnesses and how they spread has been proven very wrong. We are facing a situation not unlike what the Victorians (my own research area) faced when they slowly took in the realities of the emerging medical science of their era – that, for example, some diseases, like cholera, can spread via the water, and that microorganisms on one's hands can be transferred between patients with devastating consequences.

Much as the Victorians had to learn to wash their hands and clean their water – the latter being a massive infrastructure project, and both requiring an entire shift in understanding – we need to clean our air and practice respiratory hygiene in addition to hand hygiene.

Thank you for taking in these comments. Those of us who are already taking COVID-19 and other airborne diseases seriously – as well as the historians who will study this moment one day – look forward to following this closely. I hope we can learn from history, the distant as well as the recent past.

Sincerely,
Rebecca Richardson

---

Topic: Masking In Healthcare - Re: HICPAC INPUT

My name is Claire Jones.
My family of three feel you should follow the science regarding COVID.

I am the co-founder of a Black led grassroots project in collaboration with my disabled daughter, Amaranthia Sepia. The project is called Sista Creatives Rising, which is centered on disability accessibility. We highlight artworks and stories from marginalized women and marginalized genders. We advocate for masking, as it protects people and the most vulnerable in society.

After emergency surgery to remove a large diffuse B-cell lymphoma from my upper spine in March 2022, I lost my mobility. The doctors said I had a 50% chance of paralysis. However, they were shocked after a 5 hour surgery and tremendous blood loss that my feet began moving again. In a week's time I was rushed to rehab and started recovering immediately. One of the doctors told me I was in the 1% to walk again after such a surgery.

Through all of this I masked and all those around me did the same. I never caught COVID. Since May 11 when protocols were rolled back I experienced stress and panic worrying about many appointments. I am diagnosed with panic disorder, and complex ptsd. The past few months have been harrowing as I watched common sense go out the door at every level of our society about a virus that is proven to cause disability & harm the more you catch it.

I ask you to consider implementing mask protocols and to not reduce infection mitigations once again. People like me deserve protection by those in leadership. This is ableism and discrimination towards the most vulnerable in society. I also urge you to read the stories gathered in our "Black & Still COVIDing" story project, where Black disabled folks share harrowing stories about how the COVID emergency orders disappearing have caused harm. https://www.sistacreativesrising.com/Black-and-still-coviding

https://www.canva.com/design/DAFjCzepFj0/Vk5KCnqje12bASHr8knNdA/view?utm_content=DAFjCzepFj0&utm_campaign=designshare&utm_medium=link&utm_source=publishsharelink&fbclid=PAAaZL8dZvdwdwfGqLq_pne0sn_6xWtUJQJ12g-BzFio7dcpyT29YfcJK7Oaw_aem_AeNUKvHO1yqjnVKvd6YLXdYAcwDeNaLfvCEfuc2Dx9D2ObrB_52JNanSLX1xHAvdN5s

Thank you
Name:
Claire Jones, Amaranthia Sepia, Keith Jones
Address:
Concord, NH

---

Hi:
I'm sure you're getting a lot of these so I'll be brief.
I had inflammatory breast cancer in 2018 and am now nearing the 5 year aftermath mark with the expectation that I'll be taking the aromatase inhibitor up to the 10 year mark if my now osteopenic bones allow it. I am 53 years old.
When the State of Oregon dropped the mask mandate, my cancer clinic - unlike all the ones attached to hospitals- dropped masking as well. It is only a cancer clinic. This is all they do. There are immuno-compromised patients in their waiting areas, lab, infusion room every single day they're open.
When I went in for a blood draw before a zometa infusion, I was dismayed by the lack of masking and queried the lab tech about it. She simply shrugged her shoulders and essentially said the state said they didn't have to mask anymore so they weren't going to do it anymore. She had zero concern for any resultant threat to patient health and safety due to not masking. Only some patients were masked in the waiting area. The oncologist and her nurse were masked. The infusion room nurses were not masked while a very few of the patients were masking. When I was doing adriamycin/cytoxan in 2018, I had to have Neulasta the next day to keep my immune system from crashing so this lack of masking in the chemo room is deeply concerning to me.
There is no signage at the clinic stating whether or not they do multiple air changes per hour or if they have HEPA filters. The receptionists/schedulers at main waiting were unmasked. There might or might not have been an air purifier tucked in deep amongst the receptionists in their space on the ground floor next to Main Waiting but there wasn't one out where the patients were sitting.
So this is where I beg you to care about the lives of patients and mandate 12 air changes per hour or a MERV-13 or better HEPA filtration of the air space. There should also should be mandated signage about what is or is not being done to keep their air free of respiratory viruses

etc. If there is no filtration/airchanging then staff and patients must be required to wear N95/KN95 masks.
Sincerely, Anna Gorman
Portland, Oregon

---

My name is Dorothy Wigmore. I am a long-time occupational hygienist and ergonomist, trained to protect workers from airborne and other hazards. I am in the Canadian Aerosol Transmission Coalition (\\Users\dorothywigmore\Library\Containers\com.apple.mail\Data\Library\Mail Downloads\A867E97B-007E-4AF1-8FDC-FC19670058BF\aerosoltransmissioncoalition.ca) and work on contract with organisations in Canada and the US.

Prevention and precaution guide occupational health practitioners' professional ethics and activities to eliminate and reduce hazards **before** they enter or affect someone's body. It's the public health approach, for occupational health is part of that broad field.

As a Canadian, I am very conscious of the CDC's influence here and elsewhere in the world. Transmission truth matters. Getting it right leads to the right protections for workers and the rest of us, inside the United States and far beyond US borders.

There are many reasons (https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf) to be concerned about HICPAC's process and approach to protecting health care workers, and by inference, other people. Many have brought up the importance of acknowledging and effectively dealing with the long-standing evidence about aerosol and airborne transmission of viruses, and therefore the protections needed in the way of ventilation and respiratory protection (amongst other things). That can't happen without broadening the disciplines in the decision-making room and giving those affected by HICPAC's and CDC's decisions (e.g., workers, their unions, those with disabilities, the immunocompromised) a real voice at the table.

I want to focus briefly on the Committee's reliance on the discredited droplet dogma and its consequences for protecting healthcare workers, other workers and the rest of us. There also is the question of what counts as evidence and lessons others have learned in this pandemic and the SARS-1 epidemic.

It seems HICPAC is ignoring the fundamental historical misunderstanding about aerosol and airborne transmission of viruses. The 2021 paper (https://royalsocietypublishing.org/doi/10.1098/rsfs.2021.0049), by Katherine Randall and her colleagues, about that history is essential reading to understand why infectious disease specialists describe that transmission incorrectly and very differently from occupational hygienists, aerosol scientists, ventilation engineers, physicists, chemists and other scientists. They found the foundation for size and spread ideas may be "well accepted" in infectious disease but "their foundation is muddled and misleading, and is not consistent with physics". Jimenez and an impressive multidisciplinary array of co-authors, including some who dropped the dogma, reviewed historical reasons for that resistance in this pandemic in 2022 (https://onlinelibrary.wiley.com/doi/10.1111/ina.13070).

One of those authors, Canadian physician and microbiologist Raymond Tellier, learned about aerosol transmission in his own work. After trying to deliver the message around SARS-1, he reviewed the evidence for aerosol transmission of influenza A in a key 2006 paper (https://pubmed.ncbi.nlm.nih.gov/17283614/). With others, he's since written about the

increasing evidence for viruses being shared in the air, including a 2023 paper (https://pubmed.ncbi.nlm.nih.gov/36866737/). That most recent review made it clear that embracing current knowledge about airborne and aerosol respiratory virus transmission, and controlling that spread, will protect workers, patients and communities.

Outside the medical field, as Randall discovered, the 1930s and 1940s physics-based work by William and Mildred Wells provides key understanding about virus transmission. Then there's William C. Hinds's authoritative *Aerosol technology: Properties, behavior, and measurement of airborne particles*, now in a third (https://www.wiley.com/en-us/Aerosol+Technology:+Properties,+Behavior,+and+Measurement+of+Airborne+Particles,+3rd+Edition-p-9781119494041) edition. As a professor and researcher, he made clear (since the first edition in 1982) that aerosols come in a wide variety of sizes and shapes, with varied properties, and covers important features of protecting workers and dealing with bioaerosols like viruses.

Many papers before and during the pandemic, in journals covering topics from occupational hygiene to infectious disease to physics, have the same message: use the A words (aerosol and airborne) to describe virus transmission. Furthermore, as the authors (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00869-2/fulltext) of "Ten scientific reasons in support of airborne transmission of SARS-CoV-2" point out, there is limited evidence for droplet or fomite transmission, and:
*(I)t is a scientific error to use lack of direct evidence of SARS-CoV-2 in some air samples* (as done in *Cochrane Reviews* and by other droplet dogmatists) *to cast doubt on airborne transmission while overlooking the quality and strength of the overall evidence base. There is consistent, strong evidence that SARS-CoV-2 spreads by airborne transmission. Although other routes can contribute, we believe that the airborne route is likely to be dominant. The public health community should act accordingly and without further delay.*

Finally, a key response to the latest *Cochrane Reviews* assessment of masks and respirators and similar documents came in a May *Scientific American* article (https://www.scientificamerican.com/article/masks-work-distorting-science-to-dispute-the-evidence-doesnt/), "Masks work. Distorting science to dispute the evidence doesn't". The authors rightly say "studies relying on a medical paradigm do not erase decades of engineering and occupational science that show they work":

*A well-understood technology, respiratory protection has been validated over decades, with standards (NIOSH in the U.S., CSA in Canada) that codify protection from viruses and bacteria. Mining, biomedical research, chemical processing, pharmaceutical production and many more industries follow these laws and standards worldwide. Without exaggeration, millions of people trust their lives to the effective "real-world" science of respirators, with no need for randomized trial evidence.*

*It is therefore deeply concerning that prominent medical figures have misrepresented the protection provided by masks, when the evidence supports N95 respirators or better, ideally with two-way masking.*

What counts as evidence? David Kriebel has laid out why RCTs are inappropriate for studies about masks and respirators, amongst other occupational health topics. Based on his Lifetime Achievement Oration at the 2023 International Epidemiology in Occupational Health meeting, he wrote (https://oem.bmj.com/content/80/9/485.long) that:

*(I)t is simply unethical to consider only the randomised controlled trial evidence and reject as flawed all the other studies. If we accepted this view, we would be unable to protect workers from literally hundreds, if not thousands, of occupational hazards.*
*.. As an occupational epidemiologist, I believe our job is to try to answer the question: 'do we know enough to act as if X causes Y?' and not simply: 'does X cause Y?'*

It is unethical and inappropriate to rely on the Cochrane Reviews -- done by those apparently devoted to droplet dogma, a definite bias -- that insist only RCTs matter, especially when there is a long-standing history of respirators providing protection for workers in all sectors, including healthcare (see the National Academy of Sciences 2019 report (https://oem.bmj.com/content/80/9/485.long) and various presentations (https://www.ohcow.on.ca/ohcow-events/occ-covid-webinar-series/)).

Lessons have been learned in this pandemic.

In 2020, Dr. Anthony Fauci was a presenter at the National Academy of Sciences session, *Airborne transmission of SARS-CoV-2 (https://www.nationalacademies.org/event/08-26-2020/airborne-transmission-of-sars-cov-2-a-virtual-workshop)*. There, and since, he emphasises the need to be humble when it comes to learning about aerosol transmission of the SARS-CoV-2 and other viruses. He's not alone. The WHO's chief scientific officer left her post in 2022 regretting (https://www.nationalacademies.org/event/08-26-2020/airborne-transmission-of-sars-cov-2-a-virtual-workshop) the organisation did not forcefully say "This is an airborne virus" much, much earlier.

Dr. Michael Klompas, a long-time infectious disease physician and researcher, changed his mind about viral transmission and the need for respirators in this pandemic, based on evidence around him at a Boston hospital. His presentation in October 2022, *Preventing viral transmission in the workplace*, is a succinct summary of the evidence. It includes the 2009 CDC photo (https://phil.cdc.gov/Details.aspx?pid=11162) of someone sneezing, showing the various sizes of airborne particles, like the more recent work (https://jamanetwork.com/journals/jama/fullarticle/2763852) of MIT's Dr. Lydia Bourouiba.

The 2022 Lancet Commission on Lessons for the Future from the COVID-19 Pandemic pulled a lot of this together, saying (https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(22)01585-9.pdf) the second of 10 multiple factors about the world's problematic response were the
*costly delays in acknowledging the crucial airborne exposure pathway of SARS-CoV-2, the virus that causes COVID-19, and in implementing appropriate measures at national and global levels to slow the spread of the virus.*

These lessons aren't new. Seventeen years ago, Justice Archie Campbell dove into the "tale of two cities" (http://www.archives.gov.on.ca/en/e_records/sars/report/v2-pdf/Vol2Chp3iii.pdf) and the specific infectious disease-occupational health divide (http://www.archives.gov.on.ca/en/e_records/sars/report/v3-pdf/Vol3Chp8.pdf.) in his mammoth five-volume report about SARS-1 in Canada. Key paragraphs from the report include:
*There were during SARS two solitudes: infection control and worker (health and) safety. Infection control relies on its best current understanding of science as it evolves over time. It is unnecessary to point out again that infection control failed to protect nurses during SARS. Worker (health and) safety relies on the precautionary principle that reasonable action to reduce risk should not await scientific certainty.*

*SARS taught us that we must be ready for the unseen. That is one of the most important lessons of SARS. ... (T)here is no longer any excuse for governments and hospitals to be caught off guard and no longer any excuse for health workers not to have available the maximum level of protection through appropriate equipment a*nd *training.*
*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.*
*If we do not learn from SARS and we do not make the government fix the problems that remain, we will pay a terrible price in the next pandemic.*

Workers -- and the rest of us -- have paid a terrible price in this "next pandemic" for the failure by key infectious disease and public health organisations and voices to accept and use Campbell's recommendations and the evidence from occupational hygiene, aerosol science, ventilation engineering, evolutionary biology and other disciplines.

It's long past time they heeded Campbell's report and lessons from the last three years. It's a matter of public health.

HICPAC can be a leader in setting the record straight about aerosols and airborne transmission and truly protecting healthcare workers, patients and others. That's public health.

---

Good evening,

I'm writing to beseech HICPAC to acknowledge that COVID-19 is airborne and require airborne precautions in all healthcare settings.

For the past several months, I've heard a lot of catchphrases around covid such as "we have the tools" and "personal responsibility." And whereas I believe there is some truth to both of these, the fact remains that COVID-19 is a public health issue and needs to be addressed as such. Until we have widespread, adequate, and utilized ventilation and filtration to ensure clean air and reasonable safety for patients and healthcare workers alike, requiring masks in all healthcare settings is a bare minimum. We should be requiring high-quality respirators, such as N95s, in all healthcare settings.

There is an abundance of evidence that COVID-19 is airborne, that ventilation and filtration are effective at removing the virus from the air (including in Covid-wards in hospital settings), and that respirators such as the N95s are highly effective at protecting both the wearer and others from disease transmission. Despite the CDC changing the way COVID cases are tracked, it's also quite apparent from wastewater monitoring that cases are still quite prevalent and currently increasing nationwide. The CDC as well as countless other agencies, healthcare departments from other countries, and individual studies have shown that Long Covid is extremely prevalent, ranging from 10-20% or more of all infections, including asymptomatic cases and those amongst vaccinated and boosted people. Finally, the mortality rate for hospital-acquired COVID infection is quite high.

When the above information is analyzed through a perspective of public health, as well as simply from that of a considerate global citizen, the only option is to require masks in healthcare settings, at least until proper filtration, ventilation, and potentially far UV technology can be implemented.

I can't tell you how many people I know, including myself, who have had to put off healthcare, including preventative care, due to concerns regarding COVID and inadequate precautions for an airborne virus. Sadly, some of my friends who are immunocompromised have seen their health further deteriorate from COVID infections, and have to decide whether the care they so desperately need is worth the risk of another healthcare-acquired COVID infection. The fact that the disabled, immunocompromised, and otherwise high-risk community has been abandoned to "personal responsibility" when they frequently cannot adequately protect themselves with the resources available is nothing short of eugenics. It is the duty of public health to step in and protect those who cannot protect themselves.

I cannot sufficiently express the anger I felt when I saw signs from children's hospitals celebrating the removal of mask mandates. What parent of a child with cancer will be thankful to see the smiles of healthcare workers when those same smiles could kill their precious child? How can immunocompromised patients protect themselves in a maskless hospital when they have no choice but to remove their own respirator for an MRI? This is wrong.

In July of 2022, I had a potential exposure with COVID in a healthcare setting when I had my son via C-section. Luckily, the mask mandate was still in effect. Despite that, most healthcare personnel wore a "baggy blue" surgical mask, which has some if limited effectiveness, and some wore their masks inappropriately.

Upon returning home from the hospital, I received a COVID exposure notice. I was distraught. I had just undergone a major surgery. I was exhausted from the toll pregnancy and the surgery had taken on my body, not to mention providing around-the-clock care to my newborn. As a female, I was already facing a higher prevalence of long covid (~75% LC sufferers are female), and I knew the biggest recommendation to lower risks of Long Covid (to get substantial rest both during the acute infection and for weeks afterwards) was impossible. My newborn needed to nurse every two hours, and I had a three-year-old at home to take care of as well. Considering the increased risks of hospital-acquried covid infections and considering the high percentage of Long Covid sufferers who qualify for a debilitating ME/CFS diagnosis, I was terrified. How would I be able to care for my precious children if I was seriously ill with COVID or disabled by Long Covid. Not to mention, if I not only contracted COVID, but also passed it on to my family.

Several new studies are also elucidating the prevalence of Long Covid in children, and the news is not good. It seems to affect children in similar numbers as adults. So if I had contracted COVID in the hospital, my brand new baby boy, born healthy, could've faced the potentially life-long effects of chronic COVID. Or, perhaps my young daughter or my high-risk family members. All because we don't take adequate precautions to protect the most vulnerable.

I'm lucky that my exposure was before the mask mandate lifted. The mask mandate was nowhere near sufficient, but it was at least something, a layer in the Swiss Cheese Model, if you will. But now, those protections are gone.

My son is still too young to mask. Every time I take him to the pediatrician, I have to weigh the risk of his care. One of his doctors scoffed at my decision to mask (so much for "individual responsibility") and refuses to mask despite recognizing that wearing a mask at the very least can protect others from infection. Aren't our youngest and most vulnerable worthy of that protection? Don't they deserve a chance at living a full and complete life?

And if that doesn't encourage a requirement for airborne precautions, don't we want a population that is healthy and able so we can have a functioning economy? How will the staggering number of disabilities induced by Long Covid affect the workforce? Don't we want to protect our healthcare workers? We certainly don't want to lose healthcare workers to disability and disease! Doesn't a healthcare collapse affect us all?

I understand that a mask mandate in healthcare settings is... unglamorous. But if we actively worked to clean our air and invest in the tools we have, it wouldn't take long to make a massive difference. I truly believe we could drastically reduce the risk of COVID transmission, as well as that of other respiratory viruses, which would make all of our lives infinitely better. We can do this. But we have to be willing to try. And sometimes that requires difficult decisions.

That's where you come in.

Please.

For all the children.
For the immunocompromised.
For the high-risk and disabled.
For those who are putting off necessary care.
For those who aren't yet disabled but face disability from this virus.
For healthcare personnel.
For our economy and the entire healthcare system.
For me, and everyone like me who wishes this was over but is still willing to do what we need to protect ourselves and those around us.

Please require high-quality masks and respirators in healthcare settings and please invest in high-quality ventilation and filtration.

Thank you for your time.

Danielle Terkhanian

---

My name is James Sackett, a normal citizen. I am writing regarding the recent proposed changes to the recommendations for transmission precautions of airborne viral infections in a health care setting. I strongly suggest air filtration and n95 masks remain in the recommendation. Surgical masks are ineffective to protect the wearer, who in this case is the uninfected party. Clearly the proposed changes are either politically motivated, or the result of corporate profit driven influence. The CDC decisions should be evidence based and motivated to prevent the spread of disease, not based one political or corporate biases. Please do your job.
James Sackett, member of the public.
Tucson, AZ

---

Dear Members of HICPAC,

As an expert in ventilation and the use of building systems to reduce the risk of airborne disease transmission, I was surprised that these engineering controls were not adequately addressed in the draft Isolation Precautions. Fortunately, a new pathogen mitigation standard was published by ASHRAE last month (June 2023) and can now be referenced and adopted by other entities.

Standard 241-2023 *Control of Infectious Aerosols* sets, for the first time, minimum equivalent clean airflow rates to reduce disease transmission risk across building types, including existing buildings and healthcare spaces. I was one of many people to contribute to the Standard, alongside experts in infection control and prevention, healthcare facility design and management, epidemiology, public health, industrial hygiene, building science, and indoor air quality. Standard 241 incorporates many of the lessons learned during the COVID-19 pandemic about engineering controls, allowing for flexibility in using ventilation, filtration, and other air cleaning technologies (subject to new requirements for safety and efficacy). I encourage you to visit ashrae.org/241 (http://ashrae.org/241) to learn more about the Standard through articles (and a podcast!); a free read-only version is posted here (https://www.ashrae.org/technical-resources/standards-and-guidelines/read-only-versions-of-ashrae-standards)(ctrl+F "241"). Additionally, your working group may be able to receive copies of the Standard by contacting govaffairs@ashrae.org. If you have any questions about the standard, I would be more than happy to answer them or put you in contact with my fellow committee members who have the appropriate expertise.

ASHRAE Standard 241 is a significant step forward in public health. I hope that you can use it to strengthen the Isolation Precautions, so that healthcare workers, patients, and their loved ones are better protected.

Sincerely,
Meghan K. McNulty, PE
Atlanta, GA
commenting on my own behalf, as a Professional Engineer

---

Good evening,
I am writing to urge you not to weaken airborne infection control hospital policies in hospitals. Patient outcomes will worsen when they contract a nosocomial infection. N95 and elastomeric respirators are required to protect healthcare workers and patients from airborne pathogens. There is overwhelming evidence that they provide far superior protection to surgical masks which are designed to prevent fluid splashing on healthcare workers during procedures. You don't have to take my word for it--include aerosol scientists and engineers in this discussion. They are the experts whose voices must be heard on this issue.
Thank you,
Allison Alvarez

---

The CDC is failing public health during the Covid pandemic just like it did during the early years of the AIDS crisis. And like then it is a people led (and a lot of people sick from Covid) who are leading the way in rightfully criticizing the CDC and their failure to inform and protect the public from acute covid and long term covid. Covid is "clearly airborne" as even Ashish Jha said. Surgical masks are not designed for protection against airborne diseases. N-95 (& better) masks are designed for protection against airborne diseases. To equate surgical masks with n95 masks in incorrect and criminal negligence. You all should be ashamed of yourselves. Protect people not the short term profit interest of CEOs.
Judah Friedlander

---

I am extremely concerned with the recent CDC work that would weaken safety standards inside of healthcare facilities by not recommending improved air quality through ventilation and filtration enhancements and also makes wrongful claims that surgical masks are as good as N95s.

I fully agree with the evidence that shows “Surgical masks cannot be recommended to protect health care personnel against inhalation of infectious aerosols.” as shared with the agency in the following letter:
https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf
Over the course of this summer my family experienced multiple hospitalizations and when talking to staff one of the most common reasons for a procedure delay or test being impossible to schedule was healthcare workers out sick. Surgical masks were not adequate PPE for the work they were doing and many experienced covid infections that made them both less safe to be around patients and an active risk to the very people they were there to work with along with their colleagues.
I work in the clean air space on vehicle electrification and have completed an OSHA10 training as part of basic safety awareness prior to being on job sites. No contractor would suggest a painter or woodworker sanding equipment use a surgical mask in place of an N95 mask because aerosols and small particles getting into the lungs is an active risk and could both harm the worker and introduce the company to additional liability. In a healthcare setting where risks include colds, flus, RSV, covid, and other respiratory viruses - the same standard of care that one would use for protecting their lungs in a construction site should be used to protect the lungs of a woker and their patients in a healthcare setting.
While some evidence shows specific models of N95s can be tiresome to wear, that is a reason to buy a better mask not cut all standards. Like PPE in any other industrial application, buying the correct PPE fitting for the user is essential to having safe and comfortable results. 3M aura masks are extremely effective and do not cause the fatigue associated with some of the harder structured models. When I cared for my own father who had covid for over a month, use of layered protections including better ventilation, upgrades in home air filters, placing HEPA filters in shared spaces, and wearing a mask ensured my own safety as a caregiver during the 31 days he tested positive. We already are facing shortages of healthcare workers today, and reducing protections that could lead to more worker sickness and death, increase risks to patients and visitors to healthcare settings, and increase community spread in high risk areas is extremely unwise and would further erode trust in the agency.
Please consider strengthening standards on air quality and PPE for both source control and protection from in work exposures to ensure healthcare settings can be a safe place to access care.
--
Urvi Nagrani
Los Altos, CA
Unaffiliated

---

The CDC is failing public health during the Covid pandemic just like it did during the early years of the AIDS crisis. And like then it is a people led (and a lot of people sick from Covid) who are leading the way in rightfully criticizing the CDC and their failure to inform and protect the public from acute covid and long term covid. Covid is "clearly airborne" as even Ashish Jha said. Surgical masks are not designed for protection against airborne diseases. N-95 (& better) masks are designed for protection against airborne diseases. To equate surgical masks with n95 masks in incorrect and criminal negligence. You all should be ashamed of yourselves. Protect people not the short term profit interest of CEOs. Proper ventilation, filtration, n95 masks should be mandatory at all medical facilities. And just like elevators and cars list their inspection dates - medical facilities should be inspected and they should be required to publicly post at all hours their ventilation co2 levels, what their ventilation system entails, what their filtration

entails, and everyone should be wearing n95 masks. There's no cure for long covid. What you're doing is criminal.

Judah Friedlander

---

My name is Anna Pakman and I'm writing as a concerned member of the public. As a person with a disability, I not only have an outsized risk of developing Long COVID and other health complications if I were to get a COVID infection, but I am more dependent than the average person on close contact-requiring assistance from healthcare providers when it comes to accessing care. According to the CDC's own data (see Long COVID Pulse Survey), people with disabilities are at 700% greater risk than non disabled folks when it comes to developing ADL limiting Long COVID complications, yet the CDC is poised to weaken the few remaining infection control guidelines that keep people like me reasonably safe from contracting COVID and other infections when accessing care.

I implore you to listen to the many infectious disease, aerosol science, and engineering experts who have already testified and institute a minimum standard of respirator masking and improved ventilation and filtration systems. Healthcare providers have the moral duty to "first do no harm," and the CDC too needs to follow that philosophy in deploying these simple readily available tools in the point of care setting.

Thank you.

Anna Pakman

New York, NY

---

Hello,

I’m a member of the public and I have breast cancer. I shouldn’t be worried about catching a dangerous virus while I am fighting for my life, but I have to go into unmasked clinics and hospitals every few weeks. I am one of few wearing a N95 mask or better in these health care facilities. We need to protect patients and health care workers. Individual risk assessments shouldn’t happen in health care, it’s insane. It shouldn’t be a risk to seek healthcare.

More needs to be done to protect patients and health care workers in regards to air filtration, air ventilation, and N95 respirators. Wearing Respirators (N95 masks or better) and air filtration is incredibly important to help reduce the spread of many airborne infectious diseases in health care settings, not just COVID. It is necessary in public health settings because they give everyone the most protection. COVID is a level 3 pathogen and we are not treating it as such. One-way N95 masking doesn’t work! Healthcare should not be the responsibility of the patients.

I am exhausted. Before every appointment I call in and request that my provider wear an N95 and have had pushback such as “you know, this protects me more than it protects you”, and that’s just not true. Several times when I have asked my providers at cancer centers to wear N95s I was asked if I was immunocompromised. My response was “I have cancer. Are you kidding?” We need to expand the use of N95s and respirators not reduce. Universal masking in health care is a necessity.

We need to do more to protect everyone and the CDC and HICPAC need better and more thorough guidelines. Don't normalize poor health practices that ignore science.

Erika Ritzel

---

HICPAC/CDC Must Protect Patients and Healthcare Workers August 24, 2023 Submitted Comments: Michelle L. Imber, Ph.D., ABPP

As a clinical neuropsychologist as well as a vulnerable patient who is struggling to access safe care, I am begging HICPAC to follow the science and to bolster, rather than decimate, protections in healthcare settings for both patients and staff. We definitively require N95 respirators or better as the standard-of-care in medical settings, combined with enforceable ventilation standards. We also need to stop conflating "mild" *acute* illness with the severe sequelae that can nevertheless result from COVID-19 infection.

I am dismayed to hear glancing references to "respiratory illness" from this Committee with regard to infection by SARS-CoV-2. COVID-19 is indeed spread through transmission of infectious aerosols, and we need to treat it as such. But more than three-and-a-half years into the pandemic, we are very well aware that COVID-19 is not a respiratory-only illness. It wreaks multi-system havoc. Importantly, both morbidity and mortality are increased after COVID-19 infection, and these risks are sustained over a period of months to years. Studies have shown an increased risk of death, even in the post-acute phase (e.g., Uusküla et al., 2022). There is an increased risk of major cardiovascular illness (Wan et al., 2023). Neurological sequelae of COVID-19 can include inflammation, seizures, nerve injury, pain syndromes, sleep disorders, difficulty regulating the autonomic nervous system, cognitive dysfunction, loss of taste and smell, microclots, and strokes (Taquet et al., 2022; (https://www.ninds.nih.gov/current-research/coronavirus-and-ninds/coronavirus-and-nervous-system). And there are risks to multiple other organ systems, including GI, musculoskeletal, endocrine, pulmonary, and hematologic (Bowe et al., 2023).

Furthermore, persistent COVID-19 sequelae are associated with long-term disability at an alarmingly high rate. A recent VA study (Bowe et al., 2023) showed a higher burden of disability for Long COVID than for either heart disease or cancer.

According to CDC data, vulnerable patients, including those of us who are elderly, immunocompromised, or have a variety of very common conditions (diabetes, asthma, hypertension, obesity, mood disorders, etc.), are at great risk in settings that do not require masking. One-way masking is not an effective solution for these patients, particularly at close range with an infected, unmasked person (Chow et al., 2023). Permitting health care facilities to set their own guidelines ignores the very real and debilitating risks associated with even mild initial infections, and permits short-term political and financial pressures to guide safety policies rather than the scientific evidence. These dangers were starkly apparent during the public-comment portion of the August 22 HICPAC meeting, when several individuals testified about themselves or their loved ones getting sickened repeatedly in a healthcare setting despite their own adherence to one-way masking with respirators.

For the safety of health-care providers and patients alike, you must recommend universal masking as the new standard of care in medical settings, along with enforceable ventilation standards.

Sincerely,

Michelle L. Imber, Ph.D., ABPP Board-Certified in Clinical Neuropsychology

Board-Certified Subspecialist in Pediatric Neuropsychology Licensed Psychologist/Certified HSP, Commonwealth of Massachusetts Private Practice

Brookline, MA

---

I was not surprised to learn that the same nation whose enamoured efforts and lasting communication "played a powerful part in shaping the opinions" of Nazi Germany, has a lengthy and consistent history of compulsory sterilization, an at least decades long decline in pregnancy health along with attacks on other forms of reproductive health, and so much more would be responsible for once of the most vile and despicable approaches to the ongoing COVID pandemic. And yet despite that, I've heard from those who survived polio and experienced the modern miracle that was the vaccine's rollout, and I never thought I'd witness the nation use minimizer tactics similar to those used in the during the 19th century cholera epidemic, use prison labour to bury mass graves in New York City, some of the most fundamental and basic principles of medicine being willfully ignored including by some medical professionals, and both vulnerable groups and the general population being left for dead in such a massive scale.

I've heard a lot from different groups over the course of the pandemic so far. Countless healthcare workers experiencing burnout and trauma from being abandoned and unequipped on the frontlines. Consistently conveying the situation with such phrases as "[the] medical system is imploding". People with family in nursing homes, both worrying about and experiencing outbreaks within the facilities where their already compromised relatives get infected and abruptly meet their final days. Children who barely escaped death and instead of support, received aggression and threats from their community and denial and confusion from medical professionals. Healthcare workers working with immunocompromised children, observing that they are the only employees wearing masks and other PPE. Disabled and Immunocompromised people having to put off their lives and medical care because they can't risk getting COVID. Those very same people and their family saying they are ignorantly accosted over wearing a mask by people working in healthcare settings. Epidemiologists, Virologists, and experts in other similar fields demonstrating time and time again that their research and innovations were (and as often the case still) are ignored in favour of cherry picking, denial, or flat out just making fallacies up until a moment of un-veneerable crisis occurs. And even then much is intentionally scrubbed from the public consciousness until perhaps the next un-veneerable part, yet that isn't even guaranteed.

I caught covid in the summer of 2022, the original Omicron. Having experienced many health conditions beforehand, and heard from those who had already experienced it, I knew this virus was not to be messed with. Despite that caution, I was infected. I had experienced nearly all the symptoms before with previous ailments, but Covid was different. During the initial infection, my throat, upon any movement distinctly, lit up like an ignited line of petrol. My legs could barely hold while walking. There was no treatment, no solution. 5 months later I got long covid. Monthly, for half the month, I get episodes which have consisted of; days long brink of vomiting level nausea, frequent vomiting, reflux, and diarrhea, all with uniquely overwhelming smells, hair falling out en masse, heart palpitations, and an irregularity where it would beat so strongly that i could physically see my entire body bouncing along with it. No treatment, no solution, all

debilitating. I've had to deal with a spinal cord injury with zero medical assistance, and yet that is somehow exponentially easier and more pleasant than experiencing long covid. My only possibilities, albeit thin, for treatment were walking 3 miles, on a 2 inch wide sideline of a major highway, to the nearest urgent care, or relying on my bathtub if things went further downhill. I chose the latter as I could not guarantee that I would be safe from reinfection if I went to the clinic. Neither of those situations should ever be something a patient even has to consider when getting healthcare.

Furthermore, I have personally witnessed some of the devastation it has caused others, friends who's infections offered so much mental strain that it reminded me of my late grandfather's alzheimers. Friends who have lost relatives due to getting infected, never being able to say goodbye without risking spreading infection onto themselves and others. Friends who now face chronic pain, brain fog, chronic fatigue, heart issues, strokes, blood issues, due to long covid. Folks who go to hospital for treatment, but end up with covid due to the hospitals taking no precautions let alone for other pathogens as well. These people are all valuable members of society, who can no longer live to their full potential due to your incompetence and blatant disregard for actually taking both the covid pandemic, and any other pathogen, seriously.

With the debacle of this week's meeting and the preceding and subsequent actions following it, I am reminded of a quote said by a friend in a conversation about immigration; "it is impossible to get citizenship in a country that doesn't want you to have it". I'd say it is a rather applicable statement if you replace citizenship with healthcare, prosperity, or even just the ability to live your life. Especially so since you'd rather choose eugenics policies over healthcare with such passionate methodology as (but not limited to): not requiring masks in healthcare, instead spreading disinfo regarding the inefficiency of surgical masks and covid actually being airbourne, not even mentioning masks including in wildfire PSAs, cherry-picking data and literature, closing all avenues of monitoring data, outright refusing to listen to experts, cutting off and quite literally turning your backs to the public, and being as closed door as possible on such a wide reaching aspect of public health policy. That is of course until the backlash, like any pathogen, is too widespread to deny.

Get your act together, everyone getting lifelong health conditions, disability, and trauma, isn't much better than everyone being dead, and problems don't disappear by pretending.

Regards,

Zoë Tether

---

Hello,

I am writing to you today to implore you to please make healthcare facilities a safe and accessible place for all. No one should become infected with additional illnesses that could be prevented just by seeking care.

I am a mother of two children with additional needs, one of whom is very immune-compromised. Unfortunately she has come to know a world that has no place for her, is judged for having to keep herself safe, and knows this society will not only *not* keep her safe, but puts her at increased risk. Imagine yourself at age 9, and how you would’ve felt to be left behind by literally almost everyone. She is growing up knowing pretty much only her family will try to keep her

safe, and we do try our best despite almost no one else even remotely trying, including those who provide her care. That's a horrible and sad thing to grow up with. It's hard enough just growing up with disabilities and health problems, but then also knowing even the grown-ups around you, even the professional "helpers," just don't care or won't do the right thing, even to protect the most vulnerable.

Every single person in my household- myself, my two children, and my elderly parents, are high risk, for multiple reasons. But even if we were not, we understand how airborne viruses work, we know the havoc Covid wreaks, and we care about others so we would still wear masks to prevent the transmission of a debilitating, and sometimes deadly, airborne virus. This seems like the LEAST people in healthcare could do, to strive for cleaner indoor air and wear well-fitted respirators/N95 masks around patients.

I need you to know what happened to my neighbor in the spring. We watched the EMTs go into his house for a long time, come out and put him in the ambulance with them, never putting on a mask. Knowing his wife is very high risk this was even more upsetting. About a month later I saw his wife outside and asked her how he was doing. He had died.

He caught Covid while in the hospital, or the ambulance, and died a few weeks later. He never came home again after that day. She is now a widow and she's heartbroken, lonely, and rightfully angry. The system that should have just helped him get better, made him worse. Much worse, it killed him. This matters, HE mattered. That man should be alive, but he died because the people who were supposed to care for him were either misinformed, lazy, uncaring, or maybe all of the above. That's just wrong. It is YOUR job to help people avoid that injustice and unnecessary grieving.

My dad, who has a pancreatic tumor, asbestosis, and multiple major heart issues, among other health issues, was taken in an ambulance in July and the EMTs refused to mask, rudely, even when we politely asked and told them how immune compromised my father is. They didn't care. Most of the hospital staff and doctors didn't mask either. It's mind-boggling and frankly it's revolting.

We know that high quality masks when worn correctly, work. We know cleaning indoor air helps. Yet we do nothing, even to protect those who need it most. My dad was much luckier than our neighbor, thankfully. But any given day any of us could be unlucky.

There is no backup parent for my children, it's just me. There's no one else to care for my parents. Who knows what Covid will do to me the next time. I shouldn't have to avoid trips to the dentist or doctor visits because they put me at increased risk. This system has become so broken, and you need to fix it. **You have the power to fix it.**

I care about my family. I shouldn't have to delay or avoid care due to it not being safe, and neither should they, but that is the reality of millions of Americans right now.

My father had hernia surgery last week and the surgical team put his N95 aside before he was intubated, he asked them to make sure he got it back after surgery, and turned out they "lost it," and gave him a surgical mask, which we know is not good enough. N95 also aren't cheap and my parents live on a fixed income, and they *lost* it? He requested a simple thing to advocate for himself and they failed him. He just wants to be healthy enough to recover, not infect his family upon coming home, and they couldn't even do that for him. He had a very, very rough Covid

infection a year ago, and his health deteriorated further after that, why should he have to go through that again, when he's actively trying NOT to? We know the risks of the damage that Covid can do increase with each infection, he can't just take a chance. He's got a LOT of health problems and doesn't need any more. It's reprehensible that they not only put him at additional risk by not masking, almost NO ONE in the entire hospital wore a mask and certainly not high quality ones, but *especially* now when cases are on the rise, but to not even honor his simple request to help himself stay safe, it's disgusting.

As someone who has suffered from Long Covid symptoms since July 2021 I can assure you, this isn't over, this isn't "mild," and we can't wish it away or pretend it's done. Millions are suffering from Long Covid with no cure, no help, no answers, no way to live anything close to their former life, and people are still dying every day.

It is abundantly clear that hospitals and most healthcare workers don't get it, and don't care. They need to be required to do the bare minimum to keep people safe. You should do everything in your power to ensure that happens.

Thank you, Briana Mackay, North Syracuse, NY

---

Representative of HICPAC,

My name is Deanna Schauben, I am writing today regarding the woefully insufficient HICPAC proposed updates. I live in Nashville TN, and I am writing as a concerned member of the public and apparently one of the last bastions of common sense disease control in this country. I am sick and tired of those who are tasked with the responsibility of controlling the spread of disease instead encouraging infection and leaving individuals to the impossible task of protecting themselves in a country full of people who refuse to acknowledge this real threat to life and well being.

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 implement the recommendations below.

- 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.

Please restore a modicum of my faith in the institutions that are meant to protect me and my loved ones.

---

YES to N95 respirators in healthcare settings

Dear CDC,

I urge you to include in your guidelines use of N95 respirators for healthcare workers. Our most vulnerable Americans can be found in healthcare settings, and they have no option to avoid these situations to protect themselves. People should feel safe going to the doctor or hospital,

and this begins with being treated by workers who are masking to prevent the spread of infectious disease.

COVID-19 is obviously today the most pertinent such disease, but as y'all know, there are many others as well that masking provides effective protection from.

These respirators also protect the workers themselves. This is just good policy, and I strongly urge you to consider this update to your recommendations.

Thank you,

Edward Miller, Henderson, NV

---

Dear members of HICPAC,

Thank you for hearing our comments. I am not a healthcare provider or any kind of expert. I'm an American citizen with chronic health conditions who is doing their best to avoid contracting Covid 19.

I am avoiding receiving necessary care, because it is unsafe at this time.

I did get a mammogram a few weeks ago. I asked that my rad tech wear an n95, since she would be less than 18 inches from my face. I was told this was "expensive", that the tech was not determined to need a fit-tested n95 per CDC guidelines (even though she would be interacting closely with dizens of people in a small room daily), and that my own mask would protect me adequately enough.

You and I both know that one-way masking is not as effective as 2-way masking. We both know that Covid is transmitted by aerosols that can linger in the air.

I'd like to stop taking PPIs. To do so I need an endoscopy. I do not feel safe being unmasked during a procedure or recovery. I know not all the providers in that provider's office are even vaccinated against Covid.  I know that more than half of Covid infections at this time are asymptomatic. I know if I ask my providers to wear n95 respirators when caring for me, my request will be denied.

It's expensive,  you see.

My PCP wants me to get a baseline colonoscopy. I do not feel safe doing so. I am delaying necessary cancer screening because n95s and clean air are unnecessary in clinical settings. And expensive, you know.

If I do end up needing cancer care,  I know the providers managing chemo and other treatments won't even be masked. Not even with procedural masks. I know,  because my friends who have cancer have told me that theirs aren't. Some of those friends have contacted Covid in healthcare settings, so they get to manage that on top of their cancer.

This is ridiculous. What happened to "do no harm"? Why do I have to beg for my providers to take the necessary steps to prevent Covid transmission when I make an appointment, and again before my appointment, and again with an ombudsman, and again when I'm in the clinic, every single time? Why is all the burden of stopping the chain of transmission falling on me?

We know the action to take. Stepping down mask protections and air filtration is not it.

Surgical/procedural masks are for droplets. We need protection from aerosols. We know this.

Please act to protect the public and providers.

Please require kn95 or better masks in healthcare.

Please require improved air quality and filtration.

Please ensure your methods are open to input from experts in the field and transparent to the public you answer to.

Thank you for your time and consideration.

Kate Pitroff, Redmond, WA

---

Hello,

My name is Conor Bleistein, I live in Nashville, TN and am a member of the public. I have been frustrated by the lack of input the public has been able to give in terms of updating the 2007 isolation Precautions guidance. The CDC and HICPAC's process has been all but closed, with little knowledge given to the general population. This frustrates me as someone who has experienced a number of family and friendly deaths due to viral diseases in the last few years. It is not an extraordinary task to provide HICPAC meeting presentations and documents used to advise the CDC. The decisions made by HICPAC and the CDC impact myself, my family, and beyond. I think transparency is vital in this process. It is also worth noting that revealing these documents is standard process for other federal advisory committees including those at the CDC. I urge HICPAC and the CDC to consider involving the public as well as properly sharing information that would be public under many other federal institutions.

Thank you for hearing my concerns,

Conor Bleistein

---

Hello,

My name is Trista Gallagher. I am a public servant and a private citizen. I urge you to include air filtration and N95 masks as standard precautions against airborne pathogens such as Covid 19.

Thank you for your time,

Trista

---

Dear CDC,

I am writing to express my concerns about the varying protection levels of different masks in healthcare facilities. I am particularly worried about the safety of immunocompromised and disabled individuals who rely on these facilities for their health needs.

It is evident that regular surgical masks do not provide the same level of protection as N95/KN95 masks, which are more effective in preventing the spread of airborne particles. This discrepancy puts vulnerable individuals at greater risk of exposure to infectious agents. To ensure the safety of everyone, especially those who are immunocompromised or disabled, I urge the CDC to implement measures that enhance protection within healthcare facilities.

I would like to request that the CDC issue Indoor Air Quality targets for all healthcare facilities. One such measure could be mandating a minimum ventilation rate of 12 air changes per hour or the equivalent utilization of HEPA filtration systems. Improving indoor air quality is crucial in reducing the transmission of infectious diseases and safeguarding the health of patients and healthcare workers alike.

I understand that there are limitations to the CDC's legal authority. Therefore, I am not asking for mandates that are beyond your jurisdiction, such as a nationwide mask mandate or travel mask mandate. My intention is solely to emphasize the importance of enhancing protection within healthcare facilities through measures that fall within the CDC's purview.

Thank you for your dedication to public health and safety. I hope that my concerns are taken into consideration, and I look forward to seeing improvements in infection control practices within healthcare settings.

Sincerely,

Phoebe Burchill

Ashland WI

---

Madeleine Grigg

Fort Collins, CO

Organizational Affiliation: People's CDC

Topic being addressed: Latest HICPAC COVID-19 infection transmission recommendations/review

Dear HICPAC Advisory Committee,

There's a common word one comes across when reading media pieces about the COVID-19 pandemic: *unprecedented*. No word could better capture what the last three years have meant to the global population. At the onset of the pandemic, many of us realized that the world would never be the same

– that any attempts to manufacture or recreate pre-pandemic life are futile.

This line of thinking was front of mind for me when I read HICPAC's COVID-19 review and the recommended policies for ventilation and mask-wearing.

Lower standards for ventilation and mask wearing do not yield better outcomes for infection rates. It is contradictory to medical research and messaging

– messaging that the CDC disseminated to the general public in the past – to propose that surgical masks and N95s will perform the same in preventing transmission and infection. This novel virus mutates rapidly and, in most cases, each strain becomes more infectious as vaccines wear off. It will be imperative that individuals, especially health workers, use stringent measures to protect themselves, and need access to the proper resources to do so.

My opposition to HICPAC's review is not only based on empiricism in research, but also my personal connection to the impacts of this virus: A dear friend of mine was on bedrest in the

hospital before giving birth to her baby boy. Because masks were no longer required in hospitals, she contracted

COVID while in the hospital and, after giving birth, was deprived of the first 10 days with her newborn son. Also, professionally, I work as a 504 Coordinator in K-12 education. I see the first-hand impact this virus has on kids with health conditions and how scaling back COVID precautions leads to more barriers to their participation in school

I recommend that the committee engage proper stakeholder engagement and consultation; healthcare workers and patient advocates are collaborating with the CDC to manage (currently) rising levels of infection, and can offer brilliant perspectives on appropriate preventative measures. I urge HICPAC to embrace 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); and 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. 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 stakeholders, and by making 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 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. 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.

- 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. Guidance around what to do when one tests positive must include the

latest scientific evidence on contagiousness before testing positive and/or showing symptoms so individuals know who to inform

- 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 and other PPE requirements and access as critical methods for preventing health care personnel and patient inhalation 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.

Sincerely, and with respect,

Madeleine Grigg

---

Lani Boschulte

New York, NY

Topic: Standard Precautions

Hello, my name is Lani Boschulte and I am not associated with any organization. I attended the HICPAC meeting on Tuesday, August 22nd. After watching and listening to all of the presentations I found something particularly concerning, the lack of precautions and mitigations such as masking with proper fitting masks and respirators as part of the standard patient precautions. While masking was mentioned for things such as port changes in the slides shown, their effectiveness nor their necessity were brought up for the general precautions that should be practiced with all patients seen by medical professionals.

At the beginning of the meeting, the rise of SARS-COV-2 cases nationally was mentioned. Several studies have shown that well-fitting masks and respirators as well as purified air are effective in preventing the spread of this disease. Additionally, these precautions help to prevent the spread of other respiratory transmitted diseases such as; Influenza, Tuberculosis, and

Respiratory Syncytial Virus, among others. Despite this, none of these measures were spoken about nor brought up in this meeting speaking about infection control.

Before the SARS-COV2 pandemic, it may have been excusable to not know that air and its cleanliness were needed to ensure a healthy population, but we now have the data and the information to know and do better than we did before. Just as there are standards for uncontaminated water to prevent diseases such as Cholera and Hepatitis A, there need to be standards for uncontaminated air to prevent diseases like the Flu and most importantly SARS-COV2. These standards should be in place in all public settings but, most importantly they should be in place in medical settings. With a virus as contagious as SARS-COV2 precautions such as universal masking and clean air standards need to be put in place in medical settings as a **minimum**.

Not including things such as masking into the standard precautions misleads medical professionals and staff causing them to expose not only themselves but most importantly, their patients to damaging diseases such as SARS-COV2. With the knowledge we have now, as of 2023, I would argue that not commissioning these actions into the standard precautions is the equivalent of removing hand washing from the standard precautions. With the information available today there is no excuse to not do better than what was done in the past. Not promoting proper guidance to prevent respiratory infections puts an unnecessary strain on both individuals, due to the responsibility they now have to prevent getting infected by their medical professionals, and the healthcare system, due to the sheer number of people getting both acutely sick as well as becoming chronically ill and disabled from this damaging virus. Well-fitting masks need to be added to standard precautions, as well as an emphasis on air purification and clean air standards.

---

Dear members of the committee,

I am a professor and member of the public. I am appalled at the CDC's proposal that surgical masks be the standard precaution to prevent transmission in healthcare settings. This means that I, and many others, will not be able to safely seek medical care. I have already deferred or canceled many health care visits and screenings because I do not feel safe. The last three medical appointments I went to I was surrounded by unmasked coughing, hacking, patients and staff, including people who said they had Covid-19. In addition to being immunocompromised, I have a likely facial/skull fracture that would require me to unmask in such a setting -- so I had to make the hard choice to avoid visiting the hospital due to the ongoing threat of

Covid-19 transmission. Numerous scientific studies support the efficacy of N95 respirators and air filtration to reduce the risk of

Covid-19 spread. Please heed these expert studies and the will of many citizens.

Jenifer Winter

Honolulu, HI

---

Dear Healthcare Infection Control Practices Advisory Committee,

I am writing to submit public comment following the August 22 HICPAC meeting. My comments address HICPAC's work to revise the CDC’s Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

I share the concerns of those who provided verbal comments that HICPAC has so far failed to involve experts and those who would be most affected by these changes into the revision process. This includes 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 also urge HICPAC and the CDC not to adopt a more "flexible" approach to precautions, but rather to maintain an approach in the updated guidance that is explicit about the precautions that are necessary to protect health care workers and patients from infectious diseases. Furthermore, I agree that 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.

Patient safety is a particular concern for me, my loved ones, and my communities. It is unconscionable that so many people, including a number of disabled people I know in my communities, are delaying both preventative and even more immediate medical care because the risk of contracting COVID comes with such serious consequences. While my situation is not quite the same, I have found medical appointments increasingly stressful as precautions have decreased because I am a cancer survivor and want to avoid the kind of long COVID complications that could once again debilitate me.

I am also concerned about family members in high-risk groups. My father – who has multiple forms of cancer and dementia – has been in and out of the hospital regularly over the past three years. I continue to be very worried about him or my mother contracting COVID in the emergency or inpatient hospital setting, especially after my mother got COVID from visiting him at his adult care home almost immediately after mask requirements were lifted in Oregon health care and long-term care settings this past spring. She took 4 weeks to recover from her case of COVID, even with Paxlovid, and has had mild but still lingering effects for the past several months.

No one should get sick and face debilitating or even fatal consequences as a result of receiving essential health care, and no one should even be faced with that choice. Protecting those at the highest risk of severe COVID outcomes protects all of us. Please recommend guidance that ensures the highest level of health care worker and patient protection.

Sincerely,

Lisa Wilson

Portland, OR

---

I've been following HICPAC and I have to say that I'm disappointed with the process you've used providing infection control advice to the CDC. From what I've seen, the public has been largely shut out as have experts in aerosols & respiratory protection, frontline health care personnel, unions and many others who want to truly protect patients and the public.

And this stuff you've put forward about a surgical mask being equivalent to an N95 respiator is laughable. You need to get better information by including more advice from experts and get serious about public health & infection prevention. Right now, you're failing to protect Americans and you don't need to look far to see the tragic consequences, much less the needless death & long term disabilities being created under present circumstances.

Thanks for your time and consideration.

Dan Mason

Whitman, MA

---

EL Kruse

Brooklyn NY

Independent Covid Safety, Disability Justice Advocate

I am a 34 year-old disabled and chronically ill American from Brooklyn who has had their world shattered by this pandemic and the CDC's own recklessness in advising the public and healthcare professionals alike. My ability to access medical care has gone from bad to abysmal. I am writing to urge the CDC to **strengthen** rather than weaken infection control guidelines for healthcare settings.

HICPAC's proposals to further weaken infection control measures will destroy lives, ending many outright; they will steal futures, steal dreams, steal opportunities and steal the world out from underneath millions of people. If the CDC moves forward with these updated guidelines, it will continue to betray and harm the very public it purports to serve.

There is an abundance of evidence to demonstrate the superiority of N95s to surgical masks (which the CDC itself at one point made into an infographic!). There is an abundance of evidence to demonstrate the effectiveness of clean air and ventilation in mitigating the spread of airborne pathogens. There is an abundance of evidence – despite the CDC's own efforts to obfuscate it – to demonstrate we remain firmly in the throes of an airborne pandemic that is disabling and killing people in America every day. Yet HICPAC has made it their goal to vote in contrast with this overwhelming data? The CDC cannot claim to serve an agenda of disease control and prevention, then. It cannot promote itself to be evidence-based, then.

I am tired of having to weigh the choice between forgoing healthcare to avoid covid exposure and seeking healthcare at the risk of everything I have, including my life and the lives of my family. It is an impossible choice that carries a tremendous physical and psychological toll. I have already caught covid *at least* once in a healthcare setting (I say at least, because it has become increasingly difficult to access testing and treatment – another outcome of CDC's disregard for the most vulnerable in favor of corporate interests). The CDC's role in enabling nosocomial covid spread is scandalous and appalling. No one should have to risk their life to seek healthcare. This should not even have to be stated. I know I am not the first member of the public to speak to the catch-22 that is having to choose between seeking care & risking covid and forgoing care & ensuring the deterioration of my pre-existing conditions. You are putting me in this position. You are putting millions of Americans in this position. Weaking infection control protocols will compound this reality.

The CDC has heretofore demonstrated an utter lack of regard for human life – most especially disabled, chronically ill, and immunocompromised life – and this is, as so many others have pointed out before me, **eugenics**. These proposed changes will only intensify healthcare inequity and the CDC's contribution to a cultural rise in eugenics. Disabled, chronically ill and immunocompromised Americans deserve equitable access to healthcare, but throughout this

pandemic the CDC has done next to nothing to ensure that, instead consistently setting guidelines that strip us of our dignity, our rights and in far too many cases, our lives. **This must change.** Please make the ethical and humane choice, and choose to use this as an opportunity to bolster infection control safety measures in healthcare – with things like compulsory N95 use, improved ventilation and other effective measures to reduce aerosol transmission – rather than weaken them. It is by now the absolute lowest bar to clear.

Thank You.

---

i am writing a letter of concern that healthcare masking guidance be changed to include N95 masking for protection from airborne diseases.

the CDC states it is dedicated to improving healthcare quality. prove it. protect me and my family.

i have plans for procedures in the coming months and i find it incomprehensible that i could catch an easily controlled airborne sickness like covid-19 in a healthcare facility because the CDC guidance would state that a unsecured blue surgical mask has similar aerosol protection as an N95.

sincerely,

Jeff Wong

---

Good evening,

I'm writing in to urge you not to diminish infection control protections for healthcare facilities -- *especially* not healthcare facilities. The CDC itself has determined that surgical masks do not provide as much protection against COVID-19 as N95 quality masks.

As Forbes has reported, no less than 900 experts in infectious diseases and other disciplines have already criticized your guidance, and you have not been able to provide a substantive response. It's bad enough that former members of the Biden administration like Dr. Ashish Jha peddles disinformation about being able to "ignore" COVID-19. The CDC can and must do better, or risk further eroding its credibility.

Sincerely,

Arturo R. García

San Diego, CA

---

My public comment is regarding CDC/HICPAC's impending update to the CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Per your workgroup's presentation at the June 2023 HICPAC meeting, draft notes for the aforementioned guidelines include concerning proposals:

"DRAFT: Transmission-Based Precautions to Prevent Transmission by Air"

Under the "Routine Air Precautions" category, you propose using a "Medical/Surgical Facemask" for "Seasonal coronavirus, Seasonal influenza" but then recommend an "N95 respirator" as part of "Novel Air Precautions" for "MERS, SARS-CoV-1, Pandemic-phase respiratory viruses (e.g., influenza, SARS-CoV-2)"

SARS-CoV-2 is the same virus, whether the term pandemic is applied or not. It spreads primarily through infectious aerosols, which can remain suspended in the air for hours. It is ludicrous to recommend surgical masks at one time but N95 respirators the next. These days, most healthcare facilities are not testing the patients or staff for SARS-CoV-2 upon entrance or exit, but lack of test results does not denote lack of SARS-CoV-2 circulation. There is no debate anecdotally that it is circulating widely among staff, patients, and visitors, continually. So "pandemic-phase" vs. "seasonal" designation is arbitrary and not in fact representative of transmission when testing is so infrequent, both in healthcare settings and the community. Additionally, it makes no sense to have HCPs try to differentiate when to use an N95 respirator vs. surgical mask because of the high percentage of asymptomatic people with SARS-CoV-2, including themselves, patients, and other staff members.

In "Kalu, I., Henderson, D., Weber, D., & Haessler, S. (2023). Back to the future: Redefining 'universal precautions' to include masking for all patient encounters. Infection Control & Hospital Epidemiology, 1-2. doi:10.1017/ice.2023.2", HICPAC members David J. Weber and David Henderson along with the other authors note:

"It quickly became obvious that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) could be transmitted from symptomatic, pre-symptomatic and asympto?matic people. Thus, implementing precautions only after identi?fying infected persons could not effectively mitigate transmission risks." Later in the article, the authors also assert that "mask use by HCPs should be codified into the defi?nition of standard and universal precautions and should not be based on seasonal respiratory viral patterns, another COVID-19 surge, or the next pandemic."

I urge HICPAC members to heed the words of two of their own and re-draft your guidelines.

I would also like to note that many healthcare employers allow staff to work when infected. Since that's the case, and many don't even know they're infected given the high incidence of asymptomatic cases, how does it make sense to recommend anything less than a respirator at all times? Healthcare workers have close contact with the public, and since patients and visitors in the healthcare facility frequently aren't required to wear masks at all, then the likelihood of transmission is quite high. If there is to be one-way masking (i.e. HCP masked but patients and visitors not), significant reduction in infection transmission would result from the use of N95 respirators but not surgical masks. Respirators are more effective as PPE and as source control. It is a well-known fact so since you know better, do better! There's no excuse for deliberately pushing a substandard option. N95 respirators are no longer in short supply or expensive as in early 2020, either. Expand your evidence review and consult experts in aerosol science, occupational health, and respiratory protection.

I urge HICPAC to create robust recommendations that protect healthcare workers, patients, and the public to the greatest possible extent, and not write the playbook of minimum standards. Even if you say facilities can adopt other, "stricter" policies if they want to, over the course of this pandemic to date the vast majority of healthcare facilities have not done that and have instead done the bare minimum. That bare minimum is the cause of countless preventable infections, many resulting in Long COVID which itself is pushing HCPs out of the workforce due to the severity of disability. They deserve better, and patients who seek aid don't deserve healthcare-acquired infections, either.

Healthcare workers have a duty of "do no harm" and even unintentionally infecting others with coronavirus does harm them when there are ways to prevent it. Your guidelines should also

include ventilation and HEPA air purification. Not recommending N95 respirators at all times when you know they are the most effective option would violate "do no harm" on your end, HICPAC.

Sincerely,

Erika Gould

Member, World Health Network

---

Hi Secretariat,

My name is Ramin Barghi

Please STRENGTHEN and do not weaken the infectious disease protocols for the CDC.

Surgical masks are not the same as N95.

Air filtration should be added to all hospitals.

I live in Palo Alto, California and am a concerned citizen of the United States.

Thank you.

---

Hello, everyone. My name is Morgan Tierney, and I'm an undergraduate student of health sciences and public health education at Trident University International. I also have a professional background in occupational process improvement and quality control, am a survivor of Long Covid, and am one of many who have acquired Covid19 in a healthcare setting after mask mandates were lifted. Thank you for giving me the opportunity to speak today.

I'd like to echo concerns that others have shared about the proposed updates to infection control guidelines. My main concerns are as follows:

**First, the proposed updates do not adequately acknowledge the ongoing airborne spread of Covid19 or potential for future airborne disease outbreaks.** I believe we are at a point in history when NIOSH-approved respirators should be an everyday part of every healthcare worker's attire. Most regulated industries have OSHA-required PPE requirements, which are not always comfortable to wear, but have been deemed to be a necessary safety precaution. Please note that in virtually every industry outside of healthcare, safety guidelines are never eased to meet the demands of the underperforming employee who does not wish to follow safety protocol.

**Additionally, the proposed updates ignore extensive evidence of N95 respirator efficacy in occupational settings.** Demanding more retrospective, healthcare-specific studies on mask efficacy before acting in the best interest of patients, instead of using the existing wealth of evidence from other occupational spaces and/or erring on the side of caution, is *treading dangerously close to our nation's disturbing history of conducting health-related experiments on its citizens without their consent.* I urge the CDC and HICPAC to consider the optics of making such decisions at a time when trust in public health and the CDC are at an all-time low.

Putting people in the position of risking exposure to pathogens in order to access healthcare is not only highly unethical, but also represents a massive loss of revenue for the medical industry from people avoiding healthcare altogether and from liability lawsuits that will undoubtedly result

from healthcare workers failing to take simple precautions to protect their patients from dangerous airborne viruses like Covid19.

**Last-- but not least-- the proposed updates defeat the intended purpose of Standard Precautions.** Several proposed updates revolve around the theme of taking precautions only when a pathogen is known, which is contradictory to the purpose of Standard Precautions. As a reminder, we take standard precautions because we so often do not know what health threats each patient represents until further investigation, and that *we have a global responsibility to uphold these values.*

Healthcare workers, many of whom historically have not been properly trained in risk assessment, should not be tasked with making on-the-spot decisions about PPE use. Doing so presents practical challenges for adherence to infection control precautions in high-pressure situations, and neglecting to set firm infection control standards for all healthcare settings ahead of time will make it difficult to assess the efficacy of these proposed measures in the future.

This is an extremely rare opportunity to restore public trust in the CDC. By swiftly updating and implementing guidelines that are patient-centered, science-based, and require healthcare personnel to wear N95 respirators universally, you would be restoring healthcare access for millions of Americans and demonstrating a commitment to the standards of medical care that Americans deserve. Thank you.

I don’t want to be forced into exposure to multiple infections when I need to seek healthcare. I almost died from infection twice in my life because of inadequate investment in healthcare in 2 different countries.

If we are to be forced into preventable exposure to covid and other diseases in healthcare settings, against our will, the goal of this forced infection needs to be spelled out, along with clearly stating the known consequences so the American people can say whether we want to bear those consequences.

You can’t just rip away the freedom of individuals to protect ourselves from disease, and not have a clearly articulated reason because the masks off, let it rip plan sounds an awful lot like the “natural herd immunity” garbage we heard in 2020 and the American people said no to that already.

There are other names for this ideology and it’s a pseudoscience that patriots like my father, my uncle, and my step-father, all fought in a war to protect us from 80 years ago.

Do not make guidelines that give cover for genocidal negligence in our hospitals and nursing homes.

People in healthcare settings need to wash their hands and put on a mask and have air quality engineering controls to prevent disease spread in healthcare.

Universal masking and broad use of N95 respirators in healthcare and essential spaces is a simple and valuable investment to save lives and that’s what I think we should do as a civilization.

Chloe Humbert

Scranton Pennsylvania

Hi,

My name is Maria Starck. I live in Louisville, KY. I have no organizational affiliation to report.

I am writing to share my public comment. I attended the August HICPAC meeting and wanted to share some comments with your Committee related to updating CDC's *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.*

I am very concerned about the Draft Proposal coming from the Working Group related to "Transmission by Air" as well as the lack of openness on the development of the guidelines over the period of the Work Groups meetings. Covid-19 is an airborne disease that spreads asymptomatically in nearly half of all cases and continues to lead to death, disablement, and long term health impacts (e.g. stroke risk, diabetes risk, organ damage, etc.) among the general public.

Its spread continues to go unchecked in our healthcare settings as universal masking has disappeared. Patients have been left to fight or be denied to receive care with the minimal protection (N95 respirator) that has been well documented - including in the transmission-based precautions - as the standard for filtering aerosol pathogens. However, the Evidence Review that was presented in the June meeting presented flawed research equating the effectiveness of surgical masks (that are not sealed) and respirators (N95 or PAPR) in protecting patients and HCW when exposed to diseases like COVID-19, which primarily spread via aerosols. In addition, the HICPAC Working Group June presentation did not fully address 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 for controlling worker exposure to infectious aerosols have not been considered, and the proposed use of airborne infection isolation rooms (AIIRs) is significantly limited. Source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation. **Thus, corrections should be done to this draft product and evidence review, and an amended draft proposal should be created collaboratively and transparently with the engagement of additional experts and the public. This should be done before any more voting by the members of the HICPAC on this topic.**

If the CDC would like us to find a way to live alongside the SARS-COV-2 virus with continuous waves and unchecked mutation (which contributes to less effective vaccine targeting), we must have infection control guidance that understands that patients, HCW, and other staff could be infected at any time (not just "pandemic-phase" or "seasonally"). We need new Standard Precautions that understand the world we are living in based on the best science. We want to move forward with better protections, not fewer. Vulnerable people, especially, must be able to receive healthcare that <u>does no harm</u>, and workers deserve robust workplace protections from infection that reduce the risk of repeated exposure to airborne pathogens in the workplace.

Thank you for considering my comment. I look forward to more robust public engagement and communication in advance of the November meeting.

Thank you,

Maria Starck

---

Mask mandates and vaccine mandates need to return. The more "flexible" approach for health care employers to implement precautions is clearly not working and is putting workers, patients,

and the public at large at risk. There's the old saying, "If you give them an inch, they'll take a mile!" Health care facilities aren't exempt from it. The people in charge rationalize it's OK to drop precautions (like mask mandates and vaccine mandates) because the CDC and other higher authorities have provided the go-ahead. The rest of society rationalizes that it's OK to drop precautions because health care professionals have done so. This is analogous to the days when health care professionals routinely smoked cigarettes on the job, even around patients.

Some additional suggestions:

- Everyone should be free to choose the Novavax vaccine and NOT be limited to the Moderna and Pfizer vaccines. Some people have had side effects from the mRNA vaccines and should not have to jump through hoops to get the Novavax vaccine instead. ANY of the three available vaccines is MUCH better than no vaccine.
- Everyone should be allowed to be boosted more frequently. Once a year is not enough given how quickly the coronavirus mutates and immunity fades.
- The vaccines should be updated more frequently. Once a year is not enough given how quickly the coronavirus mutates.
- The CDC should be pushing for the use of Corsi Rosenthal boxes and other air purifiers in schools, churches, gyms, offices, medical facilities, and other indoor environments where large numbers of people breathe the same air. While extensive renovations are necessary for many buildings, air purifiers are much cheaper and can be implemented much sooner. Corsi Rosenthal boxes and other homemade air purifiers are cheaper AND more effective than expensive commercial air purifiers.
- The CDC should be encouraging people to make sure they get enough Vitamin D. Vitamin D testing should be a routine medical test, just like cholesterol testing. Deficiencies in this essential nutrient are common, because not everyone can get enough from sunlight and food. Vitamin D deficiency weakens the immune system and promotes inflammation.
- The CDC should be encouraging people to make sure they get enough Vitamin B12 and selenium as well. Deficiencies in these nutrients weaken the immune system and are pro-inflammatory. Selenium deficiency may even make it easier for viruses to mutate.
- The CDC should be encouraging people to consume healthy diets and pushing for a healthier food system. Unhealthy diets weaken the immune system and promote inflammation. It was established early on in the pandemic that obesity is a comorbidity.

Jason Hsu

St. Paul, MN

---

Despite numerous medical conditions which require medication and monitoring, I cannot safely visit my primary care physician, my oncologist, my gastroenterologist, my ophthalmologist, or even my dentist because of the absence of masks in health care settings. The elimination of masking now requires me to risk my life to be seen by any medical practitioner, have blood

drawn for testing (testing without which my insurance will refuse to pay for my necessary medications/supplies), or receive preventative screenings such as a colonoscopy or endoscopy.

The elimination of masks in medical settings is a significant barrier preventing the elderly, people with disabilities and those who are immunocompromised from receiving health care without risking their lives. Personally, with the exception of 10 visits to medical practitioners once vaccines were available in 2021, I have lived in quarantine since March 13, 2020. But, now I can no longer even visit those practitioners because without masking my risks of infection are too high.

Vaccines were never tested on people who are immunocompromised. They lose effectiveness after only a few months, but boosters are not available. And vaccines are not effective against newer variants. The only effective ways to prevent infection by Covid-19 (and other respiratory viruses which have become more virulent since it emerged) are masking and significantly improved ventilation. Neither is available in most venues, including health care facilities.

For  anyone with a cancer that is latent or in remission, a Covid infection is a literal death sentence. It's not a matter of if, just how long they will suffer and how painful and costly their demise will be. And, of course, for anyone who has not been infected (or whose prior infections have not yet resulted in Long Covid disabilities), a Covid infection presents the risk of additional long-term, probably permanent, disabilities (most of which will lead to an early death) including dangerous blood clots; high blood pressure; diabetes; lung, gastrointestinal, and musculoskeletal diseases; dementia; chronic fatigue; stroke; heart attack; kidney failure; etc.

I urge the CDC and HICPAC to fully recognize aerosol transmission and protect health care workers and patients by returning to the requirement that masks be worn by everyone -- patients, staff, practitioners, visitors -- in *any* medical setting including clinics, hospitals, long-term care facilities, pharmacies, laboratories, etc. Mask requirements will remove a significant barrier to accessing healthcare for people with disabilities (especially if those disabilities are caused by Long Covid which could be exacerbated by another infection) and other disabling medical conditions.

Sincerely,

F.I. Goldhaber (they/them)

Oregon

---

Name: Lara Moore

Sparks, NV

To the committee:
I'm an American citizen with several chronic illnesses whose public life has been seriously curtailed by the ongoing COVID-19 pandemic. One of my biggest worries is accessing needed medical care when I am the only one masking, much less wearing high-quality masks, and there are no good standards for air quality within medical buildings. I also worry for the protections of staff in such locations, and the stability of the medical system as a whole being repeatedly taxed by infection and illness when there are effective means of protection available.

Please create guidance to increase indoor air quality in healthcare facilities and encourage use

of N95s or better over lower-quality surgical masks.

Thank you.

---

I am Margo, a member of the public with no affiliation.

In late 2022, I developed worrisome symptoms, so I phoned a doctor. He agreed that I needed medical care, in fact, he was ready to refer me to a cardiologist. Then I asked about covid precautions. He said covid didn't kill people anymore. I said that wasn't true, I'd see reports of new deaths. He blew me off, and said with pride that his N95 respirator stayed in his desk drawer all the time. I later checked, and the CDC's own data claimed thousands of people in the United States had died of covid that very week.

I'd already read articles about covid causing heart damage. If this doctor believed I should see a cardiologist, why should I risk causing further harm to my heart? Would the cardiologist refuse to wear a respirator to prevent infectious aerosols, just like the doctor on the phone?

I borrowed a family member's blood pressure monitor. I gambled on a quick blood draw which only required a few minutes in an enclosed indoor space with others, some of whom were unmasked, while wearing an N95. That gave me some information on my condition, but it was inferior to a full exam done by a cardiologist. I figured out lifestyle changes which reduce my symptoms, lifestyle changes which are much more difficult than wearing a mask, but I made the changes because I need my heart.

I've learned even more about the effect covid has on the heart, and I want to avoid it even more. I wondered if a covid infection had caused my trouble, so I took an at-home nucleocapsid antibody test: not detected. I wear N95s in public. As far as I know, I've never caught covid. Respirators work if you actually wear them.

Chances are if I wore an N95 to a full cardiological exam I'd be protected from airborne pathogens, even if everyone else were unmasked, but I've lost much trust in doctors, including cardiologists who don't read the scientific papers about covid and the heart. I don't want to listen to a cardiologist who doesn't take covid seriously. And there's always a small chance the seal on my N95 will break.

I think I made the better choice for my health, but this choice shouldn't have been forced on me. All healthcare clinics should have universal masking, ideally with N95 or better respirators, and ventilation and filtration should reduce the spread of airborne pathogens even further.

---

The whole reason your organization exists is to control and prevent disease. That is incredibly important. In fact, it's a life or death matter. So, maybe you shouldn't be caving to political pressure to let people spread disease. Masks need to be required and ventilation systems need to be added at least sometimes in order for disabled people to be able to safely participate in society. Public transport and grocery stores would be good. Schools would be really good, since that's where covid is spread the most. Hospitals are the absolute most important, since that where both vulnerable people and contagious people go. The risk of death from a hospital-acquired infection is extremely high. It's truly the absolute least you can do. Please protect us. I'm losing my early twenties to this pandemic and I fear I will lose the rest of my life to it too because everyone else is just ignoring the problem, and I certainly can't solve it on my own. Thank you for your consideration.

Vienna Mumm

Hello,

Thank you for allowing me to send you my comments related to precautions and mitigations in healthcare settings.

I urge you to prioritize proper NIOSH quality masking and cleaner air standards to support those of us who are most vulnerable during this pandemic period.

As you are well aware, all scientific evidence points to the extremely high risk of long-term complications if a high-risk individual becomes infected at an unrelated, required health-care visit.

As a non-medical person who reads these studies, I probably have a much less detailed view on these matters than the members if HICPAC, but it is critical that we push for a higher standard of respiratory hygiene.

Thank you for your time,

~David Armstrong (He/Him)

---

I would like to comment on the proposed guidelines for healthcare workers for airborn viruses.

The proposed guidelines are irresponsible and should require n-95s and air filtration. This is the best way to protect healthcare workers and patients.

Rev. Emily Otto

Schenectady NY

United Church of Christ, Hospice Chaplain

---

Dear members of the committee,

I am writing to request that you please strengthen the guidelines for masks and PPE in healthcare facilities. Hospitals and other healthcare facilities are places of vulnerability: cancer patients, transplant patients (a family member is one), newborn babies, seniors, and people who've had the misfortune of terrible accidents or disease. We all--but especially healthcare workers--should be doing our best to ensure their safety from hospital-acquired disease. In addition, patients and visitors should also be subject to masking guidelines. I have lost count of the number of times that I, accompanying my transplant recipient family member, have waited in a hospital-based blood draw lab with coughing and congested patients. It's truly a disgrace that people in a hospital can decline even more from reckless PPE policy than from their original illness. For this reason, I am urging you to strengthen the guidelines.

Thank you,
Korina Cornish, Pembroke Pines, FL

---

On August 22nd, community members unanimously urged the CDC's HICPAC members to recognize airborne transmission of SARS-2 and to require airborne precautions that include respirators, ventilation, and filtration in healthcare settings.

Today, I am joining ActionCareEquity.org and these community members who spoke during CDC's HICPAC public comment to emphasize the urgency of recognizing airborne transmission and to require airborne precautions in healthcare settings to save lives, prevent growing rates of long covid, and create safer conditions to access healthcare.

Lives should not be harmed in healthcare settings, lives should be saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence. People are dying tragic deaths from hospital acquired infection of SARS-2 that could have been prevented with mask requirements. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses.

And 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 masks will help our healthcare workers stay safer and help address critical staffing shortages which is reducing the overall baseline of care and is leading to a healthcare collapse. In closing: You are the CDC, 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?

Act quickly, our health and lives are depending on the requirement of airborne precautions in healthcare settings.

Thank you,
Joaquín Beltrán
Founder, ActionCareEquity.org

---

Joanna Daniels, J.D., Saint Petersburg, FL. Conflicts of interest: None. Representative Status: Self. I do not speak for any employer or client, past or present. I am an attorney who formerly practiced in workers' compensation and health care regulation, presently a patient and a caregiver of an elder veteran who is a relative.

Distinguished HIPAC members: A survivor of the 1918 Great Influenza Pandemic, Johannah Fitzgerald, taught her family an ounce of prevention is worth a pound of cure. She, my grandmother, shook telling me about those days losing her young adult friend, but not the world wars or the Great Depression. Non-pharmacological interventions (NPIs) of testing, ultraviolet germicide, ventilation, filtration, and personal protective equipment are the ounces of prevention needed against present and emerging airborne diseases in the era of growing antibiotic resistance yet are largely absent from the recommendations discussed in your August meeting. I urge you to solicit input for these recommendations from experts in engineering and the science of atmosphere and aerosols like Professor Linsey Marr. Otherwise, the status quo will be catastrophic.

With evidence, you can lead. Recall the change in public opinion after education regarding seatbelts and public indoor smoking. The current approach to appeal to the least cautious would have us still without seatbelts filling up cars with leaded gasoline and other follies.

Compare the NPIs provided at the 2023 World Economic Forum Davos meeting aka #DavosSafe and for personal contact with President Biden. See the CDC's TB Respiratory Protection in Health-Care Settings Fact Sheet as a starting base. In addition, the elastomeric

respirator raised in the public comments has established use in The Texas Center for Infectious Disease since 1996 without a single health care worker testing positive for TB through at least 2020. The hospital reported a saving of over $40,000 a year. https://www.kens5.com/article/news/health/san-antonio-hospital-could-have-an-answer-to-the-ppe-crisis-elastomeric-masks/273-882e7ea3-e377-4776-906c-33ce89e193cc).

NPIs are needed even more given the prevalence and persistence of Long Covid as it adds to the burden of health care staff in volume and as patients themselves. In February 2023 Vital Statistics Reporting Guidance, CDC wrote that "emerging evidence suggests that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, can have lasting effects on nearly every organ and organ system of the body weeks, months, and potentially years after infection (11,12). Documented serious post-COVID-19 conditions include cardiovascular, pulmonary, neurological, renal, endocrine, hematological, and gastrointestinal complications (8), as well as death."

I care for an elder veteran and we both have conditions which by CDC's guidance place us at higher risk for disability and death. One-way masking even with an N95 is not enough for us or for the countless people who do not know they are at higher risk while they share reception and treatment areas with people who are not tested and are not required to use any mask even though asymptomatic or pre-symptomatic transmission of SARS-CoV-2 and other diseases is known. Both the person for whom I provide care and I have deferred needed routine and preventive care and sometimes emergent care once the local health care system became hostile to masking and testing. Even if the procedural masks in theory would work, in nearly every single health care service encounter as both a patient and a caregiver, I have had to remind health care professionals, even board-certified physicians, to pull the mask up and cover the nose. In contrast, the N95 respirators are worn correctly. The complex care is hindered when I must watch the staff for something so basic while navigating testing and treatment options. A health care appointment should not be a battleground. Please protect him as he once did for you in war.

---

this letter was written for comment in April 2023. I am still masking whenever I go to the clinic or main campus. Only now I am in the minority of those who continue to mask.

To the CDC:

My name is Caitlin and I live in Boston MA. I've had Crohns since 2000 so I use one of the many large hospitals in the city for my appointments. Whenever I see my GI I go downtown to the main campus where there are always a ton of people passing through the lobbies, sitting in waiting rooms, killing time in the cafeteria. (it's like a city within a city)

<u>It would be really awesome if the CDC could issue Indoor Air Quality targets for healthcare facilities.</u> That way I'll feel a little better going to my next appointment when the hospital drops their mask mandate.

When I see my PCP it's at a clinic that's in a building that is *100 years old*. I have no idea how their ventilation system works, but I can tell you that the building is too small for the patient population. It feels cramped like everyone is on top of each other. SO if there are Indoor Air Quality targets that the hospital has to follow, then the building will be at the same standard as the main campus and that will make me feel a lot better.

No matter what, I'm still masking, but with the Indoor Air Quality targets in place, I won't be as anxious when others around me ditch their masks, or if my providers decide to stop masking.

thank you for your time

-Caitlin,
Boston MA

---

To the CDC's Healthcare Infection Control Advisory Committee:

I understand that your group is considering revisions to infection control requirements at health care facilities in the US, revisions that would certainly increase the airborne spread of SARS-Covid-2. As a citizen of the US, a person who has already lived through disabling conditions, and someone vulnerable to the worst consequences of SARS-Covid-2, I urge you to not only reject revisions that would weaken existing infection control measures, but to STRENGTHEN those measures.

According to a piece on Forbes.com dated 21 August 2023, the current proposals:

- Would water down infection control protections, particularly for aerosol transmission and multidrug-resistant organisms;
- Declare that plain, unfitted surgical masks protect health care workers, patients, and caregivers as well as fitted N95s;
- Fail to include ventilation, UV disinfection, and HEPA filtration, all critical tools against a documented airborne pathogen.

There are increasingly alarming signs that even mild SARS-Covid-2 infections can trigger long-term catastrophic health consequences in any bodily system. These consequences are not uniformly recognized, much less tested for or diagnosed, and few have adequate treatments.

If you do not reverse the foolish decision to weaken infection controls at medical facilities and choose to strengthen them vigorously, you will be complicit in countless unnecessary deaths and the disabling of millions of Americans. The cascade of consequences will be catastrophic: millions will lose employer-sponsored "good" health insurance when they can no longer work traditional full-time jobs; the health care system, already under extraordinary strain, will be unable to handle the explosion in patients with chronic/disabling conditions, including early dementia; individuals, families, neighborhoods, and entire regions are likely to become destabilized from lack of income, lack of health care, and lack of adequate social safety nets. And that's not half of it.

Ask any disability advocate--we already know how bad it can get. Please don't weaken infection control standards at US health care facilities. STRENGTHEN THEM.

Lisa Smith
Northborough, MA

---

August 20, 2023
CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC)
MS – H16-3, 1600 Clifton Road Atlanta, GA 30329-4027
hicpac@cdc.gov
**Re: 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 proposed revisions to the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. It is our understanding that the Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission to "air" and "touch." This approach 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. 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.

We would welcome an opportunity to partner with your committee to advance and protect the health and safety of the health care workforce, and the patients they serve.

Sincerely,

*Yolanda Lang*

Yolanda Lang, PhD, MSN, CRNP, COHN, FAAOHNAAOHN President

---

August 22, 2023

*Sent via email transmission Aug 25, 2023; re: aerosol transmission and respiratory protection*

Alexander J. Kallen, MD, MPH Chief**,** Prevention and Response Branch National Center for Emerging and Zoonotic Infectious Disease Centers for Disease Control and Prevention

Dear Dr Kallen,

On behalf of the Occupational Health and Safety (OHS) Section of the American Public Health Association, a diverse community of public health professionals that champions the health of all people and communities, we are providing comments to the Healthcare Infection Control Practices Advisory Committee (HICPAC) regarding updates to foundational infection control guidance for health care settings, last updated in 2007. We hope our contribution to this process will lead to improved measures that protect health workers and patients during future outbreaks of infectious diseases.

Our comments support comments by other occupational health and safety professionals.

- The science since 2007 has evolved a great deal and the CDC and HICPAC must fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens. It is essential that practice recommendations align with the scientific evidence regarding transmission mechanisms and protective control measures.
- With regards to recognition of airborne transmission, respiratory protection for health workers caring for patients with suspected or confirmed respiratory infections must be increased, including the requirement for N95 respirators or equivalent respirators into updated guidance for standards of care. The lack of appropriate guidance and resources for respiratory protection in healthcare settings during the COVID-19 pandemic led to uncounted illnesses among patients and workers, as well as unnecessary costs. A great deal of money, time and personnel would be saved by instituting more protective measures. Please refer to the

Commentary by Lisa Brousseau, et. al. (2021)[1] regarding the analysis of misinformation regarding surgical and cloth masks compared to N95 respirators.

• The CDC and HICPAC must maintain a consistent approach for all employers to follow, not a crisis response standard, that is clear and explicit on the precautions that are needed in situations where infectious pathogens are or suspected to be present in health care settings. There must be a standard approach that does not leave it up to individual employers to be their own decisions with little or no accountability, and often lack sufficient expertise to make appropriate decisions without guidance.

• CDC and HICPAC should engage with stakeholders more effectively, including direct care health care workers, their unions, patients, community members and a range of public health professionals, including occupational health and safety to provide them with the ability to review and provide essential input into guidance updates. Increased OHS presence is needed on this committee.

_____

[1]*COMMENTARY: What can masks do? Part 1: The science behind COVID-19 protection https://www.cidrap.umn.edu/covid-19/commentary-what-can-masks-do-part-1-science-behind-covid-19-protection*

Sincerely,
Mary E Miller, RN, MN Co-chair, OHS Policy Committee American Public Health Association

---

Name: Rebecca Krikorian
Topic: HICPAC Recommendations
Address: 207 Wicks Lane Malverne, NY 11565 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 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. We know the damage it can do to people of all ages. We know this. And yet here you are essentially promoting eugenics. 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

---

Hello,

I just wanted to add my 2 cents here. My local hospital has reinstated their mask mandate, as they seem to repeatedly suffer outbreaks of COVID-19.

https://www.pressdemocrat.com/article/news/kaiser-permanente-reinstates-covid-19-mask-mandate-amid-spike-in-cases-but/

https://www.pressdemocrat.com/article/news/covid-19-outbreak-reported-at-kaiser-santa-rosa-hospital-local-health-offi/

The first article is from this week, the second is from last April. Maybe we could have a national policy to protect people in medical settings?

Regards,

Andrew Hudson
Santa Rosa, CA

---

Dear Sir/Madam,

I am writing to advocate for the ongoing utilization of masks in healthcare settings as a critical measure to combat the spread of COVID-19 and other infectious diseases. The significance of masks in safeguarding the health of healthcare professionals and patients cannot be understated, particularly in light of the challenges posed by these infectious diseases.

Masks have emerged as a proven tool in reducing the transmission of respiratory pathogens, such as COVID-19. Their proper use is pivotal in curbing the dispersion of infectious droplets and aerosols, effectively limiting the risk of exposure to both healthcare workers and patients. As the world continues to navigate the complexities of the COVID-19 pandemic, sustaining mask usage in healthcare settings is essential to minimize transmission rates and protect vulnerable individuals from severe illness.

Healthcare settings inherently house individuals with varying degrees of susceptibility to infections. Patients seeking medical attention, particularly those with preexisting conditions, are at an elevated risk of severe outcomes if exposed to COVID-19. A steadfast commitment to mask usage not only shields these patients from potential outbreaks but also underscores the healthcare system's dedication to patient safety and welfare.

Equally important is the protection of healthcare workers who selflessly provide care to patients. By consistently employing masks, healthcare professionals safeguard their own health and well-

being, which is paramount to delivering uninterrupted medical services. This practice minimizes the likelihood of healthcare workers becoming carriers of infectious agents, preserving their ability to serve as a crucial link in the healthcare chain.

I respectfully implore the CDC to continue its guidance and enforcement of mask usage in healthcare settings, particularly in the context of COVID-19. This approach aligns with established infection prevention strategies, reflecting a proactive commitment to public health and safety.

Thank you for your unwavering dedication to safeguarding public health. I trust that my perspective on the importance of mask usage in healthcare settings for the prevention of COVID-19 will be considered as you shape and refine infection control protocols.

Sincerely,

Kelsey Valles

---

Dear HICPAC,

My name is Kathleen Gadd and I am a librarian with expertise in the health sciences. In my work at a Canadian medical school and in the hospital system, people contact me to conduct literature searches to find evidence so they can make decisions with the best evidence. These decisions are made to improve patient outcomes, save patient lives, ensure safe working conditions for healthcare workers, and to run healthcare efficiently so the best care can be delivered to the most people. Throughout the pandemic I have noted that significant evidence on airborne transmission of SARS-CoV-2 has been ignored. This results in real harms to patients, healthcare workers, the healthcare system as a whole, and society. HICPAC must acknowledge what engineers, physicists, chemists, and other experts such as industrial hygienists know about SARS-CoV-2 and airborne transmission. N95 respirators are the appropriate PPE for an airborne hazard. Respiratory protection must not be downgraded to surgical masks, which are not designed for the hazard presented by aerosols.

Some studies have been conducted dishonestly recently regarding respiratory protection. Excellent critiques of these studies can be read at the website for the Canadian Aerosol Transmission Coalition. Please do not rely on these poorly-conducted RCTs to determine infection control measures. Respirators can be evaluated using direct observation - the RCT study design is appropriate for pharmaceutical interventions, but not for physical interventions like respirators. I hope this public consultation process has shown you the tremendous importance of recognizing the various motivations and biases at play here when dealing with airborne transmission.

Other groups have developed rigorous documents that can help with your process. It is imperative that you consult ASHRAE 241; Canada's Chief Science Advisor's March 2023 report on post-COVID condition (which contains recommendations on ventilation); the Ontario Society of Professional Engineers' reports on Indoor Air Quality available on their website. Engineers Canada also has a National Position Statement on ventilation on their website. The importance of air quality and ventilation/filtration should be included in your work.

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. Please work with these experts to develop your recommendations. In my small hospital network in New Brunswick, Canada, for a quarter in 2022-2023, 7.85% of patients who had healthcare-acquired COVID died within 2 weeks of their nosocomial infection. We need to acknowledge airborne transmission and use effective mitigation measures in order to save lives. Thank you,

Sincerely,

Kathleen Gadd, MLIS

Canada

Organization: Canadian Aerosol Transmission Coalition; Protect our Province New Brunswick

---

The Centre for Disease Control May not pick and choose which diseases it “controls”. Public health bodies are responsible for all public health, even if caused by an illness your political masters wish was over.

The only way to make Covid disappear, is to continue to monitor cases of Covid so we can apply the necessary mitigations of proper masking, ventilation and air filtration and vaccination.

Kelly MacIntosh

---

To whom it may concern,

Please recommend N95 respirators for controlling the spread of airborne pathogens in hospitals. Access to healthcare is a human right, and we do not have access if we must become sicker in order to seek care. Please do not abandon your responsibility to the American people. We will all start our lives as newborns and hopefully reach old age. During these most vulnerable stages in life, and anytime in between when we might become sick, we ought to be able to seek care knowing that evidence based measures are in place to prevent the spread of disease. Additionally, we must protect the health of those working in healthcare. They are a resource we cannot afford to make disposable.

Thank you,
Emily Miller

---

COVID is airborne, and continues to circulate. Lack of masking in healthcare facilities effectively denies safe healthcare to vulnerable populations. Immune-compromised people, those undergoing chemotherapy, the elderly, Long COVID patients, and many others have the right to seek medical care in places where they will not contract a serious disease that could have been prevented by mask use. Instead, they often must weigh the tradeoff between needed medical care and the risk of infection. It doesn’t have to be this way. Please promote and recommend mask use in all medical facilities, and require it where there is jurisdiction to do so.

Other measures to clean the air, such as HEPA air purifiers, UV-C treatments, and others should also be promoted and funded.

Thank you,
Frances Veasey

---

Hello,
I am writing to express my extreme concern for the ways that the HICPAC committee is avoiding public accountability while making proposed updates to the Infectious Disease protocols. While the Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings protocols absolutely should be updated, as we have learned much from infectious disease researchers since 2007, the proposed draft has the potential to cause dangerous effects on the protections that healthcare workers, advocates, and patients would have in healthcare settings. The draft recommendations fail to reflect what has been confirmed about aerosol transmission by inhalation during the COVID-19 pandemic, and the suggested protections and protocols put healthcare workers and patients at higher risk for catching and spreading COVID-19 and other infectious diseases due to a lack of quality PPE and infection control protocols.

As a chronically ill and high-risk patient who has to have access to doctor's offices and hospital settings, I have put off seeking needed care because of staff shortages and unsafe healthcare settings where staff are unmasked, and there is not testing or other protocols to prevent infections from COVID-19 and other respiratory diseases. **This is a blatant abandonment of healthcare workers and patients.**

I urge CDC, HICPAC, and the workgroup to take the following immediate actions to correct their review and decision-making processes and recommendations (based on letter to HICPAC and CDC letter from scientists, doctors and public health advocates):

1. Make the process for updating the guidelines fully open and transparent and open work group meetings to the public.

2. Seek input on proposed changes during the development of the draft guidelines from the public and all key stakeholders, including:
a. Health care personnel and their representatives
b. Industrial hygienists, occupational health nurses, and safety professionals
c. Engineers, including those with expertise in ventilation design and operation
d. Research scientists, including those with expertise in aerosols and respiratory protection
e. Experts in respiratory protection, including scientists from NIOSH's National Personal Protective Technology Laboratory (NPPTL) and the Occupational Safety and Health Administration (OSHA).

3. Improve the CDC's and HICPAC's understanding and assessment of key scientific evidence by seeking input from scientific researchers and key stakeholders, including healthcare personnel and their unions, and by making those written reviews publicly available.

4. 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 health care settings.

Best,
--
*Leticia Urieta (she/her/hers)*
Community Teaching Artist
Program Director-Austin Bat Cave
Program Co-Director-Barrio Writers Austin and Pflugerville

Name: Lauren Goldberg
Address: Queens, NY
Topic: Proposed changes to the CDC's Isolation Precautions
Organization: Member of the Public

Comment:
As an immunocompromised individual with a disabled partner, the updated guidelines and recommendations set forth by the CDC and HICPAC deeply concern us. It is critical for our health and safety that healthcare settings provide the highest possible protection against infectious aerosols. We will be exposed to further risk with the proposed changes, making it even more unsafe to access necessary medical care without risking other health complications.

We strongly urge the CDC and HICPAC to consider the vulnerabilities of patients like us when revising these guidelines. As the COVID-19 pandemic has shown, infectious diseases can have severe, long-lasting effects, especially for those with pre-existing health conditions. The new guidelines must prioritize the safety of all patients, ensuring that we do not have to choose between our health and receiving medical care.

Lastly, we appreciate the dedication and hard work of the CDC, but we urge you to reconsider the proposed changes, keeping in mind the most vulnerable among us. Healthcare settings should be a place of healing and safety, not a potential source of further harm.

---

Over the last few weeks, I have learned about HICPAC's proposed guidelines for infection control and I am extremely disturbed and concerned. The lack of transparency around planning and implementation is also unethical and unacceptable.

All healthcare workers and their patients deserve a safe space to administer and receive care and treatment. No one should be at risk of contracting preventable infections -- whether that's COVID-19, influenza, measles, candida, etc. -- in a setting where they are trying to heal and STAY ALIVE.

Let's keep these facilities well-ventilated, with clean air and clean surfaces. High-quality N95 (or better) respirators must be required and available for all workers as well as patients who are able to wear them.

Right now, our country is facing massive levels of illness and death, across all age groups. We're also facing a shortage of healthcare workers, which is going to further compound existing issues. There MUST be considerations that take precedence over profits for our healthcare system.

Please strengthen and broaden protections for workers and patients; do not lessen or roll them back. Our lives and our collective well-being depend on it.

Rebecca Hadley

---

Dear HICPAC Personnels,

My name is Dan Goetz. I am writing to you as an individual with firsthand experience of the challenges faced by immunocompromised individuals and their disabled partners in accessing

essential healthcare services. As an immunocompromised person, I understand the critical importance of stringent infection control measures, especially in a healthcare setting. Currently, my partner and I are unable to safely access healthcare services in accordance with the existing CDC recommendations, let alone any potential weaker ones.

The draft proposals presented by the Healthcare Infection Control Practices Advisory Committee (HICPAC) at the June 2023 meeting have ignited deep concern within our community. These proposals appear to compromise the protection of both healthcare personnel and patients against infectious aerosols, including the transmission of SARS-CoV-2. It is alarming to note that the draft recommendations lack the necessary input from key stakeholders, including frontline personnel, patient safety advocates, and experts in the field.

Of particular concern is the inadequate attention given to aerosol transmission and the essential control measures such as isolation, ventilation, and NIOSH-approved respirators. As someone whose health relies on stringent infection prevention strategies, I strongly urge the CDC and HICPAC to rectify these issues. The proposed flexible approach to precautions is likely to put healthcare personnel at unnecessary risk, which could lead to severe consequences for those, like myself, who are already vulnerable.

During this critical juncture, we implore you to reconsider the course of action and collaborate closely with a diverse range of stakeholders, including immunocompromised individuals, disabled persons, healthcare personnel, industrial hygienists, engineers, and experts in aerosol science. Transparent communication, open meetings, and public engagement are imperative in developing guidelines that truly safeguard the well-being of all individuals involved. In the midst of a pandemic that has disproportionately affected the health and safety of healthcare workers and the general population, it is essential that the CDC takes proactive measures to protect those who are most vulnerable.

We appreciate your attention to these matters and hope that you will consider our perspective as you make decisions that impact the lives and health of so many individuals.

Sincerely,
Dan Goetz — A Member of the Public
Astoria, NY

---

Dear HICPAC/CDC,

I attended the August 22 webinar, and the public comments should be enshrined and a lesson to you all about putting science first.

There are far more folks than you are willing to acknowledge that do get the science — understanding importance of attention to ventilation and masking to minimize being the target of airborne transmission.

I am a healthcare educator in Mountain Maryland. The CDC is not providing the science education grounding upon which local educators could launch primary prevention efforts. Instead, you are working against us.

To follow on one of the August 22 public comments: **This is eugenics**. Not only are you killing the disabled and the elderly, you're decimating our health care providers. Why would a culture or community want to disable our care providers?

People are avoiding going to hospitals! And why would hospitals be content with losing customers? Because they're understaffed? Do they feel like they will lose more staff if they require masking? What is the effect of nosocomial transmission on hospital's bottom lines? These are questions with available, data-driven answers. I understand that many HICPAC members have tight hospital connections, so your committee would have ample opportunity to steward data collection.

Research on public health education has consistently demonstrated that transparent, science-based, factual information — no matter how hard the message is to hear — is valued and fosters trust in the messenger. CDC is shooting itself in the foot by failing as a public health education institution. In this way, your are playing into the hands of those who wish to eviscerate federal government capacity to promote and support well being. I can only assume that this is the outcome you're willing to be a part of.

Sincerely,
Ann Bristow, Ph.D.
Frostsburg, MD

---

Please reconsider your stance on weakening covid precautions in health care settings. N95s and air filtration are much more effective than surgical masks.

As a high-risk person who can't make immunity from vaccines, I have been locked away at home for 3 1/2 years now. I have not been able to get any medical or dental care during that time. I am concerned that a dental infection may one day lead to my catching covid, and I may very well not survive that.

I have also lost nearly everyone in my life to the propaganda saying I'm crazy and controlling just for staying home. Democrats and Republicans alike have encouraged this mindset.

Please help us.

Erika Walker
Monroeville, IN

---

Hi,
My name is Gerard Glover, I'm writing about the change to airborne viral infection precautions in healthcare settings, I STRONGLY disapprove of these new standards lacking N95 requirements and air filtration systems. Anyone working with masks, or engineering them will tell you that surgical masks are not appropriate to stop viral infections.
I live in Saugus Massachusetts.

I work at the Boston Alliance For LGBTQ Youth as the Transgender health advocate and at University health services at University of Massachusetts Boston.

---

Hi there,

I am 34 years old, a mom and healthy but I am high risk for developing cancer. My aunt died from breast cancer in her 50s & my mother had it twice first diagnosed at 38 years old and again in her 50s, my brother just died in January of this year at 38 years old of terminal cancer. I did

genetic testing and found that I have an increase risk of developing breast cancer and so I have to go and get MRIs done every year along with a mammogram along with follow ups to make sure that I catch any cancer that may develop early.

Because of my risk I looked into the risk of cancer after having COVID. I came across an article in The American Journal of Managed Care talking with an MD who is CEO of Carolina Blood and Cancer Care Associates told them in both the United States and overseas, they're seeing patients with rapidly progressing cancers of several types, such as breast cancer and renal cell carcinoma that is linked to a COVID infection. Among the patients there was even a 26 year old with rapidly progressing triple-negative breast cancer after a COVID infection. (read more here: https://www.ajmc.com/view/kashyap-patel-md-sees-link-between-covid-19-and-cancer-progression-calls-for-more-biomarker-testing) Based off this information that means catching COVID even as a healthy 34 year old woman means it increases my risk of developing terminal breast cancer.

Thankfully I have avoided COVID so far. However in the Spring when mask mandates were lifted and I went to my high risk cancer specialist office, not a single person was wearing a mask even the nurses and doctors. What goes through my head is the risk I'm taking on of not only catching COVID but a new COVID variant at these offices especially among immunocompromised patients who as data is suggesting, that the weakened immune system may play a role in spurring mutations of current COVID variants and creating new variants. This is the theory around the origin of the new variant of concern you at the CDC are monitoring BA.2.86. (see https://fortune.com/well/2023/08/18/ba286-bax-highly-mutated-covid-omicron-strain-detected-united-states-pirola-pi-rho-world-health-organization/)

So I'm entering into a cancer specialist office, who sees immunocompromised patients, completely unmasked, exposing themselves and their other patients such as myself to potentially new variants if that immunocompromised person has a persistent COVID infection. My doctors don't seem to be aware of the risk or link of cancer development from the spread of a COVID infection. They follow the CDC guidelines that do not require masks in their facility and do not seem to be keeping them up to date as to the risk of COVID is to those with cancer risk.

Therefore I ask the CDC to reinstate masking in medical facilities especially cancer offices where immunocompromised patients go. We are seeing new variants & increase risk of cancers from COVID, I along with others should be kept safe when going to appointments where there's an increase risk of exposure.

Thank you for your time,
Amber Freeman

---

To Whom It May Concern:
I am submitting written comments in response to the recent HICPAC meeting, which took place on August 22, 2023.

**Name:** Adina Gerver
**Topic:** concern with rollback of Covid infection control measures
**Address:** New York, NY
**Organizational Affiliation:** Founding Member of Long Covid Support (https://www.longcovid.org/), a UK-based non-profit that supports those who have Long Covid throughout the world

Please, please correct your review on COVID infection control measures to reflect the current science of aerosol transmission through inhalation. As someone who caught Covid in March 2020, before we knew any of this, and who is still dealing with long-term, chronic health issues ("Long Covid") as a result of that infection, Long Covid Support and I are in favor of doing what is practical to save others from this fate. That certainly includes requiring high-quality masks and filtering air in healthcare settings.

1. Surgical masks are not enough to protect most workers and patients against transmission of Covid (see this, from the CDC: https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm). Please recommend well-fitting N95 respirators and other effective face masks.
2. In addition, indoor air must be filtered (using HEPA filters, MERV-13 filters in HVAC systems, and other scientifically-proven means) to reduce aerosol transmission of Covid-19 and other respiratory pathogens.
All of these infection-control measures, if deployed in health care settings, would protect health care workers, patients, and the public at large not only against Covid-19, but also against other respiratory infections, including RSV, influenza, and tuberculosis.

Finally, I am disappointed that your decision-making process failed to include patient advocates, infectious disease transmission scientists, aerosols scientists, healthcare personnel (providers and other front-line workers such as cleaning crews), union representatives, and occupational safety and health experts.
Please strengthen your guidance on respiratory protection for workers and patients alike. Doing so will protect us all. Permanently adopting the crisis standards from the start of the pandemic, when N95 masks weren't available and droplets and fomites were thought to be the only mode of transmission, really does not make sense going forward. We know better and we can do better.

In short, please:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.
2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.
3. 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 present or may be present in health care settings; don’t adopt a crisis standards approach.
4. Engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

Sincerely,
Adina Gerver
Founding Member, Long Covid Support

---

Hi,

For the public comment period, we wanted to state that we agree with the feedback that masks should be required in healthcare settings. Healthcare settings are places that people go when they need medical care, either for long standing issues or for immediate care due to becoming sick. Also, healthcare settings are often visited by the most vulnerable of our population that have recurring medical conditions that need help and that are likely more susceptible to catching viruses.

The vulnerable population should be comfortable seeking care in a medical setting without having to fear for their lives that they will likely catch a potentially deadly disease by other people not wearing a mask. Masks have shown to reduce transmission and that is something we always need in a medical setting. In our opinion, this need isn't specific to covid, but should be in place across the board to help with all diseases. In addition to protecting the vulnerable, it also helps protect the medical staff that are vital to keeping patient services running. It also protects other patients and visitors from continuing community transmission by picking up new viruses while at medical facilities and carrying them out to the public.

For us personally, we have a family that is in the vulnerable population with complicated chronic conditions that have yet to be fully diagnosed. What we do know though is susceptibility to diseases is high and recovery time is long once sick. We need to continue working with medical professionals on diagnosing the conditions but are fearful that we'll get sick in doing so. Any time we go to a doctor or hospital appointment the rooms are filled with sick, unmasked people coughing everywhere. This does not create a safe space for treatment of those in need.

Thank you for your consideration,
Eric Tindell

---

I attended the HICPAC meeting on August 22, 2023 as a member of the public and as a health care worker. I was disappointed to see that the CDC and HICPAC are still not advocating for enhanced safety measures or following the available data. Viruses like Covid-19 coronavirus can be spread through aerosols and passed in the air to many people. Washing one's hands does not prevent one from inhaling particles of virus present in the air. Better ventilation and more air changes are needed in public (especially healthcare) spaces to keep people safe from further disability and death. Better respirators such as N95 masks are needed in public (especially healthcare) spaces to keep people safe from further disability and death. HICPAC discussed neither of these ideas supported by data and even made the public video of the meeting private until individuals noticed and spoke up. We need better transparency about the regulations that are or are not happening. Distrust, well justified distrust, in public systems is only being increased by HICPAC's choices. Spreading illness and distrust is not a viable long term plan. Healthcare must be available and safe for ALL people.

Thank you,
Linda Muckey, no public organization affiliation

---

As an Anesthesiologist, I resent the attempt to downgrade respiratory protections. We have plenty of science showing N95s offer superior protection against airborne pathogens e.g TB. Enough of the gaslighting; N95s are not equivalent to surgical masks. Both were created by scientists for different applications. Stop putting my health at risk with this nonsense.

KC Holeyfield MD

---

As an epidemiologist and someone with high risk conditions, I strongly urge you to recommend that all medical personnel to follow best practices to reduce transmission of all pathogens, including wearing well-fitting, high filtration masks such as P100, N99, N95, and KN95. Surgical masks are only for splashes, not for protection against respiratory infections and aerosolized pathogens. We are over 3.5 years into this COVID pandemic. This should be common knowledge by now, particularly in the health sciences community. We are already losing a lot of

health practitioners to burnout, suicide, and disease--please do your part to protect medical staff in all the ways you can.

Sincerely,
Caroline Hugh, MPH

---

Dear HICPAC, Division of Healthcare Quality Promotion (DHQP),
My name is Elizabeth Freise, and I am writing to you today as a disabled American citizen who is at increased risk of death or severe disease from covid-19 and other highly transmittable diseases. The CDC has chosen to take a 'you do you' approach to this pandemic which has placed the entire burden of avoiding death on the shoulders of the most vulnerable, such as myself.
It should not be this way. It does not have to be this way.
Again and again, the CDC has said, 'we have the tools' and instructed citizens such as myself to use these tools to make informed decisions about what actions to take. Unfortunately, because of the CDCs own actions, these tools (infection rates, masks in healthcare settings, mask mandates based on infection rates, testing sites, free tests, etc) are ENTIRELY GONE.
It is increasingly difficult to live my life in reasonable safety.
But far worse: I can no longer visit a healthcare facility without risking a deadly pathogen. I do not need to explain that masks and air filtration work. The science is clear. It is shocking and shameful that the CDC has lifted mask requirements from healthcare settings where our most vulnerable citizens have NO CHOICE but to go. Cancer patients cannot opt out of chemo, I cannot opt out of my life saving breathing treatment, my brother recovering from a major heart attack cannot opt out of his cardiology tests and rehab.
Please, I am genuinely and literally begging you, for the sake of my life and the sake of people I love, please institute masks and air quality standards in all health care facilities. Do not play games and pretend that surgical masks are equivalent to N95s when they are not. These lives have value. My life has value.
Thank you,
Elizabeth Freise
American Citizen
speaking on my own behalf and not affiliated with any formal organization, Overland Park, KS

---

To the CDC and all responsible for keeping the citizenry safe from iatrogenic and publicly acquired airborne infections:

Because you have:
1-stopped testing and subsidizing home tests
2-stopped requiring statistics and reports on Covid infection acquired both communaly and in healthcare settings-thus in essence denying any possibility of actually determining the scope and severity of infections
3-stopped requiring universal masking of ALL healthcare personnel and patients in healthcare facilities, and refused to inform and stress to the public the function, efficacy, and use of masks as a preventative measure
4-minimized risks of Covid infections and sequelae, and recommended useless actions like handwashing to curb an AIRBORNE virus
5-refused to even mention ALL of the mitigations that need to be practiced (in addition to FREE testing, tracing, and treatments) such as air cleaners, air exchange devices, UV disinfection of indoor air, etc etc:

is, in essence a willful abrogation of the duty and ethical responsibility of a (supposed) public health agency. If the CDC cannot, and will not, even ATTEMPT to keep the populace “Davos safe” the responsibility for hundreds of thousands of needless deaths and disabilities will rest on your shoulders.

Julia Williams, RN

---

As we continue to navigate the challenges posed by the ongoing COVID-19 pandemic, I wish to draw your attention to the critical importance of implementing and upholding stringent respiratory virus protective measures within our healthcare community. The threat posed by COVID-19 and ‘long COVID’, particularly the long-term effects and potential for transmission, cannot be underestimated.

We have a moral and ethical duty to ensure the safety and well-being of both our vulnerable patients and invaluable healthcare professionals.

COVID-19 remains a persistent and evolving threat, with 'long COVID' presenting a clear reminder of the virus's enduring impact. The long-term health complications experienced by individuals who have seemingly recovered from the acute phase underscore the need for preventative strategies. Widespread use of N95 masks, along with enhanced air exchange and ventilation systems, represents a formidable defense against the transmission of respiratory illnesses, including COVID-19. The combination of these measures can significantly reduce the risk of both initial infection and subsequent transmission within our healthcare community.

Our healthcare professionals, including nurses, respiratory therapists, and doctors, are at the forefront of patient care. Their unwavering dedication places them in direct contact with various illnesses, making them particularly susceptible to viral exposure. By providing them with the highest level of protection, we not only safeguard their health but also ensure that our facility continues to function effectively during these challenging times. The well-being of our staff is intricately linked with the quality of care provided to our patients.

It is alarming to note that despite the visible threat posed by COVID-19, complacency and underestimation of the risks remain prevalent. We cannot afford to overlook the potential consequences of ignoring these dangers. By prioritizing the implementation of N95 masks and improved air exchange systems, we send a clear message that the health and safety of our patients and staff are paramount.

I urge you to consider these points and collaborate with relevant government officials and agencies to swiftly support these types of basic protective measures. It is imperative that we remain proactive in the face of the persistent threat from COVID-19. Let us lead by example and set a standard of excellence that ensures the continued well-being of all those entrusted to our care.

Thank you for your attention to this matter.

Together, we can create an environment that exemplifies responsible and comprehensive healthcare practices.

Steven V. Joyal, MD

---

My husband, daughter-in-law and a grandchild all have health conditions that place them at high risk of bad outcomes to viral infections. My husband is a nurse, too. Two-way masking works; one-way masking less so. Why should they place their health at risk when seeking healthcare services? Why should healthcare providers be placed at risk of infection while doing their job each day?

Please continue to require masking in healthcare settings for providers, auxiliary staff, patients and visitors.
Pamela Montgomery

---

My wife is a clinical nutritionist and works in a hospital where they do not routinely mask. I am concerned about her exposure to Covid and other infections and I wish that the hospital would require masking. I work in a library and we mask, but in my wife's hospital they do not!
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.

Yours truly,
David Chusid

---

Dear Members of HICPAC,
Please adequately take into account the science of infectious aerosols and make appropriate guidance on ventilation and masks. The totality of the science is clear and regardless of the financial burden on hospital systems that it entails, infection control needs to protect communities from the spread of viruses, especially the vulnerable. Suggesting that surgical masks are as effective as N95's and being silent on ventilation is reprehensible given the science.
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.
The 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,
Michael Stein, PhD

---

Name: Steven Lumpkin
Address: Playa Vista, CA
Topic: Covid Protections in Healthcare Settings

Organization: Private citizen

To whom it may concern-

I urge you with my strongest encouragement to listen deeply to and align your strategies for Covid Protections in Healthcare Settings with the recommendations put forward by National Nurses United, as well as the People's CDC.

It's crystal clear that Covid is neither endemic nor receding, that Long Covid is devastating for high proportions of those who catch the disease. Our most vulnerable go to healthcare settings at their weakest- we cannot allow them nor healthcare workers to be infected by this dangerous disease as a result of lax protocols.

Please acknowledge fully the import of the aerosol transmission vector of Covid; recognize that universal masking with N95s, high ventilation, and UV air cleaning are multiple layers of effective transmission reduction. Encourage free vaccinations for healthcare workers and hospital visitors. Recognize that much transmission is asymptomatic; invest in better testing, but also recognize the need for constant vigilance in our defenses against this disease.

Please- keep our healthcare spaces and our healthcare workers safe. Don't politicize the reality of this disease by pretending the facts about it don't exist. Address the science directly and issue concise, clear, and effective control guidelines.

Respectfully,
Steven Lumpkin

---

My name is Sarah Smith and I am urging HICPAC to require masks in healthcare settings because lives should not be harmed in hospitals, lives should be saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence. I have a personal friend whose mother died from a hospital acquired infection of SARS-2, a tragic death that could have been prevented with mask requirements. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses. Additionally, we have lost a tragic amount of healthcare workers due to death and long covid from hospital acquired infections of SARS-2, requiring masks in healthcare settings will help our healthcare workers stay safer and help address the critical issue of staffing shortages which is reducing the overall baseline of care being provided in healthcare settings and is leading to a healthcare collapse. Thank you for your urgent actions on making masks required
in hospitals.

---

It is unbelievable to me that masking was removed in healthcare. If there is any place a person should feel relatively safe, it is when accessing healthcare.

Many people are afraid to go to the hospital or doctors office when even the most basic of precautions are not being taken.

I dread the day when I will require hospital care knowing that clean air and masking protocols are not happening.

Please keep us all as safe as possible.

Sincerely
Penny Paynter

---

I support the imposition of N95 masking by HCWs, non-clinical staff, and patients in hospitals. I also support masking in doctor's offices.

These measures reduce the risk of infection with a disease now proved to damage organs, damage mitochondria, and damage the immunosystem.

Please protect patients and HCWs. Paula Marie Young

---

To: The Healthcare Infection Control Practices Advisory Committee (HICPAC)
From: Jacqueline Esposito
Date: August 25, 2023
Re: CDC/HICPAC's Plan to Weaken Infection Control
I submit this public comment as a patient battling a 9/11 incurable cancer that has metastasized to my lungs. First, I strongly oppose HICPAC's Work Group on the Isolation Precautions Guidance proposal to adopt 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. Second, I believe the process to update to the 2007 Isolation Precautions guidance is flawed because it fails to meaningfully involve patient input and lacks transparency.

I call on HICPAC and the CDC to reverse course on this misguided approach and immediately take action to address patients, health care workers, and the public health community's concerns.

First, ensure greater community involvement in the process. I urge HICPAC and the CDC to ensure a transparent process to update the 2007 Isolation Precautions guidance, increase public access and engagement and make recommendations and presentations publicly available.

Second, adopt meaningful infectious control measures. I urge HICPAC and the CDC to adopt effective infectious disease control mechanisms including assessments of the level of exposure, appropriate control measures (including PPE) for each job, task, and location, and a written exposure control plan.

Third, stop deceiving the public about aerosol transmission of pathogens. The Work Group on the Isolation Precautions Guidance fails to 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 the CDC and HICPAC propose the new category of "air" transmission, it fails to recognize the critical role of inhalation and continues to recommend use of surgical/medical masks, which do not provide respiratory protection against inhalation of infectious aerosols. Finally, the CDC 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. The Work Group's proposals ultimately weaken protections for patients and health care workers which is,

quite frankly, shocking.
Submitted by Jacqueline Esposito, NY, NY

---

I am very frustrated after attending your online meeting via You Tube that the entire process you all covered mentioned NOTHING of aerosolized protections in the healthcare field. We've known COVID and the flu are transmitted through aerosolized means and we must protect people better. I can't believe that I now have to attend doctors appointments with sick patients without mask requirements. And surgical masks aren't going to protect me from getting ill. I have friends who got COVID receiving care in an ED visit. I'm nervous about getting my next colonoscopy as I won't be protected and I have worked very hard to stay COVID free these past 3.5 years.

I am disappointed to learn that HICPAC's process for updating the 2007 Isolation Precautions guidance did not involve 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 would like to request that HICPAC and the CDC slow down their process and open up to get input from a larger, incredibly knowledgeable field.

Your Work Group on Isolation Precautions Guidance's' proposal of adopting a more "flexible" approach when implementing precautions recommends very few protections and allows health care employers (often privatized/profit driven) too much discretion to create their infection control plans. This needs to be more comprehensive and protect patients and caregivers alike.

When I watch China struggle at the beginning of the pandemic I had so much faith that our country, and the CDC, while headed by the Trump administration, would keep us safe. I am so disappointed in the CDC's care of vulnerable individuals and your policies need to change. Thank you for taking the time to hear from more than just 14 people in your meeting.

Georgia Rosenblum
Asheville, NC

---

Dear Committee,

I would like you to consider your oath to: "First, Do No Harm". Maskless medical personnel coming in contact with patients who are covid symptomatic and asymptomatic spread the virus and contribute to people suffering long term effects. The aerosol transmission of covid is based on science and I am confounded that mask wearing is even up for debate.

Please allow sick people to get medical care without the threat of becoming sicker. It's that simple.

Debra DiMaio
Enola PA

---

Dear HICPAC,

I write to urge HICPAC and the CDC to take additional time to deliberate and to open up the process of discussing the updates to the 2007 Isolation Precautions. We don't know what COVID-19 is fully capable of, so let us err on the side of caution.

It’s especially important that you recognize that surgical masks do not provide respiratory protection against inhalation of infectious aerosols. Please also add recommendations on ventilation to your discussion.

As an immunocompromised adult who has lost family members to COVID-19, I ask you to work to make everyone as safe as possible.

best wishes, Leah Shafer

---

Please see my public comment on the August 22 Meeting below:

"As a member of the public who requires frequent visits to medical offices inside of hospital systems, I have been unable to access safe healthcare since April 2023, when local systems followed the rest of the country and dropped universal masking. It is negligent and misrepresentative of the science of N95 mask technology, to suggest that surgical masks are sufficient to mitigate the spread of airborne infections. Staff should be wearing well-fitted N95's to protect patients at all times, since aerosolized particles carrying viruses spread through the air like smoke. Physical distancing, or designating areas in buildings where masks are not required, is a dangerous practice that contributes to the spread of disease within medical facilities."

Thank you,
Chris M.

---

Hi,
Please, please, please, I am begging you re-instate masks in healthcare facilities. I have not been able to got to the dentist since the pandemic started and this is only because I don't want to get infected. I dread going to my PCP or getting any kind of care for the same reason. Getting care should not come at the cost of getting infected with a deadly, disabling virus. What happened to do no harm? Patients aren't always able to advocate for themselves because of power dynamics. They are vulnerable and at the mercy of the healthcare facility staff. PLEASE make masks a requirement just like wearing gloves or washing hands. People's lives depend on it.
Thank you,
Shirin Jaafari

---

Please, it’s super important that healthcare facilities, which are non-optional gathering points for the ill and those in precarious health, require effective well fitting n95 or kn95 masks to be on faces over mouth and nose!

People catch transmissible diseases and even if one considers individuals to be expendable, just think ahead to how covid amplifies poor surgical outcomes, and turns 1 in 10 acute covid patients each time into chronically ill Long Covid patients. Who will re-enter the health system. And be unable to work if they are staff. Please prevent this suffering through employee masking (everywhere) and patient masking (where doable) as well as enforced air filtration or UV sanitization in addition to ventilation.

Thank you for considering this, to help individuals and families, who bear the burden of illness once patients leave healthcare facilities.

Sincerely,

Lily Tinkle, MD PhD

Esteemed colleagues,

I would like to add a comment regarding the meeting on August 22nd, 2023.

I have been looking forward to volunteering in person at the local VA in Dayton, OH, and I started the process of interviewing. But when everyone stopped wearing masks, I knew the risk was too high for me. As much as I would love to work with this patient population, the lack of mask mandates is stopping me.

I also know so many patients who are postponing needed medical care because of their legitimate risk of catching COVID during a hospital stay and developing Long COVID. Patients go to the hospital to get better, not to develop a life-altering nosocomial infection.

Please consider bringing back mask mandates (N-95 masks, not surgical) in hospitals and other healthcare settings.

Sincerely,
Carla Eisenstein, Pharm.D.

**Comments Concerning HICPAC-CDC**
**Infection Control Precautions**

**Mark Nicas, PhD, MPH, CIH Emeritus Adjunct Professor**
**School of Public Health University of California, Berkeley**

**August 25,2023**
On May 26,2023, I submitted the following comments to HICPAC. From what I can tell, they were ignored. Therefore, I am submitting them again.

**Comments submitted on May 26,2023**

My understanding is that under consideration by HICPAC and/or the CDC is a respirator selection logic whereby: (i) medical/surgical masks would be worn by healthcare workers (HCWs) who attended patients with seasonal coronavirus and seasonal influenza infections, and
(ii) N95 filtering facepiece respirators (FFRs) would be worn by HCWs who attended patients with respiratory tract (RT) infections due to pandemic-phase or novel respiratory tract virus (such as SARS-CoV-2), measles virus, and *M. tuberculosis*. I recommend that, *at a minimum*, a successfully fit-tested NIOSH-approved N95 FFR be worn by HCWs when attending patients with all the RT infections specified above. For agents that can be transmitted person-to-person by aerosol inhalation and that cause severe morbidity and substantial risk of death, a higher level of respiratory infection beyond an N95 FFR is more appropriate.

Two items deserve further comment. First, I have the impression (hopefully a misimpression) that some parties still doubt SARS-CoV-2 is transmissible via aerosol inhalation. However, air sampling studies, experimental animal models, and infection incidence studies all support a primary role for inhalation transmission of SARS-CoV-2. For HCWs who attend patients with a

RT infection due to SARS-CoV-2, in general, a successfully fit-tested NIOSH-approved N95 FFR is the minimum level of respiratory protection.

Second, I have the impression that the types of respiratory protection being considered by HICPAC-CDC are based on epidemiology studies of the comparative efficacy of N95 FFRs versus medical/surgical mask in reducing infection incidence among wearers. I offer a comment about interpreting a finding of no difference. Arguments about disease causation based on epidemiology studies usually invoke the Bradford Hill criteria for causation, one of which is *biological plausibility*, i.e., it is biologically plausible that the agent causes the observed disease. The analogous criterion when comparing the efficacy or two types of respiratory protection in preventing RT infections by a pathogen is *physical plausibility*. That is: (i) if RT infections by a pathogen like SARS-CoV-2 can be transmitted person-to-person via aerosol inhalation (and I believe they can), and (ii) given it is established via laboratory testing that a successfully fit-tested NIOSH-approved N95 FFR permits less total inward leakage of aerosol than does a non-fit-tested and non-NIOSH-approved medical/surgical mask, why would one credit a study that claimed there was no difference in protection between the two types of devices when the finding is physically implausible? I do not think such study results can be credited, but I see three possible reasons for the results.

First, the assumption that infection by the pathogen (say, SARS-CoV-2) can be transmitted via aerosol inhalation is incorrect. I do not think the assumption is incorrect, but if it were, that would argue for transmission only by droplet spray and direct contact (touch). In that case, a face shield should be recommended as opposed to a medical/surgical mask, because a face shield protects against contact with the eyes and the mucous membranes of the nose and mouth; a medical/surgical mask does not protect the eyes.

Second, the study itself was faulty. For example, the exposure assessment was poor such that actual exposure differences between the N95 FFR and medical/surgical mask wearer groups were not discerned. These differences might involve the total time of attending patients, the procedures performed on the patient when attending, and the relative infectiousness of the patients. Or perhaps differences in study subject compliance with wearing the two device types were not accurately assessed. Given that a N95 FFR tends to fit more snugly on the face than does a medical/surgical mask, the greater discomfort might lead to less compliance with wearing the N95 FFR. If study subject exposure and compliance were assessed by self-administered questionnaires, with no attempt at verification by direct observation, I do not think one can have much faith in reported findings about comparative efficacy.

Third, in actual field usage, the N95 FFR physically performs worse than it does in the laboratory, whereas the medical/surgical mask physically performs just as well as it does in the laboratory. I suppose anything is possible, but I see no reason a priori why such a difference in physical performance would occur.

In closing, I urge HICPAC and the CDC to recognize the firm scientific evidence on RT infection transmission by aerosol inhalation. I recommend that HCWs be provided with N95 FFRs *at a minimum*, and where appropriate more protective respirators such as halfmask elastomeric and powered air-purifying respirators, when attending patients with RT infections due to seasonal coronavirus, seasonal influenza, pandemic-phase or novel respiratory tract virus (and specifically SARS-CoV-2), measles virus, and *M. tuberculosis*.

---

Hello,

My name is Eileen and I have lost several family members to Covid-19, two of them from nosocomial infections. I am shocked and disgusted that, **in 2023**, the CDC refuses to recognize that this virus is airborne and that N95 masking and clean air protocols can help save countless lives.

I know so many people, myself and my immediate family members included, who are afraid of seeking routine healthcare and/or getting hospitalized because medical settings are no longer safe. Healthcare is a HUMAN RIGHT and the CDC should be tightening infection control practices not loosening them. We have a shortage of healthcare workers in this country and citizens are still dying, falling seriously ill and getting disabled thanks to mismanagement and muddled communication on your part.

Urge our hospitals and medical providers to give care, not covid. Give them guidelines on air purification and proper mask hygiene. Stop avoiding the word "mask" like it's the plague, while this virus mutates and renders our vaccines less and less effective and testing disappears. We can't wish our way out of this pandemic. DO BETTER. Our lives depend on it.

Eileen

---

Please reinstate medical mark mandates. We can’t find masked/safe providers, and the risk is too high. We are missing what could be essential appointments for serious issues because of how high risk were are for Covid/long Covid issues. We deserve full access to medical care.
Rebekah Cross

---

Hello,

I'm writing to express concern with your proposed updates to Isolation Precautions guidance, in particular, your adoption of a "flexible" approach that will allow health care providers to set their own precautions. This will inevitably harm both patients & employees by enabling:

- inconsistent safety standards & levels of risk between medical facilities
- healthcare-acquired cases of COVID-19 and other airborne infectious disease
- elderly, disabled, immunocompromised & otherwise COVID-cautious patients avoiding care
- burden on patients to ask for masking from each of the staff members they interact with
- healthcare providers weighing safety precautions vs. cost considerations
- healthcare employees being forced to work in a risky environment or risk their source of income

Personally, I have lost two family members to healthcare-acquired COVID infection and I lost a good friend who was in her twenties last year. She was immunocompromised and was rationing meds and medical care since the beginning of the pandemic.

COVID is a serious, life-threatening infection with long-term ramifications like permanently disabling long COVID and heightened risk of heart disease, stroke & diabetes. More likely than not, there are yet unknown long-term consequences of infection - God forbid it behaves similarly to HIV, leading to death 10+ years after the acute infection. We simply cannot accept widespread, multiple infections.

Patients should be able to expect a safe healthcare environment. Healthcare providers and employees should be able to expect a safe workplace. Neither of these goals will be achieved by abdicating your responsibility to set clear, research-backed safety standards.

Please, please, please revise your recommendations.

Thank you,
Emily Walker
River Grove, IL

---

Peg Seminario, Industrial Hygienist - Submitted Comments on Isolation Precaution Guidelines – CDC HICPAC meeting August 22, 2023

My name is Peg Seminario. I am an industrial hygienist, and served for 30 years as the S&H Director at the AFL-CIO, until my retirement in 2019, where I specialized in occupational safety and health policy and regulatory matters including work on healthcare worker protection regulations and guidelines for bloodborne pathogens, TB, SARS, H1N1 and airborne transmissible diseases. I have continued to assist the unions to strengthen workplace protections on COVID-19, other infectious diseases and other safety and health hazards.

This July, I was one of the authors of a letter to CDC Director Mandy Cohen from 900 public health and medical experts expressing great concern about CDC/HICPACs update of the Guidelines for Isolation Precautions in Healthcare Settings- both about the closed non-transparent and the failure to address and protect against aerosol transmission of infectious aerosols. In our view the updated guidelines ignored experience and evidence gained during the COVID-19 pandemic and would weaken existing guidelines and protections for HCWs and patients.

On late Friday we received a response to our letter from CDC, informing us that HICPAC would not be voting on recommendations on updated Isolation precaution guidelines at today's meeting. We appreciate the delay in the vote.

But we were deeply dismayed that CDC's response did not address any of our substantive concerns about the weakness of the guidelines – the failure to protect against aerosol transmission - nor provide any indication that CDC, HICPAC or the workgroup intend to open-up the guidelines development process to involve key experts or stakeholders or make the process more transparent.

We once again urge CDC and HICPAC to change course and open-up the process on the IP guideline development.

The majority of HICPAC and workgroup members are Infectious diseases professionals from hospitals or large health care organizations who share the same views and perspective. It is not "balanced" as required by FACA and include representatives of health care workers or patients who have different interests and different views than hospital representatives. HICPAC members are not experts in aerosol transmission, ventilation, respiratory protection or industrial hygiene, the kind of individuals with the deep expertise and understanding on how infectious diseases are transmitted and effectively controlled.

For more than 3 years we have all been immersed in efforts to protect the public, patients, healthcare workers and other workers from COVID infection, death, and other health impacts.

We have failed miserably in those efforts. Over a hundred million have been infected, over a million people in the US have died, and millions are still suffering the debilitating effects of Long-COVID.

In healthcare settings, the CDC has refused to collect data on COVID infections and deaths among hospital staff and has collected only minimal data on hospital acquired infections among patients, but we know that hundreds of thousands of healthcare workers and patients have been infected and thousands have died due to infections acquired in nursing homes, hospitals and other healthcare settings.

And today, those infections and deaths continue to occur.

The latest CDC/CMS COVID nursing home data reports that since mid-June the number and rate of nursing home staff infected with COVID has tripled and the more than doubled among nursing home residents.

During the same time period, COVID deaths among nursing residents have increased by 60%. In June, CDC stopped collecting data on nursing home staff deaths so it is no longer possible to track these deaths.

According to CDC data, in July COVID deaths among nursing home residents accounted for 18% of all COVID deaths in the US. This means that nearly 20% of all COVID deaths in the country last month were due to health care acquired infection,

Clearly, hospitals, healthcare infection control professionals and CDC are still failing to protect healthcare workers and patients from infections and deaths in healthcare settings, despite the terrible toll that has already occurred and all we have learned about the transmission of infectious aerosols and how to control transmission and exposure.

To protect healthcare workers and patients who are at high risk of exposure, infection and death CDC must develop strong infection control guidelines for healthcare settings that fully protect against aerosol transmission. CDC should open-up the Isolation Precaution Guideline development process to include experts in aerosol transmission and control and HCW and patient representatives and not allow the healthcare care industry to dominate the process and dictate the guidelines as is now being done through HICPAC and the workgroup.

Thank you.

---

As a human and a parent I have a strong interest in my family being able to get routine medical care without acquiring respiratory infections including COVID. Similarly residents and employees at nursing homes have a right to a reasonably safe working environment. In light of those I found puzzling the near total absence of discussion about mitigations against respiratory infections in this week's meeting. The last few years have yielded a lot of experience and data showing that we have effective tools for controlling airborne infectious agents including respirators, ventilation, filtration, and upper room UV. We can do a lot, and we should, please write your recommendations accordingly.

Thanks,
Choong Ng

---

Dear HICPAC:

RE: Concerns Regarding Proposed HICPAC Changes for Infection Prevention & Control

I am writing you as a member of the public. Although I am located in Canada, I am following the HICPAC process because, for better or worse, CDC policy is very influential in North America and globally.

I am appalled to see the very poor grasp of some reasonably basic physics. It is disturbing to see seemingly well-educated professionals not grasp that a surgical mask provides poor source control and protection from inhalation of infectious aerosol particles (airborne diseases) due to the fact it has gaps all around it.

I am also disturbed to see how poorly such supposed professionals have kept abreast of the scientific literature. There is irrefutable evidence that SARS-CoV-2 is airborne. Further, thanks to the incredible volume of aerosol and transmission related research conducted in response to the current pandemic, it is very clear that almost all transmission previously attributed to droplets (i.e., most 'respiratory' diseases) is actually aerosol transmission that occurs more frequently when someone is in close proximity (not close contact) with an infectious person because the concentration of aerosols in the space between them is very high versus the concentration some distance away from the infectious person. I refer you and your colleagues to this excellent overview, for example: Airborne transmission of respiratory viruses | Science (https://www.science.org/doi/10.1126/science.abd9149).
Lastly, I have deep ethical concerns that the discussion places a lesser value on the health and safety, and therefore, on the lives and livelihoods, of healthcare workers and their patients. Every worker deserves a safe workplace, with access to scientifically and ethically sound workplace safety supports. And no one – I repeat NO ONE – should face a reasonable risk of acquiring an infection while seeking healthcare.
Thank you very much for considering my concerns and those of the hundreds of experts and members of the public. It is not unreasonable to expect scientifically and ethically sound workplace safety plans. So, that is what we unequivocally demand.
Sincerely,
Tracy Casavant, BASc (Chml), MES
Vancouver, BC, Canada

---

From Jamie Sanin, Kingston NY, on behalf of Celebrate845: As an organization created by and for marginalized, working class creatives in New York's Hudson Valley region, Celebrate845 is urging HICPAC and the CDC to prioritize people over profit, human life over corporations, and new healthy ways of living over outdated status quo. Both must correct their review on COVID infection control measures to reflect the science of aerosol transmission through inhalation. 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. 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. To not instate precautions is to assume we are of higher intelligence than a virus that is still so young and whose effects continue to change while always harming us (via Long COVID). To not adopt safety measures is to knowingly dispose of humans

who want to or need to keep themselves and their loved ones safe. Do the right thing and put human lives first.

---

I am writing to offer my thoughts on your recommendations and guidance to "DHHS and CDC regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections, antimicrobial resistance and related events in United States healthcare settings."

I have been so deeply disappointed in the guidance thus far that was presented in your draft. I think we can all agree (and the research shows) that masking is one way to prevent the spread of airborne illness. It seems there should be no debate that in a healthcare setting both providers and patients should be masked and in my opinion providers should be wearing N95s. Speaking as a patient I have an expectation when I go to a health care facility that I am as safe as possible and that my risk of getting an illness that I did not walk in with is as low as possible. I was treated with chemotherapy and radiation. These treatments knocked down my immune system and made me vunerable to viruses and infection. Being vulnerable and at risk, a person should be able to walk in to a healthcare setting and there should be mitigations in place to keep everyone safe, especially those at high risk. Because of Covid and what we have learned, a light has been shone on how something like masking can prevent the spread of airborne illness. Another thing that we should not be ignoring is air filtration. This is something that should also be addressed in your recommendations and guidance.

What is the expression? Know better, do better. Please stop gaslighting people into thinking it is acceptable for them to go to the doctor or hospital when doing so is exposing themselves to an illness that could have lifelong consequences. We have preventative measures that can be taken. Please do the right thing and let's get those measures put into place.
Karen Kelley-Barnes

---

Hello,

Thank you for giving us this opportunity to share our thoughts with you during this ongoing pandemic. I hope you will see this as a chance at a better, less risky, more healthy environment for all of us who are seeking care in these public spaces.

A bit about our family situation: we were all ill in March of 2020, and while we cannot confirm we had covid because we were not allowed to test, my husband and I continue to carry the side effects of this one illness into today.

He currently has bodily inflammation bouts where he has trouble walking, and eventually he has to have bed rest for days at a time due to the heaviness of his limbs and exhaustion he has. Getting a diagnosis for this situation has been a very long process; only now have we been able to secure an appointment months out for a rheumatologist. We are thankful to have that appointment, but are tempering our expectations, as his labs don't show any usual inflammation markers, so we feel we are flying blind.

I am continuing to have issues with digestion and reflux. I don't have hope that this will improve as it has been ongoing for years with little improvement, and no effective treatments.

Added to all of this is our need to do our normal routine screenings; colonoscopies, dental cleaning, mammograms, pap smears, etc. As we have been unable to access these spaces

safely, we have put many things off at risk of making a deadly miscalculation (avoiding covid, but getting cancer) in the hopes that mitigations would improve; that air would be filtered, HVAC systems upgraded, perhaps far UV would be utilized. Instead we've watched any effort to protect patients and their caregivers slowly eroding, until they're mostly nonexistent, making it even more unsafe than it ever has been to seek care or give care.

I sit with others in the radiology suite who have breast cancer, and watch as they and their caregivers breathe directly into each other's faces unmasked. It is a tragedy. Covid is still here, it still kills, and even when it doesn't, it disables millions of people. We have safety precautions for so many other diseases; why is this an exception when study after study shows it is something to be taken seriously?
We should not have to visit healthcare spaces knowing seeking care could mean a disabling event for us. Providers should not have to risk their lives and livelihood with subpar precautions in place we know don't work. We have to do better for healthcare providers and patients.

One of the areas where I feel improvement could be made are on The Work Group on the isolation Precautions Guidance. When we are considering how this virus spreads (aerosol transmission), the new draft has significant errors. As this virus travels primarily through the air (and not so much fomites/touch), there is failure to recognize the critical role of inhalation of this virus. Surgical/medical masks do not protect from this virus, unfortunately. We do not need droplet protection, we need aerosol protection, to protect us from breathing in virus that others are actively breathing out, potentially filling up rooms like smoke.

It's 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. We don't want to weaken protections for healthcare personnel, let alone the patients they see.

Thank you for reading this and taking this information into consideration. We need respirators, ventilation, and filtration to control worker exposure to infectious aerosols. These workers are sitting ducks for long term health issues, they are in a position to spread this disease to all who seek care, and it's only a matter of time after they've been infected repeatedly that they will no longer be able to provide care.  Please help them. Please help us.

Sincerely,

Melony Peters
Flagstaff AZ

---

Dear HICPAC Committee:

I am an immune compromised citizen living with multiple complex medical conditions. I do all I can to stay safe by masking and avoiding high risk environments. One environment I cannot avoid is a healthcare setting. I see multiple doctors and healthcare providers. I get infusions at infusion centers. I need both vision and dental care. I am now routinely told that healthcare providers will not mask because it is no longer required. Even in an infusion center full of cancer patients and immune compromised individuals. This makes obtaining the healthcare I need to survive risky and stressful. Yet I have no choice. I wear a mask but one way masking is not as effective as two way masking. Health care providers often come to work sick due to lack of staffing. Other patients come to facilities while ill. Universal masking prevents illness and death among healthcare providers and patients alike. Like hand washing, gloves, and other infection

control practices, it should be a part of the healthcare environment. Masking saves lives and money. Masking is supported by evidence based science. There is very little downside. Why are we spending massive amounts of time, energy and money to keep patients alive only to put them at risk by not requiring something as simple as a mask? Masking makes sense from a scientific, humanitarian, and economic perspective. Please support masking in healthcare settings if nowhere else. We the immune compromised and vulnerable are begging for your support on this issue. Our lives have value. Please don't make us fight alone.

Sincerely,
Joy Hoeffler

---

Re: Comments on your work to revise the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

Dear Members of HICPAC,

I was dismayed to see that the August 22, 2023 working group meeting continued to dismiss the importance of recognizing aerosol transmission.

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.

I urge you to ensure that 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

Thank you for taking the time to review my comment. I hope you will do all you can to make my medical care safer.

Most sincerely,

Kelsey Smolen, Exton, PA, concerned citizen and immunocompromised patient who cannot find a doctor that still masks and uses air filtration in tiny exam rooms to ensure my safety during this ongoing pandemic because the CDC says it is not necessary

---

To HICPAC,

I am a 48 year old metastatic breast cancer patient, which means that I will likely be in active treatment for the rest of my life. I rely on medical care to extend and preserve the quality of my life.

I'm deeply concerned about preserving anti infection practices and protections (such as high quality masking and engineering informed infection control ventilation) in medical settings.

I personally know three individuals who contracted covid directly from medical settings since the pandemic began, two of which died as a result and one whose hospital stay was extended beyond her initial need for care far from her family due to a lack of available hospital beds in her small community. I also know many individuals who are still struggling with long covid with significant ongoing impacts to quality of life.

I have fully leaned into vaccine protection, but I'm keenly aware of the science behind breakthrough infection and the limitations of one way masking. It's my hope that we can set medical standards for infectious disease control that not only protect us from worst case scenarios of death and hospitalization, but also from additional and preventable short and long term compromises in quality of life that many disabled and high risk people like me face at higher frequency with infectious illnesses.

We need transparent processes that include stakeholders and experts at the table and that prioritize both patient and worker safety above profit.

Jennifer Fowler

Kingston, NY

---

Name: Briauna Barrera

San Antonio, TX

**Comment:**

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.

Please advocate for increased public oversight of the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC), the committee that oversees policies on the prevention of infectious diseases in healthcare settings. Policies need to be developed with the input of impacted stakeholders, such as health workers and patients. I am concerned that the CDC will soon profoundly weaken its Infection Control guidance which could place health workers and patients at risk of short- and long-term harm and even death from infectious diseases. Universal masking is a simple measure to reduce the risk of infectious disease transmission that has been implemented broadly in healthcare settings for the last three years. **HICPAC should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators.**

Adopting weaker infection control policies will endanger millions of workers and patients across the country. Airborne infectious diseases such as COVID-19 are transmitted in the air we all share, which is why wearing high-quality, face fitting respirators is important to prevent transmission, in combination with ventilation and other layers of protection . COVID-19 has already caused over 42,000 deaths this year, placing it among the top 10 killers in the US in 2023, and 15.8% of U.S. adults have experienced Long COVID, a condition that persists after initial recovery from a COVID infection. Similarly, other airborne diseases such as MERS or SARS could also lead to large numbers of hospitalizations and deaths, the 2015 MERS crisis led to 38 deaths among 186 diagnosed cases in South Korea, and the 2002-2004 SARS crisis led to 774 deaths among 8,000 diagnosed cases across several countries in Asia and Canada.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms, they may pass it to their coworkers or patients in maskless healthcare settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages.

The recommendations were based upon a widely-critiqued, flawed literature review. The guidance even contradicts the CDC’s own data which demonstrated that continuous use of N95 and KN95 respirators cut the odds of infection by 83% compared to 66% with surgical masks.

CDC/HICPAC decisions are made undemocratically and developed behind closed doors, without input from nurses unions, healthcare workers, patient, disability and elder advocacy groups or even independent aerosol experts, occupational safety professionals and industrial

hygienists. The HICPAC committee is packed with representatives from the hospital industry, and lacks procedures for meaningful public input.

The American Hospital Association has explicitly declared that hospitals are facing a “crushing” financial crisis. Given this, I am concerned that the hospitals may be pursuing this short-sighted infection control approach to reduce their expenses by cutting fit-testing programs and limiting access to N95 respirators and other airborne protections. However, increasing rates of health worker COVID infections will further worker shortages and may lead to additional disabilities caused by Long COVID. **Ultimately, infection control that ensures the highest protection of healthcare workers and patients based on evidence-based science, and integrates the input of stakeholders is a necessary approach.**

Sincerely, Kathleen Hammerman, Clayton, MO

---

Dear Committee,

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. 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.

As a public school teacher in an inner city district, and immune suppressed kidney transplant recipient, your polices and lack of oversight put my life at risk every single day. Stop ignoring science to assuage the general public. It is your job to do the right thing, despite politics.

I trust you to proceed with intelligence, facts and protection.

Truly, Sandra Solimene, Southbury, CT

---

CDC HICPAC must follow the CDC's own FDA, NIOSH. OSHA guidelines that require the usage of N95 respirators or better, ventilation and filtration. These are the only evidence based options that prevent the spread of deadly pathogens like Covid 19 and other airborne spread illnesses. HICPAC's risky and profit-oriented proposed guidance is a society disaster waiting to happen. No one should seek medical care in fear of contracting a serious illness like COVID with long-term debilitating effects and even early death.

What you're proposing is unethical, frightening, and extremely dangerous across the entire population. If you shrug this off, then you will be party to this mass tragedy. You would be partially responsible for needless suffering and death. I hope you can live with yourself. Ponder that.

Jason Miller

---

To whom it may concern,

I am nearing my 40th birthday, have three young children who are my world, and am a kind, loving human. I have worked and paid taxes since I was 14. I obey the law and try to help where I can. I feed my family healthy foods, am (was) active and physically fit, and focus on overall health. Our family has always masked in public since COVID hit the US. My husband was laid off at the beginning of the pandemic and we slid into poverty. When he was able to obtain employment, he was forced to work in public service in a high-risk environment. He masked, but brought COVID home anyway. As soon as he tested positive, he left to isolate in my mother’s camper. I masked up in an n95 mask, but was too late and tested positive the next day. I stayed in an n95 around the clock and cared for my kids while sick. They were spared because of good masks. I was not so lucky. I got very sick and had trouble breathing and heart rate issues. I didn’t have anyone else to care for my kids, though, so had to stay home and just try to survive. After my initial infection, I was plagued with heart rate issues and severe fatigue and brain fog. It’s been over a year and I still get hit hard with fatigue by evening, even if I don’t do much during the day. I don’t really have the option to not do much, though. I homeschool, work from home part time, and cook and clean all day. Some days I can hardly move. Some days my memory is almost obsolete. Every day I worry if I will see my children grow up. I worry what their lives would be like without me. I worry. I can’t even go to the doctor now because they don’t require masks. Please understand how baffling that is - I can’t be treated for long COVID because the place that provides that care doesn’t take measure to prevent COVID spread. I

can’t go to the grocery store safely. I can’t find kids for my kids to safely play with. Because no one masks.

Do you know why most people don’t mask? Because YOU have told them they don’t need to. COVID has run rampant and mutated repeatedly because the public relies on YOU to guide them. YOU ARE FAILING. Your very name charges you with the duty to control and prevent disease, yet you refuse to tell the public that a simple mask can control and prevent the very disease that is disabling us at an alarming rate.

As a parent, I often have to enforce rules that my kids don’t like. Would my kids be thrilled to be able to eat sugar all the time and skip their veggies? Of course. Would I be doing my job as the protector of their health to allow them to do so? No.
Most of the time, doing the right thing is hard.

Will all people be happy if they’re told that wearing masks in public is required to control and prevent the spread of disease? No. Are you doing your job of controlling and preventing the spread of disease by appealing to public opinion? No. Please do your job.

The future of the human race very much depends on the ability to control and prevent disease. You have the power to determine how our future looks. Accurate messaging, whole truths about the long term damage that can be done by each infection, increased risk of a multitude of other health issues, etc. are all things that most are oblivious to right now because of your messaging.

Facts about mask effectiveness should be front and center.

Testing negative before returning to work or school and masks in public are very simple measures that can and should be taken to control and prevent the continued spread of COVID (as well as other viruses that currently cause mass illness in communities).

Removing mask requirements in healthcare was the last straw for many of us. Now there is no place that is safe.

Please, at the very least, reinstate mask requirements in health care settings. If you actually want to stop the long COVID pandemic within the COVID pandemic, please also be blatant and honest to the public about the simple act of masking and how very effective it can be in preventing and controlling the spread of disease.

Desperate for safe care,
Shandi Hudson

---

Good morning,

I am a nurse and saw that you are trying to relax some of our infection control practices. It feels like healthcare providers are being sacrificed in the name of profit margins. I stood up for the CDC through the main shut downs explaining that what you do is evidence based and to protect the community as a whole. These guidelines you are trying to pass do not at all seem like you are trying to protect anyone except maybe the pocketbooks of corporations. You already have left us out with your current community covid guidelines/recommendations and do not seem to be following evidence based practices by ignoring that covid is airborne and good quality masks

help. I am begging you to please give guidance that will help protect both Healthcare workers and the immune compromised patients we care for.

We all know surgical masks are not as effective as N95 masks.

Thank you,

Monica Ciccarelli

---

As a concerned American, I am asking that the CDC Healthcare Infection Control Practices Advisory Committee commit to 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.
        - 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.
        - **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.

Sincerely,

Katherine Angus,

Spring Lake, MI

---

Dear CDC HICPAC Members,

I am writing to express my deep concerns regarding the recently proposed infection control guidance, which seems to deviate from the evidence-based recommendations set forth by esteemed organizations within the CDC, FDA, NIOSH, and OSHA. It is with a sense of urgency that I implore you to reconsider this course of action, as it has the potential to inflict grave consequences on both healthcare professionals and the broader community.

The established consensus among reputable institutions, including the CDC, FDA, NIOSH, and OSHA, underscores the significance of employing N95 or superior respirators, alongside robust ventilation and filtration systems, as the most effective means to mitigate the spread of deadly pathogens such as Covid-19 and other airborne illnesses. These guidelines have been crafted through rigorous research and scientific scrutiny, providing a comprehensive framework that ensures the safety of healthcare workers, patients, and the public at large.

By diverging from these well-founded principles, your proposed unproven guidance risks compromising the health and wellbeing of individuals within hospital systems, including medical staff who are at the forefront of battling infectious diseases. The potential repercussions extend beyond healthcare workers to impact the broader community, as the failure to adhere to established evidence-based protocols exacerbates the transmission of contagious illnesses and leads to dire consequences.

It is imperative to acknowledge that the stakes are high and the decisions made in this regard carry significant weight. The medical community, healthcare institutions, and the public at large look to CDC HICPAC for guidance that is rooted in scientific rigor and a commitment to safeguarding lives. Failing to do so undermines the integrity of your organization.

I strongly urge you to reconsider the proposed guidance and align with the well-established recommendations provided by the CDC, FDA, NIOSH, and OSHA. This alignment not only upholds the integrity of evidence-based practices but also serves as a testament to your dedication to public health and safety. The repercussions of straying from these established guidelines would be far-reaching and profoundly detrimental.

Thank you for your attention to this urgent matter. I implore you to prioritize the wellbeing of healthcare professionals, patients, and the community by adhering to proven and effective infection control measures.

Sincerely,

Dana Whitfield

---

Dear HICPAC,

I write to you as a concerned constituent regarding the Healthcare Infection Control Practices Advisory Committee's (HICPAC) plan to revise the CDC's *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, last updated in 2007. The proposal to implement a more "flexible" approach puts the lives of patients and healthcare workers in grave danger, and ignores not only longstanding science on infectious disease transmission, but the lessons we have learned about infectious aerosols over the last several years of the COVID-19 pandemic.

I implore the Work Group on the Isolation Precautions Guidance to recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. There is a large body of evidence on the effectiveness of respirators, ventilation, and air filtration for controlling exposure to infectious aerosols, which must be recognized by HICPAC and the CDC. Healthcare workers deserve an approach that recognizes what we know to be true about infectious aerosols like SARS-CoV-2 and provides them the necessary protections (including PPE) to keep themselves and their patients safe.

It is the responsibility of this body to take this science seriously and act to protect healthcare workers and the public. I am not a healthcare worker or a scientist myself, but I am a member of the general public who fears seeking any medical attention due to the risk of contracting an infectious disease in an environment without proper precautions, like wearing N95 respirators, being taken by healthcare professionals. I am gravely distressed by the reality that I could enter a hospital or other healthcare facility without COVID and contract it from a healthcare worker while seeking treatment for something else. The proposed updates to the Isolation Precautions Guidance will increase this risk for patients and workers, and I urge you to heed the advice of the occupational safety, aerosols science, public health, and medical experts submitting public comment.

Thank you for your time.

Aurora Clare

Ridgewood NY

---

Dear Center for Disease Control and Prevention (CDC) Officials:

I'm writing to you in response to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), which I understand is considering new infection control guidelines. I am deeply concerned by these guidelines, as they do not recommend increased or improve air filtration in healthcare settings and they claim that surgical masks are as good as N95

respirators, when all the evidence shows that N95 respirators are necessary to protect both healthcare workers and patients from airborne viral illnesses such as Covid-19, RSV, and flu. As we enter another Covid surge as well as flu season, if we weaken infection control in healthcare settings, we are leaving people vulnerable to Covid-19 infections and the risks of long Covid - blood clots, strokes, heart disease, dementia, and the many other long-term health risks associated with repeated Covid-19 infections.

Instead of weakening infection control guidelines, I ask the CDC to implement safeguards in healthcare settings to ensure that vulnerable individuals are not risking their lives and health in medical settings. Specifically, the CDC should issue indoor air quality targets for all healthcare settings and should recommend source control measures, prioritizing N95 respirators, in healthcare facilities. These measures would ensure that those who are immunocompromised, elderly, or who have other health risks that make them vulnerable to Covid-19 could safely visit their doctors and receive necessary medical care.

My father was undergoing treatment for stage III cancer during 2020 and 2021, and without precautions (including providers wearing N95 rated masks, proper ventilation and air quality, and separation of patients with communicable illness) for high-risk and immunocompromised patients, he could have easily contracted Covid-19 and died or become further disabled while seeking lifesaving cancer treatment. This is the case for many, and unfortunately many high-risk patients have contracted Covid-19 from medical settings while seeking care, due to negligence in infection control practices. Since the end of the Public Health Emergency was declared on 5/11/23, many treatment centers for cancer patients and otherwise high-risk patients have removed precautions like masking that were in place before Covid-19, at the risk of both the patients and healthcare providers. No one should have to choose between accessing necessary medical care and avoiding Covid-19 infection that could exacerbate pre-existing conditions or create new ones, which we are seeing from research can be fatal.

Prioritizing N95 respirators and indoor air quality and ventilation improvement is essential to continue protecting healthcare workers and patients alike from airborne illness, especially Covid-19 which carries the most risk.

Thank you for your time and consideration.

Sincerely,

Emma Sullivan

---

Good afternoon,

Thank you for allowing public comment on precautionary measures for the continued threat of COVID-19 and its ever-mutating variants. I have many family members that put their full trust in this institution who are also severely immunocompromised. I too am already down that same path towards a weakened and deteriorating immune system. My faith and trust however has been shaken. It’s difficult to watch them get more sick as they walk through life now unmasked around an airborne virus that continues mutate faster than vaccines can even help. It’s especially difficult being with them in health settings or being in health settings myself and seeing physicians and staff unmasked and at the ready to shake hands. There are medical procedures that would require a patient to remove their mask which increases the risk of the physician too is not wearing a respirator.

My hope is if enough of us express the urgency with which we feel this issue needs addressing that a decision is made in the best interest of peoples lives and not the whim of insurance companies and out of touch politicians. We live in a world now where wearing a mask needs to be required. Please consider this when making any further decisions.

Thank you again for the opportunity to make a public statement, exercising my civic right and duty.

Sincerely,

Nicholas J. Wager

---

We need more realistic infection control measures for COVID

Renee Lorrain

---

My husband, Jay Dahl was scheduled for a stress test on a treadmill for heart problems after a covid infection. He is at high risk for these types of complications from Covid, Flu or RSV because he had to have a rare and dangerous procedure six years ago to remove the protective sac around his heart because it had been attacked by a previous virus (scarlet fever) as such, he is covered under the Americans with Disabilities Act. He requested the technician put on a mask so that he would be safe while breathing rigorously for this test. The tech refused and was rude and hostile toward him. He further explained that the ADA is federal law and that as a person with a disability, he is protected under this law. The tech refused. We called the doctor's office and spoke with the Manager who had never heard of the Americans with DIsabilities Act and refused to follow it. So, we asked to speak with the owner of the business. Dr. Usman M. Sheriff. Dr. Sheriff was not concerned with our health, but his staff instead. I explained the ADA law, who can use it and that it is federal law and superseded Texas law and that with Jay's severe condition we can't take a chance that he would get sick when he is already here because of his first and only Covid infection causing severe arrhythmia and chest pain. I further explained that failure to follow the federal law would result in a federal complaint to the Department of Justice for civil rights violations and this complaint to the Department of Health and Human Services for abuse of a vulnerable disabled person. He also had never heard of the Americans with DIsabilities Act and refused to follow it. He told me I should print out the law and bring it to him. He fired us both as patients for asking for masking to protect us.

I printed out the Americans with Disabilities Act and proof from the Vermont Center for Independent Living Directions on how a patient can receive masking under the ADA. I immediately ran these over to the office. Today I got a letter firing us as patients by certified mail.

It took months to get this appointment and Jay has been having heart issues since his first Covid infection in March. This will dangerously delay his care indefinitely as we try to find another doctor, set up new appointments and testing etc. This is not only breaking federal law but putting a vulnerable person in harm's way as they wait endlessly for care. This is irresponsible and potentially deadly. Dr. Sheriff has violated our civil rights and put us both in danger by delaying and denying care. (Note I am also a patient because I had tachycardia and

dangerously high blood pressure following our Covid infection in March and I am a disabled teacher with a neuromuscular condition).

If you told me Jay would still be begging people for his life in medical offices after four years of this pandemic, I don't think I could have gone on. I'm so tired. We have a right to safety in the doctor's office. This is essential in continuing healthy screenings as well as sick care. We have to stop forcing the individual to invoke ADA rights over and over with less and less cooperation to the point of begging for our lives and health each time we visit a medical professional. This is not right. The power dynamic is unjust. Patients have the right to safety. The disabled have the right to reasonable accommodations and medical professionals have an ethical duty to provide that.

Jay was seen on Tuesday 8/22/23 The tech who refused masking was named Seline (we asked twice for her last name but were not given it). We spoke with the Manager & Dr. Sheriff on Wednesday 8/23/23. I brought printed proof of the ADA on 8/24/23 and we were fired formally by certified letter on 8/25/23.

Erin Dahl

---

We are tired of being exposed to a virus that can be controlled with universal masking do some thing or we will have nobody left

Leigh Cavanaugh

---

We highly encourage WHN members to submit a comment and advocate for proper airborne infection control in hospitals. We know that COVID is fully airborne and we know what airborne infection control looks like. There is no excuse for continuing to ignore the science and the data around COVID's harms to patients.

Sincerely,

Dawn Parker

Portland, OR

---

My name is Duncan McGraw, I live in Albuquerque, NM and today I will be talking about the updated infection guidance in hospitals and other health care settings and how it is harmful, particularly the false equivalence of N95 performance compared to surgical masks.

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. This evidence review omitted applicable data and studies and as a paper published by the Annals of Internal Medicine, *Medical Masks Versus N95 Respirators for Preventing COVID-19 Among Health Care Workers* by Loeb, et. al. points out, "acquisition of SARS-CoV-2 through household and community exposure, …, uncertainty in the estimates of effect, differences in self-reported adherence, and differences in baseline antibodies" can all act as sources of error in randomized studies, so this must be considered

when incorporating that form of evidence. Additionally, this review ignores an overwhelming amount of evidence from laboratory studies and studies in non-health care workplaces that verifies the efficacy of respirators in preventing airborne infectious disease transmission. I urge you to revise this guidance on the effectiveness of N95s in comparison with surgical masks, as well as the majority of the update infection guidance for healthcare settings as it will put the already endangered wellbeing of health care workers in a substantially more precarious position. Thank you for your time.

---

Dear HICPAC members:

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.

In the current environment of healthcare worker shortages, if one facility lowers their infection controls, others follow suit in order to not lose employees who for non-scientific and often ill-informed reasons prefer to not wear N95 masks or abide by other proven measures to mitigate aerosol spread of covid and other respiratory viruses. Even if a practitioner wants to maintain a safer environment for themselves and patients, it becomes impossible.

My mother, who has late-stage Alzheimer's, is in a facility that does not require masks for visitors or staff. As a result, I cannot safely see her or give her comfort, and I just have to wait for her to catch COVID again, as she did last year, which accelerated her decline from ambulatory to wheelchair. I could not find a facility that did have masking requirements. This is an unbearable heartbreak. I cannot protect her. I understand the facility cannot keep staff if they don't follow suit with other facilities in the area. It is truly a race to the bottom, and we are there!

We need strong, clear guidance from the CDC that practitioners and administrators can cite as they always have that "we are following CDC guidance". At minimum, all staff should wear N95 or better respirators, and require all patients in the facility who are able to mask in N95 or better. Anything less results in a race to the bottom, and increased patient and staff harm.

My husband (newly diagnosed Parkinson's) and I (Type 1 Diabetes for over 30 years) are forgoing medical appointments, which poses a risk to our health, because masks have disappeared from medical practices here. We are carefully weighing the risk of forgoing care against the risk of contracting covid and hoping we are "guessing" well. This includes retina exams, further neurology assessments, dental visits, and so on. We just pray we don't have to go to the hospital or urgent care.

Please act to protect us! We cannot navigate the current medical system safely without your leadership and clear, unequivocal guidance in place.

Sincerely,

Carol Ezell

Las Cruces, NM

---

I am writing to urge you to recommend permanent mask requirements in healthcare. With the rise in COVID-19 cases and the emergence of even more new variants, including one (BA.2.86) that's mutated so extensively that WHO have nominated it as a variant under monitoring (https://www.nature.com/articles/d41586-023-02656-9), it is important to take all necessary precautions to protect vulnerable patients from rampant and lethal hospital-acquired infections.

Relying on personal responsibility in settings like hospitals is completely inadequate and suggestions that people "assess their own risk" demonstrates an ignorance about asymptomatic transmission. It takes a healthcare mandate to ensure that the people who are most at risk can access treatment safely.

Nosocomial infections are a serious concern, and vulnerable patients are more likely to experience severe outcomes should they contract COVID in hospital. Information about nosocomial infections in Victoria, Australia shows how deadly COVID transmission in hospitals can be. https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html

As you know, hospital-acquired infections can be devastating for patients who are already dealing with health issues. These infections can lead to complications, prolonged hospital stays, additional medical procedures, and in some cases, even death. By requiring masks for visitors and staff, you can greatly reduce the risk of transmission and help keep patients safe.

In addition to protecting patients, reinstating mask requirements will also help ensure that you provide healthcare workers with a safe workplace. These individuals are on the front lines of caring for patients and are at a higher risk of contracting infectious diseases. By requiring masks, you can help prevent the spread of these diseases among healthcare workers and help keep them healthy and able to continue providing essential care to patients.

As I'm sure you are aware, we know Covid is airborne, it can hang in the air for hours. The infected aerosols are produced simply by breathing & speaking, acknowledged in the report from the Australian Federal Parliamentary Inquiry into Long Covid and Repeated Infections.

As Dr Monique Ryan said in her powerful statement in Australian Federal Parliament recently:

"*The Australian Charter of Healthcare gives all Australians the right to safe, high quality healthcare. Our National Cabinet promised to protect the vulnerable from the COVID-19 pandemic. This promise has not been kept.*

*There are no longer any legal requirements for healthcare workers to wear protective masks. All pandemic orders have now expired. Chronically ill, disabled and elderly Australians can avoid restaurants, shops and travel to protect themselves from Covid, but they have no choice about accessing healthcare where they are now at risk - high risk - of hospital acquired infections.*

*If you go to hospital for something unrelated to Covid but you are infected with it while in hospital, your risk of dying from it is one in 10. This is more than 50 times the community mortality rate for Covid. It is an unacceptable & unnecessary risk. The Covid pandemic is not over.*"

This is a genuine, global health crisis.

Thank you for this opportunity to comment.

Sue Jennings

Co-founder - Cleaner Air Collective, Australia

---

Dear Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),

I am writing to provide a comment for the public HICPAC meeting that took place on August 22nd, 2023.

I would like to strongly urge you to adopt life saving measures in medical settings that will protect both patients and healthcare workers. These measures need to include respirators (N95 or better) for all staff and patients, Far-UVC systems and HEPA filters in all hospitals and clinics.

Our public health agencies have truly let the public down during the past three years with inaccurate information such as pretending that staying safe from COVID involves sanitizing our hands and standing six feet apart. As you know, nothing is further from the truth. COVID and other viruses are airborne. We do not breathe through our hands. Unfortunately, the vast majority of the US public still believes this misinformation as well as that vaccines prevent infection (which they don't).

I am a healthy and very active person who is up to date on all my vaccines and boosters. I have not had COVID because I wear an N95 or better respirator in all indoor spaces. I can tell you that respirators really do work. I do not plan on getting COVID because the risk of getting long COVID is up to 20% each time I get infected. More research is coming out saying that even mild cases cause a heightened risk of lung problems, fatigue, diabetes and certain other health problems typical of long covid two years later (see https://www.washingtonpost.com/health/2023/08/21/long-covid-lingering-effects-two-years-later/?utm_campaign=wp_post_most&utm_medium=email&utm_source=newsletter&wpisrc=nl_most).

These days, when I walk into a doctor's office, urgent care or hospital, I feel like my health is at risk. None of the doctors, patients or staff are wearing masks. There are no HEPA filters. Hospitals are not screening people for COVID, nor are they quarantining sick people anymore. As a result, if I am unlucky enough to wind up in the hospital, there is a nearly 100% chance that I will catch COVID. This is simply not acceptable. Hospitals should not be death traps. Mandating respirators and HEPA filters is an economical and simple solution. Hospitals need to also install Far-UVC systems to keep patients and staff safe.

I strongly urge HICPAC to recommend the following actions to healthcare facilities across the nation:

Universal Masking: Implement a policy mandating universal respirator use for all individuals within healthcare facilities, including healthcare personnel, patients, and visitors. This should apply to all areas of the facility.

Advanced Air Filtration: Encourage healthcare facilities to assess and upgrade their air filtration systems to include HEPA filtration and far-UVC, especially in critical care areas and high-risk patient settings.

Guidance and Education: Provide comprehensive guidance on the proper use of respirators, including fitting, and appropriate disposal. Additionally, offer resources on selecting and maintaining effective air filtration systems.

Research and Development: Support ongoing research into innovative technologies and practices for infection prevention, including the development of more efficient air filtration solutions.

By championing these measures, HICPAC can play a pivotal role in improving patient safety and reducing the burden of healthcare-associated infections. Enhanced infection control practices will create safer healthcare environments for both patients and healthcare workers, will protect our healthcare system, and will reduce overall costs for hospitals and other healthcare providers.

Lastly, I want to note that I 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). Please listen to experts in ventilation, aerosol science, and public health. It is your job to set standards that will actually keep people safe, and not to kowtow to hospital officials who are only interested in saving money.

Thank you for your dedication to improving healthcare quality and safety. I look forward to the continued efforts of HICPAC in advancing infection control practices.

Ella Elman

Redmond, WA

---

Alexandra MacWade

Brooklyn, NY

HICPAC Testimony

Hello,

I'm writing in response to the CDC, who is considering lowering infection safety precautions for healthcare workers. Although we are only beginning to understand the consequences of Covid infections, particularly repeat Covid infections, we already know how devastating this disease is. It is unconscionable, after all we've been through and all we have learned, to abandon protecting our healthcare workers and the patient populations they treat. We are all entitled to an expectation that basic safety precautions are being taken when we work at or visit a healthcare setting.

https://www.forbes.com/sites/judystone/2023/08/21/cdc-weighs-lower-infection-safety-precautions-for-healthcare-workers/?sh=6c839e8d7ba4

Worryingly, the CDC/HICPAC has not acknowledged 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.

Sincerely,

Alexandra MacWade

---

The CDC has a duty to control and prevent the spread of infectious disease. This includes establishing guidelines that adequately protect patients and health care workers from airborne diseases, such as SARS-CoV-2. Rather than weaken existing protections, the CDC should strengthen them, including promoting the use of well-fitted N95 (or better) respirators, HEPA air filtration, and sufficient ventilation as standard of care in all health care settings.

Patients have a right to safe health care, where they can be secure in the knowledge that they will not leave sicker than when they arrived. They and those that care for them should feel confident that they will not become disabled by a preventable illness. Anyone that enters a medical setting – whether a patient, provider, support staff, or visiting family – should know they are entering a space where health and safety are the top priority.

Sadly, no such security or confidence can currently be found in most health care spaces. Many of us have had to put off not only routine examinations, tests, and procedures but also more pressing medical needs due to the high level of risk from airborne diseases in such settings. It is a travesty that this situation has been allowed to occur and that neither “health” nor “care” are valued.

I would like to see the members of HICPAC recenter their focus on practical, evidence-based ways in which they can improve infection control (such as those noted above), and I urge them to recommend proper precautions against airborne illnesses as the standard across all health care settings.

Tracy Craig

Pittsburgh, PA

---

Dear HIPAC work group:

I am personally impacted in a harmful way because of the lack of health care safety that already exists and will suffer even more from the polices that you are proposing because of the reasons below.

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.

Gretchen Seichrist

---

On behalf of the Organization for Safety, Asepsis, and Prevention, I would like to submit the following statement in reference to the Isolation Precautions Draft Guidance:

The Organization for Safety, Asepsis, and Prevention supports evidence-based guidelines that include a tiered approach that allows flexibility to adapt to changing situations and acknowledges the evolving nature of advancement in scientific knowledge.

Best regards,

**Michelle Lee, CPC**

Executive Director

**OSAP, Atlanta, GA**

---

Good afternoon,

My son is immunocompromised so as a family we wear masks in ALL indoor settings. One way masking does not always work. Masks should be in ALL healthcare settings, he should not have to risk infection from another when attending doctors visits, and he has over twenty a year. In addition, he MUST remove his mask to eat at in his K-12 school however it is poorly ventilated (confirmed with over a year of CO2 tracking), therefore every single day he risks infection. Am I to tell this kid he can't eat? Mandated clean air standards should be in schools ESPECIALLY CAFETERIAS.

Thank you

Virginia Baldwin

Floral Park, NY

---

To Whom It May Concern at CDC HICPAC,

I am begging for N95 mask mandates in healthcare settings to reduce the spread of viruses amongst already vulnerable patients. Seeing all healthcare workers using quality masks would dramatically increase trust between doctors and patients who are currently avoiding routine checkups in fear of picking up COVID, Ravi, flu… on their way out as one-way masking is not nearly as effective as 2 way masking.

Thank you for your time in reading this.

Concerned human,

Nil

---

I am 67, with a husband who is 80 and a mother who is 96. I work hard every day to protect all of us from a possibly life threatening COVID-19 infection. People like us, along with the disabled, and other vulnerable populations, are able to avoid places like bars, restaurants, and movie theaters. We should not be forced to consider avoiding healthcare settings.

I call on the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), to provide strong, clear guidance to healthcare facilities, including requiring universal PPE

(including fitted N95s masks, as they clearly provide superior protection against the exposure to and transmission of infectious aerosols and droplets), for healthcare workers and patients at all times to control aerosol-transmitted virus spread. Universal masking is necessary to make healthcare settings more accessible to all vulnerable people and those who cannot mask, including individuals with conditions that make masking prohibitive, and infants.

For those misinformed people who believe being required to wear a mask impinges on their rights, remember what Oliver Wendell Holmes Jr. had to say on this topic. “Your right to swing your arms ends just where the other man's nose begins.”

Thank you for your consideration.

Best,

Leah Gillon, Concerned Citizen

Ann Arbor, MI

---

Hello,

As a chronically ill person, I have a strong and personal interest in being able to safely partake of medical treatment.

That's why I am urging HICPAC to develop infection control guidelines that involve those who are most at risk. This is to include patients and healthcare workers as well as their representative organizations.

I am also urging HICPAC to develop guidelines that are based on the precautionary principle, emphasizing 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.

Thank you very much for your attention, and best regards,

Ingrid Hasenhuendl

---

Cassie Hackel
Ridgewood N
Re: HICPAC/CDC updated guidance in *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*

I am writing with strong concerns about the proposed CDC/HICPAC guidelines around infection control in healthcare settings. 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.

CDC/HICPAC also 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 every level of government has stopped taking COVID seriously, there are few spaces left that are reasonably safe to access. With mask mandates being dropped at healthcare settings around the country, healthcare providers are bafflingly willing to expose patients to airborne pathogens including SARS-COV2. It should be common sense to require respirators and clean air in healthcare settings to limit airborne disease spread, just as providers wash their hands to prevent transmitting germs. Weakening these precautions make the CDC complicit in the quest to ignore the ongoing pandemic and subject millions of Americans to the short- and long-term effects of a novel disease, not to mention others that are already common and spread through airborne transmission. Moving backwards on this guidance will be disastrous and ignores the fact that everyone is at risk of serious complications from COVID, which we should not be forced to expose ourselves to just to access health care.

---

As a multi generational household in Van Nuys, with both vulnerable older adults receiving IHSS and students at LAUSD, my family feels abandoned by public leaders.
Healthcare facilities are the last place my family can go with any reassurance that we won't be harming the vulnerable 83 year old who lives with us. Requiring masks in these facilities is the lowest bar, and should not ever have been on the table for elimination until we have sterilizing vaccines.
People are becoming disabled from long covid and dying from hospital-acquired COVID infections and this change to "recommend masking" rather than *require masking* will lead to even greater levels disability and death in our communities. Moreover, we will be putting our healthcare workers at greater risk of reinfections, disability, and death as we are already experiencing a worker shortage in our healthcare system and a healthcare system collapse.
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.
Please make it possible for families like mine to continue accessing critical medical care.

Emily Skehan
Van Nuys, CA

---

On August 22nd, community members unanimously urged the CDC's HICPAC members to recognize airborne transmission of SARS-2 and to require airborne precautions that include respirators, ventilation, and filtration in healthcare settings.

Today, I am joining these community members who spoke during CDC's HICPAC public comment to emphasize the urgency of recognizing airborne transmission and to require airborne precautions in healthcare settings to save lives, prevent growing rates of long covid, and create safer conditions to access healthcare.

Lives should not be harmed in healthcare settings, lives should be saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence. People are dying tragic deaths from hospital acquired infection of SARS-2 that could have been prevented with mask requirements. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses.
And 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 masks will help our healthcare workers stay safer and help address critical staffing shortages which is reducing the overall baseline of care and is leading to a healthcare collapse. In closing: You are the CDC, 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?

Act quickly, our health and lives are depending on the requirement of airborne precautions in healthcare settings.

Thank you.
Saajida Deen
Ottawa, Ontario Canada

---

Hello,

I am writing to express my opinion about masking in healthcare facilities. As someone with blood cancer who receives chemotherapy, I am immunocompromised. Because of this health status and because healthcare facilities have dropped masking requirements, every time I need to visit a healthcare facility, I need to think long and hard if that visit is important enough for me to put myself at risk of covid. I actually skipped going to the Mass Eye & Ear ER a few weeks ago when I had blurred vision and pain in an eye because they told me they had 40 other people waiting for care and the wait would be 7 hours. Knowing that their waiting room is quite small, there was no way I was going to risk getting covid from the many people packed into that waiting room and then the unmasked healthcare professionals. I took the chance the blurred vision came from something I've experienced before and that it would be self limiting. But that is not a gamble I would ever want to take, except if I might catch a virus that could kill me or make me seriously ill for an extended period. When I go for health care, I should have the right for SAFE health care and not run the risk of catching covid from the healthcare providers and other patients. Considering that many people have asymptomatic cases of covid, screening patients for symptoms and asking staff to stay home when not feeling well is nowhere near enough to protect vulnerable patients. We could easily catch covid from people with asymptomatic cases. Additionally, it is known science that two-way masking is much more effective over time than one-way masking. Plus, N95's are much more effective at preventing the release of exhaled aerosolized virus than surgical masks. So please, reinstate the requirement for mandatory masking in healthcare facilities to help the millions of vulnerable people in the USA obtain healthcare more safely.

Thank you,
Judy Teitelman
Boston, MA

---

Hello and thank you for accepting my comment on the topic of mitigations and disease control settings. I am a 51 year old woman who got covid in November 2022. I am still fighting for my health. As an avid hiker and a vegetarian, never in my wildest dreams would I have considered I would be fighting for my life because people refuse to wear a mask to protect me from a virus. I've been dealing with LONG COVID after my first and only infection. I have acquired multiple chronic illnesses as a result such as Pre-diabetes and fibromyalgia. Everyday is painful, brain fog, irregular heart palpitations. Since the removal of masks the risk of getting sick once more while getting medical attention is high. It is medically unethical to continue disabling people in the name of economics. Please take action urgently and stop this massive disabling event we are going through. History and your descendants will judge your actions. How you listen to science and act in a compassionate manner and make a difference in the world. A matter of life and death shouldn't be up for debate, more so in a hospital.

Thank you,
Carla Zarate S
Santa Ana CA

---

August 25, 2023

Re: CDC/HICPAC's Plan to Weaken Guidance for Health Care Respiratory Protection and Infection Control

To Whom It May Concern:

The Healthcare Infection Control Practices Advisory Committee (HICPAC) to the CDC has initiated work to revise the CDC's Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated in 2007. I would like to ask that this be revisited and reconsidered as the pandemic has shown us that more, not less, precautions should be taken in healthcare settings.

We have seen in the past how hand washing and sanitizing has entered the norm of healthcare, and in the 80's and 90's we have seen the advent of the regular use of gloves to protect against blood borne illness. We know that Covid and other viruses are airborne and owe it to the population at large to protect their health as well as our very needed healthcare workers who should not have to go to work and become infected. To keep staff and patients safer, and to keep healthcare facilities running smoothly, I ask that more protections and preventative measures be added to your guidelines for healthcare settings.

All we really have is our health, and once it is gone, we cannot gain it back. We already have millions of people disabled and we don't have the resources to support all of them plus the newly disabled as a result of Covid-19. It is imperative that healthcare move forward with the times, with new technologies, innovations for protections, and clear and concise medical thinking. This means doing the utmost to ensure patients coming into facilities who are not contagious don't become infected during their visit.

Masking (using respirators and KN95 level protection) is part of the protections we need to prevent airborne virus transmission. This is part of "living with" Covid-19. Letting our guard down and allowing for rampant infection has not created herd immunity and with new variants always coming just one step ahead of our efforts, we need to put more effort, not less into getting

ahead of it and protecting all of our population. This is not a "control" or "political" issue, it is simply logical and rational to do our best to preserve life and reduce human suffering.

Thank you,

Maureen Dee

---

Good afternoon,

I am writing to urge the HICPAC process to be amended with a strong focus on safety, health, public transparency, and input.

In addition to being an ordained United Methodist pastor and public health advocate, I'm a disabled wheelchair user with cerebral palsy who is in need of safe, quality healthcare and an ability to interact in public spaces without feel.

Frankly, what is happening here is far less than offering these things that should be a right, not a privilege in our society.

As you know, amongst other concerns:

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.

Therefore, again, 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.

Moreover, 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.

Need I remind you that people are still dying preventable deaths from Covid 19 and other things at an extremely high rate beyond what anyone should accept as reasonable?

I suspect not and I urge your reconsideration in these areas and, in fact, in the entirety of how you work. Everything should be done with the best health and safety in mind. Clearly, right now, this isn't the case with what you are proposing.

Sincerely, Rev. Chris Wylie

---

Dear CDC/HICPAC,

I'm writing to you as a childhood cancer survivor, a mom to a child with an autoimmune disease, and a disability ally. The last 6 months of the pandemic have been shockingly disappointing with the loss of masking in the healthcare setting. At risk individuals and folks with disabilities are given the undue burden of begging to be protected from COVID in every healthcare interaction. We need fit tested masks and improved ventilation to protect against infectious aerosols. There is a large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker and patient exposure to infectious aerosols, yet there are currently no recommendations on ventilation. Many of us are forced into risky situations to manage our illnesses. I beg you not to weaken protections as we head into the fall and winter with cases of COVID-19 are already rising nationwide. Please consider stronger recommendations for both masking and ventilation in the healthcare setting to keep healthcare workers at work and fragile patients safe.

Sincerely, Melissa Mills, Menlo Park CA

---

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 writing to express my deep concern regarding 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.

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.

Allow me to share a personal experience that underscores the urgency of this matter. Just a few weeks ago, while undergoing a medical procedure that necessitated the removal of my NIOSH N95 respirator, I contracted COVID-19 from a healthcare worker who was wearing only a surgical mask. This unfortunate incident highlighted the vulnerability of patients during such procedures and the potential for transmission due to inadequate respiratory protection for healthcare workers.

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.

**Synergistic Benefits:** N95 respirators are essential for near field aerosols. But for far field aerosols improvements to indoor air quality are also important. Upper room germicidal UVC, in duct UVC, in room Far UV, vacant room UVC disinfection, humidity levels, ventilation, air filtration, CO2 monitoring and PM2.5 monitoring are all important. Clean air is as if not more important that clean water. Clean air improves many health measures.

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,

Jamie Vineski

Colorado Springs, CO

---

Precautions that include HEPA filtration and N95-or-better masks on all employees and visitors to healthcare facilities should be the standard, not an emergency measure. We lost a lot of healthcare workers over the past four years, and we'll never have enough if we don't take protective measures now. Our nation's most vulnerable are delaying or forgoing medical and dental care to avoid infection. Please keep protections, especially masking, in place.

Thank you.

Jane Lorenzen

---

I feel the need to comment regarding infection control policies in medical facilities and hospitals during COVID outbreaks.

My husband is 85 years old and is at serious risk of death should he contract COVID. We live in Oklahoma, and have been unable to obtain proper medical care for him or myself, since

obviously if I get sick, so does he since I am his home caregiver. The population in our state feels their "rights" are more important than wearing a mask and during the few times he has HAD to receive care, we have had to beg medical personnel to mask, and other patients in busy waiting rooms have flat out refused.

This has resulted in delayed care for him and myself as well. Last year I fractured my femur, required surgery and asked to be discharged the next day due to the lack of concern and care with unmasked medical personnel. The doctor wanted me in the hospital for five days with discharge to a skilled nursing facility for an additional 30 days. I have not seen a doctor since discharge and was not able to attend physical therapy for the same COVID concerns. A year later I am struggling with disability over having to make life and death decisions over infection control decisions that should have been enforced. The mandates were in place, but were blatantly being ignored.

My husband is still in need of care but chooses to "wait it out" a decision that no American should be forced to make. He served his country in the military and worked and retired in the airline industry.

I ask that you please consider our older Americans and their caregivers in your decision making and enforcement of mask mandates. All Americans have the right to life and our older Americans are being treated like second class citizens during this difficult time.

I am a citizen and member of the ADA Facebook group.

Anne Landers

Collinsville OK

---

I'm urgently writing you today to implore you to correct your review on COVID infection control measures so they reflect the science of aerosol transmission through inhalation and to expand your decision-making process to include patient advocates, infectious disease transmission scientists, aerosols scientists, health care personnel, unions, occupational safety and health experts. We need to increase prevention of infectious diseases in healthcare settings not weaken them.

My husband is severely immunocompromised, due to an infection that he acquired while hospitalized. He lost vision in his left eye, due to a virus he acquired while hospitalized. He is permanently disabled. This was before COVID. Despite being fully vaccinated and boosted, he cannot develop immunity from the vaccines because he has a life-threatening, chronic autoimmune illness and is prescribed very potent immunosuppressant medications. Now, with masking removed from healthcare facilities, he does not have safe access to healthcare or his regular transfusions. He will not survive if infected with COVID. I am an elementary school teacher and have been forced to take an unpaid leave of absence for 2 years due to continued spread of COVID in school settings. My school says it does not need to accommodate me because the CDC and State of NJ no longer mandate any prevention measures.

The CDC, WHO and NIH have known since 2020 that COVID is transmitted by aerosols. Vaccines do not stop transmission of COVID as promised, or prevent Long Covid. Natural immunity from infection is short-lived. Life expectancy in US is decreasing. Vax and relax measures have failed and they are letting COVID win. You don't have to let this continue.

Healthcare facilities should be a place where people go to get well, not sick. You need to introduce control measures that recognize the transmission characteristics of COVID: pre/asymptomatic transmission predominates, aerosol spread; and inform the public that outdoor transmission is possible. You need to reinstate testing and universal masking (N95), implement ventilation, air purification (UV Light) and isolation.

Exposing healthcare professionals and patients to COVID and other respiratory viruses/infectious diseases is reckless. Scientists now know that COVID weakens the T-cells/immune system - it prematurely ages everyone infected. The policies of “let it rip” and “you do you”, are creating mass disability. We can no longer allow you to look away and cross your fingers, hoping that COVID goes away. It is time for all PH professionals to lead, inform and collaborate with patient advocates, infectious disease transmission scientists, aerosols scientists, health care personnel, unions, occupational safety and health experts to stop COVID transmission and other respiratory infections/infectious diseases. We need to move towards better healthcare so PLEASE correct your review on COVID infection control measures to reflect the science of aerosol transmission through inhalation. We cannot afford the cost of losing this battle. Our lives and livelihoods depend on it. Thank you for your service.

Sincerely,
Mary Gutierrez
Concerned Citizen
Farmingdale, NJ

---

I am writing to address a matter of utmost importance regarding the guidelines set forth by HICPAC concerning the use of masks in healthcare settings during the ongoing COVID-19 pandemic. I am writing to underscore the gravity of the situation and the need for stricter measures to protect both patients and healthcare workers.

It is crucial to acknowledge that contracting COVID-19 within a hospital environment carries a risk that is multiplied fiftyfold when compared to community transmission. The data leaves no room for doubt: patients who acquire the virus while receiving medical care face a staggering fifty times increased risk of mortality. This statistic alone should serve as a resounding call to action to enhance preventive measures within healthcare facilities.

One critical concern I wish to highlight is the removal of masks during procedures or interactions with patients. The act of removing masks without the utilization of NIOSH N95 respirators is, in essence, consenting to actions that can potentially harm patients and lead to increased disability or even death, particularly for those who are most clinically vulnerable. Patients entrust healthcare providers with their lives and well-being, and this trust must not be compromised by lapses in respiratory protection.

Patients' lives and safety should never be subjected to trade-offs for the sake of comfort or convenience. It is our collective responsibility to uphold the highest standards of care and safety within healthcare settings. The sacrifice of patient safety for the sake of ease is both ethically and morally unacceptable.

In light of these concerns, I respectfully urge HICPAC to consider the following points:

1. Robust Protection: The use of NIOSH N95 respirators must be mandated during all patient interactions, procedures, and situations where the potential for aerosol transmission exists. This

will serve as a strong safeguard against COVID-19 transmission, protecting both patients and healthcare workers.

2. Ethical Imperative: It is our ethical duty to prioritize patient safety above all else. Allowing any compromise in protection due to comfort or convenience undermines this imperative and jeopardizes the core principles of healthcare.

3. Communication: Clear communication of these requirements to healthcare workers, along with comprehensive training on proper usage of respiratory protection, will be essential in ensuring compliance and understanding.

4. Reusable Respirators: switching from disposable N95 respirators to reusable elastomeric respirators is an excellent way to reduce cost, improve comfort, and reduce waste. There are now a variety of models available with integrated or add on source control filtration. There are too many choices to even list them all here. There are even clear body respirators to allow lip reading and facial expressions, such as OmniMask.

The lives entrusted to healthcare facilities are invaluable, and their protection should always be at the forefront of our efforts. I implore HICPAC to take swift and decisive action in addressing these concerns. Together, we can create an environment where patient safety is uncompromised, healthcare workers are protected, and our commitment to healing remains steadfast.

Thank you for your dedication to public health,
Joy Vines
Buffalo, WY
Concerned member of the public

---

Dear HICPAC,

I am reaching out regarding the Healthcare Infection Control Practices Advisory Committee's (HICPAC) plan to revise the CDC's *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, last updated in 2007.

I want to add my voice as a concerned citizen to urge HICPAC 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 you are proposing the new category of "air" transmission, you 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.

I also implore HICPAC 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.

And after nearly 4 years of data on aerosols in relation to the COVID-19 pandemic, it is dangerous and unscientific to not acknowledge the importance and function of core control measures for infectious aerosols. HICPAC must 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. Recommendations on ventilation are desperately needed to protect the lives and wellbeing of healthcare workers and patients.

Thank you for your time and I urge you to take our comments seriously.

Kenny Prince
Ridgewood, NY

---

I am submitting comments for consideration to HICPAC regarding masking in medical settings.

I am a high-risk individual and a covid infection could devastate my health. I have existing chronic illnesses, including long covid from an infection in April 2020, when masking was discouraged to save PPE for health care workers. I have lost my future because I had to enter a grocery store for my once-every-two-weeks trip for food. And if I lose more of my health, I honestly fear for my ability to support myself and remain housed.

With a chronic illness, every time I enter a medical facility, I am forced to play Russian roulette with the unmasked staff and other patients. Even when masked, it's mostly blue surgical masks that are not adequate for an airborne virus and are most often seen around chins. Pointless theater.

I was in the ED recently, with one arm in a blood pressure cuff and the other with a pulse ox monitor and a central line, and the nurse pulled my mask down to take my temperature and then ***walked away*** leaving me to breathe whatever happened to be in the air for a full half minute and I had to yell at her to come back and put my mask up.

I cannot stress enough, I CANNOT get covid again. Even if I survived the infection, I would not survive the aftermath. It's already been 3.5 years of endless doctors appointments, endless new medications, endless gaslighting by specialists who still think long covid isn't real. I'm exhausted, both physically, mentally, and existentially. And my life is essentially just survival now.

Proper PPE is needed to protect everyone, but especially vulnerable people like myself who cannot opt out of medical care.

I read a tweet once that for everyone who goes maskless, their contribution to someone's death is greater than zero. Is this how health care is supposed to work? Is this "first, do no harm"? It's not care, and it's not evidence based for masks to be optional in health care.

Do better. Reinstate masks in health care and make respirators required for all.

Jennifer Cole
Brooklyn, NY

---

Name: Elizabeth J. Rublev
Address: Somerville, MA
Dear HIPCAC/CDC,

We are now in year four of the Covid pandemic. We are experiencing another surge, with Eris and BA 2.86. Please do something to protect us.

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.

Ventilation upgrades and air filtration need to be mandated across the board.

Please, I urge you to do something to help prevent the repeated spread of Covid and the continued reinfections which are disabling more and more people every day.

Regards,
Elizabeth

---

Hello,
My name is Bernadette Martin, a resident of Oregon. My address Portland, OR

I'm very concerned about the hicpac's proposed guidelines in healthcare settings, especially the proposed efficacy of equating surgical masks to n95 masks when dealing with COVID-19. Air filtration and proper masks are our best defense for airborne viruses like COVID, second only to vaccines. Please revise your guidelines to include air filtration in healthcare settings and that n95 masks are the best masks to help stop the spread of COVID. Thank you.

---

Hello,
My name is Victoria Reese. I am emailing to comment on the Health care Infection control practice advisory committee's consideration about precautions to do with airborne diseases. My address is 51 Bainbridge court Mobile Al 36606. I am a immunocompromised member of the public. I have already had such a hard time navigating the health care system and feeling safe going to the doctor. It is dangerous for me to go out and get the necessary care i need. I have delayed treatment and visits because I am afraid of catching an airborne disease. I beg of you to think of the people who are most often in health care setting, chronically ill individuals. It is of the upmost importance that we feel safe to go to the doctor. Please continue to recommend n95 mask and air filtration systems. I am so afraid to get covid and have to deal with the disabling effects of another chronic illness that is long covid. I am already having such a hard time as a 25 year old with rheumatoid arthritis. I do not think I can mentally handle the idea of having another chronic issue on top of this. as you may know chronic illness is correlated with depression and anxiety. I have had suicidal thoughts connected to high levels of pain and discomfort due to my disability. I am begging you to help me stay alive. Right now I need to see

a doctor about swollen lymph nodes, I'm due for a covid booster and a dentist appointment. All things I have avoided because I do not feel comfortable in the health care system in my state. No one is masking, no doctors are making accommodations for covid cautious patients. I cannot do this safely and it will only get worse if these reccomendations are removed. I am pleading that the CDC not only consider health people. Please show some compassion for the disabled and chronically i'll public.

---

I am writing to request that you bring masking back in health care settings. I am a patient with mast cell activation disease and I am afraid to go to any health care visits due to health care providers and other patients not wearing masks. I get incredibly ill with long term effects from the common cold or other mild viruses. I have still not recovered from a minor stomach bug back in March of this year; I have still not regained the ability to digest dairy products which is serious as I cannot tolerate any Calcium supplements and my MCAS has caused osteoporosis. My doctor told me that I must not get Covid. So I am putting off my mammogram, colonoscopy, dentist and any appointments where the provider will not see me virtually.

I believe that I should be able to access healthcare in a safe manner. Masking is really not that hard! I do it all the time to prevent illness and I believe the science indicates that it is extremely effective in preventing the spread of infectious diseases. I can't believe that the health insurance industry and the government are not pushing for masking in health care settings to decrease our health care costs overall and decrease work productivity lost to preventable disease. Masking also shows a compassion for others, something that our society is truly in need of. Please bring required masking back to health care settings in the US.

Judith Sheldon
Sudbury, MA
no organizational affiliation - just a private citizen hoping you will follow the science

---

Full name: Michelle Fiesta
Topic: Healthcare Infection Control
Address: Sacramento, CA
Organization affiliation: Member of the public

Hello,

I am writing to you today as a very concerned member of the public to URGE you to reconsider the guidelines on airborne infectious disease control that you proposed, and seek to adopt policies and regulations that are actually sufficient in containing infectious aerosols.

My partner is a cancer survivor, and I suffer from anemia. Both of these conditions make us more high risk for COVID, and thus we have lived in quarantine since March 2020. We have both been forced to take only fully remote jobs, we wear a mask everywhere we go, we do not do any indoor dining or other activities like going to the movies. I live half a country away from family, and my typical 2-3x year travel has been reduced to one, if lucky, because it is not safe to travel. Our lives are completely and utterly changed.

So, I am absolutely shocked that HEALTHCARE FACILITIES are not adopting and standardizing control measures that are at least as stringent as the ones my partner and I have to do *every single day.* We have postponed healthcare many times for this reason.

**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.

For our health and the health of so many others, **I urge you to reconsider these measures and to adopt measures that we *know* are effective.** Healthcare has adopted many new measures in the face of new information - glove wearing, hand washing, sterilization. Air filtration and masking should be on this list.

**This is your responsibility and your duty. Please do this, or the deaths of many will be on your hands.**

Thank you,
Michelle Fiesta

---

I am Dejana Becker, Austin, TX, Independent Clean Air Advocate .

We should do everything in our power to ensure disease control and safety within medical settings and reduction of harm to both patients and personnel. This means that the use of respirators such as N95 or higher should be required on top of all the other measures already in place.

This should be standard practice like hand washing or gloves have become.

I 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.

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,
Dejana

---

The thought that infection control measures could be weakened further is appalling. I recently had a full thyroidectomy for cancer and many post op complications. At the time, masks were still mandated in NYC hospitals, and in my 7 day stay I felt safe. I cannot imagine going through this with no masking in the hospital. My follow up appointments at the cancer center have been fraught- with no more mask mandates and even cancer doctors and nurses gleefully explaining that I could remove my mask. Also giant hepa filters in exam rooms unplugged and unused. I do not understand how it is ok to put people at risk of contracting covid when they have no choice but to seek treatment for illness or ongoing care.

Sandi DeGeorge
New York, NY

---

Peg Seminario, Industrial Hygienist - Submitted Comments on Isolation Precaution Guidelines – CDC HICPAC meeting August 22, 2023

My name is Peg Seminario. I am an industrial hygienist, and served for 30 years as the S&H Director at the AFL-CIO, until my retirement in 2019, where I specialized in occupational safety and health policy and regulatory matters including work on healthcare worker protection regulations and guidelines for bloodborne pathogens, TB, SARS, H1N1 and airborne transmissible diseases. I have continued to assist the unions to strengthen workplace protections on COVID-19, other infectious diseases and other safety and health hazards.

This July, I was one of the authors of a letter to CDC Director Mandy Cohen from 900 public health and medical experts expressing great concern about CDC/HICPACs update of the Guidelines for Isolation Precautions in Healthcare Settings- both about the closed non-transparent and the failure to address and protect against aerosol transmission of infectious aerosols. In our view the updated guidelines ignored experience and evidence gained during the COVID-19 pandemic and would weaken existing guidelines and protections for HCWs and patients.

On late Friday we received a response to our letter from CDC, informing us that HICPAC would not be voting on recommendations on updated Isolation precaution guidelines at today's meeting. We appreciate the delay in the vote.

But we were deeply dismayed that CDC's response did not address any of our substantive concerns about the weakness of the guidelines – the failure to protect against aerosol transmission - nor provide any indication that CDC, HICPAC or the workgroup intend to open-up the guidelines development process to involve key experts or stakeholders or make the process more transparent.

We once again urge CDC and HICPAC to change course and open-up the process on the IP guideline development.

The majority of HICPAC and workgroup members are Infectious diseases professionals from hospitals or large health care organizations who share the same views and perspective. It is not "balanced" as required by FACA and include representatives of health care workers or patients who have different interests and different views than hospital representatives. HICPAC members are not experts in aerosol transmission, ventilation, respiratory protection or industrial hygiene, the kind of individuals with the deep expertise and understanding on how infectious diseases are transmitted and effectively controlled.

For more than 3 years we have all been immersed in efforts to protect the public, patients, healthcare workers and other workers from COVID infection, death, and other health impacts.

We have failed miserably in those efforts. Over a hundred million have been infected, over a million people in the US have died, and millions are still suffering the debilitating effects of Long-COVID.

In healthcare settings, the CDC has refused to collect data on COVID infections and deaths among hospital staff and has collected only minimal data on hospital acquired infections among patients, but we know that hundreds of thousands of healthcare workers and patients have been infected and thousands have died due to infections acquired in nursing homes, hospitals and other healthcare settings.

And today, those infections and deaths continue to occur.

The latest CDC/CMS COVID nursing home data reports that since mid-June the number and rate of nursing home staff infected with COVID has tripled and the more than doubled among nursing home residents.[22]

During the same time period, COVID deaths among nursing residents have increased by 60%. In June, CDC stopped collecting data on nursing home staff deaths so it is no longer possible to track these deaths.

According to CDC data, in July COVID deaths among nursing home residents accounted for 18% of all COVID deaths in the US.[23,24] This means that nearly 20% of all COVID deaths in the country last month were due to health care acquired infection,

Clearly, hospitals, healthcare infection control professionals and CDC are still failing to protect healthcare workers and patients from infections and deaths in healthcare settings, despite the terrible toll that has already occurred and all we have learned about the transmission of infectious aerosols and how to control transmission and exposure.

---

[22]CDC National Healthcare Safety Network (NHSN), Nursing Home Covid-19 Data Dashboard. https://www.cdc.gov/nhsn/covid19/ltc-report-overview.html. Accessed August 19, 2023.
[23] CDC, https://www.cdc.gov/nhsn/covid19/ltc-report-overview.html. Accessed August 19, 2023.
[24] CDC, COVID Data Tracker, Data Table for Weekly Deaths - The United States. Data as on August 18, 2023. https://covid.cdc.gov/covid-data-tracker/#trends_weeklydeaths_select_00. Accessed August 19, 2023.

To protect healthcare workers and patients who are at high risk of exposure, infection and death CDC must develop strong infection control guidelines for healthcare settings that fully protect against aerosol transmission. CDC should open-up the Isolation Precaution Guideline development process to include experts in aerosol transmission and control and HCW and patient representatives and not allow the healthcare care industry to dominate the process and dictate the guidelines as is now being done through HICPAC and the workgroup.

Thank you.

---

Hi,

I am Sara Tavela, a member of the American public, and I am writing to share my comment regarding the CDC/HICPAC's plan to weaken guidance for health care respiratory protection and infection control.

As an immunocompromised person with a complex case of Long COVID developed from a single infection acquired in a health care setting, I am very concerned about the intentions to weaken protections for infection control. I care very deeply about protections for patients and health care workers in health care facilities; for me, and for patients like me, it's a matter of life, increased disability, and/or death.

Navigating health care as a high-risk patient is a minefield at best in a world where COVID is spreading unmitigated, and the lack of protections in health care settings (high-quality masking with NIOSH-approved respirators and updated, improved ventilation systems) makes it even more difficult to seek necessary medical care while weighing the benefits of that care against the risk of infection. If health care providers are to 'do no harm,' the current work of this committee seems to be seeking to do the exact opposite.

It should be the most basic requirement for health care professionals to keep their patients safe by using well-fitting N95 respirators, especially when patients are required to unmask during appointments and procedures. In addition to N95 respirators, which we know have been incredibly effective against the spread of Sars-CoV2, it should be a requirement that clean air be a priority in health care settings with the use of air-cleaning machines and HEPA filters. This is necessity to protect the millions of Americans who need medical care on a regular basis. The lives of the vulnerable, and the lives of all, are worth protecting, and reducing the likelihood of infection and potential disability is paramount.

If I, a member of the public and layperson, can understand the implications of aerosol transmission of respiratory illnesses and the value of quality protections in health care settings, surely this committee and the CDC can as well and will, therefore, implement science-backed protocols for the protection of patients and health care workers.

Sincerely,

Sara Tavela, PhD

---

Hi, HICPAC.

My name is Mel Chua, and I recently earned my PhD in engineering. One of my research foci is open science; I have seen how powerful transparency and community and outside expert involvement can be.

Consequently, I'm concerned that HICPAC isn't following best practices for developing updated isolation precautions, and that the resulting precautions will be lax and harmful to many, including those like me who are immunocompromised patients.

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.

You have seen for yourselves these past few days how much the broader public is interested in CDC's guidance to protect health care personnel, patients, and the public from infectious diseases.

Please, please slow down and openup the process to effectively engage these experts in developing drafts.

Best,
Mel Chua, PhD

---

Hello,

I am writing to express my opinion that universal mask mandates should be reinstated in healthcare facilities. Despite the government declaring the COVID-19 public health emergency over, people are still being infected and hospitalized by this disease daily. Healthcare facilities are a place where many people cannot avoid going to, including disabled and immunocompromised who are disproportionately impacted by this pandemic. We know from the last three years that healthcare settings very easily spread this virus (and other illnesses), and with case numbers rising now it is critical that we reinstate mask mandates for all in these facilities to prevent an even worse outbreak. If we refuse to take this simple step to prevent infections, then cases will undoubtedly rise even more dramatically. This puts everyone who has to go to the doctor or hospital at risk, particularly disabled people who often do not have a choice but to enter these situations to access the care they need. Healthcare is already not accessible in this country and removing mask mandates only worsens this problem. I am urging you to please consider the millions of Americans at risk and reinstate mask mandates in all healthcare facilities.

Sincerely,
Lukas Cain

---

Good afternoon,
I'm writing to express my support for masking in Healthcare settings. This will help protect people from getting sick with COVID and lots of other things we get sick from.

Thank you
Lisa

---

I write to request the CDC:

· Recommends increasing indoor air quality inside health care facilities
· Acknowledges that N95 respirators are more effective than surgical masks for preventing transmission of airborne diseases

As a disabled person, it is incredibly demoralizing and dangerous for me to regularly visit healthcare facilities and be virtually the only one masking. Those few healthcare workers that do mask invariably use the less effective surgical masks. I have had to delay or cancel regular healthcare check-ups because I cannot be sure of the air quality in health care facilities.

The CDC's guidance here is crucial for providing better protection against airborne diseases to both healthcare workers and patients. Given the long-term negative effects of COVID-19 in particular, working to prevent transmission of the disease is absolutely vital.

I beg you: please work to strengthen--not weaken--infection safety precautions.

Thank you,

Erin M. Pryor Ackerman, PhD
Walla Walla, WA
No organization affiliation

---

Name: Cyle Ferguson
Orlando, FL
Organizational Affiliation: none

We've known the science for years. COVID-19 is airborne, and the pandemic is not over. Not only do we need better filtration to clean air in healthcare facilities (and public indoor buildings in general), but we also need to continue wearing N95 (or better) respirators at a minimum to keep everyone safe!

People should not have to risk infection to get healthcare. We know one-way masking is insufficient. Failing to require proper respirators in healthcare is a spectacular failure of "do no harm". Weakening existing guidelines is dangerous for everyone because we're all at risk of serious health complications from COVID-19, but it's an especially callous act of violence toward the immunocompromised.

It is imperative that we keep respirators in healthcare to save lives and keep everyone safe.

---

My name is Kathleen Turturice, I am a volunteer with the World Health Network and I am speaking on behalf of myself, and as a patient and a patient and healthcare worker advocate.

It is critical that HICPAC adopt guidance that fully acknowledges airborne transmission and its prevention including masking with N 95 respirators or better. There is no justification for adopting non-airborne precautions for airborne pathogens.

I am a type one diabetic and am unable to safely seek healthcare without universal appropriate masking with N95 respirators or better in all, healthcare facilities. Without this guidance under

the current situation, I am forced to implore my healthcare providers to wear a mask to keep me safe from being infected with COVID-19. I risk contracting Covid every time I see my healthcare providers.

The disabled community was early to realize that Covid was dangerous. Research and lived experience have shown that no one is safe from Covid, the young, old, disabled, abled; we are all at risk from Covid related, disability and death. Not having universal masking guidance during an active airborne pandemic of a level three biohazard endangers, all medical workers, their staff, their patients and all of their families and the entire community. Clearly, there has been enormous public interest in this issue from both the patient and the healthcare communities.

Offering appropriate guidance for appropriate protection from airborne virus and pathogens will have a real world impact. It will save lives and prevent disabilities. I implore you to take action to protect us. Please do your job. Please follow the science, keep us safe.

Thank you,
Kathleen Turturice

---

Since March of 2020, I have been diagnosed with:

1) Post-viral illness/PASC

2) ME/CFS - a disabling and complex
illness now linked to COVID-19

2) Long COVID with neural inflammation and chronic central nervous system

I am an attorney and director of philanthropy having worked over 12 years in global health, and now an advocate for post-viral chronic illness treatment. I first contracted COVID in January of 2020, incurred post-viral symptoms three months later in March, have been reinfected several times since 2020 despite being boostered and fully vaccinated, and am now a long COVID sufferer. Every organ system in my body does not work well, I have nerve and inflammation pain that has never left but only gotten worse, and according to my post-COVID doctors, I am now disabled.

For this purpose, as I am living it, there must be the following:

1) Vigilant monitoring of wastewater to show community need and scale of positivity
2) Isolation with (well-known by now) COVID Respiratory symptoms for 5-10 days - do not require a positive PCR or RAT as a threshold for treatment
3) Consistent mask orders until positivity rate declines and stockpile N95 masks and distribute for free until the outbreak recedes
4) Make antivirals available for free
5) Treat with PAXLOVID 2-3 days after symptoms start and consider a longer course of treatment to prevent long COVID
6) Assume anyone who lives in the same household but does not show symptoms as asymptomatic and treat as infected
7) Have government play an active and supportive role by covering the costs of vaccines, masks, antivirals, and any post-COVID prescription drugs

8) Encourage pharmaceutical drug designers to innovate new treatments at cost that correspond with symptom control, alleviation of pain, and treatment of downstream chronic illness involving major organs, the vascular system and neural inflammation.
9) Have the CDC work directly with academic medical institutions, teaching hospitals, consulting hospitals, medical nonprofits and patient advocates to obtain the latest research and share information with the media to correctly inform the public
10) Work with institutions over the long term that treat the whole patient suffering from post-viral induced chronic illness.

Please reach out if you need further information.

Respectfully,
Cynthia Garbutt

---

I shouldn't have to be afraid to go to the hospital.
I shouldn't have to be afraid to be seen by a doctor or a nurse.
This shouldn't be extremely dangerous.
I'm writing to request that you require masking with well fitting N95 masks and upgrading air filtration I in the healthcare setting.
Doing so shows you care about patients and staff.
Hospitals are one of the most dangerous places you can go if you're trying to avoid infection. That's
where people who have the disease go. Hospital staff are at high risk of getting and spreading that
infection especially if they are not taking precautions.
Universal masking in the healthcare setting is the only option.
It not only shows the public that you care about health. It also models for them what proper precautions look like.
Masking and indoor air quality are critical. They are the only defense. Repeated infection degrades your
immune system and increases your chances of long Covid.
I've seen what Covid does to people. It destroys their quality of life. Loss of ability to think. Loss of
balance. Loss of ability to drive. Loss of taste and smell. Dementia, diabetes, stroke, shingles, fungal
infection. Loss of ability to fight off other infections.
We should all be terrified. You should be terrified. Not willing to protect people from the worst infectious disease of my lifetime. You should be ashamed.
The only hope we have is that responsible people take every action we have to mitigate the risk.

Masking and air filtration. We don't have anything else. Monoclonals don't work. Vaccines are continually less effective. We are drowning in a slowly rising sea of diseased population. Please do your
job. I shouldn't have to ask you this.
Sincerely,
Michael Shaw
Girard, KS
Retired

---

Devin Quinn

Bucyrus, KS
Student of Public Health and Medicine
Guideline changes
To the Members of the Healthcare Infection Control Practices Advisory Committee (HICPAC),
My name is Devin, and I am a master's student in public health and a prospective medical student with a passion for public health and infectious diseases. I am writing to you today because I am concerned about the reports of what this committee is considering regarding changes in Infection Prevention guidelines. I have spent the last 6 years working in healthcare, with over 3 of them throughout the ongoing COVID-19 pandemic. I have worked in the frontlines as a CNA in both emergency rooms and intensive care units where I have witnessed the horrors only the pandemic could produce. I spend much of my time educating myself and others on the nuances of the public health systems and infectious diseases generally.
Firsthand, I have witnessed very tragic instances of not just COVID-19, but tuberculosis, Candida, near complete drug-resistant pathogens, and more. In many of those instances, we had the necessary PPE to care for these patients and their families. However, as a result of the mistrust the public has of public health systems and the CDC generally, colleagues and I have been physically and emotionally threatened when trying to enforce isolation protocols, etc. to prevent the unnecessary spread of disease within and outside of the hospital and clinics.
During this time, I have seen the effects of individuals I work with falling ill to a slew of infections and, as a result of minimal accountability from our employer in enforcing isolation/quarantine protocols, are no longer able to work or have left healthcare altogether. I am writing to you to state that any changes to infection prevention guidelines, other than the complete revamping and bolstering of protection for patients, the community, and healthcare workers, is an ethical and moral failing of the highest degree. We are at a point in the history of our nation and healthcare system wherein the costs, corporate leadership, mistrust, deleterious outcomes, and so forth have us hanging on the edge. Removing barriers to disease, letting them spread more easily, and abandoning an entire workforce sends a message to the People that the CDC, and America’s public health system, do not care about preventing disease.
You all have the chance to do the right thing by passing guidelines that not only protect healthcare workers, patients, and communities - but actively hold hospital systems, clinics, governmental agencies, and more accountable for failing to do so. I am not alone in this; I seek to change the systems to address and overcome inequities and injustices of the past. Reducing guidelines for preventing the spread of infection would do nothing more than empower the already crippling systems at play.
Primum non nocere, First do no harm,
Devin

---

I am a member of the World Health Network and am gravely concerned about the inattention currently given to infection control for airborne diseases, in particular for COVID. I’m especially concerned about the proposed policy which seeks to weaken patient and provider protections in healthcare by advocating surgical masks for airborne diseases that actually require N95 respirators, as well as ignoring other science-based precautions. It is a blatant disregard in the face of established science and data currently available about COVID in particular, but also against all airborne diseases. I lament the backward slide of public health that this displays. The only thing it could possibly mean, as the science points clearly in the completely opposite direction, is that health corporations want to save money by cutting costs from infection control. This is abhorrent.

Guidelines should actually include the following:

- 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 on safety, any more than laxity in providing any medical care is tolerated.
- 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.

People who go to medical institutions are obviously in a vulnerable condition. This should not have to be pointed out and it is absurd that we are having to state this basic fact. Vulnerable people in these institutions have the right to not be infected with dangerous pathogens simply because the corporations who run these institutions have decided that this is yet another place to squeeze out some profits to their already overly bloated profit margins. It is sickening to watch this happen, and I don't know how you all sleep at night.

Really and truly, you should be ashamed of yourselves for even proposing this completely misguided policy, and I sincerely hope that you change it to require proper prevention of airborne transmission.

Thank you,
Gayle Madeira

---

Dear HICPAC / CDC / Senator Tim Kaine,

I am emailing to provide you with my public comment as it pertains to safety standards in healthcare. I was infected with SARS COV 2 at work in March 2020. I now suffer from LONG COVID. I was a healthy 37 year old with no pre existing conditions. Now my blood work looks like an AIDS patient. I have constant ear infections and pinkeye. I have organ damage which requires that I take heart medicine and thyroid medicine. My doctors are at a loss at how to help me. They believe this condition is being caused by either viral persistence or a prolonged injury to my immune system or a combination of both. I've even been to Johns Hopkins and they have no answers either.

As you know, SARS COV 2 is still a threat to the public. The vaccines do a poor job at preventing infection and LONG COVID as the virus mutates quicker than big pharma can keep up with. Folks are still getting sick. Children are still getting LONG COVID. We need mitigation. I demand a return of respirators in public health. I don't want to see children with cancer get infected with SARS COV 2 in the hospital. I don't want to see nurses continue to get sick and burned out from having to cover other's shifts. This impacts my care. Failure to implement masks in healthcare is likely a violation of the ADA. I'm immune compromised and another SARS COV 2 infection would bury me.

I've asked my entire family to hold back donations to the Democratic Party until SARS COV 2 is taken seriously by our government and law makers. Folks suffering with LONG COVID need a moonshot. We need warp speed funding and expedited research and the development of therapeutics immediately. Mitigation should not be reduced until we have better vaccines and better therapeutics. This pandemic is not over and the next wave one is right around the corner. Respirators should honestly be permanent in healthcare.
And now you know the rest of the story.

James Roussos
Suffolk, V

---

My name is Renee Levant. My address is Amherst M, United States I am a masters level mental health counselor with a focus on the relationship of physical and mental health, i am writing to express my deep professional concern regarding the current reduced health control measures and the proposal to further reduce these measures in healthcare settings. These have had a significant adverse impact on both the physical and mental well-being of my clients, as well as on myself and my colleagues. As a Licensed Mental Health Counselor with a doctorate in Philosophy, specializing in ethics, I believe it is my responsibility to advocate for policies that prioritize the health and safety of both patients and healthcare workers at present we are collectively failing to meet the professional ethical obligations of our health related professions.
In my capacity as a psychotherapist, I have witnessed firsthand the distressing consequences of these measures on individuals seeking medical attention. Just last week, I encountered several clients who opted to avoid essential medical care due to fears of inadequate COVID-19 protections in healthcare facilities. These instances include patients with underlying health conditions who felt unsafe visiting hospitals and medical offices, a young woman apprehensive about seeking care for potentially severe symptoms, and even vaccinated individuals who fell ill with the virus.
It is evident that these concerns are not mere emotional reactions; they are supported by scientific evidence. Immunity has shown signs of waning, and emerging variants further complicate the situation. Studies have underscored the potential for long-term disability resulting from mild COVID-19 cases. In such a critical environment, I urge the committee to consider adopting scientifically proven and straightforward measures such as universal masking with N95 respirators, KF94 masks, and ensuring robust air filtration systems based on established research. We all know COVID-19 is airborne- standards cannot be based on outdated droplet theory.
Guidelines for health control measures should not compromise on safety, just as we do not compromise on the quality of medical care. The precautionary principle should be the guiding force, emphasizing the need to prioritize risk reduction when making policy decisions that impact society at large. It is crucial to incorporate insights from multidisciplinary experts who study airborne transmission and to involve at-risk individuals, including patients and healthcare workers, in the development of these guidelines.
Additionally, I implore the committee to fully embrace the established science of airborne transmission prevention, which includes the use of effective masks and comprehensive ventilation and HEPA air purification systems. As healthcare workers, we must set higher standards to protect both ourselves and our patients. By incorporating these measures, we can collectively work towards reversing the current policies and educating the public on the ongoing realities of the pandemic.
In conclusion, I appreciate your dedication to public health and your consideration of these urgent matters- but they are urgent. Suggesting otherwise is counter to the scientific evidence

and results in gaslighting many who are aware and attempt to take the few individual measures available to them—even knowing the impact of these measures is far more limited than public health measures taken by the community to protect us all.
Thank you for your time and attention to this critical issue.
Sincerely, Dr Rene Levant

---

Dear CDC & co:

I am a concerned citizen who is writing in response to continuous poor decisions and dangerous misinformation the CDC is making that puts vulnerable lives in danger. It is time to be honest with the public about the real and present danger of covid as it mutates and threatens to create more disabilities that will create a public health crisis. Just because masking has been lifted, does not mean it cannot be reimplemented. We must stand on the right side of history and create a just and fair culture that does not throw away our most vulnerable people in the face of another wave of a deadly virus. Please, reimplement masking. Invest in new vaccines and research. For many of us, you are signing off on our disposal.

Sincerely,
June Otten

---

I am a Health Sciences student with a focus in Public Health. I'm affiliated with the World Health Network but my comment is my own. I'm a medically vulnerable patient and I've experienced healthcare-acquired infections myself, so I'll mainly testify from that perspective. However, I'd like to emphasize that this issue affects everyone—nobody should contract infections in medical settings, regardless of health status or whether they're a patient or a worker. All people deserve safe healthcare. We also deserve to have our voices heard in decisions that affect us—public health policy must involve input from the *public*.
Accessing necessary care for my chronic illnesses has grown unacceptably dangerous throughout the ongoing SARS-CoV-2 pandemic due to the lack of airborne transmission mitigation in healthcare settings. I've repeatedly been exposed to sick staff and patients who were wearing inadequate source control or were totally unmasked, on the grounds that "N95s are not required," and some facilities do not even have N95s available on-site since they're not standard PPE. The failure of public health agencies to emphasize the distinction between medical masks and respirators and their appropriate applications, especially that non-respirator masks are ineffective for aerosols such as SARS-CoV-2, has caused dangerous misinformation to be disseminated among healthcare workers that threatens both their safety and the safety of their patients. This false equivalency has resulted in them removing and replacing my respirator with a loose medical mask without consent, pathologizing me for trying to protect myself, and denying me ADA accommodations, among other adverse incidents. As a result, medical personnel infected me with a severe iatrogenic viral bronchitis that left me further disabled. This is not the fault of individual staff, it is a systemic failure of leadership—they often cite CDC guidance to justify their lack of regard for PPE. In the last year I have had to upgrade to an elastomeric to compensate for the rollback of universal masking policies in healthcare settings. Requesting personnel to wear N95s is often met with refusal, has negative consequences on the provider-patient relationship, and is negated by other unmasked people present in the shared air space. Consequently, I have had to ration crucial medical appointments due to the unreasonably high probability of catching COVID from my care team or from fellow patients. Right now, my mother and I are having to wear respirators inside our own home to quarantine from each other since she took my grandmother to the hospital where there were no precautions in place.

In the same way that patients should not be responsible for independently requesting contact precautions for touch-based pathogens, we should not have to beg healthcare staff to wear respirators so they don't infect us with airborne pathogens. It is unethical to place the onus of ensuring safety measures on patients, many of whom are unable to self-advocate. We should not have to fend for ourselves because of substandard guidelines that are not grounded in science! It is unacceptable to subject people to forced biohazard exposure through negligent standards of care and occupational safety. If HICPAC chooses not to instate universal N95 usage as the baseline, along with layered precautions (such as ventilation and filtration, isolated/cohort rooming, sick leave for workers, routine testing, etc.) as others have described, it will only further impede medically vulnerable peoples' access to the care we depend on to live and will directly result in disabilities and deaths from preventable healthcare-acquired infections. You have the power to reduce the rates of morbidity and mortality from airborne infectious diseases if you so choose. Countless lives depend on you.
— A. Jurman

---

I am writing to express my opinion about masking in healthcare facilities. As someone with blood cancer who receives chemotherapy, I am immunocompromised. Because of this health status and because healthcare facilities have dropped masking requirements, every time I need to visit a healthcare facility, I need to think long and hard if that visit is important enough for me to put myself at risk of covid. I actually skipped going to the Mass Eye & Ear ER a few weeks ago when I had blurred vision and pain in an eye because they told me they had 40 other people waiting for care and the wait would be 7 hours. Knowing that their waiting room is quite small, there was no way I was going to risk getting covid from the many people packed into that waiting room and then the unmasked healthcare professionals. I took the chance the blurred vision came from something I've experienced before and that it would be self limiting. But that is not a gamble I would ever want to take, except if I might catch a virus that could kill me or make me seriously ill for an extended period. When I go for health care, I should have the right for SAFE health care and not run the risk of catching covid from the healthcare providers and other patients. Considering that many people have asymptomatic cases of covid, screening patients for symptoms and asking staff to stay home when not feeling well is nowhere near enough to protect vulnerable patients. We could easily catch covid from people with asymptomatic cases. Additionally, it is known science that two-way masking is much more effective over time than one-way masking. Plus, N95's are much more effective at preventing the release of exhaled aerosolized virus than surgical masks. So please, reinstate the requirement for mandatory masking in healthcare facilities to help the millions of vulnerable people in the USA obtain healthcare more safely
Thank you,
Judy Teitelman
Boston, MA

---

I am writing to express my opinion about masking in healthcare facilities. As someone receiving regular B-cell depleting infusions for a rare, incurable form of vasculitis, I am immunocompromised. Due to my health status and because healthcare facilities have dropped masking requirements, every visit to a healthcare facility is fraught with anxiety because of the ever-present risk of Covid or other airborne pathogens.

Even the infusion center where I sit for six hours receiving the very drug that is simultaneously saving my life and making me immunocompromised, does not require healthcare providers or other patients to mask. Imagine my horror and disbelief at walking into my infusion center in late May — a facility serving immunocompromised patients, cancer patients, and others at high risk

of serious illness or even death from Covid, the flu, RSV, or a myriad of other pathogens — and seeing unmasked patients and providers and hearing sneezing and coughing!

My husband and I have self-quarantined since my diagnosis on February 28, 2020 — right before the first lockdown. When I venture outside my home to go to a healthcare facility, I have the right to be SAFE and not run the risk of catching Covid from healthcare providers and other patients. Considering that many people have asymptomatic cases of Covid, screening patients for symptoms and asking staff to stay home when not feeling well is insufficient to protect vulnerable patients. We could easily catch Covid from people with asymptomatic cases.

It has been scientifically proven that two-way masking is much more effective over time than one-way masking. Additionally, N95's are significantly more effective at preventing the release of exhaled aerosolized virus than surgical masks. Please reinstate the requirement for mandatory masking in healthcare facilities to help the millions of vulnerable people in the USA obtain healthcare more safely.

Julie Garza
Coppell, Texas

---

My name is Renee Levant. My address is Amherst MA, United States I am a masters level mental health counselor with a focus on the relationship of physical and mental health,I have a PhD in philosophy focused on issues of ethics and social justice. Additionally I am a member of the World Health Network
i am writing to express my deep professional concern regarding the current reduced health control measures and the proposal to further reduce these measures in healthcare settings. These have had a significant adverse impact on both the physical and mental well-being of my clients, as well as on myself and my colleagues. As a Licensed Mental Health Counselor with a doctorate in Philosophy, specializing in ethics, I believe it is my responsibility to advocate for policies that prioritize the health and safety of both patients and healthcare workers at present we are collectively failing to meet the professional ethical obligations of our health related professions.
In my capacity as a psychotherapist, I have witnessed firsthand the distressing consequences of these measures on individuals seeking medical attention. Just last week, I encountered several clients who opted to avoid essential medical care due to fears of inadequate COVID-19 protections in healthcare facilities. These instances include patients with underlying health conditions who felt unsafe visiting hospitals and medical offices, a young woman apprehensive about seeking care for potentially severe symptoms, and even vaccinated individuals who fell ill with the virus.
It is evident that these concerns are not mere emotional reactions; they are supported by scientific evidence. Immunity has shown signs of waning, and emerging variants further complicate the situation. Studies have underscored the potential for long-term disability resulting from mild COVID-19 cases. In such a critical environment, I urge the committee to consider adopting scientifically proven and straightforward measures such as universal masking with N95 respirators, KF94 masks, and ensuring robust air filtration systems based on established research. We all know COVID-19 is airborne- standards cannot be based on outdated droplet theory.
Guidelines for health control measures should not compromise on safety, just as we do not compromise on the quality of medical care. The precautionary principle should be the guiding force, emphasizing the need to prioritize risk reduction when making policy decisions that impact society at large. It is crucial to incorporate insights from multidisciplinary experts who

study airborne transmission and to involve at-risk individuals, including patients and healthcare workers, in the development of these guidelines.
Additionally, I implore the committee to fully embrace the established science of airborne transmission prevention, which includes the use of effective masks and comprehensive ventilation and HEPA air purification systems. As healthcare workers, we must set higher standards to protect both ourselves and our patients. By incorporating these measures, we can collectively work towards reversing the current policies and educating the public on the ongoing realities of the pandemic.
In conclusion, I appreciate your dedication to public health and your consideration of these urgent matters- but they are urgent. Suggesting otherwise is counter to the scientific evidence and results in gaslighting many who are aware and attempt to take the few individual measures available to them—even knowing the impact of these measures is far more limited than public health measures taken by the community to protect us all.
Thank you for your time and attention to this critical issue.
Sincerely,  Dr Rene Levant

---

Everyone in my family is disabled, has a compromised immune system, and is at increased risk of long term harms from COVID-19. Please issue Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration). Please supply healthcare facilities with accurate covid levels so they can respond effectively. Please require the use of N95 masks in healthcare settings as this has led to substandard care for myself and my family, awkward conversations, and a loss of faith in large governmental institutions that are designed to protect us.

Signed
Keith Sadler, Blue Springs, Missouri

---

Stephen Kwok
El Segundo, CA

My name is Stephen Kwok, from California. I have no organizational affiliation.

I am writing to support universal masking in health care settings, ideally with well-fitting N95 or higher quality respirators, in addition to existing infection control precautions.

The COVID-19 pandemic has underscored the importance of adequate infection control measures in healthcare. I urge the CDC’s HICPAC committee to incorporate the latest science on aerosol transmission of infectious pathogens into its recommendations. High quality (N95 or better) respirators are needed for providing adequate protection against inhaling infectious aerosols; surgical masks are not sufficient for this purpose.

Furthermore, the list of infectious diseases that are currently classified as being transmitted via the airborne or droplet routes should be updated to those that can be transmitted via aerosol inhalation.

Infection control measures are necessary in health care settings to protect both patients and health care workers from disease. Safe access to health care is a human right and uncontrolled transmission of disease in heath care threatens that right. Universal masking with N95 or better respirators is needed to adequately prevent disease transmission and safeguard that right.
Thank you.

Sincerely,
Stephen Kwok, PhD, MS

---

Hi,

My name is Michael Askren, and I am part of Action for Care Equity, an advocacy group that is currently fighting this exact battle for masking requirements in Los Angeles. I submitted my thoughts to the LA County Board of Supervisors, and with any luck, they will listen. But my reason for fighting so hard on this issue is simple: I have long COVID. I acquired it in 2020 and my condition has only declined since then, resulting in my personal disability. I can't tell you how disappointing it is to put the burden of this fight on the disabled and patient advocates when the science is absolutely crystal clear regarding the risks of COVID, the enduring damage that it can cause, and the grim reality that there are no treatments for it in sight. The CDC and the HICPAC could be loud in the dangers of this virus and the necessary precautions required to prevent infection, including well-fitted N95 respirators, ventilation, and patient isolation, but instead they choose to damage their reputation as a public health organization and risk millions of lives. It is nothing less than close-minded bigotry to continue to weaken infection guidance when COVID goes unchecked and and untracked in today's world. If you are not loud on the proper course of scientifically backed actions required to prevent infection, if you provide discretion to the greedy hospitals that prioritize profits over care, then you will have become nothing more than a death dealer to America and the rest of the world—a feared specter of ruthless and systemic brutality that hangs over the entire medical industrial complex. I wish you would reflect on that.

Sincerely,
Michael Askren

---

Gillian Ladd, San Francisco, A
Simultaneous Pancreas & Kidney Transplant Recipient & Disability & Clean Air Advocate

To Whom it Should Concern,

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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. 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

Here the CDC says that "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 you enter, 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 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.

I'm one of the people so-called experts at the CDC called "good news" to still be dying during an unmitigated public health disaster. The CDC's COVID19 response is nothing short of eugenics. I'm descended from Ashkenazi Jews, and I have the BRCA1 gene mutation to prove it; 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 on 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. CDC policy has locked the most vulnerable patients out of accessing 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 my government do everything you can to erase us from history?

Sincerely,
Gillian Ladd

---

I write to express my concerns and recommendations regarding the current and prospective infection control guidelines. But before delving into my specific points, I want to share my personal experience that I believe underscores the urgency of this matter.

Despite healthcare settings traditionally being places of safety and healing, the threat of COVID-19 has made me, and many others I know, deeply apprehensive. I have found myself skipping multiple essential medical appointments out of fear of contracting the virus. This feels like a lose-lose situation for me. If I skip appointments due to health risks of contracting Covid at the

doctor, I may not get Covid, but the act of skipping the appointments puts my health at risk in itself!

I am terrified every time one of my elderly parents (who both have health conditions) tells me they are going to the doctor, because they cannot afford to get Covid.

I urge the CDC to consider the following points:

1. **Commitment to Safety**: It is paramount that the guidelines recognize the vital importance of adopting effective prevention measures. Both patients' and healthcare workers' health depend on these measures. We cannot compromise on safety in this regard, just as we would never tolerate negligence in any other facet of medical care.

2. **The Precautionary Principle**: It is essential that our guidelines are rooted in the precautionary principle, highlighting the responsibility of policy makers to prioritize risk reduction. Given the broad and profound impacts of policy decisions on society, our approach should lean heavily towards minimizing potential risks for the larger community.

3. **Cross-Disciplinary Input**: The development of infection control guidelines ought to incorporate the expertise of professionals from diverse fields, especially those studying airborne transmission. Their insights are invaluable to ensuring our guidelines are both comprehensive and current.

4. **Stakeholder Involvement**: It's essential to involve those who are most vulnerable. Patients and healthcare workers, along with their representative organizations, should play a pivotal role in shaping the guidelines, ensuring the concerns of those at the frontline are adequately addressed.

5. **Adherence to Established Science**: Our guidelines should be rooted firmly in the well-established science of airborne transmission and its prevention. This includes the mandatory use of effective protective equipment like N95 respirators, elastomeric respirators, and PAPRs. Adopting non-airborne precautions for pathogens that are airborne is neither logical nor safe.

6. **Comprehensive Preventative Measures**: The guidelines should be holistic, encapsulating a range of measures such as enhanced ventilation, the implementation of HEPA air purification systems, proper masking protocols, regular testing, and efforts to minimize the sharing of air between potentially infected individuals and those susceptible.

In adopting these suggestions, I am confident that the CDC will be well-positioned to ensure the utmost safety of both our healthcare professionals and the general public.

Thank you for your time and consideration.
Sincerely,
Cassie Collins

---

To Whom it May Concern,
My name is Angela and I'm an Engineer 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. Working while sick is not moral, even if it isn't COVID. Many people not getting positive tests until days into a COVID infection as well. I have had to go without medication multiple times because all the pharmacists were wiped out by sick people coming in maskless. I am forced to only go to drive thru pharmacies as well to reduce my risk.
3. **VAX Accessibility:** Make Novavax available to everyone. Many longhaulers had horrific reactions to the other vaccines and now are advised to not get any. Do not assume a vaccine only solution we have now is all that is needed, as many of us still got infected right after getting vax. We need masking (aka n95 respirator) at vaccine sites as well. By having no masking, people have not been able to get vaxxes that wanted them as well that were high risk.
4. **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. I should be able to notify everyone I was around as well with my phone anonymously, it makes no sense we deactivated these systems.
5. **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.
6. **Adopting Further Mitigation Tech:** Far UVC lights adopted to zap the covid out of the air to minimize exposure, even with above.
7. **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 have had several infections from healthcare. I had covid Feb 3rd, 2020 that I caught from my coworker that came back from Asia sick. I saw him Jan, 28, 2020. I confirmed my infection through research, plus it gave me long covid. It sent me to the dr multiple times throughout the years. 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 caught covid again in December 2020, when long covid sent me to the ER. Staff had masks hanging off their faces and with long covid, symptoms fell under the likely had covid (eventhough I told them I had not left house for months). I was sent to where they sent the covid patients. No surprise, I caught covid. I was already not eating and my young child that was 8 at the time had stopped walking after covid, plus had stopped eating as well since we got horrific tremors everytime we did.
Staff should have been in n95 with them over their noses and should not have put me in the covid area without active covid.

I caught covid again, taking care of my mother after she had surgery. I hadn't left house, so there was only one path of transmission from my mother. I was up to date on my vax and we were told everything was fine with a vax. Nope, I got liver damage (hepatitis) from this infection and reactivated mono. It was a so called "mild" covid case and I went asymptomatic around day 5 only for symptoms to again come back after. I suffered for months and my long covid kicked up.

This past January, I had to go to the urgent care. I had been avoiding the dr, but I had to go in this case. Sure enough, sick staff was allowed to work. Why is sick staff allowed to work? CDC's own data shows 10 days of isolation to make sure virus gone, not 5 days that they lowered it to. This is ridiculous. Staff was wearing a surgical mask while sick. Surgical masks DO NOT contain aerosols and an (k)n95 is needed. Sick staff whether asymptomatic or not should not be allowed to work. I saw the staff was sick and kept my distance as they were at front desk. My kn95 did not protect me and 2 days later I had covid for the 5th time. This time it hit 3 of my organs. I was barely symptomatic and had a so called "mild" case that went asymptomatic and would flip back to symptomatic. At 7 weeks, I was still positive and rebounded when symptoms came back, even though I never had Paxlovid. I had tested negative several times before and seemed fine for a few weeks. This infection also gave me full blown reactivated mono, yet again for the 2nd time in a year. I got hepatitis from covid again. This mono infection was even worse and I could not stand up to make dinner or do anything around house. I still can't lift anything more than 10 lbs. 7 months later, my spleen is still inflamed because staff was allowed to work while sick and all staff was not wearing proper PPE. The dr had on an n95 at least, but kept pulling it off and was obviously not educated that aerosols spread the moment you do that.

Letting people walk in without masks, then handing them one, contaminates the air as well, which I have seen happen on several occasions. In the case of my 5th infection I had mitigated my risk as much as I could being the first appt of the morning, wearing my PPE, keeping distance from the sick staff (well beyond 6 ft, more like 20+) and I still caught covid. I now can't access the doctor's office at all because mask mandates have been lifted in my state. To be honest, my life sucks and I see no future where my kids will ever be able to go to school again and I can get medical care. The worst part is not being able to see anyone for holidays, birthdays, etc. This isn't living, but nobody cares if they kill me or disable me with a BSL-3. It isn't sustainable for me to keep getting infected. What is the long term plan, as each infection causing vascular damage you can't feel that touches every organ in your body?

Please consider these improvements and our experiences we can't continue to have. Sustained damage to the vascular system is already showing up as heart attack and strokes in young people per John Hopkins. It isn't about being "high risk". Anyone that assumes they aren't are one infection away from long covid which is happening at a very high rate, regardless if you were fine before. The 3rd infection turned my asymptomatic husband into a longhauler. Everyone should have a right to access healthcare, get safe access to vaccines, schools, etc as well. We can't live like this and by ignoring a problem, it doesn't make it go away. We have a chance now to reflect on what we have learned and apply it. By not doing so, we are needlessly disabling and killing people. When making decisions, they need to be based on actual data, not just because you feel it is safe because someone said so and it is ok to continue killing/disabling people because it didn't happen to you. How many infections can all humans survive? How are you so sure you aren't going to end up with long covid as well?

Sincerely,
Angela Bartholomaus

Issaquah, WA
World Health Network Member and Engineer

Dear CDC Healthcare Infection Control Practices Advisory Committee,

I am writing in response to your request for public comment on infection control guidance for healthcare facilities. I am writing in my personal capacity, but I also have formal expertise in this area because professionally I am an academic economist with significant research and writing on Covid-19 mitigation policy.*

These remarks closely track and update those I sent in pursuant to the request for "feedback and questions" around the end of the Public Health Emergency (PHE) declaration:

In my opinion, US Covid policy is already failing our nation, and the end of the PHE has further limited the government's ability to confront the virus.

1) Since the end of the PHE, healthcare facilities have heavily reduced source control and other mitigation measures. This substantially increases the risk of Covid-19 transmission in healthcare settings – as we have already seen empirically, for example in parts of the Kaiser system.

Increased Covid-19 transmission poses a risk for all patients, and may cause some to avoid or delay care. This concern is especially great for those who are most medically vulnerable, such as the immunocompromised – who in effect face an impossible choice between risking Covid exposure and potentially significant complications, or forgoing essential medical care.

At absolute minimum, the CDC should issue Indoor Air Quality targets for all healthcare facilities. Ideally, on top of that, the CDC would also mandate continued source control in healthcare facilities.

2) The CDC's Community Transmission maps (and Covid data collection, more broadly) have been used to set policy. They have also been a critical resource to individuals – including me personally – in our attempts to track the virus and understand local incidence and infection risk. I am thus highly concerned about reductions in Covid data collection and availability.

Absent the ability to maintain transmission metrics, the CDC should adopt a "worst-case" reporting posture, that uses whatever data is available to extrapolate worst-case transmission estimates. And policy for settings such as healthcare facilities should be based on those worst-case estimates, rather than the increasingly spotty "Community Levels" estimates.

These are just a few brief notes, but I would be happy to discuss further. Please feel free to reach out for clarification or elaboration, or if there is other commentary it would be useful for me to provide.

Sincerely,
Scott Duke Kominers

Harvard University
Arthur Rock Center for Entrepreneurship, Room 219
Soldiers Field
Boston, MA 02163

*See, for example, Kominers and Tabarrok (2022), "Vaccines and the COVID-19 Pandemic: Lessons from Failure and Success," *Oxford Review of Economic Policy*; and Choo and Kominers (2023), "We Need an Operation Warp Speed for Long COVID," *Scientific American*.

---

Hello, my name is Amy Jackson and I am an occupational therapist with Nemours Health System. I am advocating for improvements in prevention and precautions to decrease the risk of another airborne pandemic or outbreak for our patients and health care workers. Here is what I am asking for:

- 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 on safety, any more than laxity in providing any medical care is tolerated.
- 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.

It is deplorable that many are unable to access safe healthcare and are being ignored by those responsible for setting infection control policies.

Thank you for your time,
Amy Jackson
Morton, PA

---

Hello,

I writing to express disappointment regarding the CDC's proposal to decrease regulations surrounding the use of PPE and other preventative measures surrounding control of infectious diseases. I vehemently disagree with the proposal and I hope that the CDC will continue to require high level disease prevention measures in healthcare settings.

I am a current graduate student at Portland State University studying communication sciences and disorders. In preparation for my program, we received training with up-to-date information regarding clinical protocol. One of our 30 minute trainings focused exclusively on the use of surgical masks and respirators, the differences between them, and how to properly use each. The training emphasized over and over that surgical masks exclusively protect against droplet based disease transmission, not respiratory transmission, while respirators do not protect

against splashes. The fact that the CDC is even considering equating these two PPE measures is ridiculous and not evidence based. Further, the proposal to make preventative measures (like masking and other PPE) in medical settings optional goes against all measures regulating disease control. I can only imagine that this is a cost-cutting measure advocated for by business interests, not public health officials. A federal body such as the CDC should focus on protecting civilians, not capitulate to big businesses pressuring the organization to change guidelines. Especially in the wake of the Covid-19 pandemic, this proposed policy change is short-sighted and absurd.

Finally, the CDC is a federal agency and as such should conduct all of its meetings transparently and publicly. It is not only ethical to continue to conduct meetings with utmost transparency, it is essential to rebuilding trust with the public post-pandemic. The CDC should make policy based on the highest-level science, diverse opinions from qualified professionals, and concerns of civilians historically marginalized in medical care.

I hope the CDC will take these points into consideration while making these important policy decisions.

Sincerely,
Maia Watkins

---

Dear CDC,

1) Please issue Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration)

2) Please require the use of source control (like masks) in healthcare facilities

3) Please do not equate surgical masks with n95s, for an airborne illness like Covid they are very different.

As a disabled immunocompromised person, I have no choice but to go to medical facilities. Please don't make this even less safe than it already is.

Thanks,
Effie Seiberg
Berkeley, CA

---

Dear HICPAC members,

I am an Emergency Room registered nurse in NYC, writing with concerns over your process for changing isolation precaution guidelines for health care workers. As someone exposed daily to patients with serious illnesses spread through aerosols, including tuberculosis, varicella, and COVID-19, I rely on my hospital's provision of N95 masks, isolation gowns, and other PPE to keep me safe at work.

The Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission ("air" and "touch") but is failing to recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens. Surgical masks do not provide respiratory protection against inhalation of infectious aerosols. Your evidence review on

N95 respirator and surgical mask effectiveness was dangerously flawed and must be redone with input from scientific researchers and experts in respiratory protection, aersolon science, and occupational health.

Without the CDC requirements for N95 respirator use that we currently have for both "Airborne" and "Special Droplet" precautions, I cannot trust that the PPE I need, especially N95 masks, will be provided in sufficient quantities to protect me and my coworkers from contracting serious illnesses. When my coworkers get sick, we are unable to adequately staff our emergency room, which results in suboptimal care for patients and burnout among remaining staff. Removing the requirement for N95 respirators for aerosolized pathogens would have a devastating effect on our healthcare system. I urge HICPAC and the CDC to maintain an approach in the updated guidance that is clear and explicit about the precautions -- including N95 masks for aerosol exposure-- that are needed to protect both health care workers and our patients from infectious diseases.

Sincerely,

Rebecca Millberg, BSN RN
Emergency Room RN, NYC
SEIU 1199RN Member

---

Hi, my name is Maia. I'm writing to ask that HICPAC and the CDC please recognize the well-documented aerosol transmission of Covid and the science of reducing/preventing it with N95 respirators and HEPA filters.

Despite being vaccinated and homebound, I've gotten Covid twice from caregivers. It's hard to find educated doctors. My asthma is now a daily problem. I have trouble finishing sentences and thinking of words. My hands and feet look like a dead person's. I suddenly have spider veins on my face, chest, and hands, at the age of 42. I haven't gotten dental care, because my friend got Covid at the dentist. My left leg has been heavy and numb, but I'm afraid to get it checked out, because I don't know what getting Covid a third time will do to me. I've avoided all preventative care for 3 years.

I've been having trouble refilling my medications, because doctors require regular bloodwork. The bloodwork is only available if I go into a room full of unmasked, coughing people.

I just want to access healthcare without getting Covid a third time.

Thank you so much for your time,
(and good luck with your day, this must be so stressful),

Maia Keroff
Albuquerque, NM
(via NECSI and the World Health Network)

---

Please mandate the use of N95 respirators (or better) in health care facilities, as well as improving ventilation. It would be incorrect to assume that everyone is exposed so much elsewhere that exposure at health care facilities does not matter. Some people are making the wise choice to reduce exposure to COVID, and for them, health care is a significant source of

exposure. Health care providers have a duty to do no harm. Patients should not have to choose between accessing necessary healthcare and avoiding places where they risk contracting preventable airborne illnesses.

Claire Myers

---

Leo Smith
Topic: Increased Covid Precautions in Hospitals
Member of the Public
Pittsburgh, PA
To whom it may concern,

I am reaching out to urge you and the greater CDC to maintain and increase the COVID-19 precautions across our hospitals nationally. COVID is one of the leading causes of death in the U.S, as well as a quickly mutating and disabling airborne virus. Since 2020, we've learned that COVID infection and reinfection decreases immunity and overall function in necessary systems of the body.

As it doesn't provide a tight seal and prevention of spreading respiratory droplets, surgical masks are NOT adequate protection against COVID-19. N95 quality masks, in addition to air filtration systems (HEPA filters) have been scientifically proven to largely reduce transmission rates even if someone has been exposed.

My local hospital provider, UPMC, services 4.5 million patients across Western Pennsylvania. Lifting the COVID-19 precautions in hospitals is a gross injustice towards all marginalized and disabled people, thereby increasing their COVID exposure and risk of death. Disabled lives are not expendable. Similarly, lifting said precautions purposefully allows all groups to become disabled and reinfected by COVID. If you truly stand for public health and justice, then it is imperative for you to reconsider your policy and reinstate N95 mask and HEPA filter requirements in all hospitals across the nation.

In solidarity,
Leo Smith

---

I just can't wrap around my brain that almost 4 years into this pandemic I can't safely get healthcare in person. Why do I (and millions like me) have to keep begging for ADA accommodations which s exhausting.
Why have high risk USA citizens been left behind to struggle alone?
Drs took an OATH to do no harm but are not masking in healthcare settings therefore infecting patients.
My life matters to Ms.Byrd.
I'm chronically I'll but was doing fairly well until the pandemic hit. Now with you all declaring the pandemic over we are a dying breed.
I need tests, procedures and treatments or I won't be around much longer. How can this be happening in this country?
Masking needs to be reinstated to assist in the prevention of deadly infections.
I'm now begging you to do something. Follow the science, follow the epidemiology. I do and that's why it's very clear it's not safe for me to receive healthcare that I deserve.
Please please help us. We are trying not to give up on ourselves like the CDC gave up on us.
Thank you for reading and I sincerely hope you do the right thing.

Sincerely,
Janice M Cavanaugh
North Kingstown, RI
Organization: Self advocacy for American human right for safe healthcare

---

Hello,
I'd like to submit into the comments of the HICPAC meeting to bring back mandated masking in medical settings. We are a vulnerable family, my husband is being treated for Stage 2 colon cancer, we live with our immuno-compromised elderly mother, and we have a daughter who has asthma. Every time we enter a doctor's office whether it's for my husband's treatment at a cancer center, or at a routine pediatrician's visit, we risk our families' health and safety. It is uncomfortable and psychologically damaging to have to make special requests every time for basic human rights for safe medical care and have to confront resistance, judgment, and even abuse. Our children should not have to grow up in the world where only the able-bodied are treated equitably.

Sincerely,
Sherry Jackson
Elkton, MD

---

I am a high risk person with high risk family members. We cannot avoid medical care. It is now dangerous for us to go to the doctors, dentists, and hospitals. It also goes against science to not have high quality respirators in healthcare. It is imperative that the standard be KN95 or N95 for healthcare workers. The pandemic will only continue to get worse if the CDC keeps pretending it doesn't exist. To truly end this, measures must be taken!

Thank you
Kimmie Remis

---

Please require universal masking in health care settings. As an individual who is immunocompromised as a result of cancer therapy, I take every precaution that I can to remain healthy. Since March 2020, I have largely refrained from attending indoor events and activities including shopping, entertainment, and even visits with family, all in an effort to protect myself from Covid. The only activities that I CANNOT avoid are medical appointments. It is unconscionable that I have to be exposed to unmasked patients and medical personnel when I go to my appointments. When I went to my cardiologist several months ago, I had to ask every staff member, as well as the cardiologist himself, to mask. The cardiologist replied that he was fine with my masking but that when I am out and about in public, other people aren't going to mask. I reminded him that I have strictly avoided putting myself in such situations. Ultimately he did go out and came back in wearing a mask, though it was underneath his nose! I seriously reconsidered whether to return to his office the following week for the echocardiogram that he said I needed.

There are millions of people in the US who are immunocompromised like myself, as well as millions more who are simply older and/or concerned about contracting Covid. Many are also concerned about developing long Covid. It is imperative that we be able to visit our doctors, sit in crowded waiting rooms, and have necessary health screenings without the added worry of exposure to those who are not masked. One would think that public health agencies would value the life of every individual within the community and understand that the health of all is dependent upon responsible and unselfish action. As precautions have disappeared, numbers

of Covid cases have increased and will continue to do so. Please act responsibly and require universal masking in all health care settings.

Sincerely,
Robin Bleesz

---

I'm writing to urge the CDC to discontinue its consideration for lowering infection protocols for healthcare facilities and providers. We have seen over the course of the ongoing Covid 19 pandemic that increased air quality and ventilation and highly rated masks and respirators (ie N95 and above) have provided significant protection to healthcare providers and patients alike. Hospital acquired infections are more easily mitigated when these protocols are in place. Furthermore, people who are most vulnerable to airborne infections are protected by these protocols as they generally have more interaction with the healthcare system due to chronic illnesses or disabilities that are more easily managed when they are not fighting an unnecessary secondary infection caught in hospital. These measures have been proven categorically to improve health outcomes and it is quite ludicrous to think the organization charged with maintaining the public health of the nation would be considering eliminating protections shown to do just that. We know that hand washing and sterilization helps protect against staph and other primarily fomite infections, but I'm sure it's a bit inconvenient to implement all the time... But surely HICPAC wouldn't consider eliminating hand washing and sterilization protocols given that the science has borne out the benefits and necessity of both. Please think about the message this potential mitigation sends to patients. It discourages people from seeking prompt medical care for everything from heart attacks to appendicitis due to the increased risk of secondary infections. It tells already vulnerable patients that their safety and care is secondary. And it falsely assures the public that there is no longer any need to be cautious about Covid 19 infection and subsequent Long Covid. Dropping these measures of improved ventilation and high quality masking is the opposite of sound science and informed public health. Please amend these proposed changes to strengthen the use of high grade masks and investments in air filtering.

Thank you,
Julia Haberstroh
St Charles MO
No Organizational Affiliation
Chronically ill due to Covid

---

My name is Elizabeth Smith, I am a disabled student and worker, a child of a nurse, and I am urging HICPAC to require masks (particularly high quality masks like N95’s, KN95’s, and KF94’s) in healthcare settings because every life in a hospital deserves protection and saving. Mask requirements in healthcare settings amidst an ongoing airborne pandemic is the bare minimum. Not wearing masks and doing everything one can to prevent disabling or killing a patient is a violation of the Hippocratic Oath and Florence Nightingale Pledge. A healthcare worker is meant to protect and save, never endanger or infect.

My grandmother died in a Skilled Nursing Facility from a SARS-2 infection, a tragic death and crushing blow to my family that could have been prevented with high quality mask requirements. The facility was directly responsible for her death, as she was just about to be released prior to the infection. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses. N95’s and proper air filtration are of

utmost importance if we want to keep people alive, and prevent further disabling.

Additionally, we have lost a tragic amount of healthcare workers due to death and long covid from hospital acquired infections of SARS-2. My own mother has had to see about 5 different specialists after getting long covid. She was a nurse in Orange County when COVID broke out, and had virtually no defense. Long Covid has left her disabled and low in spirits. Requiring masks in healthcare settings will help our healthcare workers stay safer and help address the critical issue of staffing shortages which is reducing the overall baseline of care being provided in healthcare settings and is leading to a healthcare collapse.

COVID is dangerous, it lingers in the air like smoke and can stay for up to 6 hours. Deaths and Hospitalizations are both up approximately 20% and according to the CDC, and 1 in 5 previously healthy young adults weren't back to baseline health even 14-21 days after positive tests. Long COVID is the third leading neurological disorder in the US according to Dr. Koralnik at Northwestern Medicine, and on top of the 12 variants present in the US, the BA.2.86 strain going around has over 30 mutations difference from the XPV variants that are circulating, and the same difference in mutations as the strain that caused the Omicron spike according to COVID researcher Laurel Bristow. Urgent action is needed to keep patients safe.

Masks and proper air filtration make a difference. The evidence review on N95 respirator and surgical mask efficacy was flawed and must be replicated using 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 come to the inaccurate conclusion that there is no difference in the effectiveness of N95 respirators and surgical masks, completely omitting other applicable data and studies. The evidence review also failed to look at the extensive evidence on respirator effectiveness from laboratory studies and studies in non-healthcare workplaces. There is no recommendation on ventilation, and zero consideration of the importance of ventilation and air filtration for controlling worker exposure to infectious aerosols, or source control. This is unacceptable, and must be thoroughly revisited to stop the compromisation of people's health.

Thank you for your urgent actions on making masks and proper air filtration required in hospitals and other healthcare settings.

---

I am requesting that respirator use be mandated by healthcare providers and facilities. After 3.5 years of isolating, I was infected with COVID-19 in a medical facility by a provider wearing a surgical mask. I had no other exposures. It is devastating that I contracted this virus just because I sought necessary care. Healthcare should not make us sicker.

The CDC has said over and over that high risk people need extra precautions and now we cannot even go to the doctor or dentist without being exposed to this incredibly harmful virus. Everyone, regardless of risk status, should be safe in medical facilities. I ask you to establish respirator mandates before further harm is done.

Sincerely,
Shannon Deegan
Torrance, CA

---

I cannot believe you are even thinking of relaxing infection control, N95 MASKS WORK and it's not safe for some of us to go anywhere, anymore! You're health professionals not politicians. We can't even go to the hospital safely now! Don't make it worse!
katie johnsoncode

---

**Written Testimony to HICPAC**
**Lindsay (she/her)**
**Rockville, MD**
**Member of the Public**
**August 25, 2023**

COVID-19 remains a significant threat to all people. Per the World Health Organization (https://twitter.com/WHO/status/1651227079684358151), 1 in 10 infections results in long-term health consequences. I do not want to get infected with COVID, which could have short-term, long-term, or permanent impacts to my health and livelihood.

I am concerned and angry about the absence of even the most basic precautions (i.e., N95s and other respirators) in shared spaces, especially healthcare facilities and hospitals. I should not be forced to risk infection in order to access healthcare.

I consistently spend immense amounts of time and energy communicating with providers and struggling to advocate for my own safety. Providers rarely respond to my requests (in advance of my appointments) to wear respirators, and it's even more rare that they follow through on promises to wear respirators.

As difficult as my personal experiences have been, it is even more challenging for my fellow community members who are immunocompromised, disabled, or simply at higher risk for COVID complications. According to the CDC's own guidance (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-who-are-immunocompromised.html), immunocompromised people should "avoid poorly ventilated or crowded indoor settings." Healthcare facilities fall into that category, so the CDC is effectively saying that immunocompromised people do not deserve healthcare.

We have an obligation to protect each other, and the CDC/HICPAC has an obligation to establish guidelines that provide the safest healthcare environments possible. Public health is about the *public*, not individual choice.

I attended the HICPAC meeting on August 22, 2023, and the first discussion of airborne pathogen transmission did not occur until the public comment period at the end. This demonstrates HICPAC's disturbing lack of awareness of, or consideration for, the real health threats we are facing both in this country and globally.

The CDC/HICPAC must do the following:

- Fully recognize airborne pathogens like SARS-CoV-2
- Strengthen respiratory protections (e.g., universal masking, air quality standards, etc.) to protect patients and healthcare workers
- Implement feedback from community stakeholders, including healthcare workers, their unions, and patients

---

Dear HICPAC

Please fully recognize aerosol transmission in the closed spaces of hospitals and medical professional offices and therefore the use of N95 masks.

I am a 6%'er, having never gotten COVID-19 and at an age where contracting the virus could have serious impacts for the rest of my life. I live a healthy life and consider it a fundamental right to be able to continue to live that way without the risk infection by a still highly transmissible virus during the period after my vaccination wanes. Until there are vaccinations that last longer than a few months, the LEAST I should be able to do is visit a doctor or dentist without fear.

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 obvious to me as a layperson that surgical masks are inferior to N95 masks. I believe that the "we know better than thou" approach that doctors employ on a regular basis is patently false. No one is all knowing and especially now with the vast amount of medical information that was shared during the still on-going COVID-19 pandemic shows that this group is (a) not a monolith of knowledge and (b) all-knowing.

Peter Englander
Bellingham, WA

---

I write this letter as an extremely concerned member of the public in response to your Evidence Review: Masks (comparing surgical masks vs. N95s in infection prevention), included in Isolation Precautions Guideline Workgroup published June 8, 2023.

I am a 42-year old graduate of The Wharton School with an MBA focused on Healthcare for the Elderly, and an immunocompromised individual due to taking an anti-CD20 medication. I have spent the last 3 years researching ways to keep myself safe from the highly contagious, airborne Covid-19 virus.

There are significant flaws in the studies cited in your Evidence Review: Masks that have led you to the likely erroneous conclusion that surgical masks are as effective as N95s in protecting HCWs from infection by airborne respiratory diseases. For example, in Radonvich (2019), HCWs only put on N95s when they were within 6 ft of a patient - airborne viruses travel much further than 6 ft. Loeb (2022) shortened the distance to only 3 feet! Beyond these flaws, there are relevant studies missing from your analysis, such as https://elifesciences.org/articles/71131, https://onlinelibrary.wiley.com/doi/full/10.1002/rmv.2336, https://onlinelibrary.wiley.com/doi/10.1002/emp2.12582, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7996059/

Please revise your analysis to take into account study design as well as all relevant studies. I am confident that you will find that N95s are far superior to surgical masks in protecting against Covid-19 and other airborne diseases. Most of these studies focus on protecting healthcare workers from infection, but I am confident that you will also conclude that N95s offer equally

strong protection to other individuals as well, by lowering infection rates in non-HCW 95-wearers as well as lowering the spread of infection from HCWs wearing N95s vs. surgical masks.

Why does this matter? First, in periods of high transmission, immunocompromised individuals like me need to be able to access healthcare safely. Certain procedures require me to remove my mask (dental procedures, throat procedures, resuscitation if I pass out from my anti-CD20 infusion, etc.). My HCW need to be in N95s to protect me from their germs (even if/when Covid-19 ever becomes truly seasonal). Second, the wearing of N95s when dealing with other patients lowers the chances that HCWs are infected with germs that can kill me. Third, the CDC standards informed by HIPAC guidance will serve as a baseline for other organizations; the erroneous conclusions in this research will lead to sub-par CDC standards and then workplace standards. My employer, for example, follows CDC standards. Policies that conclude that surgical masks are equally effective to N95s will make it harder for me to advocate for continuing to wear an N95 which, as explained above, is much safer alternative for me.

What did I do before Covid-19? There has not been such a highly contagious airborne disease in wide circulation in my entire life, let alone the last 6 years I have been on an anti-CD20 medication. I did actively avoid sick individuals, but I also suffered from several severe infections prior to Covid-19. I now know how to much more effectively protect myself through the use of well-fitting, high quality masks in poorly ventilated situations and will continue to do that even if we miraculously eradicate Covid-19.

This letter addresses just one issue in your draft Isolation Precautions that I happened to be familiar with based on my own research. Based on the feedback of trusted experts in my network, I also urge you to involve aerosol scientists in this topic, address the role of ventilation, and be more transparent about your research and process. Anything short of this can be considered no less than eugenics, by crafting policies that very obviously drive higher death rates among immunocompromised individuals.

Best,
Lauren Christman

---

Hi,
My name is Joan Goldberg, Newton, MA.
I am writing regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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 have 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,
Joan Goldberg

---

It is a basic part of health care to protect the wellbeing of both health care providers and patients, particularly the most vulnerable patients. It is unbelievable to me that, with everything we know about infectious disease generally, and specifically the dangers of COVID-19, that vulnerable patients are having to plead for protections that could mean the difference between life and death.
People at high risk avoid obtaining health care when it puts them at further risk; this includes me and some of my family members. We know that a shockingly high percentage of people infected with COVID end up with some degree of disability. People should not be forced to risk infection in order to see a medical professional.
Richard Black
Amity, Oregon

---

To Whom It May Concern,

My name is Joal Chen, and I am an educator from Brooklyn, New York. I am incredibly hurt, angry, and disappointed with the handling of the on-going COVID-19 pandemic by local, state, and federal institutions. I am emailing with immense concern about the easing of guidance for Isolation Precautions as suggested by the HICPAC's Work Group. As an educator with family members and loved ones who are immunocompromised, I am incredibly disheartened to hear of proposals for 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. We have seen time and time again how profit-focused organizations will use any reason to cut costs and provide the bare minimum, and these changes would enable 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.

Thank you for considering this note in your evaluations.
Joal Chen

---

We need proper airborne infection control in hospitals. Especially now that we're well aware that SARS-CoV-2 spreads via airborne transmission. And even if SARS-CoV-2 magically disappeared, there are other viruses and pathogens that need to be addressed in a hospital setting.

I'm not a scientist. I'm an exhausted stay-at-home mother who understands that uncontrolled spread of viruses is a Very Bad Thing. And seriously, why should I be required so to spend my few minutes of spare time writing to an organization that should frankly KNOW BETTER. Shame on you. You are part of the richest country in the world and you're making citizens begs for basic accommodations to protect themselves and their loved ones.

We live in 2023. The world is not what it was. We need to adapt to survive, and you are at the pinnacle of this change for our country. Please protect all of us by increasing protections for patients.
Thank you,
Julie Vanderschaegen
Sequim, WA

---

Dear members of HICPAC,

Please officially recognize that Covid is primarily airborne and promote safety measures designed around airborne transmission in healthcare settings given that medical patients are disproportionately vulnerable to infectious diseases and people with infectious diseases are more likely to be in a hospital where they can infect vulnerable patients unless there are optimal airborne-mitigation measures in place.

The greater risk of harm from airborne transmission in healthcare settings ethically obligates higher standards of aerosol safety therein. [*]

Thank you kindly for your attention! ~Ian Goddard

Ian Goddard
Hagerstown, MD

[*] See, https://aquila.usm.edu/ojhe/vol19/iss1/4/ ...showing how a higher risk of harm to others corresponds proportionally to a greater obligation to mitigate that harm, which in turn obligates using stronger measures to mitigate the elevated risk.

---

To whom it may concern,

As someone who is part of the disabled community, with immunocompromised family members it is imperative for my safety, my families safety and others like us that the CDC treat the on-going pandemic of Covid as the threat it is.

Numerous reports are showing that with each infection it damages a person more and more showing everything from brain aging, permanent organ damage, permanent disabling qualities, similarly attacking t cells, and weakening our immune systems.

We need proper mask guidance not just in medical care but across the nation. We need you to actually tell medical providers that they need to be masking not just for those of us with no immune systems but to prevent others who are currently healthy from getting a disabling and deadly virus.

It is an extremely disheartening thing to have to beg the CDC to do what is scientifically proven to help prevent illness and so very dehumanizing.

But here I am.

Begging you to do what is ethically and morally the right thing to do if you don't want to see our disabled community sky rocket in the next five years.

Sincerely,
Cynthia Dixson

---

Topic: COVID-19 & HICPAC Recommendations
Name: Madeleine Stirling
Address: Washington, DC
Affiliation: Member of the public

Good afternoon,

I am writing as a concerned citizen regarding this body's opaque and fascist proposal to weaken protections for healthcare workers and patients. You have an opportunity to be on the right or wrong side of history when it comes to infectious disease protection, and your proposal as it currently stands is squarely on the wrong side. I urge you to consider your legacy in light of the power you hold at this time. Will your descendants be proud that you sided with corporate shareholders in the waning days of our for-profit healthcare system, resulting in millions more deaths and disabilities, just to line the pockets of the few? Will you be proud?

As you know, the Work Group on the Isolation Precautions Guidance has proposed updated terminology on infectious disease transmission (“air” and “touch”) - but fails to recognize the science of aerosol transmission and the role of inhalation of aerosolized pathogens. You recommend the use of surgical masks, which you know do not provide adequate respiratory protection against inhalation of infectious aerosols. Cherrypicking research to reduce protections for healthcare workers and patients is disgusting, eugenicist, and cruel. The fact that your committee has proposed cutting corners and costs by any means necessary is deeply troubling and antithetical to your appointed mission.

People deserve access to care without risking death and disability during an ongoing pandemic - the first of what will be many over the next few decades. Healthcare providers deserve a safe place to work with the adequate protection of N95 respirators. You have the opportunity to make things better or worse for everyone in this country in the coming decades. I strongly urge you to locate your courage and resist the pressures of shareholders. You are the ones who will have to live with yourselves, but the rest of us will have to live - and die - with your decisions.

Sincerely,
**Madeleine Stirling**

*Former Advisory Neighborhood Commissioner, Washington DC*

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.

Additionally, 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: Kaila Trawitzki
Address: Roseville, CA
Organizational Affiliations: People's CDC, World Health Network, COVID Survivors for Change

---

Re: airborne viral precautions in healthcare settings

N95 respirators should be the standard of care in all medical facilities. They should be mandatory for all staff and patients.

Emily Schmidt
Woodland Hills, CA
Please wear a mask!

---

Attention: HICPAC

I am writing today in support of the proposal to require masking in health care facilities. Please take action today to advance this simple, cost-effective public health policy that will help protect the health and lives of the most vulnerable among us.

I am the sole caregiver of my spouse, who was diagnosed with Stage 4B ovarian cancer three and a half years ago. We stay up to date on our vaccines and mask whenever we're out in public. It's not an inconvenience and the benefits are real: my wife is alive and healthy today and neither of us has had Covid, the flu, or any major illness since her diagnosis.

It's sad and extremely stressful that in our daily lives, we're most at risk of contracting what could be a life-ending illness when we're required to visit the doctor's office or hospital for either routine and emergency care. Those are the times when we're in close proximity with people who may be sick with any number of airborne illnesses and the folks who take care of them and may be infectious without knowing it. One-way masking helps, but the science shows that two-way masking is much more effective.

I will never forget that when masking was required in the early days of Covid, the entire country skipped flu season. Now "flu season" is every day of the year. The science shows that masking works. We should have required masks at hospitals, clinics and doctor's offices long ago for both the safety and health of the people who work there and the sick people who are seeking care in those settings. With TB outbreaks becoming more common, there are so many good reasons to require masks!

The anti-science bullies are loud but there many, many more of us who support rational, reasonable, common sense, fact-based public health policy. Requiring masks in health care facilities is rational, reasonable, fact-based, and sound public health policy, and the sooner this policy is instituted, the more lives will be saved.

Thank you.

Gretchen Van Ness
Hyde Park, MA

---

Dear HICPAC:

SARS-CoV-2 is spread by aerosols. I strongly urge you to make N95 or elastomeric respirators mandatory for healthcare workers. Please protect vulnerable patients from airborne pathogens. Loose surgical masks do NOT provide the same protection from aerosols.

Just as hand washing and sterile operating rooms became standard practice, so should be N95 usage by healthcare workers interacting with patients. We shouldn't have to risk getting Covid-19 when accessing medical care.

Thank you for your consideration in this matter.

Sincerely,

Grace Norton
Shreveport, LA

---

I am a 73 year old male living in Colorado. I have been fully vaccinated against Covid following CDC guidelines.
I have a continuing cardiovascular condition following a 2012 heart attack and have 4 stents in my aorta. I have asthma.
As such, I am at risk for serious effects from covid. Despite a vaccination 5 weeks before, I contracted Covid on Thanksgiving
weekend of last year. It took me 6 months to fully recover, although I'm certain that what feels like full recovery to me now may
actually be a step down from my reasonably good health of a year ago.

I have two friends near my age, also fully vaccinated for covid. Despite that, both contracted covid while in a medical facility.
One is now dead, the other in end-stage hospice care at home. They were both exposed by unmasked medical professionals after the pandemic guidelines were relaxed.

You can appreciate why I strongly believe that it is the CDC's responsibility to restore respiratory protections and other PPE requirements for all medical facilities, particularly those that deal with immunocompromised patients. Medical personnel
should also be required to isolate from patients whenever ill...and a comprehensive routine of testing be required. Vaccines and masks should be free and available to all

The failure of the CDC to diligently protect the health of all Americans, particularly those most at risk, is a serious stain on the history of an organization that set world standards for public health.

Please listen to people like me who fear for their own and the country's future.

Respectfully
Larry Bruce
St Fort Collins CO

---

I am an older American, and like most Americans of any age I have health conditions that place me at high risk of severe complications from infection with the SARS-Cov-2 virus. I am also increasingly demoralized by the failure of government officials and healthcare policymakers to listen either to the findings of scientists and researchers or to the concerns of healthcare workers, patients, survivors, and other ordinary people who do not want to risk contracting--or contracting again--this potentially deadly, often disabling, and frequently debilitating disease.

This virus mutates rapidly, and the lack of adequate mitigations has led to the continued emergence of new and immune-evasive variants, dragging out the pandemic, which, as the World Health Organization noted in May and June, has not ended.

The removal from YouTube of the video of the August 22 meeting is indicative of the lack of transparency in this whole process. I thank you for again making it available, but it is only a start, not nearly enough. 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. 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.

Even more importantly, 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 open the process to effectively engage these experts in developing drafts.

Broader consideration of relevant expertise would have indicated problems in the current evidence review on N95 respirator and surgical mask effectiveness. That review 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.

More generally, 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 addition, source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Please do not continue to require patients to choose between seeking healthcare and avoiding a virus that can lead to disabling post-viral conditions and other injuries. Please do not continue risking the health of the very healthcare professionals we need to rely on. Thank you for your attention.

Frann Michel, Ph.D., concerned private citizen
Portland, Oregon

---

Written Comment From:
Jonathan La Mantia
Chicago, IL

Organizational Affiliation:
None / Disabled & Immunocompromised Citizen

I am writing to urge you to take all of the expert testimony from National Nurses United seriously as it is of grave importance to all Americans. I am among the disabled and immunocompromised population and have been living in isolation with my partner since the beginning of the pandemic in 2020. I am deeply frustrated with the removal of mask mandates across the board, particularly in medical settings -the only area that I regularly interact with in person. The need to take masking seriously is of the utmost importance and part of that includes understanding the clear scientific differences between N95 masks and surgical masks. Surgical masks are not nearly enough to provide sufficient protection in general, least of all in high-risk environments such as hospitals where disabled and immunocompromised people such as myself spend hours in close proximity with unmasked and possibly infected individuals, and the medical professionals and hospital staff who may also be interacting with those infected individuals. This is also where the need for correct control measures of infectious aerosols are of the highest importance. These shared environments must be equipped with proper ventilation and filtration and N95 respirators must be mandated in healthcare settings and other high-traffic shared space environments.

Thank you for your time.
-Jonathan La Mantia

---

Madelynn Amalfitano
Woodland Hills CA
Airborne Viral Precautions in Healthcare Settings Member of the Public

As an immunocompromised American, the fact that the CDC is not including improved air ventilation and KN95 mask requirements for healthcare settings is unbelievable. Especially in

light of all the science that supports it, and the overwhelming majority of public comment that wants it.

The CDC is failing all Americans by not including these requirements in their guidelines, and it's difficult to even fathom why.

---

I have multiple health issues that require regular visits to medical facilities and manual therapy procedures. At best, one of the many practitioners whom I visit would wear a baggy surgical mask. I recently tested positive for a serious illness. I often weigh the pros and cons of maintaining this office visit schedule, as the ventilation/filtration in the rooms are very good and practitioners are not masking or barely wearing surgical masks.

SARS-CoV-2 is an airborne pathogen that causes COVID. An increasing amount of evidence is pointing to COVID being an endovascular disease. There is no proven cure for long COVID, and the more infections a person accumulates, the more their immune system suffers and their life shortens. An infected person is more susceptible to other types of infections. Many ER doctors have commented on the vast array of infections that incoming patients (previously infected with COVID) have presented with.

*Even if I didn't* find myself in a constant state of exposure at facilities or *even if I weren't* currently in a high-risk category, I would still deserve to NOT acquire a COVID infection at these facilities. I do not deserve to increase my risk of stroke or organ failure. I also do not deserve to be infected with any *other* airborne pathogen when I try to visit a professional who is supposed to help me manage my health.

Please do the right thing and require state-of-the art filtration, ventilation, purification (without creating additional ozone), AND high-quality masks (KN95s, N95s, or better) in medical facilities.

Sincerely,

Kara Tutunjian
Arlington, MA

---

Benjamin Tuggy
Sacramento, CA
Affiliation: Private citizen

I am writing as a concerned layperson about the HICPAC proposed Infection Control Guidelines. I have multiple high-risk family members who do not deserve to die from COVID-19 or another infection acquired in a healthcare setting, so this is very personal for me. I am very concerned about the proposed guidelines. For one thing, treating N95 respirators as equivalent to surgical masks flies in the face of decades of research and rigorous testing, including the established NIOSH respirator certification process.

I am also concerned about the relatively closed and opaque process for updating the 2007 Isolation Precautions guidance. I urge you to open up the process and invite full engagement from public-health experts, healthcare worker unions, and others.

Thank you,
Benjamin Tuggy

---

To the Members of the Healthcare Infection Control Advisory Committee, Centers for Disease Control:

I am a volunteer member of the Cambridge Healthy Children Task Force in Cambridge, Massachusetts. The views expressed here, however, are my own.

My views are also informed by my experience as a parent of a public school student in my city and additionally, for the last 9 years, an employee of a nonprofit partner of the public school district, where I worked in a shared office located inside our public high school.

My family, including my spouse who has suffered from Long COVID for the last 18 months, is at a higher risk of contracting COVID, some for the second or third time, because masks are not required in our public schools. In turn, masks are not required in schools because the CDC has strangely defaulted on its pledge to the American people. The CDC's website contains a pledge to "base all public health decisions on the highest quality scientific data that is derived openly and objectively."
In particular, HICPAC seems to have selectively omitted scientific data on aerosol transmission of COVID-19 in considering new infection control guidelines.

I attended the HICPAC meeting on August 22 and was surprised that masking, ventilation, and other measures that reduce spread of airborne infectious disease were absent from the discussion.

In considering revision of infection control guidelines, please do not exclude data and analysis from aerosol scientists, industrial hygienists, ventilation engineers, and respiratory protection experts. Even I, a layperson, can see with the naked eye that surgical masks often have gaps in fit and that the fit of N95 respirator is considerably greater. Even I can understand that, since COVID-19 can be transmitted through very small particles which may remain suspended in air longer than heavier droplets, masking is protective.

To prevent further harms from COVID-19 as it continues to evolve, I believe the CDC should require masking with a well-fitted mask, combined with other infection control measures. Hospitals, long term care settings, and other health care facilities, as well as performance venues and schools, such as the public school attended by my son and in which until recently I worked, should all have a reinstated mask mandate during the pandemic, which is by no means "over."

I urge you to decide on a bold course of **transparency** (releasing draft guidelines and workgroup meeting minutes for example) in your process. I also urge you to see your historic role as one of providing **guidance based on science, not politics**, in order to safeguard the American public from the threat of continued catastrophic effects of infectious diseases such as COVID-19.

Sincerely,
Julie Croston
Cambridge, Massachusetts

---

Public comment on the 8/22/23 HIPAC meeting concerning air transmission precautions: Because of SARS-CoV-2's continued morbidity, transmissibility and prevalence, HICPAC should recommend that all people within healthcare institutions wear well-fitting respirators rated as N95 or better—as long as they are medically able. In consultation with aerosol scientists, HICPAC should also recommend that healthcare institutions implement high levels of ventilation and filtration to reduce concentrations of infectious aerosols within healthcare buildings.

SARS-CoV-2 is here to stay and we must learn to live with this virus. Its prevalence, transmission and morbidity continue to be extremely high—even at relatively low ebbs in its prevalence, and even amongst "fully vaccinated" people. I'm aware of no evidence that any of these factors are likely to change within the next several years.

That's why it's disturbing that the June 8 Isolation Precautions Guideline Workgroup draft does not recommend broad, continued respirator use and ventilation. Instead, the draft suggests: *Consider* [mask or respirator] *use during periods of high local prevalence of acute respiratory viral infections for all individuals entering a healthcare facility or a part of a facility where patients at risk for more severe outcomes are housed* (p. 19)

Well-fitting respirators are far more effective than surgical masks at preventing transmission—therefore, only they, and not masks, should "be considered." Further, there's no reason to recommend that institutions merely "consider" using respirators. There is every reason instead to recommend that they require people to use respirators within their buildings.

The draft does recommend N95 respirators, but for what it calls, "pandemic-phase respiratory viruses (e.g. influenza, SARS-CoV-2)" (p. 41). This suggests that the recommendation to wear respirators to protect against SARS-CoV-2 depends on an arbitrary verbal designation as to whether some entity has labeled it as being in a "pandemic-phase" or not. Infection controls should be indexed to the actual risks they pose to individual patients and healthcare workers—not whether they are nominally "pandemic-phase." This recommendation should make explicit that SARS-CoV-2 has been, is, and will continue to be for the foreseeable future, highly prevalent and transmissible, and that it causes significant long-term risks to life and health—thereby warranting respirator use unless and until those conditions change significantly.

My interest in your recommendations is in part selfish. I have a congenital heart defect that will likely require me to have a fifth open-heart surgery soon. The price I pay for treating my illness should not be easily-prevented infection with a virus that is highly likely to cause cardiac, vascular and renal damage that will make my survival even less likely.

But, you should not make recommendations based on my individual risks—nor should I feel compelled to disclose them to generate sympathy from you. But, I do feel so compelled because your draft seems to ignore the ample evidence that lack of robust respiratory protections will damage the patient population, general population, and healthcare institutions themselves.
Andrew Knoll, Ph.D.—*Unaffiliated*
Sewanee, TN

---

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee (HICPAC):

I am writing to you today because as an immunocompromised person who is at high risk of severe covid infection, hospitalization, and death despite being up to date on my vaccinations, I have had to drastically limit my risk to COVID-19 since March 2020. I have lost income over the

years and safe access to public spaces because of this pandemic. The only high risk situations that I have been forced to have include healthcare visits. I am lucky that I have had providers who understand my risk and wear masks during my appointments despite the clinics and hospital removing requirements, but I am still forced into packed waiting rooms through which I actually have to pass through an urgent care seating area full of sick, unmasked individuals to access my infusion center.

As many have pointed out, it is absurd that it is not a standard to reduce and mitigate hospital acquired infections which were very much a risk prior to the current COVID-19 crisis. It is nonsensical that we have not implemented the following infection control guidance in health care settings that will mitigate this risk:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

• Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
• Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don’t adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

We urge you to implement the above procedures and protocols to ensure equitable access to healthcare for all.

We are concerned about the lack of transparency in your process to update the CDC’s guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers,

patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

Thank you for your time,
Kayla

---

Dear members of the committee,

I am appalled by the reports that you are planning to recommend weakening infection control guidelines in health care settings. Given the continued prevalence of COVID-19 in the environment, such a move is a heinous attack on the many people who are especially vulnerable to infections by COVID-19, be they disabled, immunocompromised, chronically ill, or simply old. Clinics and hospitals are by definition where sick people congregate, and as such the risk that vulnerable people encounter infectious agents in these settings is extremely high.

I am a geographer and environmental scientist at the University of California, Davis. As a geographer, I am trained to recognize and study interrelationships between humans and their environment. Having an environmental perspective is a part of epidemiology -- indeed there is even educational material for children on the CDC website teaching the epidemiological triangle of agent, host, and environment (https://www.cdc.gov/healthyschools/bam/teachers/documents/epi_1_triangle.pdf).
But it is apparent the medical profession tends to leave out the environment in their thinking, and has difficulty seeing that there has been a profound shift in the indoor environment after February 2020 due to the evolution of a respiratory pathogen that is extremely good at dispersing in this niche. Jimenez et al. (2022) in a historical review attribute the resistance to understanding that COVID-19 is airborne to "belief perserverance", a bias that all scientists should strive to avoid.

I can only interpret the move to weaken infection control guidelines as a devilish combination of psychological denial, rampant greed, and extreme ableism. I urge you to strengthen infection control protections, not weaken them particularly in health care. At minimum these include i) making it standard practice to use appropriate respirators (N95 or better) throughout health care settings and ii) developing standards, guidelines, and mandates for air filtration and ventilation. Such changes in practices are both scientifically justified and morally necessary.

Reference: Jimenez, Jose L., Linsey C. Marr, and 20 other authors.
“What were the historical reasons for the resistance to recognizing airborne transmission during the COVID-19 pandemic?” Indoor Air 32 (2022). https://doi.org/10.1111/ina.13070

Yours sincerely,
Allan D. Hollander, PhD
Davis, CA

---

August 25, 2023
To: Healthcare Infection Control Practices Advisory Committee
Re: HICPAC Meeting, August 22, 2023, Infection Control Guidelines, Public Comment

The AFL-CIO is a federation of 60 national unions representing 12.5 million working people in this country, including millions of health care workers, those who work in health care settings, and those who have been or will be patients. We have been actively engaged in advocating for strong protections to protect health care workers from infectious diseases for decades.

The AFL-CIO registered for the August 22, 2023 meeting to provide public comment; however, we were not called upon before the public comment period ended. As the alternative, we are submitting our statement as a written comment.

We have noticed some increased transparency to the process that has occurred since the June meeting. However, what has changed so far seem to be check box items that should have already been in place and are already done for other FACA committees. The work done by HICPAC is *still* occurring in a vacuum without the involvement of a broad range of experts that have real decision making power— checking off procedures and having meetings late in the process is not an approach that allows for meaningful input.

This is evident in what we do know about the draft guidance. Due to the insular nature of these committees, HICPAC has relied on studies that have been shown to have low confidence due to study design resulting in recommendations that are not scientifically sound and do not protect health care workers or patients. For one example, these include poorly designed studies that concluded medical masks may offer similar effectiveness as N95 respirators in protecting healthcare workers exposed to COVID-19. This is a choice by committee membership to ignore the plethora of studies on the effectiveness of respiratory protection, the fact that respiratory protection was developed and certified specifically for protecting wearers from aerosols and particulate matter, and outspoken dissent by respiratory protection experts.

This is a step backwards and the health impact would be devastating. Looking at the reported COVID-19 infections within nursing homes, the number and rate of infections among nursing home residents has more than doubled since mid-June, and the number and rate of infections among nursing home staff has more than tripled. Our call, supported by hundreds of experts, health care workers and members of the public, is not just an issue with the process for the sake of process—it is because this broken process is resulting in harmful guidance.

This is about health care workers needing protections from their employer because what is happening now is not working. This is about preventing infectious disease transmission among health care workers and patients. This is about safeguarding our communities.

Sincerely,
MK Fletcher
Safety and Health Specialist

---

To whom it may concern,

I write to add my comment to the recent meeting of the CDC's Healthcare Infection Control Practices Advisory Committee.

I'm horrified that loosening the already inadequate precautions in healthcare settings is actually on the table. I and many I know have already been delaying necessary healthcare appointments as these settings, ironically, represent a major vector for becoming infected with COVID-19.

My husband recently contracted his first COVID infection, the symptoms arising 48 hours after his annual physical in which he was the only one masked. Of course he had to remove the mask for part of the exam. He masks in all other indoor scenarios and through caution, privilege and luck had managed to evade it until then. This scenario will only be multiplied by the tens of thousands if restrictions are loosened further still.

You are only generating a growing mistrust of commercial healthcare with the lack of transparency, mixed-messaging, and personnel that are not informed. Covid is airborne and masks work. N95 masks are superior to blue surgicals. Multiple infections incur cumulative damage. Ventilation is important. "At risk" people means everyone, we are all at risk. You have allowed faulty studies and misrepresented conclusions to become the loudest talking points. This is your opportunity to correct course!

Your proposal to adopt a more “flexible” approach to implementing precautions recommends only minimal protections and allows health care employers undefined broad discretion to create their infection control plans. We saw how this approach "worked" when adopted by the CDC during the COVID-19 pandemic: health care employers felt enabled to avoid providing necessary protection for health care personnel and patients, based on cost considerations —not safety.

Lastly, when these guidelines are complete, they must be publicly available and easy to understand. Too many times have I heard "We are following CDC guidelines" when in fact they were following their own interpretation of the ambiguous and convoluted guidance presented – many times to a faulty conclusion.

Carey Ascenzo
Private individual
Richmond Hill NY

---

Tierney McGuire
Indianapolis, IN
Topic: the HICPAC revision recommendations to the current Isolation Precautions Guidance

I am deeply concerned by the proposed changes by HICPAC’s Work Group on the Isolation Precautions Guidance. There should be no "flexibility" to rules that protect patients and healthcare workers from infectious disease. Reducing protections will result in even more nosocomial infections which are already too high at current levels. We should not be decreasing masking requirements in healthcare, but instead increasing them. Mandatory universal masking in fit-tested N95s and reusable respirators should exist in all medical settings not only to reduce nosocomial infections but to protect healthcare workers from illness, disability, and death as well.

As a high risk person, with multiple pre-existing conditions, I am deeply concerned at the general acceptance of spreading airborne disease in healthcare. This puts me, and other disabled, high risk, immunocompromised, and vulnerable people at huge risk when we seek healthcare. Disabled and vulnerable people are the most likely to frequent healthcare facilities and when masking mandates dropped, seeking healthcare became an extreme risk for vulnerable populations for infection with SARS-CoV2 and other airborne diseases. We cannot reduce access to healthcare for disabled people, it is already extremely inaccessible due to the extreme costs in the US healthcare system, in addition to medical racism and other systemic problems.

It's baffling to think that "experts" on infectious disease would promote the lessening of protections of healthcare workers when we already had a shortage of medical personnel before the pandemic and at this point in the SARS-CoV2 pandemic the shortage is at an all time high. We cannot afford to lose healthcare workers to illness, disability and death. Additionally healthcare workers should not go to work ill, but because this is so common, universal masking should never have been dropped. Healthcare workers should not be spreading disease at their jobs, "do no harm" includes spreading airborne pathogens.

The evidence about the efficacy of N95 and P100 respirators is overwhelming but the data that the HICPAC referenced is not in-line with this huge body of evidence. The review on N95 respirator and surgical mask effectiveness used by HICPAC was flawed and must be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health.

I will add from the testimony from the National Nurses United: 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 Committee Members,

The long-term effects of COVID-19 are still mostly unknown, but significant issues are being routinely discovered that will affect public health for many years to come. As I'm certain you are aware, systemic vascular sequelae can have a devastating impact on the quality of life of our citizens. It is very disheartening to seek medical attention, only to have healthcare providers risk transmitting and/or being infected with COVID-19. With new strains being identified on an ongoing basis and what looks to be another surge, it is imperative that the guidelines include appropriate use of effective PPE.

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.

Sincerely,

Pamela Schauben, RPh, MS
Clinical Associate Professor

University of Florida College of Pharmacy

I am writing to voice my endorsement of bringing back Covid protections and prevention measurements. We have seen that it is not over, it is obvious that without these protections the disease has been allowed to creep through the population and become more varied and harder to diagnose by conventional methods. Our household is at severe long term risk if we catch the virus, and currently we can't even obtain free tests anywhere. Weakening infection control standards is absolutely unacceptable.

Kelsey Baker
Troy Missouri

Nicole Mullin
denver co
CDC/HICPAC Acknowledge the Science on Aerosol Transmission and Importance of Core Control Measures for Infectious Aerosols

CDC/HICPAC needs to recognize the science on aerosol transmission so we can adequately protect ourselves and each other. The large body of evidence on the effectiveness of respirators and the importance of ventilation and air filtration for controlling worker and patient exposure to infectious aerosols have not been considered. We need proper ventilation in the workplace and health care settings. As an immune compromised individual, precautions for illnesses transmitted via aerosol in health care settings is paramount to my safety.

I am writing to express my concern about the Healthcare Infection Control Practices Advisory Committee ("HICPAC") revised guidelines for healthcare facilities.

The guidelines contain no mention of improving air quality inside healthcare facilities and essentially claim that surgical masks provide as much protection as N95 respirators.

HICPAC provides evidence regarding efficacy of masks, but they appear to have chosen a limited selection of available literature upon which to base their guidelines. Aerosol scientists, industrial hygiene professionals, epidemiologists, and other experts in relevant fields have published extensively on this subject and the consensus is that respirators are far superior to surgical masks.

Please adopt some common sense and scientifically based guidelines for infection control to protect patients and healthcare workers.

Thank you for your consideration.

Best regards,
Heather
Los Angeles, CA

To whom this may concern,

I am writing as a high-risk individual with several immunocompromised family members. As the end of the PHE occurred on May 11th, and my family and I continue needing to go to the doctor, urgent care, specialists, etc. for our healthcare needs I find myself in the dire situation of

choosing between my personal health and the potential of catching COVID-19 or other airborne pathogens from a healthcare facility.

I have chosen to put off crucial preventative care because of the lack of safety regarding not just COVID-19, but any other airborne disease. I am several years behind on preventative care that looks for cancers in my body because of trying to keep myself safe from disease in healthcare settings.

I am writing to ask that the CDC please issue Indoor Air Quality targets for all healthcare facilities, ideally requiring ventilation of 12 air changes per hour or an equivalent level of HEPA filtration. I am also writing to ask that healthcare facilities continue to encourage the usage of N95s, as any other option is simply not keeping myself or other Americans safe and has been disproven by countless studies.

Most recently I went into urgent care for a simple sprain, and the doctor was not wearing a mask and had a white noise machine that I had mistaken for ventilation. Getting care for something unrelated seriously put me at risk for catching airborne disease such as COVID-19, and makes me less likely to seek out care in the future.

I would also ask in all sincerity to seriously consider implementing a permanent requirement of source control in healthcare facilities. A hundred years ago washing our hands seemed ridiculous, and now it's standard procedure. I hope you will take these words into account and consider doing the right thing for immunocompromised and disabled Americans and be ahead of what will surely be a requirement decades from now. Clean air is a right, and we would all benefit.

Please consider implementing Indoor Air Quality targets at the federal level for all healthcare facilities and encouraging the use of N95s. I am not affiliated with any organization.

Thank you,
Sofia Dolce

---

Hello,

My name is Jasmine Goldman and I am a member of the public. I am deeply concerned with the proposed changes to airborne/viral disease management and mask requirements in hospitals.

The public as well as a large body of nurses and other healthcare workers have flatly denounced this new proposal, as it flies in the face of known research and longstanding protocols. The data is clear - N95 or KN95 masks are best. Having HEPA air filtration is also sorely needed. Please do not pass this.

Sincerely, Jasmine

---

Dear HICPAC Members,
I am writing to address critical concerns regarding the proposed updates to infectious disease transmission terminology, particularly in light of aerosol transmission, and the need to bolster protective measures in healthcare settings. As someone who has closely followed the scientific developments and been personally impacted, I am compelled to emphasize the significance of these matters.

The Isolation Precautions Guidance Work Group's revised terminology on infectious disease transmission lacks comprehensive acknowledgment of aerosol transmission and the profound role of inhaling aerosolized pathogens. The new draft's classifications of "air" and "touch" transmission exhibit substantial inaccuracies, disregarding the vital importance of inhalation and the limitations of surgical/medical masks in offering respiratory protection against infectious aerosols. Overlooking the pivotal role of inhalation could weaken the safeguards for both healthcare personnel and patients, contrary to the lessons underscored by the Covid-19 pandemic.

I urge the necessity for recalibrating the evidence review on N95 respirator and surgical mask effectiveness. The prior review was marred by selective data inclusion and failed to incorporate insights from experts in respiratory protection, aerosol science, and occupational health. To rectify this, it is paramount that scientific researchers and specialists in these fields contribute to ensure a holistic evaluation of the available data, encompassing laboratory studies and evidence from non-healthcare workplaces.

In light of the transmission characteristics of SARS-CoV-2, the guidelines should be succinct yet comprehensive. The prevalence of asymptomatic transmission necessitates universal adherence to precautions at all times. Healthcare facilities, acting as convergence points for vulnerable populations, must deploy comprehensive precautionary strategies. The potential for pre-symptomatic and pre-positive-test transmission necessitates guidance that reflects the latest scientific findings, enabling individuals to take informed actions upon testing positive.

Recognizing SARS-CoV-2's aerosol transmission potential, I strongly advocate for regular testing of healthcare personnel and enhanced emphasis on respiratory protection and PPE access. Universal PPE implementation for healthcare workers and patients remains a crucial measure in controlling aerosol-transmitted virus spread, especially for those who cannot mask due to medical conditions.
The superiority of fitted N95 respirator-type masks in curtailing aerosol exposure is evident. To maximize effectiveness, proper implementation measures such as fit testing and widespread access to various respirator types should be prioritized.

Furthermore, I implore the adoption of minimum indoor air quality standards set by ASHRAE to mitigate infectious aerosols in healthcare settings. Additionally, clear communication on transmission risks in crowded spaces should extend to outdoor healthcare environments.

On a personal note, I am convinced that post-Covid infection issues pose risks for everyone, based on robust scientific studies. Routine medical interactions pose dangers for high-risk families like mine, underscoring the urgent need for enhanced protections. The financial, social, and health risks of Long Covid are substantial, particularly for working-class families. Without comprehensive preventive measures, countless lives could be adversely affected.

In conclusion, I strongly urge the HICPAC to consider these vital concerns, aligning guidelines with the latest scientific insights, and fostering a healthcare environment that prioritizes the safety of both personnel and patients. I am confident that with concerted efforts, we can navigate these challenges and establish a more secure healthcare landscape for all.

Sincerely,
Winsor Corkins Concerned worker, parent and citizen, St. Joseph MO

Creighton Ward
Exeter NH
#MEAction New Hampshire

My name is Creighton Ward and I urge HICPAC to:

1) Make the process for updating guidelines **fully open and transparent,** seeking input on proposed changes using the Federal Register public notice process and town hall meetings with virtual options, and

2) Create control guidance that **recognizes the airborne transmission of COVID-19.**

First, 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 highly concerning that CDC/HICPAC's process is so closed.

Second, I urge HICPAC and the CDC to maintain an approach in the updated guidance that clearly recognizes the precautions that are needed to protect healthcare workers and patients from airborne infectious diseases. A protective approach would account for the asymptomatic transmission of COVID-19, **require universal PPE for all healthcare workers at all times** (including fit-tested N95 respirator masks, which provide superior protection against infectious aerosols), ensure isolation of patients with COVID-19 in airborne infection isolation rooms, and implement the minimum indoor air quality standards established by ASHRAE to control infectious aerosols in all healthcare settings.

It is crucially important that healthcare organizations **maintain and strengthen respiratory protection and other PPE requirements** to prevent the inhalation and transmission of infectious disease. I call on the CDC/HICPAC to **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.

This guidance **should apply in all healthcare settings** where high-risk patients, disabled people, and elders will mingle with infected patients, visitors, and staff.

**Therefore, healthcare facilities and personnel should employ a layered approach of precautionary strategies,** including frequent testing, proper ventilation, air cleaning/purifying technology, isolation, respiratory protection, and other personal protective equipment (PPE).

---

Name: Hannah Yackley
Address: Akron OH
Organizational Affiliation: None
Topic: Masks and infection control in hospitals

Hi, my name is Hannah Yackley, and I am a concerned mental health professional in Ohio. I have been tracking covid since the start of the pandemic in order to keep myself and those around me safe from one of the most infectious viral illnesses I have had to face in my lifetime.

Covid is not mild. "Mild" cases can still cause organ damage (https://www.bmj.com/content/371/bmj.m4470). The WHO says 1 in 10 covid infections lead to long covid, which can be debilitating and severely affect quality of life. Around half of those with Long Covid can't keep their full time jobs (https://www.kff.org/policy-watch/what-are-the-implications-of-long-covid-for-employment-and-health-coverage/). The acute infection may be relatively mild for many people but repeat infections can lead to more chronic problems. Each re-infection increases the risk of Long Covid (https://www.harvardmagazine.com/2022/12/covid-reinfection) as well as issues with kidneys, lungs, heart, brain function, blood clots, fatigue, GI sympton, diabetes, and mental health. Many children have gone on to get diabetes due to Covid (https://www.forbes.com/sites/ariannajohnson/2023/06/15/more-people-got-diabetes-during-the-covid-pandemic-heres-why/?sh=dfea88e31d38). We must do everything we can to protect healthcare workers, patients, and the community as a whole from covid.

At a time when covid is surging and several hospital systems are considering or implementing mandatory masking for patients and staff, it is illogical to weaken infection control standards. Covid 19 is airborne and can transmit across longer distances than just 6 feet. We knew about this back in 2020 when the Skagit County Choir (https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm) practiced for two and a half hours. One person infected 32 people and maybe 20 others among the 61 people in attendance. Surgical masks are not as effective as respirators in preventing aerosol transmission. Surgical masks are not rated for respiratory protection. We cannot use droplet control measures against an aerosolized virus. Respirators are highly effective at not only reducing viral load but also reducing the probability of getting infected in the first place. I sat next to a covid-positive classmate for 5 hours and did not catch covid due to my well-fitted KN95. Vaccines are ineffective at completely stopping the spread of covid, although they do lower the risk of hospitalization and death.

More is needed to reduce aerosol transmission. Mask mandates to protect from asymptomatic and pre-symptomatic cases. Isolation of covid-positive patients in airborne infection isolation rooms. HEPA filters, ventilation, and UV disinfection. Tracking nosocomial covid infections to track effectiveness of infection control measures. We have the tools; why are we not using them? We should be rebuilding the infrastructure of healthcare settings to provide clean air. If we cannot find the cleanest, healthiest air in healthcare settings, where on earth can we find it? Research shows that cleaner air is better not only for protection from infectious diseases, but also for staff attendance, cognitive agility, and the ability to live our lives within this new normal of an ongoing covid threat. Let us adapt to covid and learn to live with it by taking the necessary precautions to keep people safe. Thank you for listening.

---

Dear HICPAC Members,

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, to say nothing of those most vulnerable to infectious diseases. I urge HICPAC and CDC to slow down and open-up the process to effectively engage these experts in developing drafts.

Respectfully,
Michaela McCormick
Portland, OR

Retired
Topic: Isolation Precautions Guidance

Please consider updating infection control guidance to reflect the current situation with COVID-19. A lack of precaution guidance for precautions like high quality mask-wearing and air filtration/ventilation may lead to a severely detrimental outcome long-term. We need to do more to mitigate diseases like COVID-19 in healthcare settings, and I urge you to increase the level of precautions taken in guidance.

Chris Miklaszewski
Member of the Public

My name is Heather Vallette. I am a travel x-ray and CT tech that has worked in emergency rooms this entire pandemic, including level 1 trauma centers and stroke hospitals.

I've watched countless patients die over the past 3 years, and continue to do so. I've done CPR on numerous Covid patients. I've held phones for last phone calls. I've held weeping, terrified patients after they lost their sons, daughters, husbands, wives, mothers, fathers, and soon after their own lives.

After the horror that I've seen over this pandemic, imagine my surprise when my life, and the lives of my family and patients, and our safety were completely disregarded after the emergency "ended".

I go to work, still dealing with active very sick Covid patients, but now things look very different. I am the only healthcare worker in my hospital that wears an N95 respirator mask, EVEN with Covid positive patients. There is no longer a wait time between when a Covid positive patient leaves a room, and the next unmasked patient is roomed there. Gone are the air purifiers once used after Covid patients are discharged. Gone are any effective mitigations to keep not only myself but my patients safe.

Nosocomial infections are not even discussed when it comes to Covid. Despite the fact science has proven Covid is an airborne disease, it is not treated as such. My fellow healthcare workers have not been informed of the scientific facts regarding Covid infection, and their lack of knowledge is strictly at the hands of those responsible to inform them.

Almost no one understands airborne transmission. No one understands masking. No one understands long Covid and the impact multiple infections is doing to their bodies.

Covid, yes even "mild" or asymptomatic cases, destroys Tcells, damaging the immunesystem for 8 months on average EVERY infection. This is seen clearly by our overwhelmed healthcare system, further burdened by frequent call ins by sick employees.

The damage to Tcells not only cripples the immunesystem, but also our bodies ability to prevent tumor growth and replication, which is clearly seen by the increase in aggressive and rare cancer.

As a CT tech, I'm seeing this very evidence in real time. Covid is a vascular disease, increasing strokes, heart attacks, and blood clots. But it doesn't stop there. It also increases risk and severity of diabetes, kidney stones, neurological disorders, and on and on it goes.

It is not mild. It is terrifying. And the lack of understanding in healthcare settings of these findings is unacceptable.

The fact I cannot work safely, and instead have to put my health and safety at risk constantly is unacceptable. The fact I watch healthcare workers deal with Covid positive patients without the proper PPE, then continue working with immunocompromised and disabled patients with no masks is UNACCEPTABLE.

Approximately 70% of Omnicron cases are asymptomatic. How many patients come to us for help only to leave infected?

Even symptomatic Covid positive healthcare workers are encouraged to work, many believing they are no longer contagious after 5 days, due to the terrible messaging from the CDC.

1/10 infections lead to long term symptoms. I will not be responsible for permanently disabling my patients, my family, or myself.

The science cannot be ignored. The impacts to healthcare, its workers, and the people will happen, the only question is how quickly those in charge will step up to minimize the damage.

Thank you.

---

**Public position statement on HICPAC Deliberations by OZSAGE: Keeping patients, healthcare workers and the public safe in health care systems during ongoing circulation of COVID-19**.

Patients have a right to safe healthcare, and to be protected, using all reasonably practicable measures, from acquiring any type of infection, including COVID-19, in healthcare facilities.

Prevention of hospital acquired infection is a core responsibility of Infection Prevention and Control Committees (IPACs), and requires cooperation of hospital management, employees, visitors and patients.

Healthcare facilities have moral and legal responsibilities to ensure that their patients are provided with safe clinical care, which includes safe systems of work for their staff and the community.

The CDC HICPAC guidance/guidelines are critical in ensuring that IPACs have the appropriate information to make these decisions.

However, despite Australia experiencing ongoing waves of COVID-19 transmission, amid decreased community testing, surveillance and reporting, baseline cases and hospitalisations remain chronically elevated with a variety of variants circulating in the community. COVID-19 affected many more people in Australia during 2022-23 than in 2020-21.

The CDC has advocated focused protection of people with chronic illnesses and medically vulnerable people, but the majority of patients in hospital meet this definition. Such protection is currently not being adequately provided.

**Dying from COVID caught in hospital**

**Data obtained from Victorian health authorities indicates that over 3000 people acquired infection with COVID-19 while in hospital in Victoria, Australia in 2022, and more than 10% of these (at least 344) died of hospital-acquired COVID-19.**

A 10% death rate due to hospital acquired COVID-19 is much higher than the death rate following surgical site infections, a measure of hospital quality and safety. The same focus that

IPACs have on preventing surgical site infections should logically be applied to preventing COVID in hospitals.

**Removal of masking in hospitals**

Most states in the US and in Australia have removed the requirement for masking in healthcare, and where guidelines state that masks should be worn around vulnerable patients these tend to not be effectively enforced in the view of OzSAGE.

While there has been some resistance to the dropping of protections against COVID-19 within health care settings, and calls for reinstating masks, there is little action by the CDC and State governments to step in and provide clear guidance to health care providers on their responsibilities under applicable Occupational Health and Safety Legislation.

**Economic and health system impact**

There is also a lack of recognition of the impact that unmitigated disease spread has on ongoing health costs, which are contributing to severe pressure on capacity. A substantial proportion of SARS-CoV-2 infection is asymptomatic, so identifying all infectious staff, visitors or patients in hospital is not possible. However, masks can mitigate asymptomatic transmission.

Even simple, low-cost mitigations protect everyone in a health worksite, and also save money. Hospitals, long term care facilities and other health care sites have experienced pressure from ongoing staff shortages, often due to COVID-19 absenteeism or long COVID, reducing their ability to meet service demands. Ambulance ramping remains prevalent. There are widespread reports of burnout among frontline health workers, including paramedics, cleaners, orderlies, nurses, doctors and administration staff.

Staff are being encouraged to continue working – or are at least tolerated in the workplace – even if infectious with respiratory disease, and with the removal of even the simplest precautions such as masks, there are few effective measures in place to decrease the risk of airborne cross-infection to patients.

In the current health crisis with staff shortages and surging demand, it is counter-productive and unfair to remove legislated assumed liability obligations and specific COVID leave access for health care workers. Forcing staff to rely on general leave will contribute to staff coming to work when unwell, rather than isolating to reduce spread, as they should for every infectious disease. Better control of COVID in hospitals would ease the pressure on staffing.

**OzSAGE calls on the CDC/HICPAC to step up and provide clear guidance prevent COVID in hospitals**

OzSAGE calls on CDC/HICPAC to protect patients from Hospital Acquired COVID-19. A core role of HICPAC is to prevent hospital acquired infections, and they must step up in this crisis.

We call on CDC/NHSN to lead the collection of data and establish systems for transparent monitoring and reporting on hospital-acquired COVID-19, including associated mortality.

CDC should publish comparison of infection and death rates with other hospital acquired infections which are key performance targets for healthcare facilities such as surgical site infections (SSI), central line associated blood stream infection (CLABSI,) C. difficile infections (CDI) and spread of antimicrobial resistant organisms. We call on the CDC, State, Territorial and local governments to add Hospital Acquired COVID to other preventable infections which are measured and reported as performance targets for hospitals.

We call for all health care settings to provide clean air to a clinical standard. We can do better than settling for unacceptably high levels of ongoing transmission and the significant burden of disease, including long COVID, associated with SARS-CoV-2. Protecting our health systems and our healthcare workers by ensuring safe air, supporting the use of high-quality masks and respirators and providing quality oversight, including that of occupational physicians and occupational hygiene experts is of vital concern for the health and wellbeing of Australians and Americans.

It is the view of OzSAGE that:

1. The spread of COVID is a major preventable hazard within health care settings which is causing preventable illness, including long COVID-19 and deaths. Steps to control transmission need to be reintroduced. The CDC, State and hospital based IPACs must urgently address the disease and death toll caused by hospital acquired COVID-19; it is their remit and responsibility. The CDC and State Health Departments should add SARS-CoV-2 to other hospital acquired infections for which prevention is a key performance target for hospitals.
2. Workplace exposure in the health care setting is common and protections for health care workers and patients should be in place, as required by OSHA laws. Enforcement of workplace safety should include protection from infectious diseases.
3. Because transmission can occur during the asymptomatic or minimally symptomatic period of COVID, appropriate precautions and protections are still needed in the health care setting. Actions that should be taken urgently now include:
– explicit recognition by all stakeholders that patients have the right to be protected from all hospital acquired infections (HAIs).
-review of the composition and actions of HICPAC and Infection Prevention and Control (IPAC) Committees to ensure diversity of expertise and understanding of airborne disease prevention.
– HICPAC and IPAC committees should be reminded that prevention of all hospital acquired infection (HAI), including COVID-19 is their primary role and responsibility. Governments should add SARS-CoV-2 to HAIs that are measured and reported, and form the basis of evaluation of safety and quality of care in hospitals.
– mandatory N95/P2 respirators for healthcare staff when treating or likely to be treating any patient who is at increased risk from COVID-19.
– visitors to health care facilities should be required to mask due to the likelihood of immunocompromised patients being present.
– Indoor air in healthcare facilities should be kept free of airborne pathogens, including SARS-CoV-2, by improving ventilation and filtration. If necessary, portable HEPA air purifiers should be used when CO2 monitoring indicates that CO2 is over 800 parts per million [ppm] with installed mechanical systems.
– vaccination booster compliance should be monitored in healthcare staff and more effectively encouraged in the wider population to reduce severe acute and long-term disease.
– patients should be tested to exclude COVID-19 on admission to hospital especially if patients are placed in multiple occupancy rooms. As we no longer have good surveillance of community prevalence, we cannot assume it is low, and this helps to define subsequent hospital acquired infection.
– the adoption of the “rate of hospital acquired infection (HAI) with respiratory disease” as a measurable performance indicator which will affect funding of healthcare facilities, in order to align institutional motivation with prevention.
OzSAGE is a multi-disciplinary network of Australian experts from a broad range of sectors relevant to the well-being of the Australian population during and after the COVID-19 pandemic. OzSAGE formed in response to the current Australian epidemic, meeting for the first time on August 16, 2021. In the midst of many competing expert opinions, OzSAGE offers well-researched and robustly debated independent expert advice. We do this to inform the common national goal of achieving an exit strategy from this pandemic with the best possible health, social and economic outcomes. Members of OzSAGE are not paid and provide their time without remuneration and without a political agenda.
Members have experience, expertise and frontline roles in public health, infectious diseases, virology, immunology, epidemiology, vaccinology, clinical disciplines (intensive care, emergency medicine, infectious diseases, cancer, paediatrics, occupational medicine, mental health, allied health, and multiple other subspecialities), Aboriginal health, engineering, built environment, occupational hygiene, laboratory science, basic science, research and development,

behavioural and social science, multicultural engagement, communications, law, computer and data science, public policy and economics.
Dr Karina Powers
Co-Director OzSAGE

---

Hello

My name is Elliot Borenstein, and I am a disabled and immunocompromised citizen from Massachusetts. I am writing this as testimony to the HICPAC regarding the new draft infection control guidelines.

I am appalled at the watering down of patient and healthcare worker safety. The guidelines should include indoor air quality targets for healthcare facilities, either through fresh-air intake or filtration. They also should *not* water down source control measures.

The science is clear on indoor air quality. Cleaner and fresher air makes everyone safer by removing pathogens in the air. Yet your draft guidelines don't even mention air quality. We should have 12+ air exchanges per hour, and yet currently there's no guidance at all. History shows that organizations will choose to do the bare minimum they can get away with, and that means doing nothing where that minimum doesn't even exist.

Similarly, the science is also clear on source control. N95 respirators drastically reduce transmission of airborne pathogens, as compared to surgical masks. Your slides say that this isn't true, but they are cherrypicking the data. Every section of the slides on this topic shows that the findings have low strength, low-to-moderate precision and confidence, and a whole host of caveats. You must not use such questionable data to base a decision on, especially when better data exists that suggests the opposite.

Trying to get safe healthcare has only gotten harder over the last year. My state has long since ended medical masking requirements, and healthcare workers are being actively belligerent toward me and other high risk patients that ask them to mask temporarily. On top of that, many providers are ceasing all telehealth options because insurers don't want to pay full reimbursement rates for them. Those two things together, along with ever increasing apathy from the public and increasingly mutating strains of Covid-19, mean that it is extremely difficult to gauge the safety of accessing medical care.

My loved ones and I are starting to have to delay or avoid important medical care because of the increasing risks of contracting Covid and other diseases. That is dangerous, and exacerbates our health conditions. Knowing that healthcare facilities at least have a requirement for indoor air quality would go a long way to helping us all be safer when accessing care. And, of course, requirements for high quality respirators in medical facilities would also help tremendously.

I hope you will reconsider these draft guidelines, and help keep us all safe.

Thank you,
-Elliot Borenstein
Somerville, MA

No organizational affiliation

Hello,

I'd like to comment on the COVID isolation and infection control measures. I am the sister of a high-risk person (heart disease & stroke & disability). I'm extremely concerned about her or I getting COVID while being admitted in the hospital for procedures. I lost family members who went to get procedures (ie a knee replacement) got COVID while in the hospital, and passed away. It is unacceptable that we don't require hospitals to have a safe protocol to protect high-risk individuals from COVID exposure. She has an upcoming procedure at MassGeneral Brigham Hospital and requests for ADA accommodations are not addressed. There are no mitigation controls to prevent transmission of COVID through the air. Patients are not tested for COVID. There are no precautions anymore. Hospitals are not elective. People with complex conditions need to be there for life-saving treatment. We can't pretend that COVID doesn't exist and just let them fend for themselves and the fact they don't get covid is just a mere chance instead of a careful hospital protocol to ensure the safety of their patients. Especially when undergoing surgeries where the patient can't wear a mask even if they wanted to. The complete disregard for the safety of high-risk individuals by hospitals is unacceptable.

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.

Sincerely,
Andrea Alegre
Worcester MA

---

> To whom it should concern(although it appears you dont.) I'm a 59 year old chronically ill, mostly bedbound person from Ohio.
> I'm unable to tolerate the stimulation & visual energy required to watch or comment on the upcoming Masks in healthcare video call.
> 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 mislea & 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 sage 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

---

Hi,

I am Lisa Starr, Weston FL, Independent Clean Air Advocate and mask wearing advocate!!

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,
Lisa

---

Hi,

I am Jeanette M Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Jeanette

---

Hi,

I am Christine Irvin. I live at Grove City, OH. I am an Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,
Christine Irvin

---

I am Diane Downey, Vista CA, concerned citizen and Clean Air Advocate .

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,
Diane

---

Hi,

I am Annette Messina, Lombard, IL Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Annette

---

Hi,

I am Joe Messina, Lombard IL, Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Joe Messina

---

Hi,

I am Rianna Gacic, Independent Clean Air Advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Rianna

---

Hi,

I am Paul Kaloper, Salem, Oregon, Independent Clean Air Advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Lazarus.

---

Meghan McCoy, MD
Salem, NH
RE: Aug 22, 2023 public meeting of HICPAC

Hi,

I am a former doctor and current patient with Mylagic Encephalomyelitis (ME) and Psoriatic Arthritis which requires me to take immunosuppressants.

I am writing in regard to this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

The WHO indicates Covid is airborne, both short and long range, and as such requires N95s. In the past the CDC has acknowledged that surgical masks are not sufficient respiratory protective equipment (RPE).

https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-how-is-it-transmitted

https://www.cdc.gov/niosh/docs/2013-138/pdfs/2013-138.pdf

We know that N95 can prevent transmission as seen in MacIntyre et al study from 2013.

https://pubmed.ncbi.nlm.nih.gov/23413265/

(Studies that allow providers to doff and donn N95s as long as they're 6 feet away or rely on surgical masks are insufficient and should not be included in your reviews as we know surgical masks are less effective and far field transmission is possible with Covid.)

As a patient myself I emphasize that there NEEDS to be universal respirator usage in hospitals. High risk patients like myself are currently having to delay or forgo medical care because the risk of catching Covid in our hospitals and clinics is too high.

Hospital acquired Covid currently has an incredibly high mortality rate ranging from 5-10%. Sadly we do not have exact numbers in the US as no one is tracking it. It's easy to say there's not a problem when you don't look for it. I look forward to the days when we once again care about hospital acquired infections.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9612874/

Lastly, we need N95s in hospitals and clinics to protect our staff. We lost too many healthcare providers to Covid and Long Covid. Many, like me, are unable to work because there are so disabled by ME. We will continue to experience staffing shortages unless we use N95s.

https://www.webmd.com/covid/news/20230306/long-covid-takes-toll-on-health-care-system

Thank you,

Meghan McCoy, MD

---

Good afternoon,

I am Lora Walradt, a clean air advocate and citizen in Phoenix, Arizona, who, along with my husband, are at high risk of a severe outcome from Covid 19. We are extremely concerned about the lack of proper ventilation and lack of masking in health care facilities. We believe that we should not have to risk our lives to obtain medical care.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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.
Again, we are extremely concerned about the lack of proper ventilation and lack of masking in health care facilities. We believe that we should not have to risk our lives to obtain medical care.

Thank you,

Lora and John Walradt

---

Good day,

I am Renee Despres, PhD, MPH; Mimbres, NM; Independent Health Systems Consultant
Regarding this meeting:https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac
I 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

I want to emphasize that 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

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 other RCTs have donning and doffing of N95s within 6 feet or less of patients....which defeats the whole purpose of testing N95s against airborne diseases.

They should not be included in your reviews.

Thank you,

---

Hi,

I am Dejana Becker, Austin, TX, Independent Clean Air Advocate .

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

We should do everything in our power to ensure disease control and safety within medical settings and reduction of harm to both patients and personnel. This means that the use of respirators such as N95 or higher should be required on top of all the other measures already in place.

This should be standard practice like hand washing or gloves have become.

I 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.

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,

Dejana

---

Hi,

I am Kelly McCord, Aptos, CA, independent clean air advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Kelly

Dear Members of HICPAC,

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Tanya Hendricks Cobb
Evansville WI

Mother, daughter and sister with multiple high risk family and friends forced to risk COVID infection when seeking necessary medical treatment.

Hi,

My name is James Falek and I have had Long Covid for over a year.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

1. Please make the video of the meeting on YouTube public. Currently it is private and unwatchable.
https://www.youtube.com/watch?v=OqjC26DGr38

2. I 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

I do want to emphasize that 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

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,

James

---

Hi,

I am Dmitri Byzalov, Philadelphia PA, Independent Clean Air Advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

---

Hi,

I am Rachel Steuer, an Independent Clean Air Advocate from Eau Claire, Wisconsin, first time parent during April of 2020.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

---

Hi,
I am Zeke Pratchett, Portland, OR, Independent Clean Air Advocate.
Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that surgical masks are NOT RPE. TThe 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

---

Hi,

I am Joey Pincus, Newton MA, Independent Clean Air Advocate.

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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,

Joey.

---

Hi,

I am Lauren Worsh, Portland, OR, Independent Clean Air Advocate.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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

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.

Your attempts to normalize eugenics, to present eugenics as science based humane policy will be seen as history as deeply dishonest and murderous. If you are actual caring human beings you must confront the harms you have been complicit in and change course immediately.

If you were able to sit through that meeting listening to the public comments the other day and not feel shame or guilt about your participation in causing such immeasurable harm, please resign from any position of public influence, including this one. I was watching your faces during the commentary and the indifference and contempt I saw there was one of the most demoralizing things I have ever experienced.

If even one of you reading this has even a moment of crisis of conscience, please pay attention to that. It's trying to get through to you. You have the power to change the situation, or at the very least to whistleblow on your colleagues about the push to normalize eugenics and destroy public health that your agency has fully embraced.

Thank you to anyone reading this who has a conscience.

Lauren Worsh

---

Hello.

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.

Now cut the xxxx.

You know covid spreads by aerosols. You know covid destroys the vascular system, causes blood clots, and is deadly to people with serious health conditions.

I'll quote Joe Biden (whom I campaigned for, so don't presume I'm some Trumpy xxxx): "I don't question people's motives." Well, I have no choice but to question your motives. From what I can see your motives are to let people with serious health conditions contract covid in medical facilities and die. That's the only obvious conclusion one can draw.

Sincerely,

Jeff Cubeta
Brooklyn NY

---

Hey,

I am George Wasilenko Jr, Northridge CA, Mechanical Engineer, Clean Air Advocate
Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I agree fully 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

I do want to emphasize that 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

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,
George Wasilenko Jr

---

Hi there,

I am Minh Tran, of Washington DC, an independent clean air advocate and a concerned citizen impacted by this ongoing pandemic.

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I agree in full with the 900 experts who wrote to the CDC director in this following letter by NNU:
https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

The surgical masks are NOT RPE. The CDC's own NIOSH has acknowledged, repeatedly, that they are not RPE. Yet RPE is needed for airborne diseases, which the WHO indicates 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

Why is the CDC contradicting itself? 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,

Minh

---

Sara W., Madison WI, Covid Education Activist

Regarding this meeting:

https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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

I do want to emphasize that 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 have 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,

Sara W.

---

Hello,

I'd like to comment on the COVID isolation and infection control measures. I am the sister of a high-risk person (heart disease & stroke & disability). I'm extremely concerned about her or I getting COVID while being admitted in the hospital for procedures. I lost family members who went to get procedures (ie a knee replacement) got COVID while in the hospital, and passed away. It is unacceptable that we don't require hospitals to have a safe protocol to protect high-risk individuals from COVID exposure. She has an upcoming procedure at MassGeneral Brigham Hospital and requests for ADA accommodations are not addressed. There are no mitigation controls to prevent transmission of COVID through the air. Patients are not tested for COVID. There are no precautions anymore. Hospitals are not elective. People with complex conditions need to be there for life-saving treatment. We can't pretend that COVID doesn't exist and just let them fend for themselves and the fact they don't get covid is just a mere chance instead of a careful hospital protocol to ensure the safety of their patients. Especially when undergoing surgeries where the patient can't wear a mask even if they wanted to. The complete disregard for the safety of high-risk individuals by hospitals is unacceptable.

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.

Sincerely,
Andrea Alegre
Worcester MA

---

To HICPAC and the CDC,

I write as a concerned citizen regarding the urgent necessity of airborne precautions in health care settings.

Covid is an airborne virus that disables 1 in 10 people every time they get infected and is linked to increased risk of stroke, heart attack, diabetes, and cognitive decline. The virus is especially dangerous for individuals who are immunocompromised or who already have Long Covid, exactly the people who utilize health care the most.

Failure to require N-95s or better in health care settings is simply unconscionable. It forces disabled and immunocompromised people to risk death every time they need health care. Given that hospitals and doctor's offices remain a major vector of Covid transmission, many of my immunocompromised friends and family have put off doctor's visits indefinitely, at great cost to their health. They would rather have crumbling teeth, unexplained pain, and overdue tests rather than die from Covid.

How can doctors, who are supposed to care about their patients' well-being, force their patients to make such a stark choice? It is grossly unethical.

The science shows that N-95s are far superior to surgical masks. Again, N-95s must be required in all health care settings. This includes doctors, staff, patients and visitors.

I believe history will look back at the lack of masking in health care settings during an airborne pandemic the way we now look back with horror at surgeons in the 1800s not washing their hands before operations.

The need for quality masking is obvious and HICPAC needs to follow the science.

Sincerely,

Melissa Barlow
Germantown, MD
No company affiliation, just a concerned citizen

---

August 25, 2023
Centers for Disease Control and Prevention
HICPAC Committee Management
MS – H16-3
1600 Clifton Road
Atlanta, GA 30329-4027

**Re: Universal Respirators in Healthcare Settings; Non-Compliance Violates Federal Law 29 CFR 1910.134 et seq.**

Dear HIPAC and its members,

I am writing as a concerned US Citizen and human with a legal and entrepreneurial background. Public Health has failed all humans during the SARS-CoV-2 pandemic to date because it has failed to adequately educate the public how it spreads and the best practices against an airborne transmissible, Bio Safety Level 3/4 virus that is known to cause acute and chronic harm to every major bodily organ.

The pandemic continues due to these failures directly resulting in millions of American deaths, with millions more disabled or will become so. This requires implementing established CDC and OSHA protocols with respirator mandates in all health care settings and warn the public that respirators are also needed in public spaces. SARS-CoV-2 is the 3rd leading cause of death for Americans trailing cancer and heart disease, but it is known that SARS-CoV-2 causes cancer as well as blood vessel damage causing heart disease, strokes and pulmonary embolisms. Like HIV, it destroys the immune system, specifically decreasing CD4/CD8 T-cells that leaves our society more susceptible to others diseases and why malaria, polio, hepatitis, fungal disease, etc. have returned/emerged.

It is necessary and dire for HIPAC/CDC to implement clearer language to all Healthcare Professionals on how diseases spread, the importance and physics behind Personal Protective Equipment ("PPE"), and enforce negligent failures by employers and/or individuals implementing them. According to the CDC, EPA, WHO and any credible aerosol scientist, SARS-CoV-2 is an airborne virus because any person who does not protect their mucus membranes (i.e., eyes, mouth and nose) allowing an infectious person's respiratory fluids to settle, most commonly through inhalation or touching, in them. A January 7, 2016 CDC Science Brief: How Infections Spread (http://www.cdc.gov/infectioncontrol/spread/index.html) make clear that "transmission refers to the way germs are moved to the susceptible persons. Germs do not move themselves" and "depend on people, the environment and/or medical equipment to move in healthcare settings… airborne transmission can occur when infected patients cough, talk or sneeze [and breathe], germs into the air…" CDC identifies SARS-CoV as airborne leaving no doubt that respirators are necessary. *CDC's Hospital Respiratory Protection Program Toolkit (https://www.cdc.gov/niosh/docs/2015-117/default.html): Resources for Respirator Program Administrators (Published in May 2015 (Updated April 2022)* pp. 19, 42.

All of the following are true; therefore, **every public** space, including and especially healthcare settings, have susceptible or potential infectious persons requiring face coverings/respirators.

· CDC defines a "susceptible person (http://www.cdc.gov/infectioncontrol/spread/index.html)" as "someone who is not vaccinated or otherwise immune or a person who has a way for the germs to enter the body."
· Since vaccines are not sterilizing (i.e., does not prevent infection) all persons are susceptible!
· Up to 60% of individuals show no symptoms but are SARS-CoV-2 infected/infectious
· Acute Symptoms do not correlate with disease severity, and these symptoms result from one's immune system – common to most viruses

· Surveillant and Individual Testing no longer occurs at a volume necessary to contact trace, which WHO and CDC make clear is necessary for infection control
· Vaccines, Rapid Antigen Tests and PCR Tests are obsolete
· SARS-CoV-2, Tuberculosis, RSV, Influenza, etc. all can transmit through the air when a person breathes and another person inhales meaning one can be infected a greater distance than 6 feet and longer than 15 minutes.
· CDC/NIOSH certify that only PPE protects against airborne diseases. PPE examples are goggles (to protect the eyes) and respirators (protect the nose and mouth). CDC/NIOSH make clear that anything less than respirators such as level three surgical and cloth masks are insufficient and illegal

**Legal Liability – Federal Law Violations:** Not only would HIPAC be hypocritical by violating its own established infection disease protocols, but HIPAC and its members will be violating Federal Law if it implements these reduced infection control measures. 29 CFR 1910.134 et seq (https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134). mandates that employers shall provide each employee a respirator when such equipment is necessary to protect employees' health. The employer is responsible to establish and maintain an respiratory protection program.

In addition, as stated in Section 5(a)(1) of the OSHA Act of 1970, employers are required to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. This is known as the General Duty Clause, and it applies to all employers covered by the OSHA Act, regardless of whether they are subject to specific OSHA standards or regulations.
Please note that most healthcare facilities and non-compliant employees have been and are in violation of these same laws. I have seen and spoken with first-hand infectious disease doctors, nurses and risk managers who all cite CDC's policies to justify not wearing any face coverings, yet they apply them incorrectly by stating non-respirators. These errors have killed and disabled, and it directly negatively impacts healthcare workers. With employee shortages, these people must be protected to ensure community healthcare access.
When respirators are worn correctly and universally, airborne diseases are blocked from transmitting Take the example of San Antonio's The Texas Center for Infections Disease ("TCID") Hospital who uses Elastomeric Masks with P100 Filters and has required them since 1996. Since then, there has not been one single reported HAI (https://www.kens5.com/article/news/health/san-antonio-hospital-could-have-an-answer-to-the-ppe-crisis-elastomeric-masks/273-882e7ea3-e377-4776-906c-33ce89e193cc). 100% real world data exceeds NIOSH's 99.7% protection against airborne particles certification on these reusable respirators.
There are no justifiable reasons to avoid respirators and prevents all persons, especially disabled and vulnerable, from accessing safe healthcare, which is a human right. Seeing smiles is not healthcare. Letting infectious individuals gather is not healthcare. Allowing the deadliest disease in modern-human history go unchecked is eugenics and not public health. We are all susceptible. Do the right thing and improve PPE knowledge and implementation in healthcare settings.

Respectfully submitted,
**/s/ Justin B. Stone**

Justin B. Stone
Toledo, OH

---

To whom it may concern:

I am Kate Nyhan, a medical librarian. I am commenting on my own behalf, not on behalf of my employer and not on behalf of the not-for-profit organization of which I am a board member, Community Access to Ventilation Information. I have no other conflicts.
I am concerned by media reports about a CDC literature review, upon which HICPAC is said to be relying, on aerosol transmission precautions and the relative performance of respirators and masks. As an expert in information retrieval and the reporting of evidence synthesis, I am concerned that this important document is apparently available to the public only through screenshots from the June HICPAC shared on social media. Transparency and openness always lead to greater trust and better results. After all, preventing airborne disease transmission is an interdisciplinary problem, with industrial hygienists and engineers having a great deal to contribute!
On a personal note: the fact that I can no longer expect health care providers and other patients to be masked in healthcare settings is exclusionary and makes me weight the benefits and risks of seeking care in person very carefully.
I hope that HICPAC members will consider seriously their ethical obligations as well as the full range of evidence (including mechanistic and observational studies) as they decide what equipment and policies to recommend.
Sincerely, Kate Nyhan

---

The consideration to weaken infection control in clinical settings at the benefit of employers' wallet as they avoid OSHA fines and the cost of protection tools over the lives and safety of patients is unconscionable, brutal, and a violation of human rights. People will get sick and die from this. To refute this is to refute the basic fact that sickness endangers people's lives and ability to stay in the workforce and have a social life. This will increase the circulation of diseases outside of the clinical setting downstream, as well.

Shame on everyone who thinks this is a good idea. You are putting people's rights and health on the table for a debate.

Moreover, CDC's unwillingness to explain clearly to the public what airborne spread of pathogens (and its solutions) means make it easier for HICPAC to lower the controls. If COVID-19, a leading cause of death and disability worldwide, is minimized and seen as no big deal, then it is no surprise that everything else starts to look unserious. It is no coincidence that the normalization of Covid has led to this HICPAC meeting.

The CDC does not have the luxury of claiming ignorance once history looks back. You have all the current knowledge at your disposal and an incredible, capable workforce. This means that the harm being done is dealt knowingly, in full awareness of the social murder they're carrying. Some of us keep the scores of your contradictions in light of the studies that come out. You are setting the stage for chaos, deregulation and an intolerable amount of sickness.

---

To Whom It Concerns:

As a disabled American, high-risk for Covid, with a weak immune system, the end of the PHE declaration concerns me. Health care facilities in my state of Washington are essentially relying on their own boards and internal procedures to decide if and how to tackle Covid safety. Because masks are no longer required, and many facilities put patients in small rooms with inadequate ventilation, going to my appointments is a much greater risk to my health and the health of other patients than they should be. Not to mention illness then being taken outside, to the general population. Now, with not one but two new variants of concern popping up around

the world, is not the time to cut corners. BA.2.86, which some media outlets have nicknamed "Pirola," is another subvariant of the omicron variant, this one descending from the BA.2 strain that led to widespread covid cases at the start of 2022. The new strain has 34 more mutations than BA.2 and 36 more than XBB.1.5 (dubbed "Kraken" in the media[1](https://www.bmj.com/content/382/bmj.p1964?link_id=25&can_id=26e7a01e6fb6b1f1bab540e93ca640d6&source=email-big-lie-co-conspirator-betrays-trump-in-court&email_referrer=email_2027071&email_subject=big-lie-co-conspirator-betrays-trump-in-court#ref-1) and the strain recommended for vaccination), said an early analysis by Jesse Bloom, a computational virologist at the Fred Hutchinson Cancer Research Institute in Seattle, USA.[2](https://www.bmj.com/content/382/bmj.p1964?link_id=25&can_id=26e7a01e6fb6b1f1bab540e93ca640d6&source=email-big-lie-co-conspirator-betrays-trump-in-court&email_referrer=email_2027071&email_subject=big-lie-co-conspirator-betrays-trump-in-court#ref-2) BA.2.86 has "at least as much" antibody escape as XBB.1.5 did when compared with BA.2, meriting high priority monitoring for signs of spread, Bloom wrote. The World Health Organization has labelled BA.2.86 a "variant under monitoring"—its second tier of notable covid variants. The mutations give BA.2.86 "all the hallmark features of something that could take off," said Kristian Andersen, an immunologist at the Scripps Research Institute in the US.

According to reports, "The most plausible scenario [accounting for its appearance] is that the [omicron] lineage acquired its mutations during a long term infection in an immunocompromised person over a year ago and then spread back into the community."

Where are there more immunocompromised people than average? HEALTHCARE FACILITIES! Why would you put the entire population at risk for immune-system- and vaccine-evading strains by not protecting this population subset? Which then enlarges this subset?

Studies show that hitting specific air quality targets for indoor settings significantly and effectively reduces the risk for Covid transmission as well as for other airborne diseases. Keeping the American population as disease-free as possible should be the CDC's highest priority—which means making sure our health care facilities are set up to succeed in this arena, in the modern world. It's of utmost importance to not just me and those like me, but our economy, our workforce, and the American way of life.

We've seen time and time again that high-ranking government officials and the wealthy the world over no longer meet without air quality taken into consideration. All Americans deserve the same consideration. As such, I'm asking you to issue an Indoor Air Quality target for all healthcare facilities, making sure they must have ventilation of at least 12 air changes per hour, or an equivalent level of HEPA filtration. You might be surprised how often that's not case in the myriad of doctor's office, hospitals, and other health care facilities I have to frequent in high-population areas like Seattle and Tacoma. I can only imagine indoor air quality is worse in places with less resources and worse weather.

Doing this now, while America still remembers the havoc and loss of life from the Covid-19 Pandemic, will ensure another such pandemic doesn't take us unprepared.

Please, please don't leave Americans to their own, inadequate devices while Covid-19 is still at large and capable of, once again, bringing our country to its knees.
Sincerely,

Sarah R. Lee
Federal Way, WA

In the process to update 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. Please, slow down the process and include these experts in developing your update.

I urge HICPAC to adopt guidelines that recognize the established science of airborne transmission and its prevention. This would include effective masking including N95 respirators (and equivalents or better). There is not reason that patients or healthcare workers should not be protected from airborne pathogens like SARS-COV2. Patients should be able to go safely to the doctor, knowing that respirator usage (as well as air cleaning and ventilation) will greatly reduce their risk of contracting SARS-COV2 and other dangerous pathogens. For instance, one of my family members is vulnerable due to a heart condition, and as SARS-COV2 is documented to negatively impact the vascular system, the risk of contracting SARS at the hospital and necessary doctor appointments makes life particularly difficult for this family member.

In addition, there is evidence that 10% of nosocomial SARS infections lead to death! Improved guidelines could make a huge difference in this devastating number. Furthermore, as CDC makes clear 1 in 10 SARS-COV2 infections leads to long Covid. CDC guidelines must do all that they can to make hospitals and medical care providers spaces as safe as possible for all patients. A patient shouldn't have to risk catching SARS when going to the hospital or a doctor's appointment for needed care. None of this is to mention the need for protecting our healthcare workers who deserve to stay as healthy as possible—and who we need to be healthy and able to work to attend to their patients.

Thank you for your time. Again, please, call on greater input from experts and stakeholders before moving forward with the updated guidelines.

Best,
Melanie Mendenhall

I am a concerned citizen wishing to urge HICPAC to maintain (and improve upon) the standards set for healthcare settings and practitioners that were established during the Covid pandemic.

In these settings, it seems imperative to maintain masking as a barrier to spreading deadly viral pathogens, and the need for proper ventilation in the form of HEPA filtration seems obvious. It is well documented that rates of Covid infection have skyrocketed in healthcare settings due to the end of mask use.

When the HIV epidemic arose, gloves and sharps disposal became a new normal for healthcare. I want to encourage practitioners to continue on with masking and proper ventilation in an age where serious respiratory illness will persist for the foreseeable future. This seems logical given new learnings from the past several years, and the obvious challenges we face now and into the future.

Sincerely,

Kristin Senty-Shaw
Girard, Kansas

The basis for infection control should never be "What's the least we can do?".
The reality is that it does not matter that surgical masks are "okay enough" to protect people healthy people. Most people seen in healthcare settings are not healthy people. "Okay enough" mask recommendations, when seen through the lens of "who are we treating" are woefully insufficient to protect vulnerable patients and the staff who treat them.
Vulnerable patients are already putting off routine care due to relaxed masking policies. This delayed care will result in poorer long term outcomes and even death. It will also result in patients seeking critical care in place of maintenance or routine care. Patients need to be safe, and to feel safe.
To make this happen, the focus should be on finding the maximized level of protections. These protections should be multi-facted (air quality, PPE, risk control) so that a critical failure at one level will not create a 'no protections' situation. The focus should be on protecting the vulnerable, not on what is "okay enough" to protect an average, healthy person. Medical facilities should be guided in making choices that are as future proof as possible, offering better air quality, better protection practices, and a level of safety for vulnerable people that is above what they'll find in a grocery store or their own homes.

In short, the CDC should ask "What's the best we can do?" and begin there.

Layla Kilpela
Tarentum, PA
No Organizational Affiliation

Hello,

My name is Jennifer Radomski and I'm a high risk, chronically ill and disabled member of the public begging you to protect us. I have had to forgo so much medical care and treatment since the decision to protect patients was left up to facilities discretion and they chose their own comfort over patient centered care, lifting mask mandates as fast as they could without updating ventilation or considering how many patients they're dooming in the process.

By refusing to implement universal mandates for high quality n95 masks/respirators and adequate ventilation in all healthcare settings, you are repeating history. You are behaving exactly like the contemporaries of Ignaz Semmelweis, who refused to implement his proposal of hand-washing for decades, costing the lives of countless patients and pushing him to a mental breakdown, institutionalization, and an early death. You are repeating the beginning of the HIV/AIDS epidemic when the CDC insisted condoms and gloves don't help with preventing transmission or that women couldn't contract the virus, even though all evidence indicated that they were wrong. You obviously don't know this history and more - please learn it - because you are unnecessarily repeating it and thus sentencing patients to death and permanent disability.

What follows is an excerpt from a letter by the National Nurses United, which articulates our demands for the updated guidelines far better than I, a patient, can express:

We urge HICPAC and the CDC to ensure the following elements are upheld in updates to infection control guidance in health care settings:
1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens.

HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including:

- Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls.
- Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.
- Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don't adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

We are concerned about the lack of transparency in your process to update the CDC's guidance document, Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (last updated in 2007). Changes to this guidance will impact health care workers, patients, and communities in every state, but you have no clear mechanism to garner input from those health care workers, their unions, or patients and community members before the updates are finalized.

If you won't protect patients and healthcare workers, who will?
Stop killing us.

Pleadingly,
Jennifer Radomski

---

Hi,

My name is Wolf Hamel. I live at Charlestown, MA.

I'm writing to request that the CDC increase, not weaken infection control standards at hospitals.

My sister is a nurse and my spouse is immunocompromised and it's very difficult to get safe medical care these days. The flu has sent us to the ER on more than one occasion and COVID would be even worse.

I request that the CDC make hospitals a safe space for everyone because you cannot opt out of medical care. We should be improving ventilation and air filtration, implementing upper room UV light, and requiring medical professionals and patients to mask, preferably with well-fitting n95 masks so that medically vulnerable people can still access care or those that live with medically vulnerable people can still access care.

Hospital acquired infections are more dangerous than other infections and hospitals should have a duty not to make their patients sicker when they seek out treatment. It is the epitome of "do no harm."

Additionally, infection passed to hospital workers makes staffing problems worse, as sick workers cannot provide appropriate care. This means patients will be more likely to receive substandard care and will be more likely to be sicker, more disabled, or die as a result.

Please prioritize preventing infection at hospitals. It's the moral thing to do and it just makes sense.

- Wolf Hamel

---

Hello,

I'm writing regarding the HICPAC draft guidelines allowing hospitals to loosen infection protocols. I'm writing as a concerned citizen, because I care about immunocompromised people and other groups at high risk for Covid, as well as healthcare professionals and their safety in their workplaces.

Drafting guidelines on infection control protocols without input from aerosolized transmission experts in the middle of a pandemic caused by a virus that transmits by aerosols is foolhardy at best. Covid is rapidly evolving and large swaths of the population are still at very high risk, with people who catch Covid in hospitals at extreme risk of serious negative outcomes. Additionally, we are facing an antibiotics shortage, increasing antibiotic resistance, and a large variety of diseases are becoming more dangerous, possibly because of Covid induced immune damage. Tuberculosis has become much more common, RSV has become more severe, and more Americans are sick than ever before.

Now is not the time to lighten up on infection control! We need high quality masks, specifically N-95 masks, to protect healthcare workers and those seeking healthcare.

We need to prevent infection, not mandate it! Please reconsider the draft guidelines! Please do not weaken protections for healthcare workers and patients! Our country depends on it!

Thank you for your time.

Sincerely,
Moriah Benthem

---

To Whom It May Concern,

My name is Emma Gomez and I am immunocompromised person. I am also a member of the American public that does agree with the committee's plan to weaken infection control. As a vulnerable member of society, it is important that my healthcare providers take extra steps to keep me safe and healthy. Equating surgical masks efficacy with that of N95 mask is dangerous and unethical. Many experts have already proven that N95 masks are far superior to surgical or cloth masks because they can filter small airborne particles like those from SARS-CoV-2 viruses and keep the wearer safe from infection. Surgical masks are not well fitted to any persons face and the wearer of these surgical masks runs a high risk of contracting or spreading infection. It's also important to note that healthcare facilities should take extra steps to filter the air in their buildings to prevent the spread of airborne viruses and to keep high risk and vulnerable patients safe from unhealthy airborne particles.

It's a disgrace that most members of this committee are healthcare administrators who have already placed millions of patients at risk by not mandating the use of mask during a pandemic that has killed over a million and disabled thousands. My voice and the voice of millions of others matter in this fight to make sure healthcare faculties and workers are following the highest standards of safety when caring for patients. Please do not ignore the concerns of the public.

Sincerely,
Emma Gomez

---

Dana Allen
Member of the public
Fort Myers, FL
RE: Urgent Concerns Regarding Proposed Changes to Weaken Airborne Transmission Protocols in Healthcare

Dear Members of HICPAC,

My name is Dana Allen, and I am immunocompromised and high risk for severe Covid. I am writing to you today as an individual significantly affected by the ongoing COVID-19 pandemic and as someone who continues to suffer the consequences of unmasked healthcare. Since March 8th, 2020, I have been compelled to take extensive precautions to safeguard my health due to the elevated risks associated with COVID-19. I live in Florida, where healthcare settings have been unmasked for a considerable period of time now.

My experiences in seeking medical care in an environment where healthcare providers have been unmasked have been nothing short of harrowing. At this point, I have been forced to forgo necessary medical appointments, including vital physical therapy sessions that could significantly alleviate the severe pain I endure every day, as well as testing and treatment for autoimmune disease. Not to mention having to completely give up preventative care because the risk is too high. The reason is simple yet disheartening: the absence of mask mandates in healthcare settings has made receiving care an extremely dangerous endeavor for individuals like me.

Multiple healthcare professionals have explicitly advised me to stay away from healthcare settings, as the risk of exposure to COVID-19 in an unmasked environment is unacceptably high, particularly being high risk. It is deeply distressing that my pleas for masks have been met

with ridicule and laughter by these same doctors rather than empathy. This has left me in a state of profound physical suffering that is entirely avoidable, forcing me to neglect all but emergent care.

People in my position are being forced to make unimaginably difficult choices: to either allow their medical conditions to decline due to the lack of access to essential care or to risk accelerated and worsened conditions or even death from a COVID-19 infection acquired via healthcare. These are choices that no one should be compelled to make.

Furthermore, I am deeply concerned about the lack of mention of air filtration in the proposed updates to the CDC Isolation Precautions for Health Care Settings. Adequate air filtration is essential in healthcare settings to reduce the transmission of infectious diseases. The omission of this critical aspect is concerning and requires immediate attention.

Additionally, the proposal to equate surgical masks to N95 masks and to downgrade the recommendation for COVID patients from N95 masks to surgical masks is outrageous. Research has conclusively shown that N95 masks provide significantly higher levels of protection against airborne pathogens than surgical masks. This downgrade not only jeopardizes the safety of healthcare workers but also puts patients at risk, particularly those who are already vulnerable, like individuals with disabilities.

I request that the HICPAC process be opened up to include representatives from the disability community and all stakeholders impacted by these recommendations. The active exclusion of disabled people from these vital decisions and conversations is not only discriminatory but also unconscionable.

Furthermore, I urge all members of the HICPAC committee to remember that they are not immune to the vulnerabilities that have affected disabled individuals throughout this pandemic. COVID-19 has proven to be indiscriminate in its impact, and even healthy individuals can become disabled due to its lasting effects. Each of you is just one moment, one COVID-19 infection, one comorbidity away from becoming disabled and facing the same challenges we do. Will you be satisfied with this level of care when it's your turn?

I plead for your immediate attention to these concerns and your unwavering commitment to an inclusive, equitable, and transparent process in the development of adequate guidelines for infection control in healthcare settings that actually minimize transmission. The lives and well-being of countless vulnerable individuals, like myself, depend on it.

Thank you for your understanding and consideration.

Sincerely,
Dana Allen

---

Hi,

Please do not adopt the proposed guidelines. We very much need stricter air quality standards everywhere, but ESPECIALLY in health care facilities; to lower the standards now to serve the short-term profits of the facilities will be devastating to the entire economy in the long term as increasing numbers of Americans become (entirely preventably) disabled and leave the labor market (thus also ensuring they have minimal disposal income).

Additionally, while surgical masks are better than not masking at all, they are in no way the equivalent of fitted N95s. We are already experiencing shortages of medical providers due to long covid; both providers and patients (especially the immuno-compromised and high-risk folk in both groups) need and deserve the added protection N95s provide.

Regards,
Megan Sumerell
Greenville, NC
no org affiliation

---

To the Healthcare Infection Control Advisory Committee,

My name is Ariel Benson, and I live in Los Angeles, CA. I'm reaching out today to express my dismay about another loosening in the recommendations about preventing the spread of covid in healthcare settings. The idea that a surgical mask is "good enough" and that air filtration is no longer important is ludicrous. If the standard of care is not what would be acceptable for the welathiest and most powerful among us, why are the rest of us being sacrificed in this way? It is bad enough the way everyone is letting covid spread unchecked, with full blessing from the CDC, but the doctor's office or hospital are the bare minimum of those who should be working to protect us and prevent spread. No one should be forced to risk getting an illness which can still be deadly and debilitating to receive care. No one should have to weigh treatment vs. risk in this way. Do your damn  jobs!

Sincerely,
Ariel Benson
Los Angeles,  CA

---

CDC HICPAC,

It is urgent and essential to follow the FDA, NIOSH, and  OSHA guidelines saying N95 or better, ventilation and filtration, are the only evidence based options for deadly pathogens like Covid 19 and other airborne spread illness. The proposed changes would increase the spread of covid, flu, and RSV in healthcare settings, killing or disabling folks who deserve access to safe healthcare.  It will further strain our healthcare system at a time in which we cannot afford to do so.  Please, DO NO HARM and recommend N95 or better.

Jessica Kelly (she/her)

---

Hello,

My name is Anastazie Cozzens and I am a member of the public living in Schenectady, New York. I am contacting you with concerns regarding the new guidelines that HICPAC proposed.

HICPAC suggested surgical masks be used as the standard masks to help prevent COVID exposure. Surgical masks are not nearly as effective as N95 masks and equating their efficacy is dangerous. N95 masks are by far superior at limiting the spread of contagious diseases.

I am also questioning the failure to mention air filtration of any kind. Healthcare facilities should be required to have air filtration to limit people's exposure to COVID and other airborne illnesses.

To reiterate, N95 masks and quality air filtration should be required in the healthcare setting.

Thank you.

---

Hi.

My name is Margaret Pleasants and I live at Charlottesville, VA and am a concerned member of the public.

I strongly support keeping strong Covid precautions in place, particularly in healthcare settings. It is known that N95 masks are significantly better at preventing the spread of disease than surgical masks and when a disease like Covid is still spreading and still mutating it is important that we continue to use precautions like N95 masks and air filtration.

Weakening these viral airborne infection precautions will lead to more infections and more people being harmed and disabled by Covid and long Covid. This pandemic is not over, it is still spreading, still mutating, and still dangerous. This is not the time to weaken our precautions.

Please keep healthcare safe.
Thank you,
Margaret Pleasants

---

Topic: Strengthening Healthcare Workers and Patient Protections

Emma M. Kennedy
Evanston, IL
Organizational Affiliation: N/A

To the HICPAC committee:

I am writing today regarding the ongoing process of revising the Center For Disease Control's "Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings."

In the Isolation Precautions Guideline Workgroup Presentation Slides at the August 22, 2023 HICPAC meeting, the Key Concepts of Standard Precautions were defined as such:

- Standard Precautions are the basic practices that apply to all patient care regardless of the patients' suspected or confirmed infectious state, and apply to all settings where care is delivered.
- Standard Precautions have multi-directional benefits—protect HCP from acquiring infection from patients and prevent HCP or the health care environment from transmitting pathogens to patients.

I want to note the phrase at the end of the Standard Precautions definition, that they "apply to all settings where care is delivered." As many of the public oral comments at the meeting emphasized, vulnerable patients are currently unable to safely access health care facilities due to the widespread prevalence of SARS-CoV-2 within society and within health care facilities. If the fast and dangerous spread of this virus has taught us anything in the last 3+ years, it is that use of high-quality respirators needs to become the basic practices of care and precaution to prevent outbreaks before they happen and potentially harm patients and health care workers. As HICPAC Committee member Elaine Dekker, RN commented in the August 22, 2023 meeting

that “your Standard Precautions are your Standard of Care for all patients.” Sadly, many hospitals and health care facilities are not employing a standard of care for all patients and many patients are being exposed to SARS-CoV-2 with many becoming sicker and many dying. Rather than a framework of risk assessment with use of PPE, PPE as the expected *standard* would benefit all.

Numerous authors have written about use of respirators to protect patients. I highlight and link here to the New England Journal of Medicine Article titled: Strategic Masking to Protect Patients from All Respiratory Viral Infections (https://www.nejm.org/doi/full/10.1056/NEJMp2306223). Additionally, studies such as this one, Sickness presenteeism in healthcare workers during the coronavirus disease 2019 (COVID-19) pandemic: An observational cohort study (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), have shown that Health Care Workers often work while sick.

This is why it is vitally important that HICPAC *strengthens* Standard Precautions to include respirators as the baseline of care and improved ventilation and air filtration. It is vital that CDC/HICPAC acknowledge the importance and function of core control measures for infectious aerosols. I conclude by pointing you to the following letter initiated by National Nurses United from experts in occupational safety and health, medicine, epidemiology, industrial hygiene, ventilation, aerosol science, and public health: https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf

Thank you,
Emma Kennedy

---

To whom it may concern,

Thank you for requesting feedback regarding the recent HICPAC meeting, I appreciate the opportunity.

I have had Long COVID since March 2020, there are ebbs and flows to the illness, but I am much improved: this means that I am housebound, can very rarely drive, cannot cook or clean, and have to rest a great deal before going to doctor's appointments. It is a far cry from the life I had, one where I could drop everything to help a friend or spend hours at the gym, but I am no longer in pain everyday and can reliably sit up for hours at a time.

One of my biggest concerns is returning to my lowest baseline or going even lower than what it was. I could not hold my head up and needed a soft collar. I was throwing up every day. Breathing was hard. Eating was hard. Even experiencing strong emotion, good or bad, was painful and unpleasant. I could not stand, sit, or walk without severe symptoms. It was bad, and yet getting worse was a very real possibility that loomed over me: Would I need a feeding tube? Would I need to find an in-home aid? Would it even be financially possible?

One of the main ways I am avoiding returning to the worst physical condition I've ever experienced is avoiding COVID reinfection. Within my own home, this is possible. But I have been putting off preventative care–the dentist, the gynocologist, the optometrist–for years. At

first because it was physically impossible for me. Now it is because of the insufficient protections in place at most doctor's offices. No one is wearing masks, no matter how high transmission rates are. It is a mystery whether there are ventilation standards that doctor's offices or hospitals follow. I simply cannot know whether a routine visit will reinfect me, and possibly make my baseline much, much worse.

I know I am not alone. In a country where preventative care is needed to catch conditions like high blood pressure, cancer, diabetes early, there are people who are told that due to their high risk of negative COVID infection outcomes that they should simply stay home. What we need is measurable guidelines for facilities to follow like indoor air quality guidelines and clear recommendations for staff if they are infected with *any* airborne respiratory virus.

I do not want anyone to go through what I have gone through. And for those who have, I want them to continue to be able to access preventative care. For that, we need structural action and clear guidance, not to tell people not to go to the hospital if they are sick.

Regards,
Crystal Lasky Robinson
Champaign, IL

---

Dear HICPAC members:

My name is Hiroko Kawana. I am 32 years old and live in Alameda County, California. As a member of the public, I am very concerned about the lack of respiratory protection included in the standard precautions discussed at this meeting. We are in an airborne pandemic, and the CDC itself published a study showing that N95 respirators are significantly more effective at preventing airborne transmission than procedure masks. Yet, most healthcare facilities are only using procedure masks, or worse, no masks at all. The CDC has also recommended 5 air changes per hour in all occupied indoor spaces, yet ventilation information is not available at healthcare facilities.
I would like to share my experience. I have a condition that causes severe urinary incontinence, and my urologist said that my only treatment option is an inpatient surgery. However, I'm not able to safely get this surgery because of the risk of getting infected with Covid during surgery or recovery. I am not able to protect myself while unconscious under anesthesia, or while eating, drinking, and taking medications during the subsequent hospital stay. The hospital defers to the CDC and does not use effective respirators or have ventilation information publicly available. I'm seriously contemplating if continuing to suffer, soaking in my own urine 24/7, is a better option than getting unsafe care.

I have had other discouraging encounters while seeking healthcare. I had an oral surgeon operate on me without an N95, even though he had told me he would wear one. Sadly I was too scared of retaliation to speak up. It is very difficult to defy the authority of someone who is about to cut you open, and no patient should be put in that position.
Besides, even if I had said something and he had put one on, any infectious aerosols he had emitted would have already been in the room. I have also struggled to find primary care, physical therapy, and sleep studies where I am not exposed to potentially contagious staff or patients.

I am relatively lucky. My medical conditions only cause discomfort, pain, and loss of dignity. I am not facing death as some other patients are, and I can only imagine how terrifying it is for them to attempt to get healthcare.

I urge HICPAC and the CDC to require universal masking with N95's or better, and ventilation and filtration, in all healthcare facilities.
Healthcare is a human right, and nobody should be risking illness or death in order to access it.

Sincerely,

Hiroko Kawana
San Leandro, CA

---

CDC HICPAC,

I think and feel it is urgent and essential to follow the FDA, NIOSH, and OSHA guidelines saying N95 or better, ventilation and filtration, are the only evidence based options for deadly pathogens like Covid 19 and other airborne spread illness. The proposed changes would only increase the spread of covid, flu, and RSV in healthcare settings, killing or disabling folks who deserve access to safe healthcare. It will further strain our healthcare system at a time in which we cannot afford to do so. Please, DO NO HARM and recommend N95 or better.

~~Molly (she/her)

---

Hello,
I am writing to submit a comment on the HICPAC proposed updates.
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. 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.
I myself, along with many members of my community, have been putting off receiving necessary medical care because of the constant spread of COVID 19 in doctor's offices and medical care facilities due to the lack of mandatory masking and filtration. These updates will make it even easier to catch respiratory viruses at the doctor, including measles, flu, MERS and COVID.
Decisions about respiratory protection, ventilation, and isolation should not be left up to employers and individual facilities. 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, and to use updated, correct data about high quality masks and air filtration to inform these decisions.
Sincerely,
Hartley Hesse
Boulder CO

---

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 writing to express my deep concern regarding 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.

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:

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.
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.
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.
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,
Rey Byrne
St. Louis, MO
Independent concerned citizen

---

I am writing to register my strong objections to HICPAC's proposal to weaken the CDC's Isolation Precautions guidance.

The Work Group has proposed updated terminology on infectious disease transmission (“air” and “touch”) that 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 has 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.

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.

Thank you for your attention to these crucial matters.

Tamara King
Member, World Health Network
Portland, OR

---

To whom it may concern:

I am a disabled, chronically ill and immunocompromised person living in Chicago. Hospitals and doctors' offices stopped mandating masking here in March. I require a number of in-office procedures to maintain my physical function, and also have to go in and get COVID boosters. I should not have to risk my health or beg practitioners to mask around me in order to get an immunocompromised schedule COVID booster, and yet, that's the situation I've been put in. I am avoiding having my orthotics repaired and going in for specialist annual check ups because the hospital is now one of the least safe places I can go. Please go back to protecting vulnerable people who make more frequent use of medical facilities than the general population by reinstating masking mandates in medical settings.

Terri Lynne Hudson
Chicago IL
Care Not Covid Chicago Volunteer/Member of the Community

---

Please, live up to your name - The Center for Disease Control's Healthcare Infection Control Practices Advisory Committee.

The name of your Committee says it all "disease control" and "infection control." What better way than to make sure that effective masks are worn properly in health care situations to protect nurses, other staff and patients, especially the elderly from airborne diseases?

I am an elderly person who dreads seeing any of my specialists or primary doctors at Kaiser because there are no more any guidelines for mask usage, an effective method. Santa Clara Kaiser even has an "in-person" Senior Support Group that many (including me) avoid because it is held in a small, closed room. What purpose does it serve to allow vulnerable seniors to risk getting a respiratory infection?

Lack of masking also puts our valuable nurses and other providers at unnecessary risk in addition to the patients they subsequently have contact with. Some are already quitting due to the threat of Covid and its long term effects. Why encourage a further health provider shortage?

Please require mandatory masking.

Thank you.

Jean Salmon, retired social worker only representing herself
Santa Clara, CA

---

Hello,

My name is Alison Cohee and I work in Clinical Trial Research as a Department of Public Health Contractor in San Francisco. I do not speak on behalf of my organization with my comments today.

I am writing to express my concerns around proposed HICPAC guidelines around infection control, specifically that of aerosol transmission. 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.

Proposing adopting a more "flexible" approach to implementing precautions that recommends only minimal protections and allows health care employers broad discretion to create the infection control plans is frankly dangerous. Not only does this contribute toward unsafe working conditions for health care workers, worsening labor shortages and the risk of new or more severe disabilities, patients will be at heightened risk for nosocomially acquired infections. Among patients attempting to avoid Covid infection, prolonging medical treatment due to unsafe care conditions can be disastrous. Having worked in a public health setting throughout the pandemic, I have heard no mention of Long Covid in discussions surrounding Covid precaution and risk. People should not have to risk becoming permanently disabled when providing or receiving care. HICPAC needs to be more transparent in receiving guidance from experts in respiratory protection, aerosol science, and occupational health.

Thank you,

Alison Cohee

---

Hello,

My name is Aurora Decker-Arendt. I am a member of the public, writing to express my concerns regarding HICPAC's proposed updates to Isolation Precaution guidance. I urge you to

please recognize the full reality of aerosol transmission of disease and properly account for it to ensure health care worker and patient protection.

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. I ask you to please revisit the evidence review on N95 respirator and surgical mask effectiveness, 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 also failed to look at extensive evidence on respirator effectiveness from laboratory studies and studies in non-health care workplaces.

Ultimately, the Work Group's proposals weaken protections for health care personnel even though the Covid-19 pandemic underlined the importance of strong protections for health care personnel and patients. I understand the risk to patients all too well because I am one of those patients. As a chronically ill person, I need access to health care - and I deserve access to health care that does not put me at risk of further health complications. These policies will harm innocent members of the public, and I kindly urge you to reconsider.

Thank you for your consideration,
Aurora Decker-Arendt
Huntington, NY

---

Good afternoon

I am writing to you today as someone who's life has been greatly impacted by the standards as they stand today throughout healthcare settings including dentists, optometrists settings. I caught Covid in 2021. It has left me with a form of Dysautonomia. I no longer am able to function in society due to no precautions in place, especially in healthcare settings.

The CDC needs to stop choosing convenience over the well being of humans, & pleasing people who do not understand science, & start acting as a legitimate disease preventative organization.

I urge you to ensure that both **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.

High quality masks, ventilation & educating the public does work. I am urging you to Please stop living in denial, & continuing to pretend Covid isn't harming millions of people. We deserve better than this, otherwise there's no point in continuing to have such authoritative bodies when they are not leading the way to a better way of life.

Thank you for your time. I look forward to hearing from you

Tosha Blackburn

---

As U.S. citizens, we are concerned with the HICPAC's Work Group on the Isolation Precautions Guidance proposed "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.

We 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.

One of the most dangerous/high risk things we have done with our children during the pandemic is take them to get their vaccination at healthcare facilities--places where healthcare workers are not wearing masks and, likely, spreading covid.

Holly Richard & James Hoefelmeyer
Beresford, SD
concerned US citizens

---

Medical masking up in medical clinics and doctors offices by staff and patients is still greatly needed in order to stop the spread of communicable germs amongst patients with compromised immune systems during doctor visits.

It is of serious concern and frustration by many from what I have read in the public square. Please reintroduce Proper PPE to protect everyone, but especially the most vulnerable people who can't avoid or opt out of medical care.

I urge the HICPAC at CDC to take this seriously for everyone's sake.

Sincerely,
Teresa Saldivar
Los Fresnos TX

---

I am someone who has paid close attention to Covid, how it is transmitted and how it can be avoided, for reasons both personal and professional.

I am someone who lives with many physical health conditions that make me high-risk for COVID-19; and after having a mild case of presumed Covid in March 2020 (I say presumed because even after ending up in the ER, testing wasn't available to me) I have been living with Long Covid and have spent the last three years trying to avoid catching it again. Therefore, I spend more time on the CDC website than the average civilian and am acutely aware of the difference between the transmission levels and the community levels.

If CDC is no longer going to be calculating the transmission levels, which healthcare facilities are supposed to be relying on to determine mitigation strategies, how will we best be able to keep people in healthcare facilities safer from virus transmission?

I urge you to consider issuing indoor air quality targets for all healthcare facilities. If CDC suggests that all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration, that will result in cleaner air for all of us who have to use healthcare facilities as patients and all staff who work there.

It is profoundly disappointing that CDC seems to be moving backwards from steps that would provide additional protection to people with regard to infection control in healthcare facilities. We need good indoor air quality standards. We need recognition that high quality N95 respirators provide better protection than surgical masks.
This request is also issued on behalf of the clients of Connecticut Legal Rights Project (the nonprofit legal aid organization which I serve as Executive Director) who RESIDE in healthcare facilities — state-operated inpatient psychiatric facilities — and all patients in all inpatient psychiatric hospitals across the country. These are congregate settings that do not have sufficient space for social distancing, which means the quality of the indoor air is that much more important.

Thank you for your time and attention.

Kathy Flaherty
Executive Director
Connecticut Legal Rights Project
Middletown, CT

---

Ventilation, air filtration, and quality respirators **must** be used in hospitals and care settings. Layered protection is proven effective against transmission of the airborne SARS-CoV-2 virus. If a layperson can support this conclusion with ample evidence, why do career public health

professionals suggest otherwise? I urge you to accept essential input from many vital stakeholders, including frontline personnel and unions, patient safety advocates, industrial hygienists, occupational health nurses, safety professionals, engineers, scientists with aerosols expertise, and respiratory protection experts.

You must incorporate accurate information about ventilation type, air exchange rates, respirator usage, and aerosol transmission. There is no ethical reason to exclude this.

I had a doctor's appointment this afternoon to examine a potentially cancerous growth on my skin. MY DOCTOR'S OFFICE CALLED ON MONDAY, SAYING HE WOULD NOT BE ABLE TO ATTEND OUR FRIDAY APPOINTMENT; NO REASON GIVEN. Now, my care has been delayed yet again. DOES MY DOCTOR HAVE COVID-19? I WOULDN'T BE SURPRISED.

THESE ARE REAL-WORLD CONSEQUENCES OF PUBLIC HEALTH AND MEDICAL NEGLIGENCE OF COVID-19.

MY FRIEND DIED AT HOME IN MARCH 2020 BECAUSE SHE NEEDED GALLBLADDER SURGERY, AND IT WAS POSTPONED DUE TO COVID-19. IT'S BEEN MORE THAN THREE YEARS, AND WE KNOW BETTER HOW TO HANDLE SARS-COV-2! GET IT TOGETHER BEFORE MORE PEOPLE SUFFER AND DIE.

R.A. DIAL
NO ORGANIZATIONAL AFFILIATION
TACOMA, WA

---

I wish to file a comment regarding masking requirements and air purification rules. A century ago we had to fight to require hand washing between a doctor conducting an autopsy and delivering a baby. We understand now how dangerous poor air circulation can be in a medical setting. Sick people go to hospitals and medical centers. Doctors, nurses, and other staff should be provided N95 masks and air purifiers should be used to prevent medical establishments from becoming permanent super spreader locations.

Respectfully, Talia Flah, JD/MPH

---

Hello,
I am a person living with an autoimmune disease. Ever since the beginning of the pandemic, the CDC has made decisions that have drastically altered my life. I can no longer safely leave my home or spend time with friends or family because I can't risk getting sick and they're almost always exposed to someone testing positive for covid in their workplaces because of the CDC deciding to side with corporate interests instead of the people's health.
I can no longer safely go to my appointments. I rely on medical transport and often the drivers will refuse to mask when I ask, my doctors are often out sick with covid, and there is very little ventilation or air filtration in the hospitals making it extremely unsafe for people like me who, if we don't die, risk losing any semblance of improvement we had in our health or gaining new illnesses by getting covid.
Lowering protections even further means I can't get the surgery I desperately need to function, it means my aunt with cancer has to get her treatments next to someone covid postive, but not masking because "they feel fine," it means making the shortage of healthcare workers even more severe so the sick can't get help, it means a lot of people are going to become disabled or lose their life.

It seems the CDC cares little for people like me, or even the able bodied anymore. I sympathize with the newly disabled from covid, many who got it following the CDC's guidelines thinking they were safe, one of them is my best friend. And now they struggle to even find a doctor taking patients within a year. A flu ruined my immune system in 2014, but at least I was able to quickly see a doctor and start treatments that likely saved my life, they don't have that. More and more people won't have that if protections are lowered.
We need more air filtration in hospitals, not less. We need HEPA filters. We need masks back in healthcare settings, though they should be mandated elsewhere as well. We need options for the at risk to still be able to get medical help.
Too many times I've had to debate if a health problem is bad enough to risk covid to see a doctor.
We know it's possible to put in protections. If the wealthy can do it for their gatherings, for their children's schools, for the World Economic Forum, why can't we do it where it's most needed in hospitals?
The CDC prioritized the economy during the pandemic. So I ask, what is the cost of 1 in 5 people becoming disabled after covid? How many of those are healthcare workers? How are we meant to function as a society if more and more people can't work and don't have access to aid or treatment for their disability?
Please, think of the people you are supposed to protect.
Don't take away what little protections we have left.
Athina Forrow

---

To whom it concerns at HICPAC,

I am writing to urge you to strengthen, rather than weaken, the COVID-19 protections you recommend to the CDC for implementation in healthcare settings.
Three years and change into this pandemic, we are fortunate to have excellent research to guide our decision making. The data proves unequivocally that efficient air circulation and purification, high-quality and well-fitting masks such as KN95s or above, and collective masking where everyone who is able to mask does so, are our best defenses against an ever-evolving airborne virus that continues to disable and kill our friends, families, and community members.
At the recent meeting on this topic, the public commented extensively and unanimously to the effect that we desperately need stronger COVID-19 mitigation measures in healthcare settings. The video including all of this public comment was taken down hours after being posted. This has not gone unnoticed. This looks like suppression of science. This looks like disregard for human life.

Many who are disabled and immunocompromised are already losing access to necessary medical care because, without strong COVID-19 mitigation practices in healthcare settings, the risk of attending appointments is too great.

We keep hearing the refrain that "we have the tools" to protect against COVID. The tools can't help us if we don't actually use them.

Use the tools.

C. Jack Barry
Member of the public
Tacoma, WA

---

We have the right to get medical attention without subjecting ourselves to the possibility of infection.

Why is it asking too much to expect medical personnel to wear masks to protect us from COVID, the flu and every other bug that floats through a medical office?

At the eye doctor, the dentist, and my primary physician, I sit in waiting rooms full of unmasked patients who are obviously ill. Then I get stuck in a tiny room with poor ventilation, to be treated by unmasked doctors and nurses who have been handling these ill patients.

No matter our age or health status, we should be able to get medical help with some semblance of safety. It's not a huge ask.

Thank you,
Kathryn Quinn Thomas
Austin, Texas

---

Dear HICPAC members,

I am writing today to demand that HICPAC acknowledges the airborne transmission of Covid and other respiratory viruses and the importance of control measures for infectious aerosols in its new guidance for infection control in healthcare settings.

We have known since early in the pandemic that Covid can be transmitted through shared air. With Covid still circulating in our communities and our medical facilities, we must utilize airborne precautions in medical environments to protect patients and staff.

That employees and patients are no longer required to mask in hospitals, long term care facilities and other medical settings is nonsensical. It is dangerous for patients, as hospital-acquired Covid has a 10% mortality rate. It is also dangerous for hospital employees who are at high risk of repeat exposure and infection. It is also highly unethical as it infringes on the right of health care providers to a safe working environment as well as patients' rights to healthcare that doesn't endanger their lives.
Our healthcare systems are already strained. We need strict guidelines for ventilation and air filtration, as well as requirements for universal respirator use by providers, to prevent their collapse. Visitors and patients should be required to mask as well, as their conditions allow. Hospitals should aim for zero Covid transmission within their walls. With the various air cleaning and respirator technologies currently available, this goal is well within reach.

As a patient, I should not have to ask my healthcare providers to protect me. I shouldn't have to ask them to don an N95 for my appointment, just as I shouldn't have to ask them to wash their hands before seeing me. I shouldn't have to risk a potentially life-altering infection just to access routine care.

The pandemic has given us an opportunity to learn and do better. We have the knowledge to reduce suffering and death from Covid, influenza and other respiratory viruses but we are not using it. Please follow the science to protect patients and healthcare workers.

Thank you for your time.

Sincerely,

Evelyn Dial
Seattle, WA
No affiliation

---

I am not an aerosol expert or a physician. But I follow the research closely and we know that:

- Many significant diseases (COVID, RSV, etc.) are transmitted via aerosols
- Aerosols can be removed from the air via HEPA filtration
- High quality masks (n95) protect people from transmission
- High quality masks work best when all people are wearing them

These issues are not controversial, are well understood, and grounded in good science. Guidelines for healthcare providers should reflect this - there is no justification for adopting non-airborne precautions (ex. hand washing) for airborne pathogens.

HEPA, CO2 monitoring, and high quality mask policies in healthcare settings ensures that all people have access to healthcare without risk. That healthcare providers can work in a safe working environment. There is ample evidence that these simple, cost-effective measures will ensure that the most vulnerable can safely access care.

Thank you for your consideration,
Alexis Dubief
Essex Junction, VT
Parent, advocate, member of the World Health Network

---

Public Health agencies face many impossibilities. The Covid crisis may be the most difficult so far. With violence and societal chaos from anti maskers, it may seem wise to lessen precaution requirements. These people are an ignorant, loudmouth minority, and this tactic is a very poor long term strategy, especially for healthcare and mass transportation, where the risk is highest for the greatest numbers and the most vulnerable.

Whether they understand the science or not, many people realize that what they're doing is wrong when they fail to follow guidance from our government agencies. We need to move the goal posts further toward caution to make this possible. To not do so, at this critical time, is a shameful moral failing. The world is watching. Many nations follow guidance from the CDC. Do the right thing.

Derek Blackwell, Seattle

---

Hello. My name is Erika Bowers, I am a Baltimore City resident, and I am emailing in reference to the weakening of infection control standards.

It is extremely disheartening and saddening to watch the CDC go against science and experts all for the sake of saving money. It's mind boggling to see an organization that I used to trust put money over the health of citizens. The proposal for weakening these standards gives me absolutely no hope for the future. This is a dangerous, completely reckless, and it absolutely will cost innocent people their lives. Their blood will be on the CDC's hands. It is well known that surgical masks offer little to no resistance to infectious diseases. It is also well known that KN95/N95 masks offer significantly more protection from these diseases. What the CDC is doing is genocide. You are going against the science. You are going against what we know is correct and what we know is the right thing to do for society as a whole.

Please, do the right thing. Keep N95 and proper air filtration in healthcare.

Erika Bowers
Member of the public
Baltimore, MD

---

Regarding the recent HICPAC meeting, I urge the CDC to reconsider and implement the following:

1. Issue Indoor Air Quality targets for all healthcare facilities. For example: all healthcare facilities must have ventilation of 10 air changes per hour or an equivalent level of HEPA filtration.

2. While Indoor Air Quality targets are in progress, require source control for healthcare workers while interacting with patients. Healthcare workers should be wearing an N95 mask while they are with any patient.

3. Do not claim that surgical masks are equivalent to N95 respirators. The N95 rating has a specific definition, and it is the mask level required to protect against airborne diseases like SARS-CoV-2.

Sincerely,
Gregory M. Stiehl, Ph.D.
Ithaca, NY

---

Dear HICPAC:

I attended the meeting digitally on August 22nd as a ordinary citizen (although I am a retired Nurse Practitioner). I am immuno-compromised as is my daughter and my retired husband. I never thought, in a million years, that we would have a pandemic of the SARS - COVID virus for 3 plus years and still have it be ongoing but that is how it is today. My great aunt died in 1918 from the Swine Flu or Spanish Flu pandemic leaving a 2 year old daughter to survive her! Watching this meeting, one would never know that we were living through an ongoing pandemic of SARS virus, which is constantly mutating, or that we had eradicated the Ebolavirus (under President Obama). In 2000,s my husband worked for a Chinese-American internet manufacturer and had to travel to mainland China frequently. He is grateful that he does not have to travel to China now, as it seemingly incapable of handling such a virus. However, based on what I saw during the HICPAC meeting on Tuesday, it seems as if the United States isn't either. Your meeting made it seem AS IF THIS IS NOT CURRENTLY going on and AS IF IT IS NOT A THREAT to every citizen of this USA according to this HICPAC group of the CDC!

When the SARS COVID 19 virus started, people were not encouraged to wear N95 Masks because it was said that the virus was spread via touch and on surfaces. This was quickly proven false. Viral matter of SARS is spread via droplets AND AEROSOL in the air and can last for some time from an infected person. Yet I heard NOTHING about mitigation of the SARS at all via air. Actually this pandemic creating virus was mentioned once in passing and nothing was said about the current status of variants or spread of variants or what to do to stop the spread of the disease at all. It was as if this disease did not currently exist and was not infecting people and causing long hauler's syndrome in 1 out of every 5 people who gets the illness. WHERE ARE YOU PEOPLE and WHERE ARE THE SOLUTIONS to rid this country of this ongoing

illness?

My conclusion is that you are doing nothing to detect or eradicate this disease at all!

My family is terrified to go to medical and dental appointments where people are not masking and not even acting like this illness can be carried and spread by humans who are patients in these facilities. NO ONE HAS TO MASK and those who do are viewed as crazy. Anybody who goes, can come back sicker than before they went to an appointment! And God forbid you should need hospitalization, where you could die from the condition you went with *plus* SARS-COVID.

I wanted to constantly throw up and throw things at the screen while watching the group speak. The only one who made sense was a nurse with the Golden Gate bridge in her background and the people who called in at the end.

Please do something to address SARS COVID ongoing pandemic in this country. The situation is disgraceful, and acting like the it does not exist is also dangerous.

Sincerely,
Esther J Howes

On behalf of all those who are immune compromised or elderly, please reinstate masking in medical settings at the very least. Please remember that you are also protecting our very important medical people when you do this.

A recent study released today regarding the use of masking, isolation, testing, and vaccinations did indeed provide good protection against Covid infections. It concluded that with all the new variants out there it might be time to reconsider masking in certain settings. For logical common sense and for love for our friends, neighbors and family, please reinstate masking at least in medical settings.

Chris Hoeffler
Prescott, Az

---

Dear Esteemed Healthcare Provider and Policy Maker,

I write to you as a concerned citizen deeply invested in public health, accessibility, and safety. It is my earnest request that healthcare providers and facilities institute mandates for respirator use to enhance the sanctity and safety of these essential spaces, thus helping to curtail the spread of SARS-CoV-2 (COVID-19).

The global community is grappling with the relentless menace of COVID-19, an airborne disease with profound implications for health and life. Voluntary mask-wearing falls short of the comprehensive protection that can only be achieved through universal masking, particularly in healthcare environments where stakes are elevated.

I feel compelled to underscore that on a global scale, COVID-19 claims at least one life every three minutes. Furthermore, the phenomenon of "Long Covid" has debilitatingly impacted over 65 million individuals worldwide.

Leading experts in internal medicine emphasize that now is not the moment to eschew masks in healthcare environments. When one acquires COVID-19 within a hospital, the associated

mortality risk escalates significantly, with death rates ranging from 5% to 10% (as evidenced by the 8.4% rate in Korea). Data from May 2023 in England reveals that 30% of in-hospital COVID-19 cases were contracted within the very hospitals meant to heal (source: NHS Covid19 hospital activity).

A 2023 investigation by The Mirror alarmingly disclosed: "Over 14,000 individuals in England and Wales succumbed to Covid-19 after contracting the virus during their hospital stays." Every hospital globally that does not mandate respirator use potentially teeters on the precipice of these grim statistics.

It is lamentable that seeking healthcare now comes with inherent risks, tantamount to discrimination. When individuals must shield themselves from systemic healthcare oversights, an unacceptable boundary is breached. Tragically, tales of these experiences are becoming all too common. For those wishing to evade the virus, avoiding healthcare entirely emerges as a distressing necessity, with profound implications for the vulnerable. Singular respirator use, further, is now met with undue stigmatization.

Kasari Govender, from British Columbia's Office of the Human Rights Commissioner, has articulated significant concerns over the human rights repercussions of such mask-optional policies. Beyond this, there have been reports of various forms of discrimination including: requests for mask removal, derision, and misinformation regarding COVID-19 transmission. These circumstances are especially poignant for those already scarred by COVID-19, whether through personal affliction or familial loss.

It is true that not everyone can don masks due to specific medical conditions. However, these individuals stand to gain heightened protection in facilities that uniformly adopt respirator mandates.

Recent studies indicate that in a hospital setting with an air quality of 800 ppm, the infection risk from SARS-CoV-2 exposure exceeds 80% when unmasked. Even with a surgical mask, there remains a 35% infection risk. Conversely, dual N95 respirator usage nearly eradicates this risk. Such evidence underscores the imperative for mask protocols, especially those equivalent to or surpassing KN95 or N95 standards, to prevent COVID-19 transmissions.

It is lamentably common for mask detractors to misrepresent data from regions with varying lockdown protocols to undermine the importance of masks. However, comprehensive and judicious respirator usage remains an exception rather than the norm, with only a few Asian nations pioneering this approach. A culture valuing communal health and defense against airborne pathogens need not rely solely on regulations.

I trust that you will give this appeal the consideration it warrants. The establishment of respirator mandates is paramount to prevent further tragedies. Immediate action is imperative.

Warm regards,

Amanda Mackin
Auburn, NY

---

Dear CDC,

I urge HICPAC and CDC to slow down the process of developing drafts and open-up the process to effectively engage 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.

So far CDC/HICPAC have failed to acknowledge the importance and function of core control measures for infectious aerosols. And, there are **no** recommendations on ventilation.

Thank you for this opportunity to comment. I look forward to following this process and to your addressing these concerns.

Rosemary Kean
Boston, MA.
Member, Massachusetts Nurses Association

---

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 writing to express my deep concern regarding 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

---

Hello,

I am a frontline healthcare worker, so I have seen firsthand how effective N95s are. There is also plenty of empirical evidence that backs up my lived experience. HICPAC should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators. Surgical masks do not provide adequate protection against airborne illnesses, such as COVID-19.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms (1), they may pass it to their coworkers or patients in maskless healthcare settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages. The claim that surgical masks provide adequate protection against airborne disease is based on a widely-critiqued (2), flawed literature review. The guidance even contradicts the CDC's own data which demonstrated that continuous use of N95 and KN95 respirators cut the odds of infection by 83% compared to 66% with surgical masks (3). Nearly 900 experts and over 1000 members of the public have already signed an open letter urging the CDC to strengthen, rather than to weaken its infection control guidelines, and to open the process of infection control guidelines to include more stakeholders and interdisciplinary experts (4).
The American Hospital Association has explicitly declared that hospitals are facing a "crushing" financial crisis (5). Given this, I am concerned that HIPAC/hospitals may be pursuing this short-sighted infection control approach to reduce their expenses by cutting fit-testing programs and limiting access to N95 respirators and other airborne protections. However, increasing rates of health worker COVID infections will further worker shortages and may lead to additional disabilities caused by Long COVID. Ultimately, infection control that ensures the highest protection of healthcare workers and patients based on evidence-based science, and integrates the input of those most directly impacted (i.e. healthcare workers and patients) is a necessary approach.
- Sindri Woodard, CMA/CNA, HCW

References
(1) Johansson MA, Quandelacy TM, Kada S, Prasad PV, Steele M, Brooks JT, Slayton RB, Biggerstaff M, Butler JC. SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. JAMA Netw Open. 2021 Jan 4;4(1):e2035057. doi: 10.1001/jamanetworkopen.2020.35057. Erratum in: JAMA Netw Open. 2021 Feb 1;4(2):e211383. PMID: 33410879; PMCID: PMC7791354. https://pubmed.ncbi.nlm.nih.gov/33410879/
(2) Why the CDC's New Mask Guideline Proposal May Actually Imperil Frontline Workers. "The decisions some of these public health people are making are not getting better. They're getting worse." by Katie MacBride, The Daily Beast, Updated Jul. 01, 2023 3:40PM EDT / Published Jun. 30, 2023 11:47PM EDT https://www.thedailybeast.com/new-cdc-mask-guidelines-may-actually-imperil-frontline-workers-experts-say

(3) Andrejko KL, Pry JM, Myers JF, et al. Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection — California, February–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:212–216.
DOI: http://dx.doi.org/10.15585/mmwr.mm7106e1
(4) National Nurses United - Urge the CDC and HICPAC to fully recognize aerosol transmission and protect health care workers and patients https://www.nationalnursesunited.org/urge-the-cdc-and-hicpac-to-fully-recognize-aerosol-transmission
(5) Becker's Healthcare - Congress can take action to help healthcare deal with 'crushing' financial challenges, AHA urges - by Nick Thomas - Tuesday, October 25th, 2022 https://www.beckershospitalreview.com/finance/congress-can-take-action-to-help-healthcare-deal-with-crushing-financial-challenges-aha-urges.html

---

Dear Director Ferrer, Health Officer Davis, and LA County Supervisors,

I am writing as a citizen, as someone born to immigrant parents in Unincorporated East Los Angeles, and a life-long resident of LA County to appeal to LA County Public Health Officers to immediately reverse the recent public health order, "Rescission of Required Masking of Workers in Healthcare and Direct Care Settings," to keep mask requirements in healthcare settings and to protect our loved ones and our community members from this dangerous SARS-2 (COVID) summer surge.

LA Public Health's role is to protect LA County residents' health and lives. The current surge of SARS-2 cases in Los Angeles County presents an emergency that demands immediate action. The dropping of the mask requirement in healthcare settings will further exacerbate reinfections, which are contributing to increasing rates of healthcare workers dying and becoming disabled with long covid, leading to an increasingly strained healthcare workforce.

In places where mask requirements have dropped, patients are acquiring infections in healthcare settings and in some cases even dying from these same infections or acquiring long covid. One of my own friend's parents acquired a COVID infection in the hospital and died from it, a tragic and preventable death. In fact, many people are delaying care because hospitals are not safe without mask requirements. Healthcare settings should not be places where lives are harmed, healthcare settings should be where lives are saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence.

While there are vaccines and Paxlovid available, the current set of available vaccines quickly wane and are based on an old formulation that doesn't target the current set of circulating and emerging variants and not everyone can take Paxlovid due to contraindications. Moreover, we have lost a critical tool in monoclonal antibodies leaving many without protection and treatment, especially those who are immunocompromised.

SARS-2 is spreading in hospitals despite the central tenet to "do no harm" when masking is dropped. Regrettably, the decision by LA County Public Health to end the masking requirement in healthcare settings, while we are in the middle of a summer surge, has added to the urgency of the situation as we have significantly dropped testing and the actual infection numbers are much higher as indicated by increasing positivity rates and wastewater data.

Even Pasadena's health department, which is in LA County, is keeping their mask requirement in healthcare settings as they've seen a 35% increase in weekly cases. We need to do the same and keep our mask requirement in healthcare settings: https://cityofpasadena.net/city-

manager/news/pasadena-maintains-masking-and-covid-19-vaccination-requirements-for-health-care-workers

Additionally, large businesses in LA County are now reversing the dropping of their masking policies due to recent outbreaks and mandating masking once more, like Hollywood studio Lionsgate. https://www.latimes.com/california/story/2023-08-22/masks-are-back-on-at-lionsgate-headquarters

There is wide community support for keeping masks in healthcare as over 11,000 letters have been sent to LA Public Health and the LA County Board of Supervisors since the rescission of mask requirements was issued on August 11th.
https://actionnetwork.org/letters/demand-los-angeles-county-keep-masks-in-healthcare

As a lifelong resident of LA County, I am appealing to LA Public Health Officers to bring back mask requirements to healthcare settings. By reversing the recent public health order that ends the mask requirement in healthcare settings, you can take meaningful steps to mitigate the impact of this deadly and disabling virus and protect the health and well-being of the residents of Los Angeles County — our families and communities.

Act quickly, our health and lives depend on the requirement of masks in healthcare settings.

Thank you for your prompt attention and actions towards protecting the health of the residents of LA County.

Joaquín Beltrán
Founder
ActionCareEquity.org

---

I am writing to endorse the letter addressed to Dr. Mandy Cohen, dated July 20, 2023, that was signed by nearly 900 public health experts, expressing concerns about the pending revision of the *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. As the letter states: "The draft recommendations, if adopted, will put health care personnel and patients at serious risk of harm from exposure to infectious aerosols." I fully support the suggestions in the letter for immediate actions that the Centers for Disease Control (CDC) and the Prevention and the Healthcare Infection Control Practices Advisory Committee (HICPAC) must take to correct the review and decision-making processes and recommendations.

I am disabled and live with serious chronic illness and a weakened immune system. I share the deep concerns of the signatories that this revision will severely weaken infection prevention and control for both healthcare workers and patients exposed to infectious aerosols. The final recommendations must include proper isolation, ventilation, and NIOSH-approved respirators to protect against transmission. The draft recommendations fail to fully recognize the science on aerosol transmission and the role of inhalation of aerosolized pathogens.

I also urge CDC/HICPAC to increase transparency and public engagement. The guidance must include input from all key stakeholders, as outlined by National Nurses United: 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 would add patients themselves to that list. Weakened recommendations for infection control and prevention mean that I and the many people who are immunocompromised cannot safely receive the healthcare we need.

As our world is changing, we likely face ever-increasing risks from new infectious pathogens. It would be a travesty if we fail to incorporate into future best practices what we have learned at great human cost from the COVID-19 pandemic. It is imperative for the health and safety of healthcare providers and patients that the CDC/HICPAC recommendations for infection control and prevention establish sound standards and processes that practitioners, organizations, and institutions in the US, and indeed around the world, can implement.

Respectfully,
El (Laura) Byrd
Portland OR

---

My name is Alida Villatoro. I live in Colorado and wish to comment on your proposed changes to your Infection Control Guidelines in Healthcare Settings.

Your guidelines need to be more rigorous. I am high risk for Covid, and also have Long Covid from an infection in Fall 2022 despite being vaccinated at least 4 times and practicing one way masking.

I need regular treatments, but I am choosing to limit care because doctor's offices and hospitals in my area no longer require masking. Even requesting that a provider wear a simple surgical mask often results in subpar care or harm because of the emotional reactions providers can have to the request.

This burden to stay safe should not be disabled or chronically ill people. One way masking is not sufficient. There needs to be 2 way masking with N95's and air filtration -- at a minimum in hospital settings, surgery centers, and offices where people are specifically seen for respiratory illnesses. Ideally these precautions would be in all medical settings.

Thank you for your time,

Alida Villatoro

---

Katherine Stitzer
Flagstaff, A
Concerned citizen

Regarding: Updates to *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*

To Whom it May Concern:
The proposed changes to the Isolation Precautions document will increase transmission of disease in healthcare settings and put both patients and staff at risk. Considering the ongoing impacts of the COVID-19 pandemic, it is disappointing that the working group has not prioritized protecting people from airborne pathogens in healthcare settings. These updates prioritize costs to health care corporations over the health of the people giving and receiving care.
I demand that HICPAC revisit these proposed changes to make the requirements stronger than before the pandemic, not weaker. Specifically:
- I urge HICPAC and CDC to slow down and open-up the process to effectively engage 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 in developing drafts.
- I urge HICPAC/CDC to increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance.
- 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, rather than giving employers flexibility in what measures to implement.
- I urge HICPAC and the CDC to clarify and update the list of infectious diseases that are airborne and make clear that medical/surgical masks do not protect against this kind of transmission. Additionally a new and more thorough review of the effectiveness of these masks compared to N95s and other respirators is needed. The conclusions of the current review are not reflective of current science.
- I urge HICPAC and the CDC to include requirements for better ventilation in all healthcare settings and to require the use of Airborne Infection Isolation Rooms or other scientifically proven source control whenever patients are diagnosed with an airborne infection.

Katherine Stitzer

---

Dear HICPAC members,

Though I write from British Columbia, outside the region of your formal jurisdiction, public health personnel around the world look to the CDC as a model – be that in implementing best practices or on the other hand, tragically, in rationalizing their own dereliction of their duty of care. So I am deeply disappointed that your revision to infection control guidance has been so flawed both with regard to inadequate consultation and, as I understand it, in the substance of the draft. There needs to be utmost clarity about the dominance of airborne transmission of COVID.

I am heartbroken at the countless stories of patients unable to access health care safely because the precautions being taken by an institution were inadequate and are inadequate. My own father-in-law, then aged 76, spent 6 weeks in hospital in 2020/2021, and just a couple of weeks after he had been discharged, an outbreak was declared on the ward where he'd been.

Transparency is essential. In the current environment of rampant distrust of public health authorities, distrust that has resulted both from distortion of the record by social actors of dubious integrity and from genuine errors for which there has been too little accountability, it is especially important to open up the policy process to scrutiny.
"Trust us!" will satisfy few people any more. Certainly not me, though early on I was pleading for more trust to be placed in our own provincial public health systems.

Early in my career as a medical editor, I had a hand in the production of the reports from Justice Archie Campbell's public enquiry into Ontario's handling of the SARS-1 outbreak two decades ago. It is a matter of bewilderment that the recommendations painstakingly gleaned from that incident have so often been sidelined, foremost, the precautionary principle.

So many persons of good will stand ready to contribute to refining your guidance. Before you finalize this critically important tool, please provide an adequate opportunity for their expertise and perspectives to inform your deliberations.

Yours sincerely,

Alan Yoshioka, PhD
Vancouver, BC
Canada
No organizational affiliation

To whom it may concern,

I was dismayed to learn that the Healthcare Infection Control Practices Advisory Committee is considering revising its guidance to the CDC such that it would seriously weaken infection control measures. The draft guidance would make the (demonstrably (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5705692/) false (https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm)) claim that surgical masks provide comparable protection to n95 respirators. Additionally, it fails to recommend HEPA filtration, UV disinfection, and ventilation--when, in fact, best practice would be setting a ventilation standard of 12 air changes per hour and/or equivalent filtration.

All of these things are key tools for reducing transmission not only of COVID-19 (which continues to kill and disable an unacceptable number of people, and whose long-term sequelae, as summarized in this review (https://www.nature.com/articles/s41579-022-00846-2), present significant and serious ongoing health risks regardless of age, prior health status, and severity of acute symptoms) but numerous other pathogens.

As an ethicist, I find this move perplexing and seriously worrying. Weakening these infection control measures precisely at the point when the evidence is overwhelming that we should instead be strengthening them creates overlapping and entangled hazards to healthcare workers, hospital staff, patients, and patients' immediate contacts. It makes healthcare environments increasingly unsafe for precisely those vulnerable people who need them the most, placing further burdens of risk on those who are already overburdened in this way. It also serves to further entrench the marginalized status of disabled, immunocompromised, chronically ill, and elderly Americans by continuing to make key public spaces and amenities inaccessible to them.

Finally, the proposed guidance changes place an insufficiently-informed and unconsenting public at risk, because failing to take commonsense infection control measures creates ideal conditions for pathogens to spread and to mutate, making it more and more likely that our existing treatment and prevention tools will fail.

Public institutions like the CDC and the government bodies that advise it have a duty to protect people, and to do so in ways that correct marginalization and injustice. The proposed guidelines comprise a dereliction of that duty, and would deepen the marginalization of disabled, chronically ill, immunocompromised, and elderly Americans. I hope that HICPAC will recognize their error and act in a way that takes their duties to the public seriously.

Sincerely,
Dr. Rebecca J. Epstein-Levi
Vanderbilt University

Topic: Isolation Precautions - Preventing Transmission of Infectious Agents in Healthcare Settings

To the committee;

For the last three years, up until very recently, I was a personal care attendant in a nursing home. And I will never forget that one of the residents I helped care for died after getting COVID-19 in a healthcare setting. So it is an understatement to say that I am upset and discouraged by HICPAC's refusal to promote policy that protects healthcare workers and the public from healthcare-acquired COVID-19 and other airborne infections.

You are supposed to be leaders, promoting policies - regardless of how difficult or unpopular they may be - that prevent illness based on the most current and reputable research and data. So why aren't you doing everything you can to prevent the spread of COVID-19 and other airborne infections? Are you aware that COVID-19 spreads through aerosols? Are you aware that N95s are proven to be more effective at preventing infection spread than surgical masks? Why are you making it easier for hospitals to cheap out on necessary PPE and air filtration/ventilation upgrades? Who is this serving?

I know people who are struggling with Long COVID. I know people who are terrified of catching COVID at a hospital, from people who are supposed to take care of them. I know people who are putting off going to the doctor, even for necessary care. You have to stop pretending that it's fine for people to get sick at hospitals, at clinics, in congregate care settings. It is not fine. It's wrong. Stop allowing deadly, disabling infections to spread. Protect healthcare workers and the public.

Sincerely,
-Adrianna Jereb
St Louis, MO
no organizational affiliation

---

Dear HICPAC committee members:

"CDC works 24/7 to protect America from health, safety and security threats…CDC increases the health security of our nation…CDC saves lives."

When the CDC fully embraces this mission, CDC is able to strengthen the resilience of the public and private sectors – and the economy.
We have been fortunate to learn a great deal during the pandemic: many businesses continued to thrive by adapting their business models (moving online for both sales and remote work).

But most importantly, CDC 's aerosol transmission guidance, addressed in patient settings, saved lives and made it possible for many individuals to get healthcare who needed it.

During the process we saw the science around masking evolve and learned the benefits of N-95 two-way protection.

HIPAC must act to address the need to recognize this science and put in place mandated two-way N-95 masking requirements in healthcare settings similar to the masking requirements adopted by US top hospitals (e.g. Mayo and Cleveland Clinic) during the pandemic, but with a new recognition of US capacity to manufacture N-95s and the science behind their use.

Anything less is the antithesis of the mission to "protect people from health threats."

Today, with limited mask guidance, infections that harm the elderly, children and infirm are harming not only nurses, doctors and other hospital workers and patients - but also workers who must care for those family members.

It is simple to robustly address aerosol transmission, and in the process not only meet CDC mission requirements to save lives, but also lower the costs of healthcare for individuals and businesses.

I urge you to do this job with care. The reputation of CDC as “a protector” depends on it.

Eleanor Bloxham
Chief Executive Officer, The Value Alliance and Corporate Governance Alliance
Westerville, OH

---

Dear HICPAC/CDC,

In early May of this year I saw my doctor for a yearly Wellness visit. In addition to specific orders related to ongoing health complaints, he ordered blood work labs, preventative screenings, and imaging tests meant to address specific health complaints —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 masking in substandard masks) OR rolling the dice and hoping that the potential problems that might show up in a blood test (or ultrasound) will hold off for a while.

Since the May 11 change I have been searching for providers still willing to mask, as well as researching ADA accommodation requirements. Needless to say, I have delayed getting any of these tests carried out.

I am now concerned that the CDC will profoundly weaken its Infection Control guidance which could place patients such as myself AND health workers at risk of short- and long-term harm and even death from infectious diseases.

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

If healthcare workers stop wearing N95 and/or downgrade to surgical masks, many more workers and patients will develop COVID-19. If you yourself are lucky it may not happen to a close family member. If you yourself are lucky it may not happen to a close friend or colleague. But given the sheer probability factor it will definitely happen to someone you know. Please protect your community and mine and vote AGAINST watering down infection control protections, particularly for aerosol transmission and multidrug-resistant organisms.

Thank you for your attention to this critical matter.

~Martina Ortega

---

Dear HICPAC committee members:

My name is Wayne Wu, and I listened with great interest to the live stream of the HICPAC meeting today. I appreciate the work that the committee does, and I want to echo the sentiments of the many well-spoken public comments.

I 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

Other comments, I am certain, will provide studies, evidence and stories of real-world impacts on people's lives to strongly urge the committee to vote for necessary protections in healthcare facilities. They will also provide evidence that many viruses are efficiently transmitted via aerosols, not only "droplets".

The specific protections that are evidence-based and necessary to protect public health are:

1) Improved indoor air quality in all areas of healthcare facilities, following at a minimum the updated ASHRAE 241 standards.

2) At a minimum, providing patients the ability to access healthcare in safe surroundings. Meaning: all staff and providers they interact with are properly wearing N95 or better respirators, and they have spaces to wait and recover that are separated from patients, staff, and providers who are not wearing respirators.

We heard from one of the presenters about two viruses, for which N95 respirators or better were recommended as standard protections. The evidence shows nosocomial infections from other viruses can cause higher mortality and complications. The above protections would greatly reduce the risks from all diseases that have airborne transmission, including tuberculosis, RSV, influenza, and SARS-CoV-2.

HICPAC has a great power, and therefore great responsibility and duty to do what is best for the American public and a duty to protect the health of all. The members of the committee have a once in a lifetime opportunity to lead on this issue, and to be recorded in history as having been forward-thinking.

Please do not repeat the mistakes of Dr. Semmelweis' physician contemporaries (they refused to acknowledge the benefit of hand washing for infection control in the 1800s, which lead to countless infections and deaths for more than a century after, until the 1980s).

Sincerely,
Wayne Wu
Member of the Public
New York, NY

---

You chose to IGNORE the USG studies & RCTs on masks that were completed before covid showed up.

You ignored the $6Billion pandemic plans that was paid by our hard earned money that caused the deaths of 300,000-500,000 of us.

You ignored National Nurses United pleas of urgency to follow aerosol precautions as/precautionary principle and now nurses died and their colleagues left the profession.

MASK MANDATES SAVE LIVES!
MATTHEW SHIELDS

---

Advances in hygiene have historically saved more lives than medical intervention. This is widely recognized in water quality, hand washing, and sterile procedures. It's well past time to apply the same standard to the air.

Healthcare settings require universal use of high-quality respirator masks–that is, respirators that meet the standards of U.S. 42 CFR 84 for filtration of 0.3-micron particles per U.S. 42 CFR 84 to the N95 or better level.

The Centers for Disease Control's (CDC's) Healthcare Infection Control Practices Advisory Committee (HICPAC) must make this important step forward in patient (and worker) protection and public health. There are multiple gaps that HICPAC needs to address:

1. The prepared presentation by HICPAC on August 22, 2023 completely neglected Covid-19; this is clearly unacceptable and warrants a period of intense re-working of recommendations and thinking.
2. Asymptomatic transmission predominates in Covid-19 [Johansson et al. 2021] and Covid-19 is widely present year-round, so any measures against it must assume a patient is infectious unless and until proven otherwise.
3. The goal must be zero healthcare-acquired Covid-19 infections, as with sepsis and methicillin-resistant Staphylococcus aureus (MRSA) infections. Current policies for public exposure to Covid-19 have tolerated a level of disease that is far too high for healthcare settings. In particular, CDC has recommended changes to community behavior based on levels of hospitalization for Covid-19 (the "Community Levels" criterion); and Biden administration advisors have suggested that a level of weekly deaths comparable to other infectious diseases would be tolerated by the public, implying this is an acceptable policy outcome [Emanuel et al. 2022]. No other infectious disease of similar lethality is treated with the same loose standards.
4. "Levels of population immunity" are not a valid consideration for HICPAC, because patients in healthcare settings are not representative of the population at large. Healthcare patients are far higher risk than the general population for multiple reasons: many of them are immune compromised and cannot develop a full response to vaccination or infection; many of them have comorbidities (after all, they are in healthcare); and many of them will have intentionally avoided infection, meaning they will not have any infection-derived immune response ("hybrid" or "natural" immunity).
5. There is no logical reason to accept current levels of *other* respiratory infections in healthcare. For the same reasons patients are more susceptible to serious consequences of Covid-19 infection, they are also susceptible to serious consequences of influenza and other airborne diseases.

6. The balance of evidence shows that respirators provide better protection than “medical” masks [Ueki et al 2020], the distinction is flawed between large “droplets” and smaller aerosols, all of which spread Covid-19 [Wang et al 2021], and that masking has been effective at slowing the spread [Royal Society 2023]. While HICPAC has been focused on a limited few studies of N95 respirators versus “medical” masks in limited settings, these studies have neglected asymptomatic transmission and deployed N95s only at limited distance based on the now-disproven “droplet” theory.
7. Anti-mask political pressure has been intense and bipartisan [Sun et al 2021]. HICPAC must tune this pressure out and do the right thing for patients and workers.
8. In addition to a threshold of zero hospitalization and death, post-acute sequelae of Covid (Long Covid) must also be considered–both as an outcome to be avoided, as well as avoiding reinfection of patients who are already suffering from Long Covid.
9. HICPAC membership should be expanded to include experts in small aerosol transmission, advocates for immunocompromised patients, and advocates for Long Covid patients.
10. HICPAC has been overly focused on dynamic responses–but because of the reality of asymptomatic transmission and the goal of zero healthcare-acquired infections, dynamic responses are not appropriate. Sterilization of medical implements and hand washing are universally applied, not deployed “dynamically,” and there is no objective reason to believe respirators for Covid-19 and other airborne infections should be treated differently.

Respirator masks are necessary, but not sufficient by themselves, to clean the air in healthcare settings. High-efficiency particulate air (HEPA) filtration must also be deployed universally. Improved ventilation can also help. With a concerted effort, we can finally protect patients and workers from airborne infections in the same way we protect them from waterborne and surface-borne infections.

Sincerely,

Daniel C. Fain, PhD

Emanuel, Ezekiel; Osterholm, Michael; and Gounder, Celine. “A National Strategy for the ‘New Normal’ of Life With COVID.” *Journal of the American Medical Association.* January 6, 2022.
Johansson, Michael, et al. “SARS-CoV-2 Transmission From People Without COVID-19 Symptoms.” *Journal of the American Medical association.* January 7, 2021.
The Royal Society. “COVID-19: examining the effectiveness of non-pharmaceutical interventions.” August 2023.
Ueki, Hiroshi; Furusawa, Yuri; Iwatsuki-Horimoto, Kioyoko; Imai, Masaki; Kabata, Hiroki; Nishimura, Hidekazu; and Kawaoka, Yoshihiro. “Effectiveness of face masks in preventing airborne transmission of SARS-CoV-2.” *Journal of the American Society for Microbiology.* October 21, 2020.
Wang, Chia; Prather, Kimberly; Sznitman, Josué; Jimenez, Jose; Lakdawala, Seema; Tufekci, Zeynep; and Marr, Lindsey. “Airborne transmission of respiratory viruses.” *Science.* August 27, 2021.
Sun, Lena; Pager, Tyler; Abutaleb, Yasmeen; and Linskey, Annie. “The right decision wrongly handled: inside the Biden administration’s abrupt reversal on masks.” *Washington Post.* May 15, 2021.

---

Name: Daria Somers
Address: Sherman Oaks, CA

Affiliation: None. Private citizen

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I am a cancer patient who has been diligently masking and isolating since the start of the pandemic and was recently infected with COVID for the first time -- by my DOCTOR. I beg you to require respirators (not unsealed surgical masks which are inadequate against airborne contagion) for all personnel in healthcare settings and enforce those regulations. I should not have to risk my life or further health problems to receive necessary medical care. Doctors and hospitals are supposed to make you better, not give you a new disease that could kill or disable you.

I 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

I do want to emphasize that 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

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 respirator 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,
Daria

---

To Whom It May Concern:
I am writing as a concerned citizen to urge HICPAC and the CDC to engage professional expertise in reviewing and updating guidelines and to protect workers and patients by promoting PPE and cleaner air. Given the public role of the CDC, a transparent process with public and professional input should be a given. I am concerned that the process and resulting guidelines favor cost-cutting in the health "industry," unfortunate as it is, rather than actual health or disease control. Patients and laborers both lose without high standards of infection control.
We have seen in the ongoing pandemic the ways in which health care employers have avoided providing protection for health care personnel and patients, based on cost considerations.

These failures are part of why it is so important for HICPAC and the CDC to be clear about the precautions needed to protect health care workers and patients from infectious diseases, including PPE and frank recognition of aerosol transmission. I am in shock that the Center for Disease Control would, in 2023 and in the midst of a devastating pandemic, continue to recommend surgical/medical masks without preference for better quality N95 respirators. Surgical masks are cheaper, yes, but it is clear that they are not as effective. While a surgical mask is better than no mask, why would a mask of inferior quality be promoted in this way? And in regards to aerosol transmission, why is the CDC continuing to ignore the importance of ventilation and air filtration? These are workplace safety issues as well as patient rights issues. I am very saddened by this failure of leadership on the part of CDC and HICPAC specifically. I hope you will change course and show that you care about public health more than cost savings in the healthcare industry.
Thank you,
Nicolette Rohr
Riverside, California

---

I am writing to express my concern and dismay at the lack of adequate safety protocols for Sars-Cov-2, an airborne BSL-3 pathogen.

It is appalling that your agency is considering further weakening the existing regulations regarding face masks in healthcare settings. An N95 mask and a surgical mask are by no means equal, as anyone with a basic understanding of the science would know.

As a formerly healthy woman in her 30's who is now completely disabled by Long Covid, I no longer feel safe nor welcome in medical settings. I routinely forego medical care unless it is an absolute emergency.

I grew up thinking that our government existed to lift up our most vulnerable citizens. As an adult, I feel betrayed by the cynical minimizing actions of this CDC and the Biden Administration. I voted for Joe Biden because he promised to "follow the science" unlike President Trump. Yet it has become clear he has failed in this promise.

I urge you to follow the science and take further steps to protect the health of everyone in medical settings, by enhancing airborne precautions against this aerosol-based virus.

Thank you,
Christina Collins

---

Hello,

Since 2020, the science has been clear: COVID-19 spreads mainly indoors through aerosols. A study of the March 2020 Skagit Valley Chorale superspreader event confirmed (https://www.colorado.edu/today/2020/09/17/singing-unmasked-indoors-spreads-covid-19-through-aerosols-new-study-confirms) this highly effective mode of airborne transmission.

“This study documents in great detail that the only plausible explanation for this superspreading event was transmission by aerosols. Shared air is important because you can be inhaling what someone else exhaled even if they are far away from you,” said Shelly Miller, lead author on the study and professor of mechanical engineering at CU Boulder.

“The inhalation of infectious respiratory aerosol from ‘shared air’ was the leading mode of transmission,” said Jose-Luis Jimenez, co-author of the study, professor of chemistry and fellow at the Cooperative Institute for Research in Environmental Sciences (CIRES). “The research adds to the overwhelming body of evidence that aerosol transmission is playing a major role in driving this pandemic and especially to superspreading events."

This airborne mode of transmission for a deadly and disabling disease has been scientifically proven again, and again, and again.

https://www.colorado.edu/today/2020/07/09/experts-weigh-airborne-transmission-covid-19

https://www.colorado.edu/today/2021/08/27/simple-safety-measures-reduce-musical-covid-19-transmission

https://www.colorado.edu/today/2022/11/03/covid-still-dangerous-global-health-threat-new-international-study-spells-out-how-we-can

https://www.colorado.edu/today/2023/02/23/tend-get-sick-when-air-dry-new-research-helps-explain-why

Scientists say we must regulate air like food and water (https://www.colorado.edu/today/2021/05/13/prevent-next-pandemic-scientists-say-we-must-regulate-air-food-and-water). In a Perspectives piece (https://science.sciencemag.org/cgi/doi/10.1126/science.abg2025) published in Science on May 14, 2021 they call for a “paradigm shift” in combating airborne pathogens such as SARS-CoV-2, the virus that causes COVID-19, demanding universal recognition that respiratory infections can be prevented by improving indoor ventilation systems.

So why then, three years and at least 1.12 million deaths later, are we not making sure our healthcare policies follow the established science—that SARS-CoV-2 is airborne—to protect all Americans?

Universal masking with N95 respirators is a simple measure to reduce the risk of infectious disease transmission that has been implemented broadly in healthcare settings for the last three years. The CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) should codify universal masking as an improvement to standard precautions across healthcare settings and expand the use of N95 respirators.
Airborne infectious diseases such as COVID-19 are transmitted in the air we all share, which is why wearing high-quality, face fitting respirators is important to prevent transmission, in combination with ventilation and other layers of protection. COVID-19 has already caused over 42,000 deaths this year, placing it among the top 10 killers in the US in 2023, and 15.8% of U.S. adults have experienced Long COVID, a condition that persists after initial recovery from a COVID infection. Similarly, other airborne diseases such as MERS or SARS could also lead to large numbers of hospitalizations and deaths, the 2015 MERS crisis led to 38 deaths among 186 diagnosed cases in South Korea, and the 2002-2004 SARS crisis led to 774 deaths among 8,000 diagnosed cases across several countries in Asia and Canada.

If healthcare workers stop wearing N95 respirators while caring for COVID-19 patients, many more will develop COVID-19. Because over 50% of COVID transmission occurs before people develop symptoms, they may pass it to their coworkers or patients in maskless healthcare settings. This could, in turn, fuel further hospital outbreaks and drive health worker shortages.

An airborne disease deserves airborne protections: please ditch surgical masks for N95 respirators in health care practices and standards.

Best,

**Kelsey Simpkins, M.A.**
Broomfield, CO
Regional Air Quality Council

---

Name: Tiffany Rossmoyer
Address: San Diego, CA
Organizational affiliation: n/a
Topic: Respirators in Healthcare

To Members of the HICPAC:

Despite being up to date on my COVID-19 vaccination and boosters, I am at high risk for severe disease due to underlying health conditions. This is also true for my wife. As a result, our household only visits essential indoor spaces such as medical facilities. When universal masking was in place at the end of 2022, I was able to have a much-needed surgery with the confidence that the healthcare workers who cared for me were not likely to also infect me. If either my wife or myself needed surgery today, we would be faced with weighing the significantly higher risk of infection against the risks of not having surgery. No one should have to face this choice.

As you know, COVID-19 infections can be both fatal and lead to Long Covid. I want to remind you that worldwide at least one person dies every 3 minutes from COVID and that Long Covid is a mass disabling event affecting over 65 million people globally. Worse still, when contracted in hospital, the risk of death from COVID is greatly increased with a mortality rate between 5 to 10%. In England during May 2023, 30% of COVID cases in hospital were caught in hospitals (NHS Covid-19 hospital activity).

The potential for consequences in a maskless healthcare facility is as real as the virus itself. Hospitals are now more dangerous to visit than ever before - especially for those who are disabled, chronically ill, and immunocompromised. When we cannot access healthcare safely, it is a form of discrimination. "Personal choice" mask wearing is ethically unjustifiable for patients and healthcare workers needing to protect themselves from this virus in a way that only universal masking can provide.

The latest research has shown that with air quality of 800 ppm the risk of infection without a mask in a hospital setting in the event of exposure to SARS-CoV-2 was over 80% and wearing a surgical mask left a 35% risk of infection. Two-way masking with an N95 respirator brought this infection risk down to a level close to 0%. Research such as this supports universal masking, equal to or greater than KN95 or N95 respirators, in healthcare settings to greatly reduce COVID infections.

As someone who cares about public health, accessibility, and safety, I urge you to recommend that respirators be mandated for staff and patients in all healthcare facilities. Lives depend on it.
Tiffany Rossmoyer

---

From:
April Lowell
Tewksbury, MA
Cell Signaling Technology

Hello,

I'm writing to you today to express my concern about infection control in healthcare facilities, and more specifically the lack of mask mandates in healthcare facilities.

I have a PhD in molecular and cellular biology, with extensive expertise in antibodies and antibody-based research assays. I am dismayed at the CDC/HICPAC's lack of attention to the abundance of peer-reviewed scientific evidence showing that COVID-19 is aerosolized and airborne, highly contagious through inhalation, and that N95 respirator masks work much better at preventing COVID-19 infection than basic paper medical masks. Additionally, COVID-19 infections occur regularly in healthcare facilities, particularly without adequate mask requirements in place for staff and patients.

The CDC/HICPAC review of evidence completed thus far on N95 respirator and surgical mask effectiveness was flawed, using cherry-picked data, and needs to be redone with input from scientific researchers and experts in respiratory protection, aerosol science, and occupational health. Plenty of other studies, including extensive evidence on respirator effectiveness from laboratory studies and studies in non-healthcare workplaces, were omitted from the CDC/HICPAC review process. I also urge HICPAC/CDC to increase transparency and public engagement in the process of updating the 2007 Isolation Precautions guidance. So far, CDC/HICPAC’s process has been mostly closed to public access or engagement.

As a person with many family members who are nurses and healthcare workers, I am also concerned about the lack of regard for the safety, health, and well-being of essential healthcare workers. Requiring masks in healthcare settings, especially high-quality N95 respirators or similar, protects healthcare workers, their families, and their patients. Additionally, as a woman with asthma and an abundance of allergies, who has a young son and a husband with underlying health conditions, I do not feel safe going to essential medical appointments when healthcare facilities have no mask mandates in place and a lack of filtered air standards for every room. The fact that the CDC is no longer tracking COVID cases means that we do not have an accurate measure of the level of the oncoming problematic infectious wave. And to be clear, COVID-19 infections are a concern for all people, not only those over 65 and with underlying conditions. Even healthy younger people who have had COVID-19 have over a 10% chance of being impacted with Long COVID, and have an increased chance of having cardiac events, blood clots, diabetes, and organ damage. If you do not follow the scientific evidence and expertise of leading global experts, and implement additional layers of mitigation like high-quality mask mandates in healthcare settings, infections will continue to occur and get worse, especially for the nation's most vulnerable patients–remember, first do no harm. You have a duty to do better for the health and well-being of all.

Sincerely,
April
Ph.D. in Molecular & Cellular Biology

---

Hello,

I'm Irina Rivkin, from Sierra City, California. 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.

Lifting 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 settings with immunocompromised patients.

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. And the majority of facilities refuse to accommodate my disabilities, claiming "we are following CDC guidelines".
Thank you.

---

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 proposed changes are weaker than existing CDC infection control guidelines. 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 be taking 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

---

HICPAC,

On August 22nd, community members unanimously urged the CDC's HICPAC members to recognize airborne transmission of SARS-2 and to require airborne precautions that include respirators, ventilation, and filtration in healthcare settings.

Today, I am joining ActionCareEquity.org and these community members who spoke during CDC's HICPAC public comment to emphasize the urgency of recognizing airborne transmission and to require airborne precautions in healthcare settings to save lives, prevent growing rates of long covid, and create safer conditions to access healthcare.

Lives should not be harmed in healthcare settings, lives should be saved. Mask requirements in healthcare settings during an ongoing airborne pandemic should be the baseline of care, anything less is an exercise in negligence. People are dying tragic deaths from hospital acquired infection of SARS-2 that could have been prevented with mask requirements. HICPAC must recognize that SARS-2 is airborne and that airborne precautions such as respirators and improved filtration and ventilation systems are necessary to prevent and reduce transmission of SARS-2 and other airborne viruses.

And 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 masks will help our healthcare workers stay safer and help address critical staffing shortages which is reducing the overall baseline of care and is leading to a healthcare collapse. In closing: You are the CDC, 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?

Act quickly, our health and lives are depending on the requirement of airborne precautions in healthcare settings.

Thank you.

Kim Ammons

Springfield, MA

Dear HICPAC committee,

I am writing to request that you consider changing your guidelines to be more protective for everyone: add air filtration requirements and good quality mask requirements in healthcare facilities. As someone who is at high risk with a disabled spouse, I am worried about acquiring covid when trying to obtain needed medical care. I am especially concerned about this when needing to get emergency care and people are coughing with no masks. People should not have to worry about getting covid or any other airborne infection while getting needed healthcare.

Besides helping prevent covid, high quality masks (KN95s or better) help prevent other airborne infectious diseases of which there are many – as someone like myself who has a PhD in microbiology knows. It is evident by record low influenza numbers during 2020 when people were wearing masks that masks can prevent large numbers of airborne infections. Adding in air filtration at medical facilities in addition to requiring masks, creates a much safer environment for at-risk people to get care in. Cancer patients and immunocompromised people need a lot of care and putting in protections to prevent airborne infections make things safer for them and everyone else who needs care.

There was a point in our history where handwashing and glove-wearing were not common practices, but they were adapted because they made healthcare safer. We stand on the precipice of that with air filtration and mask requirements to reduce acquired airborne infections from healthcare. These things are small relatively simple things to require in healthcare facilities and yet will give so many people peace of mind while getting the healthcare they need.

Thank you for your time and consideration in making healthcare facilities safer places to get care for everyone.

Sincerely,

Angela Fowler, PhD
Carmel, IN
No organization affiliation
Topic addressed: Infection control guidance for healthcare facilities

August 25, 2023
Name: Liz Borkowski
Affiliation: Comment submitted as individual (no organizational affiliation)
Address:  Washington, DC
Topic addressed: HICPAC guidance for healthcare facilities
Healthcare Infection Control Practices Advisory Committee
Division of Healthcare Quality Promo6on
Centers for Disease Control and Preven6on
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 inadequate transparency around the new draft guidelines makes it difficult to know exactly what they advise, but reports suggest that they fail to recognize a) the superiority of respirators compared to surgical masks for preventing viral transmission

and b) the essential role of using ventilation and filtration to improve indoor air quality. Both shortcomings are inexcusable given the
evidence base around SARS-CoV-2 transmission.
The severe toll of COVID-19 on healthcare workers demonstrates the consequences that can result from insufficiently protections in healthcare facilities. 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.[1] 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.[2] Employers might complain about the expense of improving indoor air quality and
supplying employees with well-fitting respirators, but these investments are worthwhile to prevent staff absences and disability (both of which are also costly) and to avoid preventable deaths, which no one
with a functioning moral compass wants to see.
It does not appear that HICPAC's process for developing new guidance included adequate consultation with the appropriate experts. Guidance that will affect future illness, disability, and death among
healthcare workers must be developed in consultation with healthcare personnel and their representatives; industrial hygienists, occupational health nurses, and safety professionals; engineers,
including those with expertise in ventilation design and operation; researchers with expertise in aerosols and respiratory protection; and scientists from the National Personal Protective Technology
Laboratory (NPPTL) of the National Institute for Occupational Safety & Health (NIOSH).
I urge HICPAC to halt any plans to release 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 facili6es. Thank you for the opportunity to comment.
Sincerely,
Liz Borkowski, MPH

[1] 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/
[2] Choo M, Moss RJ, & Arnautović N. Long COVID in Workers CompensaSon: A First Look. October 2022. NaSonal Council on CompensaSon
Insurance, Inc. h+ps://www.ncci.com/ArScles/Documents/Insights-Long-COVID-Insights-Brief.pdf

---

Submitter's name: Isabela Salema McClintock
Address: Germantown, MD
Organizational affiliation: Covid Safe Maryland

SARS-CoV-2 is an airborne pathogen. To ensure safe health care for all patients, medical facilities need proper ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls. Respiratory and eye protection is needed for health care workers providing care to patients with suspected or confirmed respiratory infections.

N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered air-purifying respirators (PAPRs) into any updated guidance on health care infection control.

PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.
--
Isabela McClintock

---

Please keep masks in healthcare settings!
Jackie Womack

---

Dear Cochairs of Isolation Precautions Committee Drs. Lin and Wright and members of the HICPAC Committee:

I am writing to provide a public comment in response to the August 22 HICPAC committee meeting regarding Isolation Precautions and Airborne Illness. I am deeply concerned about the proposed Isolation Precautions Guideline Workgroup recommendations regarding airborne illness. I am grateful that the committee has opened public comment to the broader public, although I find it deeply concerning that you only permitted 14 people to speak in your August 22 meeting. In 24 hours alone the People's CDC has received over 200 emails with public comments sent to the HICPAC Committee. An Action Network Campaign has generated over 2000 emails to legislators (https://actionnetwork.org/letters/cdc-hicpac-needs-public-oversight/) on this issue. I do hope that the HICPAC will make its minutes promptly available to the public and that the draft of the guidelines will respond concretely to the public critique. I am furthermore concerned that the committee has yet to share draft guidelines with the public, and that the committee has not promised the public that the committee recommendations will be responsive to the concerns of appropriate stakeholders, including physicians, nurses and other healthcare workers, industrial hygienists, occupational health experts, patients, disabled people, and many other members of the public.

I am a family physician who has dedicated my career to working with and caring for underserved populations, a public health and social medicine researcher and educator in the fields of global health and community based participatory research. I am a clinical instructor at Harvard Medical School and a Faculty Affiliate of the FXB Center for Health and Human Rights at Harvard University. I am also a cofounder of the Health and Law Immigrant Solidarity Network, which now comprises over 600 members across Massachusetts working to make our health systems more welcoming to immigrant patients, and the Massachusetts Coalition for Health Equity, which has advocated for an equitable response to the COVID pandemic. I am also a member of the People's CDC and spent over a year writing an External Review of the CDC's management of the COVID-19 pandemic, which is forthcoming in a public health journal. I know from over 20 years of community organizing and advocacy in marginalized communities and caring for marginalized patients, that we must invite people into the process and try to make public health easy. This is the true way to practice public health. I invite this committee to engage in a such process. Invite and meaningfully incorporate the voices of community members, healthcare workers, disabled patients and advocates who have now been systematically excluded from society and now even from healthcare by a complete abandonment of COVID mitigation measures, in the face of a virus which the RECOVER study again shows (https://www.nih.gov/news-events/news-releases/large-study-provides-scientists-deeper-insight-into-long-covid-symptoms), can be disabling, and with each repeat infection, is more likely to cause Long COVID, even in vaccinated individuals. A virus which even in this year as our leaders have declared that the pandemic has ended, remains in the top 10 causes of death in the US.

When I shared the your IP workgroup slideset with infectious disease colleagues, they didn't believe me that CDC guidance would suggest that N95 masks should be replaced by surgical masks during care for COVID-19 patients because this shift was unimaginable. Not only does it neglect years of research into aerosol transmission of viruses and physical studies of protective equipment, but it is also a complete divergence from other guidance, even from this subcommittee of the HICPAC. In your guidance, for example, varicella requires the use of N95 masks, but varicella is not currently causing a pandemic, nor is it as deadly or disabling as COVID-19. Typically in medicine, in the face of the unknown, or when we presume to make a decision on patients' behalf, we employ the precautionary principle. Hospital-acquired COVID has a 5 (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2805585?guestAccessKey=9869bfb1-4a17-4473-ae57-dd480e9b1c33&utm_source=twitter&utm_medium=social_jamaim&utm_term=10244163916&utm_campaign=article_alert&linkId=218349975) - 10 (https://www.theage.com.au/national/victoria/a-death-sentence-more-than-600-people-die-after-catching-covid-in-hospital-20230621-p5di7x.html) % mortality rate. Healthcare workers should wear the best possible protection when caring for COVID-19 patients, especially because 50% of transmission occurs when people are asymptomatic or pre-symptomatic. Thus, health workers can seed COVID-19 outbreaks in our now unmasked facilities to patients and staff. Amid healthcare worker shortages, we should also be protecting our precious healthcare workers.

The outcomes of your guidance will have downstream effects, some of which I have already seen in patient care. I have seen a patient in her late 80s with severe pulmonary disease and atrial fibrillation on a DOAC, who did not speak English, who went to an outpatient appointment the day after mask mandates ended in my state and caught COVID. She was mostly homebound and was the only person in her household who tested positive suggesting she indeed caught the infection at her medical appointment, in spite of wearing mask. She told me she wore a blue surgical mask. Her family members were not even aware that there were other more protective masks available. I have also seen Spanish-speaking patients who told me that hospital staff did not wear masks, even when they had a cough. When I advised them that they could request for their providers to mask, they told me that they didn't want to inconvenience their healthcare providers. We must remain aware that any individual's capacity to protect themselves are significantly impacted by privilege including race, language, class, digital access, geography, age and many other factors. Members of my own household have contracted COVID in one-way masking settings. We have an obligation to ensure that our health facilities are safe for all. For this reason, we must employ multiple layers of protection, rather than expecting that every individual will have access to the highest quality respirator to protect themselves. Too often your guidance fails to remember that many pediatric patients cannot even reliably wear masks.

Your literature review was also concerning. It is astonishing that the CDC HICPAC committee should seek to base guidance such a set of widely-critiqued, and admittedly low-quality studies. In almost all of the studies included in your literature review, healthcare workers were not infected in the workplace but in the community. If a study participant is infected outside of work, while unmasked, then the study cannot assess the comparative efficacy of the mask worn at work. The CDC has been educating the public for years (https://twitter.com/PPEtoheros/status/1687881429827366912?s=20) that N95 masks are significantly more protective than surgical masks. Your review also excluded the 2022 CDC MMWR (https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm#:~:text=Although%20consistent%20

use%20of%20any,by%20wearing%20a%20surgical%20mask) which demonstrated that N95 masks are significantly more protective that surgical or cloth masks. Although that was an observational study, at the very least it assessed the efficacy of the mask that the people were reportedly wearing.

It is furthermore not appropriate to weigh discomfort or communication impairments caused by masks, without directly engaging with patients and healthcare workers who will be disproportionately harmed by rolling back infection control guidance. I coauthored with nationally recognized disabled and disability justice activists a response to the Annals of Internal Medicine opinion piece (https://www.acpjournals.org/doi/10.7326/M23-0793), which some members of the HICPAC committee coauthored, including Drs. Shenoy and Wright. I will quote from the response, and I encourage you to read it in its entirety. (It can be found below the original article linked above). It is important to consult those who will be disproportionately harmed by your guidance, before presuming to speak on our behalf. Deaf-and-hard-of-hearing patients and limited-English-proficiency (LEP) patients "are at higher risk of serious illness from COVID-19 and have the right to safe and accessible healthcare. Nobody should have to expose themselves to COVID-19 to receive healthcare." Nobody should have to expose themselves to COVID-19 to work in healthcare either, especially since we have effective tools to protect us. We should not be making healthcare even less safe by catching COVID at work due to inadequate PPE and seeding outbreaks in the very facilities where vulnerable people must frequent to get lifesaving care. As we wrote, "When institutions downplay the risk of disease while removing protections against it, patients are denied true informed consent, violating their autonomy."

The CDC should also update guidance to recommend universal screening testing on admission for patients. More than 50% of COVID transmission occurs before patients develop symptoms (https://urldefense.com/v3/__https:/pubmed.ncbi.nlm.nih.gov/33410879/__;!!BspMT6SJLSDJ!LqKXv1BzIoPEUNksALbMBw8rSbaeinRvobGLf48O1uzxQq2rmoJ5mpTIAV-gT-xGgYsfxZFLZQO8LPPR5qXr$), which is why universal masks (https://urldefense.com/v3/__https:/www.pnas.org/content/pnas/118/49/e2110117118.full.pdf__;!!BspMT6SJLSDJ!LqKXv1BzIoPEUNksALbMBw8rSbaeinRvobGLf48O1uzxQq2rmoJ5mpTIAV-gT-xGgYsfxZFLZQO8LOFf0qNM$) and screening testing are critical to prevent spread. Patients have a nearly 40 percent likelihood (https://urldefense.com/v3/__https:/pubmed.ncbi.nlm.nih.gov/34145449/__;!!BspMT6SJLSDJ!MhCDWAzt273FqzfL42B-8VP7bHtA0WUeV_s9YcrtS43p3pDoqVxfxDxVKMMYjlLsYbqmJwFTJQAemkG04_oUXyGrCw$) of transmitting COVID to their hospital roommate. Hospital administrators lobbied public health departments (https://www.bostonglobe.com/2023/04/05/metro/health-groups-call-mass-keep-mask-mandates-health-care-settings/) to end COVID protections in healthcare. Hospitals also lose money rescheduling elective procedures (https://urldefense.com/v3/__https:/ldi.upenn.edu/our-work/research-updates/hospital-revenue-loss-from-delayed-elective-surgeries/__;!!AQdq3sQhfUj4q8uUguY!ms4H5y7fwawOoj6FlbKXe8eye2GbXxJ4IGWQzb6iTmGmutJOLdHETVHnI6qmdKhocN0KaH906r9YIK4n3_hujOxaboZAzw$) when patients test positive for Covid-19. Hospitals face "crushing" (http://www.beckershospitalreview.com/finance/congress-can-take-action-to-help-healthcare-deal-with-crushing-financial-challenges-aha-urges.html) financial challenges, according to the American Hospital Association. We are left wondering whether the many representatives of large, wealthy hospitals who sit on the HICPAC are putting patient and healthcare worker safety first.

Furthermore, the CDC has not updated its guidelines regarding the definition of hospital acquired COVID since the beginning of the pandemic. "Hospital-onset COVID" should be defined as infections diagnosed after 5+ days of hospitalization. The CDC currently defines *hospital-onset* COVID as as only those cases diagnosed in people who are still in the hospital after 14 days of hospitalization. This vastly underestimates (https://pubmed.ncbi.nlm.nih.gov/34332019/) *hospital-acquired* COVID, particularly because with current variants, it only takes 2-3 days from COVID exposure to developing symptoms (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2795489), and because the average hospital stay is only about 5.4 days (https://www.cdc.gov/nchs/data/hus/2020-2021/HospAdmis.pdf). Furthermore, the CDC stopped requiring hospitals to report (https://urldefense.com/v3/__https:/www.aha.org/special-bulletin/2023-04-27-cdc-streamline-hospital-covid-19-data-reporting-requirements__;!!AQdq3sQhfUj4q8uUguY!ms4H5y7fwawOoj6FlbKXe8eye2GbXxJ4IGWQzb6iTmGmutJOLdHETVHnI6qmdKhocN0KaH906r9YlK4n3_hujOy6VnN2og$) hospital-onset Covid in April 2023. Multiple (https://urldefense.com/v3/__https:/www.nbcboston.com/news/local/boston-hospital-brings-back-mask-requirement-in-unit-affected-by-covid-cluster/3076733/__;!!AQdq3sQhfUj4q8uUguY!ms4H5y7fwawOoj6FlbKXe8eye2GbXxJ4IGWQzb6iTmGmutJOLdHETVHnI6qmdKhocN0KaH906r9YlK4n3_hujOwgznWMXA$) outbreaks have been reported since the end of mask requirements in health care in the US, but we now lack the robust data to evaluate the impact of ending COVID-19 infection control in healthcare settings. We need data to follow the outcomes of our policies, if we are truly to practice evidence-based public health. Furthermore, the data originally collected by the CDC was never collected with sufficient granularity to perform meaningful data analysis (https://healthdata.gov/Hospital/COVID-19-Reported-Patient-Impact-and-Hospital-Capa/g62h-syeh). The Biden administration and CDC also never released data (https://www.politico.com/news/2022/06/25/biden-officials-to-keep-private-the-names-of-hospitals-where-patients-contracted-covid-00042378) showing how prevalent COVID spread has been inside individual hospitals, to allow members public to assess their risk of acquiring COVID while accessing healthcare. All of this data should be public for the safety of patients and healthcare workers, and for the sake of evidence-based public policy. Hospital acquired COVID has a higher mortality rate than many infections (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program) that the Centers for Medicare and Medicaid require hospitals to prevent. COVID-19 should be added to that list.

It is difficult to imagine how a group of knowledgeable clinicians, such as those who sit on this committee, who engaged in such a thoughtful discussion about protocols for other serious infections, quickly make value judgments which summarily devalue the lives of elderly, disabled and chronically-ill patients and place the entire population at increased risk of Long COVID, with little discussion or transparency regarding these major ethical decisions, or the reasons why exposing large groups of people to COVID-19 without their consent in the healthcare setting should be acceptable. Furthermore, it is not the place for infectious disease specialists to make such value judgements on behalf of the entire population. Such decisions undermine patient and healthcare worker autonomy. We are left wondering about the extent to which the financial interests of the healthcare institutions influence this policy guidance. Many of the members who sit on the HICPAC committee and employed by large hospitals, and the financial interests of their institutions are not disclosed. These large hospitals, even academic medical centers, should not have voting seats on the HICPAC committee.

In sum, the CDC guidelines have failed to educate healthcare workers and the public regarding airborne transmission spread, and the consequent need for layered protections, as

the EPA (https://www.epa.gov/coronavirus/implementing-layered-approach-address-covid-19-public-indoor-spaces) does. The current guideline update is a major step in the wrong direction. I fear that this update will offer many employers an excuse not to provide healthcare workers with high quality PPE. There is also a significant financial interest for hospitals to dismantle costly-fit testing programs, which have been expanded because of the COVID-19 pandemic. Or worse, perhaps institutions will forbid health workers to wear N95 masks while caring for COVID patients, similarly to Massachusetts General Hospital which currently prohibits employees from wearing anything but a "hospital-issued" surgical mask while caring for non-COVID patients (not even their own respirators, brought in from home). I urge your committee to instead include universal masking for all healthcare workers and patients at all times in your standard precautions recommendations.

I fully endorse the People's CDC (https://link.sbstck.com/redirect/fd3d2f5a-ded6-45ce-bdfb-fb62c9bdf29e?j=eyJ1IjoiZTNxejIifQ.j96Pm-F-v8cxOQVDh4DS_XhN1E4r3VgVeLAs9gbyK-E) and the National Nurses United (https://link.sbstck.com/redirect/668de780-29c8-44ed-8313-9682a359ca60?j=eyJ1IjoiZTNxejIifQ.j96Pm-F-v8cxOQVDh4DS_XhN1E4r3VgVeLAs9gbyK-E) recommendations for updated infection control guidance. I also support and am a signatory of the national letter (https://urldefense.com/v3/__https:/www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf__;!!AQdq3sQhfUj4q8uUguY!ms4H5y7fwawOoj6FlbKXe8eye2GbXxJ4IGWQzb6iTmGmutJOLdHETVHnl6qmdKhocN0KaH906r9YlK4n3_hujOybeJBjlQ$) from 900 experts to CDC director Dr. Mandy Cohen regarding infection control measures. Overall I would advocate that we should improve and strengthen our infection control measures in heatlhcare, including implementing the following:

-Cohorting and isolating patients with suspected or proven COVID-19
-Universal screening of asymptomatic patients for COVID-19 upon hospital admission and prior to procedures, with repeat screening on day 3 to minimize transmission
-Universal masking in heatlhcare facilities and distribution of face fitting respirators for healthworkers and patients who wish to use them
-Improved ventilation in heatlhcare facilities
-Use of fit-tested N95 respirators or elastomeric respirators for all employees interacting with COVID-19-positive patients.

I urge you to incorporate the voices of disproportionately impacted and disabled healthcare workers, patients and communities in the development of updated policy guidance. Only in partnership can we develop truly equitable public health policy, to protect the health and prosperity of the public.

Sincerely,

**Lara Jirmanus, MD MPH**
Faculty, Center for Health Equity Education & Advocacy (CHEEA)
Cambridge Health Alliance
Instructor in Medicine, part-time, Department of Medicine
Faculty Affiliate, HMS Center for Primary Care
Harvard Medical School
Faculty Affiliate, FXB Center for Health and Human Rights at Harvard University
Harvard T.H. Chan School of Public Health

---

My name:  (Katherine) Gesine Lohr

Alameda, CA
Organization:  The Cat Nation

It is crucial that you restore masking in healthcare settings!

I am high risk for covid-19 (over 65, have 2 neuro-immune disorders, had polio, was a preemie/lung issues, etc.).  I only go to urgent medical or dental appointments, and masked socially distanced walks in the neighborhood.

Taking away masking in healthcare settings means that I am at more risk when I try to access urgently needed healthcare.  This is insane and unethical.  At the very least, you could mandate "make one day a week a masks-required day".  Not masking in healthcare settings means that I am avoiding necessary healthcare, as many other higher risk people are doing.  This is putting our cohort at significantly higher risk, for the convenience of many thoughtless people and authorities.

We're not asking to go out to eat, or to go to concerts (though we're a musician who misses performing), we're not asking to go on vacation trips, we're not asking to go visit friends far away, we're not asking to go to dinner parties, we're not asking to visit friends nearby in their homes.
We're asking that healthcare settings mandate N95 or good surgical masking for all, healthcare providers, patients, and the public.

Public health isn't "oh, you do you".  Public health isn't "let's do the utter minimum, or maybe even less than that".  Public health is:
using critical thinking to determine what actions will lead to the least net morbidity and mortality.
Masking in healthcare settings is not asking the moon and stars, it is a pretty easy-to-implement ask, and it adds very significantly to the safety of everyone in those healthcare settings.
Masking in healthcare settings is "first, do no harm".

Please listen to the many many many voices saying the same thing I am saying -- those of us who are at higher risk or who are protecting someone at higher risk, along with those who ethically want to do the right thing to limit the ongoing pandemic for everyone.

Sincerely,  Gesine Lohr

---

Name: Elizabeth Estochen
Address: MD
Organization: N/A - public citizen

I am writing today to urge HICPAC to amend the currently proposed policy to protect healthcare workers and patients from covid-19. Covid has been proven through rigorous studies to be an airborne illness. It is transmitted via aerosolized droplets in the air. It is a novel coronavirus that mutates to evade vaccines, so containment is essential. Spread is mitigated via individuals wearing N95 respirators, elastomeric respirators, and PAPRs, and indoor environments incorporating better HEPA air filtration. This is all public information with the scientific data to back it. Yet HICPAC's July meeting presented a proposal to recommend surgical masks in healthcare settings if any mask at all (still not required), which have been shown to not prevent the spread.

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.

In 2021, I was diagnosed with oral cancer. Let me walk you through my experience as a patient, having seen three different doctors, all in highly reputable hospitals in three different locations.

Of the doctors I have seen, the first I started seeing in 2021 wore an ill-fitted surgical mask. The second doctor did the same the first time I saw her in 2022. When I saw her again in 2023, no mask. My third doctor wears a face shield and no mask, despite the airborne transmission of covid. Everyone else in these offices--nurses, receptionists, patients--do not mask. I have sat in waiting rooms with people coughing. I have had to get oral cancer removed and come out of sedation in a room full of other unmasked people, none of whom were tested for covid pre-surgery. I have had to beg my doctor to prescribe paxlovid, should I contract covid during surgery, as even coughing will tear the stitches at the surgical site. And of course, cancer is caused from inflammation, which covid causes. As you can see, there are a number of reasons I would not want to contract covid, besides the obvious ones like possible lifetime disability I do not have the financial means to afford.

On August 22 during the most recent HICPAC meeting, Pantea Javidan from Stanford University explained to HICPAC members that telling patients they can mask if they want to be protected is not applicable to many patient settings, citing oral cancer as one.

On August 24, two days after that meeting, I went to my oral cancer appointment, located inside a busy hospital. My partner and I were the only two people in any form of mask. My doctor, in his face shield, remarked it was interesting we were wearing masks. He is a leader in his field. If he isn't receiving the information from those above him that covid is airborne, and he isn't being provided the proper PPE for he and his employees who work directly with head and neck cancer patients, HICPAC is clearly not doing the job they are paid to do.

It is obvious that the dissemination of proper information about covid transmission and mitigation is not being handled properly. I, as well as many other people you have heard from in your public comments, am asking you to please handle it. How to do so has been laid out by medical researchers, hygienists, epidemiologists, and everyday citizens. Our needs are clear. All HICPAC has to do is listen and respond. We need you to institute the use of N95 respirators or better in healthcare settings, as well as implement improved air filtration to stop the unnecessary spread of covid and all airborne pathogens.

---

Merry Palachek
Family Caregiver for an at risk, disabled sister who deserves to have safe healthcare visits

To Whom it Should Concern,

Regarding this meeting:
https://www.federalregister.gov/documents/2023/07/17/2023-15038/healthcare-infection-control-practices-advisory-committee-hicpac

I 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. 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

Here the CDC says that "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 you enter, 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 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.

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. CDC policy has locked the most vulnerable patients out of accessing necessary healthcare because the best weapon to protect everyone against contracting the virus is evidently an "albatross."

Sincerely,
Merry Palachek

---

Date: 25 AUG 2023
To: Healthcare Infection Control Practices Advisory Committee (HICPAC)

You are a small committee but have a huge potential impact on the course of human history. Please set aside petty employment considerations and search your conscience for what you can possibly do to save lives. Not only do your decisions drastically affect the lives of 300 million Americans, they indirectly influence the lives of 8 billion more human beings in other countries that look to America for inspiration.

I am a retired Occupational Health Physician and have followed the Covid Pandemic from the beginning with great interest. Having worked in both private and public health care for more

than 11 years, I am well aware of the potential political pressure placed on those in positions of authority.

But even after making such allowances for pressure group influences, I have been flabbergasted by the CDC's apparent willing ignorance of the science of Covid aerosol transmission. There seems to also be a lack of awareness that virus containing aerosols can remain suspended in the air for at least 17 hours after an infected person, possibly asymptomatic, was present.

Not only do I have elderly parents at serious risk of Covid complications, I have personal risk factors that put me at 3-4x risk of the already relatively high risks of complications from this aerosol transmitted virus.

My spouse and I have successfully avoided catching Covid by not entering any public buildings and avoiding personal contact except outdoors while wearing well fitting N95 respirator mask. We are grateful for my previous knowledge of TB and other airborne particle transmission which has helped us ignore the foolish advice of people like Dr. Fauci who early in the pandemic claimed that masks were not helpful when even common sense says that respirators work.

However, we can delay medical and dental care only so long. I am in urgent need of some medical procedures for which I would be unable to wear an N95 mask. And yet when I ask my doctors for accommodation, they (or the administrators that control doctors these days) cite "CDC recommendations" as minimums to which they are compliant. They completely ignore the benefits of respirators and improved ventilation as well as two-way masking.

Due to the known morbidity and mortality effects of Covid both short term and long term, as well as the relative lack of effective treatment options and the known ability of this virus to evolve to a more evasive and potentially more deadly version with each infected person, we must do everything humanly possible to avoid nosocomial transmission of this virus.

Please reinstate or increase N95 mask requirements for health care facilities as well as consult with experts in room air ventilation controls to make hospitals, doctors offices, dental clinics, laboratories, and other medical related facilities safer for both employees and patients.

This is your ethical duty to humanity. It is a higher obligation than the bottom line of your employer or any other political advocacy group stating otherwise.

Sincerely,
Lydell Anderson, MD

---

I am a senior in pretty good health as is my wife. We currently are caretakers for a female adult family member who has several chronic diseases, some of which require immune compromising medications. She currently has the horrible choice of either taking her medications that control her diseases, which leave her vulnerable getting to infectious diseases including COVID, or not taking those medications, having a strong immune system, and dying from the diseases she has. Very few people mask anymore. She recently called various taxicab companies to get a ride to a medical appointment and all but one of them said, "We do not require masks of our drivers."

Healthcare providers SHOULD be required to wear masks. Their profession's first commandment is what? FIRST, DO NO HARM. I know this is basic, but it still applies.

Sincerely,
Alan Hoeffler
Prescott, Arizona
P.S. I am writing as a healthcare concerned citizen and am not with any organization.
Thank you very much.

---

August 25, 2023, Public Comment to CDC/HICPAC from COVID Safe Maryland
Dear HICPAC,
COVID Safe Maryland is a volunteer group of Marylanders working to stop the spread of SARS-CoV-2 (COVID-19) in our state. We organize to reduce transmission, support people experiencing Long COVID, and remember those who have died from COVID-19. We advocate because policies that promote the unmitigated spread of COVID-19 force many of us out of public life, and put all of us at risk. We believe that everyone deserves the right to safely access essential spaces such as healthcare offices, schools, prisons, and public transit.

During the first three months of 2023, U.S. hospitals reported an average of 1231 patients per week that had caught COVID-19 during their stay, with a high of 2287 patients with hospital-acquired COVID-19 in the first week of January 2023 (using the current CDC 14-day definition).[1] COVID-19 has been one of the top five major causes of death in the US since 2020,[2,3] and many of those deaths were likely due to hospital-acquired COVID-19, which has a 5-10% mortality rate.[4,5] Now more than ever, it is imperative to maintain standards for high quality infection control regulations and practices in both inpatient and outpatient settings. Therefore, we call upon the CDC and HICPAC to recognize and act on the following:

**1. All infection controls should be in place at all times, using a time-tested concept from patient safety that "layering" of individually imperfect controls is necessary to strengthen overall control.** Comprehensive airborne infection controls should be standard, core, and routine, for all (inpatient, outpatient, etc.) patient encounters, both to minimize infections of any type, and to improve the cognitive performance and healing progression for all the people involved. These controls are relatively inexpensive to implement, compared to the costs that healthcare-associated infections will incur on the healthcare system and our general population. The minimum controls should include:

- Air cleaning, via ventilation, filtration, and Far UV-C,
- Universal respirator (i.e. N95, P100, PAPR) use for all workers (not just patient contacts), visitors, and all medically-appropriate patients,
- All workers (not just patient contacts) staying home on paid leave when symptomatic or testing positive for an airborne disease (including COVID-19, TB, RSV, flu, etc.),
- Frequent, regular testing of all people in healthcare facilities with contact tracing programs to track any potential exposures. Additionally, public reporting of test results, exposure, transmission rates, and hospitalization counts.

**2. HICPAC membership should include professional experts on all aspects of the built environment.** The current roster lacks technical experts in air engineering, water quality, or surfaces. It is well known that many infections spread via physical vectors (air, water, and surfaces).

**3. HICPAC should recognize and adhere to recommendations separately provided in comments submitted by People's CDC, World Health Network, and National Nurses United.**

**4. HICPAC needs to improve its transparency and processes in decision making and stakeholder engagement by adopting the following changes:**

**a.** HICPAC is clearly missing the benefits of patient and public input, and should consult the FDA, CMS, or other federal counterparts to improve these input processes, and implement

changes as soon as possible. See About the FDA Patient Representative Program (https://www.fda.gov/patients/learn-about-fda-patient-engagement/about-fda-patient-representative-program).
**b.** HICPAC must drop the unnecessary and overly restrictive limits on public comments, provide more opportunities and time allotments for oral comments, and remove the page restrictions on written comments.
The HICPAC infection control standards play a crucial role in safeguarding public health. The public health landscape has not "returned to normal"; it has been profoundly changed by the spread of COVID-19. The new standards are an opportunity to build a stronger healthcare system for all, and we urge you to draft a standard that is up to this challenge.
Sincerely,
COVID Safe Maryland (covidsafemd@gmail.com, https://covidsafemd.com/ )

**Comment submitted on behalf of COVID Safe Maryland by Becky Payne.**

---

My name is Philip Knodle,  I live in Medford MA.  I am not affiliated with any relevant organization and am speaking as a private individual.

I believe that relaxing the infectious disease controls where vulnerable people will be in contact with infectious people is a bad idea.

Regards,
Philip Knodle

---

Dear CDC Director Mandy K Cohen, MD, MPH:

I'm writing to urge you that the CDC:

- Make meetings about COVID-19 protocols open to more people
- Allow more people to comment with more time
- Use plain language so more people can understand

The ongoing SARS-COV-2 pandemic is killing and further disabling our communities, particularly BIPOC disabled individuals and older adults.

We must stop this harm and eugenics by:

- Increasing availability of N95/KN95 respirators and requiring them in healthcare settings
- Increasing/upgrading ventilation/filtration
- Encouraging free and low barrier access to testing and vaccines

Please listen to disability justice communities, healthcare providers, scientists and researchers and do everything in your power to stop mass death.

Thank you for your time and consideration.

Kacei Conyers

---

HICPAC Work Group:

I am aware of the changes you are proposing to the above Precautions. I have many concerns but in particular:

**The proposal to make the guidelines more "flexible" is likely to backfire.** I worked many years in local government and I know how tempting it is to simplify regulations so that more people and organizations can meet requirements. In this case, such simplification or flexibility can lead to minimal protections for healthcare workers and patients, and can leave vital decisions in the hands of for-profit corporations and others who do not have the public's healthcare as a primary goal.

Our experience with Covid-19 should be a cautionary tale. This country had the resources to do what was needed, but instead bent to political and economic pressure and as a result the U.S. has lost more citizens to the disease than any other country. We had a chance to lead the world but instead we have fallen on our face. It's not only embarrassing. It's heartbreaking.

It is especially important, given what we know about Covid-19 and similar infections, that we address the way the disease is transmitted: primarily by non-symptomatic persons and primarily through the air. We can wipe counters until the cows come home but we will not be addressing that huge elephant in the room: air quality. We need to mandate better air quality through the use of filters and ventilation systems. We need to address airborne transmission via asymptomatic persons by requiring adequate masking, as in N95 masks, not surgical masks. Evidence shows that surgical masks do little to stop transmission but N95 and similar masks are highly effective, especially when worn correctly. At the very least, masks should be mandated in healthcare settings.

The review of evidence on mask types included in the proposal is deeply flawed. The National Nurses United says: "The 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 must listen to healthcare professionals who are on the job every day, and do our best to protect them as well as their patients.

Please open up hearings to everyone. Make sure that the appropriate scientific professionals are notified and heard.

Judith Lautner
Henderson, NV
Retired City Planner

---

To Whom It May Concern,

My name is Rebecca and I am a writer with a degree in Disability Studies. Despite having several autoimmune diseases and other chronic illnesses including Fibromyalgia, POTS, and Hashimoto's Disease, I am not technically classified as high risk by the current standards the CDC has set. However, I continue to live my life mostly in isolation and with many precautions because of the pandemic, my knowledge about Long COVID, and my knowledge about my chronic illnesses and how they respond to viruses. The isolation is something I wish I didn't have to live with but the pandemic response has unfortunately left me with no choice. I would like to share a few requests.

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.

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.

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.

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.

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).

Sincerely,
Rebecca Hayes

---

It simply beggars belief that CDC/HIPAC advice for "Preventing Transmission of Infectious Agents in Healthcare Settings" appears to have regressed from practices common since 1918.

The agency fails:
* To acknowledge the science on aerosol transmission of viruses like SARS-CoV-2
* To acknowledge the importance of ventilation, filtration, and sanitization for controlling worker exposure to viral agents

* In its assessment of the effectiveness of N95 respirators

The public needs and deserves accurate information, and support for taking *effective* action. You are not delivering that. You will be judged even more harshly by history than by those of us still now taking the pandemic seriously.

Malcolm Crawford
Mountain View, CA

---

Dear HICPAC,

This situation is absurd. It's absurd that American citizens need to beg the Centers for Disease Control and Prevention to control and prevent disease. It's incomprehensible that huge swaths of American society, including many children, are involuntarily incarcerated at home because public places have been rendered life-threatening by lax CDC guidelines. And it's devastating that medical facilities — with over a century of IPC guidelines to minimize HAIs, staffed by physicians who have taken an oath to do no harm, where patients who are by definition vulnerable go to get well, and which are the only public indoor places vulnerable people are forced to go on penalty of death — are now among the most dangerous public places. Four years ago, hospital IPC measures — like glove wearing, hand washing, surface cleaning, occasional mask wearing, and isolation of patients infectious with a deadly pathogen — were accepted without a second thought, because we all agreed that a little inconvenience, discomfort, and expense were a no-brainer tradeoff for saving people's lives. So how have we become so cavalier about death and devastating chronic illness that we as a society, and in particular the CDC, are suddenly unwilling to protect ourselves and each other?

I hold a degree from Stanford University and was a PhD candidate and mom of two young children when I caught "a virus" near Seattle in February of 2020. Now I spend 19 to 24 hours per day in bed. I can no longer raise my children. My academic career is dead. My husband has had to cut his paid working hours to near zero in order to take care of me and our children, and also to homeschool our school-aged kids because lax CDC guidelines have allowed a deadly, RG-3 pathogen, to which my children are especially vulnerable, to run rampant among children and staff in public schools. In my immediate family, covid has turned two economic spigots into economic drains. We're now almost entirely dependent on the financial generosity of extended family. And we're one family among millions like ours in the US; according to Household Pulse figures, 1 of every 20 American adults is currently at least partly disabled by Long Covid.

Please think about that for a minute. Beyond the devastating long-term economic consequences, please consider the inhumanity of allowing so many people to suffer so greatly every second of every day when that suffering could have been prevented — and could still be prevented for millions of people — by appropriate guidance from the institution you personally help control.

You don't need a Stanford degree to understand that SARS-CoV-2 is severe ("severe" is in the name!) and is primarily transmitted through aerosols (ask an aerosol scientist). You don't need to have a PhD to understand that the research methodology of the mask studies HICPAC has cited (in attempted defense of your apparent decision to lower masking standards) is deeply flawed. If you were considering the effectiveness of hard hats at preventing construction-site head injuries, would you rely on studies conducted by people with vested interests against hard hats, where participants in the "experimental" group were given ill-fitting hard hats with big holes

and told to wear them only when they expected danger? Or would you instead accept the laws of physics and logic that tell you that head protection protects heads, and better protection protects better? Ask anyone with a Portacount machine to tell you how well 3M Aura N95s work compared with surgical masks; respirators that filter out 199/200ths of contaminated air are clearly superior to surgical masks, which typically filter out only 1/2 of contaminated air. N95s are designed to harness the laws of physics (inertia, diffusion, electrostatic attraction, etc.) to effectively trap airborne contaminants. Betting your life against the physical laws of our universe is, to put it mildly, unwise. Betting other people's lives is unconscionable.

The benefits of respirator use amidst the carnage of an ongoing airborne pandemic are obvious. So HICPAC's attempts to reduce respirator use — especially given the atmosphere of secrecy and nonaccountability in which this process has been shrouded — have led your audience to believe that you are being unduly pressured by external (financial? professional?) forces. If the pressures are financial, please consider the costs of recruiting and training healthcare workers to replace those lost to Long Covid and to burnout from excessive work load (due partly to the extra burden of nosocomial covid); in my state (WA), half of all HCWs report planning to leave the profession in the next few years. Also consider this: upgrading IAQ in public indoor spaces throughout the US to be 6+ ACH (which may be the point at which, in combination with sufficient booster uptake, R0 is driven below 1, in which case the pandemic would finally, actually, end!) is around the cost of one new aircraft carrier (~$20B).

If the forces pressuring you to make unethical and illogical decisions are mostly professional, please consider this: you may very well be one of the estimated 40,000 Americans who will wake up tomorrow with the covid infection that will ruin your life. The video of your Aug. 22 meeting showed attendees who were mostly working women, the prime demographic for the ME form of Long Covid, which is what has ruined my personal and professional life. As millions of us formerly young and healthy folk can attest, you can't progress professionally, and your boss and coworkers (along with most of your family and friends) won't be there for you if you're rendered bedbound by infection. Thousands of studies now show that everyone is vulnerable to long-term harm from covid. You and your loved ones are not special in that regard.

Many of you were probably taught that virus transmission occurs primarily through fomites. We now know that covid is airborne. Many of you were probably taught that there are only two outcomes to infection: clearing the infection or death. We now know that clinical Long Covid occurs in ~10% of infections (not people, *infections*), and occult Long Covid in many more. As Maya Angelou advised, "When you know better, do better."

You personally have the power to prevent covid and other airborne illnesses from destroying the lives of countless people, and you have the power to allow people with known medical vulnerabilities to access health care without needing to perform the terrifying calculus of "Am I more likely to suffer by putting off medical care or by going to a medical facility where life-threatening viruses spread unimpeded?" I don't think I could adequately convey the terror of having Long Covid symptoms that seem life-threatening, while understanding that a hospital trip could easily result in another infection of the kind that already took almost everything from you. In healthcare facilities, we minimally need timely testing and isolation, extra-high ACH, and universal respirator use to render these environments safe enough in an airborne pandemic that those who are unable to mask in a medical crisis are still protected.

If you haven't read Martin Niemoeller's "First They Came" in a while, I encourage you to read it now. If you don't protect others — the aged, the poor and marginalized, the medically vulnerable — from the virus, then who will protect you when the virus comes for you?

Thank you for reading this.  Please let me know if you would like citations for any of the info I have presented here.  And please choose wisely.

Regards,
R. Rudy

---

To whom it may concern,

Attempting to conflate the effectiveness of respirators with that of surgical masks is a foolish idea, contrary to the very clear and obvious scientific consensus, and yet another way to undermine what little remaining claim the CDC has to be doing good science & advancing public health. Adding that nonsense to a blatant capitulation to hospitals unwilling to make unpopular decisions is a moral and ethical disaster.

It has been stated by those who study such things that we likely WILL have another airborne pandemic; preparing hospital ventilation and staff expectations for that occurrence is basic harm reduction. Allowing laziness and cultural inertia to prevent that is absurd. Did we learn nothing from the treatment of Ignatz Semmelweis?

Additionally, air quality across the country continues to degrade each summer with increasing wildfires. Proper ventilation is necessary for those of us whose lungs are already compromised.

Please rethink the incredibly foolish idea to back down on ventilation requirements & pretend a surgical mask is anything like as protective as a proper respirator.

Yours in Science,
Anna G. Radke, MSc.
Ames, IA USA
No institutional affiliation

---

I am writing to **BEG** the CDC to not lower masking requirements in health care facilities. I also want the CDC to address minimum indoor air quality standards, both for medical facilities and schools.

Speaking as a scientist, I do not understand how it is even possible for you to ignore the obvious benefits of masks and air filtration in health care situations. The data is clear -- it protects both patients and health care staff.

It is extremely difficult for me not to write in all capitals, since for the last 3 years the CDC has systematically thrown me (and all the other immunocompromised Americans) under the bus. Repeatedly.

I get that in 2020 and 2021 we didn't have the data to always make the right calls. It was a rapidly developing situation.
But we have the data now.

And the CDC is *still* utterly failing those of us who are disabled, immunocompromised, and/or elderly. I'm just so disappointed.

Increasing air filtration everywhere, not just in medical facilities, will benefit everyone. And requiring N95 masking in high risk situations around patients seems like a no-brainer.

Gwen Pearson, PhD
Wood County Ohio

---

Oliver Wilson
Somerville, Massachusetts
Massachusetts Coalition for Health Equity
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 (https://docs.google.com/document/d/e/2PACX-1vS91ZpGGT76o9JDA0_Dy0NKatwEMxDpcSqMUDqOknNEiTtu-_fhD108BcYvO_DVGPiG-Trn7YIDSJwI/pub).
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.

---

Dear Members and Staff of the Healthcare Infection Control Practices Advisory Committee (HICPAC):

I'm writing to echo the stance of National Nurses United when it comes to protecting health care workers (and by extension, all patients and the general population) by maintaining or increasing aerosol protectin standards.

Their letter reads, in part:

1. Fully recognize aerosol transmission of SARS-CoV-2 and other respiratory pathogens. HICPAC and the CDC should ensure that updated guidance includes the use of multiple control measures that have been shown to effectively prevent transmission of respiratory pathogens, including SARS-CoV-2 and others, including: • Ventilation to remove aerosolized viral particles and other pathogens, including the use of negative pressure isolation and other engineering controls. • Respiratory and eye protection for health care workers providing care to patients with suspected or confirmed respiratory infections.• Safe staffing is essential to effective infection control and prevention. Updated CDC/HICPAC guidance must recognize this and must not make allowances for health care employers to circumvent measures necessary to protect worker and patient health due to staffing concerns.

2. Maintain and strengthen respiratory protection and other protections for health care workers caring for patients with suspected or confirmed respiratory infections. N95 filtering facepiece respirators represent the minimum level of respiratory protection available and are essential to protecting health care workers from respiratory infections. HICPAC and CDC should clearly and explicitly incorporate elastomeric and powered airpurifying respirators (PAPRs) into any updated guidance on health care infection control. PAPRs and elastomeric respirators can provide a higher level and more reliable protection than N95s, be more comfortable to wear, and more cost-effective for employers to implement.

3. The CDC must 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 present or may be present in health care settings; don’t adopt a crisis standards approach.

4. CDC and HICPAC should engage with stakeholders, including direct care health care workers, their unions, patients, and community members to provide them with the ability to review and provide essential input into guidance updates.

Thank you for your consideration.
Sincerely,
Sarah Blumenthal, LMSW, Maryland
Commenter name: Adam B. Reich
Commenter address: Metuchen, NJ
Organizational affiliation: N/A
I urge the Healthcare Infection Control Practices Advisory Committee (HICPAC) to pause its adoption of new guidelines regarding protective measures to prevent pathogen transmission in healthcare settings and make significant changes to them.
The conclusion that N95 respirators offer no difference in protection from surgical masks in preventing viral transmission is deeply flawed. HICPAC states in its August 22, 2023 meeting

presentation slides that the results of the studies it considered are at least conflicting and that a sizeable number of them considered were released before the emergence of COVID-19. Further, 10 of 13 studies did not report on compliance or measure compliance objectively. If these studies comprise the "majority" showing no discernible difference between surgical masks and N95 masks, they should not be relied upon. To do otherwise would be tantamount to saying we should stop putting seatbelts in cars because of the injuries sustained by people not wearing seatbelts in collisions. Since HICPAC does not seem to suggest that N95s are *less* effective than surgical masks and appears to acknowledge that there are at least some studies that suggest that N95 masks are more effective than surgical masks, the prudent and cautious course of action is to recommend N95 respirators in healthcare settings. A lesser standard should come only if a consensus to the contrary among additional studies that account for compliance.

It is also important to note that a study released after the August 22nd HICPAC meeting recognizes that N95 respirators offer a greater level of protection than surgical masks and have been instrumental in helping to reduce the spread of COVID-19, particularly in healthcare settings. "There is also evidence, mainly from studies in healthcare settings, that higher-quality 'respirator' masks (such as N95 masks) were more effective than surgical-type masks. The evidence suggested that masks with greater barrier function were more effective than those with lower barrier function . . ." The Royal Society, *COVID-19: Examining the Effectiveness of Non-Pharmaceutical Interventions* 12 (Aug. 2023), *available at* https://royalsociety.org/-/media/policy/projects/impact-non-pharmaceutical-interventions-on-covid-19-transmission/the-royal-society-covid-19-examining-the-effectiveness-of-non-pharmaceutical-interventions-report.pdf.

A weak standard that recommends only surgical masks is particularly problematic for high-risk patients who need higher levels of protection in healthcare settings and overlooks the severe outcomes these patients face, including severe fatigue, cardiac problems, cognitive issues and death. Since treatment options for these and other complications associated with Long COVID are limited, at best, it is imperative that HICPAC take a more conservative approach and recommend the use of N95 masks in healthcare settings.

HICPAC's recommendations are also problematic because it does not appear that key stakeholders with expertise were given a significant role in their development. 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 need to be given a greater role in shaping the proposed guidelines.

Finally, patients deserve a greater opportunity to weigh in than HICPAC provided at its August 22, 2023, meeting. Since patients do not appear to have had any significant involvement in the development of the current proposal, HICPAC must recognize that it cannot make a fully informed on recommendations relating to patient care unless it hears the experience and concerns of patients in live testimony. A comment period of less than one hour on an issue of such broad applicability and import for patients is wholly inadequate and inequitable. It is also imperative that it come before a vote on recommendations and not after. Please make public comment periods earlier on future HICPAC agendas and increase the time you allocate for them.

Respectfully,
Adam B. Reich

---

Dr. Mandy Cohen,

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where

health care is delivered. These practices are designed to both protect DHCP and prevent DHCP from spreading infections among patients.

Standard precautions must be used when providing care to all patients, regardless of whether they have an infection or not. All people must be presumed infectious and take all precautions against spreading the virus.

I demand that the CDC revise standard precautions without expiration to include the following:

**Create concise control guidelines that recognize actual transmission characteristics of SARS-CoV-2.**

- Precautions must be practiced universally and always since asymptomatic infection and transmission exist.
- Healthcare facilities and personnel must use all precautionary strategies to protect everyone: high risk, disabled, and seniors will mingle with infected patients, visitors, and staff.
- Pre-symptomatic and pre-positive-test transmission exist:
    - Positive result guidance must include the accurate and current scientific evidence on contagion timeframes before testing positive and/or showing symptoms.
    - Enforce individual exposures reporting.
    - Presumed all persons infectious and must take all precautions against spread.
    - Test all healthcare personnel daily, including all who report to healthcare facilities of any size or type. Anyone with symptoms of any aerosol-transmitted infection of any type (cold, flu, COVID-19, tuberculosis, etc.), or who tests positive, cannot not enter the healthcare facility in any capacity and must be supported with paid leave, or if appropriate, remote work until a negative PCR is confirmed.
- SARS-CoV-2 is aerosol-transmitted and remains in the air for hours, like measles. Guidance must state:
    - The CDC's guidance from January 2020 must 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 must 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 must 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 provide superior protection against exposure to and transmission of infectious aerosols and droplets, compared to surgical masks. CDC must emphasize procedures that would improve implementation, such as fit testing to remove leakage and widespread, free availability of a variety of respirators to fit various face shapes.
    - Facilities must implement minimum indoor air quality standards as set by The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) ASHRAE to control infectious aerosols in all healthcare settings. All

rooms negative air pressure, minimum total 12 air changes per hour, and all room air exhausted directly to outdoors.
- Outdoor transmission exists. Clearly communicate that outdoor transmission risk exists in crowded spaces, including outdoor healthcare spaces, such as parking garages, sidewalks, and pop-up tents, health fairs, parties, banquets, info sessions, vaccination tables, etc. other outreach events.

This is what “learning to live with the virus” looks like. Learning means insight and change. Otherwise, it’s just ignoring it for short term corporate profits and corrupt political partnerships at the cost of lives and actual future profits.

Sincerely,

Sara Johnson (citizen)
Los Angeles, CA

---

I am writing regarding the new proposed infection control guidance for healthcare facilities.

I think that our healthcare workers and our patients, many of whom have disablities like me and are already under increased threat due to COVID-19, deserve increased air quality inside healthcare facilities. I also think that advising that surgical masks are as helpful as N95s is harmful and shouldn't happen.

Thank you,

Sheila M. Lane
no organizational affiliation
Hamden, CT

---

Hello,

My name is Alex Makhlin and I am a member of the public. I am deeply concerned with the proposed changes to airborne/viral disease management and mask requirements in hospitals.

The public as well as a large body of nurses and other healthcare workers have flatly denounced this new proposal, as it flies in the face of known research and longstanding protocols. The data is clear - N95 or KN95 masks are best. Having HEPA air filtration is also sorely needed. Please do not pass this.

With gratitude and urgency,

Alex D. Makhlin

---

Hi,

As a member of the public who has struggled with Long Covid since 2020, I am concerned that the CDC is looking to weaken infection control guidance and make healthcare spaces less safe for patients and workers.

Workers and patients should not be at risk of getting infected with a slew of viral diseases simply by going to work or seeking healthcare. Infection control is already so loose that patients like me are already differing important healthcare due to the risk of getting Covid or other airborne illnesses while at clinics and hospitals. This only serves to reduce our quality of life.

The CDC should always make it their utmost priority to use well-researched data to back up their decisions. Research recently used to disprove the efficacy of N95 respirators 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. The CDC already knows that n95 respirators work to protect against airborne illness, why are you backtracking now?

900 experts already wrote to the CDC to express their concern about this course of action. In summary, if the CDC rolls back infection control guidance, it poises itself to not only completely lose any credibility within the scientific community but harm workers and patients across the country. Listen to the experts, and listen to the citizens whose lives you are affecting here.

Callie Shields
Ogden, UT

---

Hello,

My name is Vered Brandman, and I am a disabled citizen from Massachusetts. I am writing this as testimony to the HICPAC regarding the new draft infection control guidelines.

I don't want to get COVID-19 when I go into my doctor's office for a physical. I and the other patients are supposed to go there when we think we might be sick, to get tested, diagnosed, treated, and to manage ongoing medical concerns. Medical settings are one space where there are, by definition, always both medically vulnerable people and sick people. It's where we are supposed to go for help.

I don't want anyone working in these healthcare settings to catch COVID-19, or anything else any of us might have when we come in for medical care. I don't want them to pass it on to the rest of us, to their families at home, to their colleagues who treat different patients.

The science on indoor air quality has been clear: good ventilation (12+ exchanges per hour) and fresher air reduce the risk of contagion by removing airborne pathogens. This is the case in any indoor space, and to not plan for that in medical settings - where we are supposed to go for care when we are sick or vulnerable - is especially harmful. To individuals. To families. To communities.

We should have 12+ air exchanges per hour, but right now there are no guidelines or minimum requirements. We know that many organizations will only do the bare minimum required, if they can get away with it - I've watched this with mask mandates, for example, when they were still in place under the legal state of emergency. Even while mask mandates were in place, anytime I was indoors I could count on several people insisting on not masking, or not masking properly - and one or two even harassing someone else for masking as required - and there were always agencies and organizations, even hospitals, who refused to enforce the mask mandate. Since

masking stopped being required in even medical settings, I've had to cancel and postpone appointments because I can't afford to bring COVID home to my immunocompromised partner. Again and again I've had to insist that one-way masking - me wearing a mask while everyone else is unmasked - doesn't protect me. So many of my friends who have been masking indoors consistently since 2020 have been exposed to coworkers and colleagues who come in still symptomatic with COVID, still testing positive; in many workplaces it's not just the norm, it's what employers require. And it means everyone on site is exposed. This is preventable.

As a healthcare worker myself, I've had to turn down job offers that required me to work in-person, though in spring and summer of 2020 my employer and patients were very happy with my performance and ability to provide care virtually, while that was covered by insurance. I've watched colleagues get sick at work when we know what we can do to mitigate that risk, because our employers - the organizations, the systems designing protocol and company practice - refuse to be responsible to the communities they serve (or even to their own staff).

I hope you have piles and piles of testimony from other disabled and medically-vulnerable people, and from our allies who are trying to help keep us safe in this ongoing pandemic. We have been asking, demanding, and begging for system-level measures this whole time, because a contagious disease can't be stopped with only "personal responsibility" and one-way masking.

As a disabled person, as a healthcare worker, and as someone with loved ones who are immunocompromised and otherwise especially vulnerable to COVID-19, I don't think it's a lot to ask: that people and systems with large-scale decision-making powers make choices that protect us, that minimize unnecessary risk to us as individuals and as communities. I just want to have my physical exam without worrying that I've brought home COVID to my partner. I just want my colleagues whose work can't be done virtually, to be safe when they come into work.

Thank you,
Vered Brandman
Somerville MA
No organizational affiliation

---

Dear CDC,

I am writing to urge the CDC to lead the nation in public health by maintaining the use of strategies implemented during the ongoing pandemic and not weakening infection controls in healthcare. Continued use of tools such as universal masking, improved air ventilation and filtration, and telehealth, can enable health care settings to strive for healthier conditions and greater accessibility than before the pandemic.

Health care is the sector of society warranting greatest prioritization of the needs of the vulnerable as obtaining health care is not an optional activity. These settings are locations where those needing more frequent health care, including elders and those who are immunocompromised, mix with those who may be infectious creating greater risk.
This era of great local and global challenges such as the pandemic, persistent health care disparities, and climate change impacts on health, calls on all institutions to think creatively for transformative solutions that prioritize the needs of people and the planet.

Best wishes,
Susan Nossal, Ph.D

Madison, WI

Dear HICPAC,
I originally wrote this in advance of the August 22nd meeting, to say during public oral comment. However, after sitting through the entirety of the meeting, my already low expectations were not even met. I was appalled that none of the presentation mentioned COVID; in fact, it was only mentioned once in passing. Further, you privated the recording of the meeting almost as soon as you posted it on Youtube, and only made it available once citizens posted their own recordings. COVID is a real and present threat to everyone, and yet you wasted your time doing things like debating whether the term "Standard Precautions" is too confusing (it's not). I am pleading with you to be open and not live in your own echo chamber.

I am alarmed that the proposed updates are weaker than existing CDC infection control guidelines. Nine hundred public health experts sending a letter of concern should make this committee alarmed too. Alarmed that you did not incorporate essential input from numerous science and medical professionals alike. Alarmed at your outdated terminology of “air” and “touch” while failing to grasp the science of aerosol transmission and inhalation of aerosolized pathogens. Further, by the fact there is a systemic failure to acknowledge the importance and function of core control measures for infectious aerosols. Where are the recommendations on ventilation and filtration? Where is the acknowledgment of the efficacious respirators, rather than this cherry picking of data to conclude surgical masks are fine?
Your proposals allow for so much flexibility that employers can put people at risk of infection to cut costs, or for pure convenience.
To use an analogy, it seems you are less concerned with preventing fires than you are with putting them out once they are too big to ignore. This is untenable. More people would be alarmed like me, if you were more public with your process, like other federal advisory committees are.

I’ve never died before, but I have had an infection from which I never got better. And I can tell you, it is hell. People’s lives, their quality of life, is in your hands. No one should be maimed by COVID they caught during a hospital stay or a doctor’s appointment because your semi-secretive process rendered guidelines that allowed for such a thing to occur.

N95s or equivalent should have been required long before the pandemic. I’m immunocompromised, my parents are elderly and we should not have to be terrified to get routine care. Boston’s Beth Israel Deaconess had an outbreak and was allowed to be very secretive as to how many were infected, and even what department it was in. If hospitals can’t even be transparent to protect patients during an outbreak, they can’t be trusted to prevent one either, without adhering to stricter guidelines provided by YOU.

Stephanie Howes

Submitted by Mark S. Lefebvre
Dracut, MA
Affiliation: member of the public
Topic: Comments on the importance of core control measures for infectious aerosols.

Please include in your updated guidelines the importance and function of core control measures for infectious aerosols. There is substantial evidence on the effectiveness of respirators, robust ventilation, and air filtration for controlling worker exposure to infectious aerosols that must be

considered. This evidence must be used to formulate recommendations on ventilation, especially in health care environments, so that vulnerable people, like me and my family, can safely obtain the health care we need without jeopardizing our health. The proposed use of airborne infection isolation rooms (AIIRs), or other approaches to isolation when use of AIIRs is not possible, needs significant expansion to account for the threat of airborne pathogens. In addition, source control (limiting outward emission of infectious aerosols) needs to be more completely considered in the context of personal protection from inhalation. When we seek healthcare we want to be confident that our health will not be threatened, especially by known airborne pathogens like COVID.

Please prioritize the safety of the public, especially the vulnerable public, above interest groups and industry lobbyists. And use the science that has already been done as the basis for recommendations.

Thank you for your attention to this serious matter.

---

CDC Director Mandy K. Cohen, MD, MPH

The Center for Independent Living is a peer-led, cross-disability advocacy and direct services organization that provides peer support, direct services, information and referrals, and advocacy to people with disabilities and older adults in Northern Alameda County. The ongoing pandemic has continued to disable and destroy our communities, and the steady lifting of mask mandates and COVID-19 protections and best practices means disabled and immunocompromised people and older adults have even less access and safety in their communities. Over one million people have died from the COVID-19 virus, and yet–we have tools to keep our communities safer.

We urge:

- That the CDC increase transparency in its decision making
- Use plain language so more people can understand the decisions you are making
- Allow more people to make public comment at these meetings

We also ask that the CDC listen to and follow the direction of patients, health care providers, scientists, experts in personal protective equipment, and disability justice communities. Many of these people have asked, and we also ask that you:

- Require well fitting N95 and KN95 respirators for healthcare settings
- Increase ventilation in healthcare facilities
- Encourage free access to PCR testing, vaccination and boosters for all

Over ¼ people who contract COVID can experience long term symptoms including but not limited to:

- Postural Orthostatic Tachycardia Syndrome (POTS)
- Myalgic Encephalitis/Chronic Fatigue Syndrome, ME/CFS
- Micro clots
- Stroke

Already, we know that of people who experience POTS, over half (52%) are unable to work full time. We do not yet know the long term impacts of this illness, but the things we do know are not good. We must do everything in our power to keep our communities safe.

[1] https://onlinelibrary.wiley.com/doi/10.1111/joim.13245

With care,
The Center for Independent Living
Berkeley, CA
Emma Martin (she, hers)
Community Engagement Program Manager

---

Artemis Rue
Charlotte NC
Unaffiliated (Public citizen)
Testimony for 8/22 HICPAC Meeting

Hello HICPAC Team,

I urge HICPAC to revise their recommendations on infection control in health care settings. As is, the measures proposed this June have left out key stakeholders: frontline healthcare workers, patient advocates, union representatives, and workplace safety experts. We the public have had no opportunity for transparency or public comment prior to this week to say: the science is clear. N95s and respirators are the only adequate protection against infectious aerosols. Medical and surgical masks leak air and fail to contain the virus at its source or protect against transmission. There is extensive research in non-health care settings that supports the use of N95s and respirators that was excluded from the evidence review.

Proper ventilation and HEPA filtration are the only adequate methods to keep workplaces- including health care centers- safe. Maskless, unventilated air is a grave risk to public safety and will keep disabled and high-risk Americans from seeking medical care. If infection control guidelines don't outline **all** routes of transmission, including asymptomatic and through aerosolized pathogens, we cannot guarantee universal precautions for healthcare workers or patients. We already have indoor air quality standards provided by The American Society of Heating, Refrigerating, and Air-Conditioning Engineers that can be implemented.

The last three years have shown us, more than anything I have ever seen in my life, how sorely we need a layered protection strategy. Protection from this novel virus does not begin and end with a vaccine. Hospital-acquired infections are more lethal and easily transmittable to all, and especially the most vulnerable. I am at high-risk for developing long COVID, suffer a more serious case, or of dying from this virus. I have had to delay medical care and surgery multiple times and take time off from work to receive care when there are fewer people, because healthcare workers where I live judged that the risk of contracting COVID was too high at their workplace. My life matters. I call on you to reconsider your guidance.

Respectfully,
Artemis Rue

---

I write as a concerned citizen, a high risk chronic disease patient, and family member of a high risk person in response to the infection control changes that HICPAC is considering recommending to the CDC. I have a rare disease that is hard to treat and unfortunately, my disease is very advanced with few treatments, mostly chemotherapeutic, left. Acquiring SARS-CoV-2 would likely kill me or advance my disease past the point of treatment, which would kill me slowly with few to no palliative  medications available to me.

My family member and I live isolated, lonely lives because indoor unmasked spaces, and increasingly outdoor unmasked spaces, pose too great a risk for us. The care setting was the one place we felt safe. Since the May 11, 2023 end of the Public Health Emergency, all the health care providers in my state which had not already done so (a small minority) dropped their mask mandates and immediately made the place we once felt safest when were the sickest a danger zone whose risk to benefit calculation must be weighed for every scan, follow up, procedure, and appointment with the almost 20 medical professionals we see. The current mask-optional care settings put myself and my loved one in the impossible situation of choosing between necessary medical care and the risk of acquiring SARS-CoV-2 in the course of seeking said care. Every time one of us steps into a healthcare setting, we pray that we'll exit virus-free.

Disabled, elderly, high risk, immunocompromised people and their care providers deserve to give and receive care in spaces made safe by evidenced-based measures including well-fitting high quality respirators N95 or better and pathogen-specific standards of ventilation and air filtration.

The proposition to declare surgical masks equivalent protection against airborne pathogens including SARS-CoV-2 is unproven and dangerous. There is ample evidence of the efficacy of well-fitting high quality respirators in preventing transmission of airborne pathogens while surgical masks have no such evidence base. This fact is born out by the fact the CDC Public Health Strategies to Reduce Exposure to Wildfire Smoke during the COVID-19 Pandemic includes the recommendation of wearing a NIOSH approved N95 respirators to "provide protection from wildfire smoke and those without exhalation valves can reduce the spread of COVID-19".

Please don't make my loved one and I choose between dying of hospital-acquired COVID infection and dying from lack of necessary medical care. Please don't allow the dedicated care providers that we depend on to become sick, die or become potentially disabled with Long Covid from recurrent infections due to lack of evidence based infection control for SARS-CoV-2 and other airborne pathogens: the universal use of NIOSH-approved, well-fitting N95 respirators and ventilation and air filtration standards that reduce transmission of SARS-CoV-2 and other airborne pathogens.

Ann Ellingson
Ann Arbor, MI

---

Good evening,
COVID-19 is airborne, as are many other contagious diseases. People should not have to risk their lives or their health to seek healthcare. People should not go into the hospital with a broken arm and come out with a broken immune system thanks to COVID. It is unconscionable that you are thinking of *weakening* infection control standards instead of strengthening them. Nosocomial transmission of pathogens should not be a thing. Period. We have the knowledge and technology to stop them. All we lack is the will. Find the will. Masks should be mandatory in healthcare settings. Clean air should be mandatory in healthcare settings. We should want people to leave hospitals healthier than when they went in. Not sick with something new. Cancer patients, newborn babies, immunocompromised people, and indeed everyone, including "healthy" people, deserve clean air and protection against infection.
Sincerely,
Karen Fraley

---

To whom it may concern:

I am so disappointed to hear that you are not recommending better ventilation practices in healthcare establishments and that you intend to advise that surgical masks are an acceptable alternative to N95s in these locations. As someone with a respiratory condition, this makes healthcare facilities less safe for me and others like me.

Yours,
Tea Fougner
Queens, NY

---

To HICPAC:

We need CDC HICPAC to act on behalf of the PEOPLE and implement airborne infection controls in hospitals to protect us from local decisions made by biased people partially based on profit, personal preference, peer pressure, competition, or politics.

COVID-19, and the global effort it unleashed, can and should bring about a revolution in clean air the way other illnesses brought about hand washing, sanitation of instruments, gloves, testing of blood donations, and clean water. COVID-19 showed us that we need to also clean the air in healthcare settings and have regular covid testing.

Airborne infection controls will protect everyone from flu, colds, indoor and outdoor pollution, COVID-19, and future pathogens. It will enhance preparedness for future epidemics. Healthcare settings must have higher air quality standards than general public settings for the same reasons hospitals disinfect equipment, wash hands, and wear gloves even though we don't in general public settings.

CDC HICPAC must require eminently effective and non-controversial steps to control any/all airborne pathogens: HEPA filtration, ventilation with high rate of turnover and intake of outdoor air, and UV disinfection of air. CDC HICPAC should also require the controversial but necessary N95 masking by staff, and patients in waiting rooms and emergency rooms. Inpatients unable to mask or sharing rooms should have additional HEPA filtration in the room. CDC HICPAC should require regular PCR testing of all staff and patients for COVID-19 on admission.

Without requirements, infection controls are at the mercy of pressures from profits, scheduling, staff preferences, competition, and/or politics. Airborne infection controls must be required, to protect people from being sickened, disabled, or killed by decisions based on other factors and pressures.

Past infection control steps faced intense pushback - doctors initially thought hand washing was an insulting, unnecessary imposition, and it took a long time to become standard thanks to opposition. Please learn from history and implement clean air in healthcare sooner rather than later - this includes ventilation, air filtration, UV disinfection, masks, and regular covid testing.

K. Rhett Nichols
address: Cambridge, MA

---

Good Evening:

We need masks required in health settings due to the risk of covid. Please make this recommendation to protect our most vulnerable. Thank you.
--
Joseph Glatzer

---

Dear HICPAC Members,

My name is Rimona Eskayo and I am a 28-year old queer and trans artist, educator, and member of the public writing to express my grave concern for your proposed changes to the CDC's Isolation Precautions guidance. My primary concern is your evidence review on N95 respirator and surgical mask effectiveness and the negligent, closed-door guidance drafting process that leaves out some of the most important experts of our time. I am shocked and appalled at the cherry-picked data presented aiming to equate the effectiveness of a surgical mask with an N95. Covid-19 is an airborne virus — our first layer of defense should be a high-quality, face-fitting N95 mask for every patient and worker that enters a healthcare setting. Surgical masks were designed to protect against splashes, not aerosols, and suggesting otherwise contorts well-documented scientific data and enables continued mass death and disablement of the people. Without these high-quality masks in healthcare, patients are made to make an impossible choice between pursuing our essential healthcare and risking our lives and health from even a seconds-long interaction with an unmasked doctor, nurse, or receptionist.

We need robust protective measures that take into account airborne aerosol transmission. The proposed CDC guidance oversimplifies modes of transmission into “air” and “touch” while largely ignoring long-distance transmission— aerosols — that linger in the air from minutes to hours and are transmitted via inhalation. Ignoring aerosols and simplifying airborne transmission into what’s essentially only guidance on droplets rolls back what we’ve learned about transmission of pathogens via inhalation of infectious aerosols during the past nearly two decades, including the SARS-CoV-2 pandemic. There is clear evidence of infectious aerosol transmission by inhalation for many pathogens, including influenza, RSV, rhinovirus, norovirus, and meningococcal disease. We need thorough guidance that incorporates the lessons of these pathogens to push us forward, protecting us in our climate-changing future in which airborne pandemics pose an ever-dangerous threat. Without sufficient leadership from the CDC in recognizing the science of aerosol transmission and the role of inhalation of aerosolized pathogens, Covid and other infectious airborne diseases will continue to devastate our communities, in the US and beyond, for generations to come — because we all breathe the same air.

HICPAC’s closed-door drafting process prioritizes profits over proven protective measures, and ultimately, human life. The working group has excluded the perspectives of a wide range of experts that would strengthen and legitimize the CDC’s guidance — HICPAC must include the invaluable expertise of scientists (including those with expertise in aerosols and respiratory protection), frontline healthcare workers, engineers (including those with expertise in ventilation design and operation), unions, patients, and members of the public living with Long Covid who have been shouting from the beginning about the grave danger Covid poses to our communities not just upon acute infection, but across our lifetimes.

You, a HICPAC member, might be wondering why my perspective matters. It matters because my human life matters, and my life is endangered every time I seek healthcare in an unmasked facility. I want to grow old. I want my family to be safe. I want all people to be safe and protected when they seek out healthcare. We have the protective tools and scientific evidence, the experts, the ventilation/filtration systems, and the best in PPE we’ve seen yet. To ignore these

proven, robust protective practices is to condone mass death and disablement. I am reminded of my queer and trans ancestors who fought for protections against AIDS with t-shirts that read, “We die — they do nothing.” It’s hard to believe they lost their lives only for the same mistakes to be repeated. This is your moment to act. Our blood will be on your hands.

Thank you and sincerely,

Rimona Eskayo
Substitute Teacher, Portland Public Schools
Portland Association of Teachers (PAT) Member
Portland, OR

---

Please do not relax infection controls and indoor air quality standards in healthcare facilities or for healthcare workings. This would be a draconian step backwards at a time when our healthcare system is already stretched thin. Relaxing existing standards will only increase the spread of a Covid-19, and would be a grave mistake. Vulnerable people have a right to be able to get the care they need without worry about contracting SARS-Covid-2. It is critically important that we utilize the tools we know work to limit the spread of this airborne pathogen-masking, increasing indoor air quality, on top of vaccines. Further, I implore the committee to please continue to issue standards for improving indoor air quality, and investing in public education around this matter. Improving indoor air quality limits the spread of Covid-19 and is one of the key components towards helping us exit the pandemic.

Thank you for your consideration.

Sheila White
Radford VA
No organization affiliation

---

As someone who is considered high risk for COVID-19, it is imperative that the CDC continues to take this airborne disease seriously. This includes mandating increased ventilation and filtration of healthcare facilities and using N95 masks and not just any mask. These requirements make it safe for me and the millions of people like me to safely receive medical care instead of being at increased risk of being exposed during critical care.

Katherine Warren
Leesburg, VA

---

Dear HICPAC,
I write to encourage you to maintain the requirement for N95 or better when treating patients with Covid and other airborne infections. Furthermore, ventilation requirements need to be strengthened to protect health care workers, patients, families, and the whole community. Health care work should be safe. Seeking healthcare should be safe. Government agencies should protect people and make transparent decisions.
In my work for a Fortune 500 semiconductor company, I meet regularly with occupational safety experts and engineers and their input should be considered. Engineers are needed when you have an engineering problem like stopping airborne viruses. We don't do randomized controlled trials of seatbelts or air bags because engineering has its own standards of evidence which are arguably more rigorous than randomized controlled trials. That evidence should be included and we should all benefit from better air quality and protection from airborne viruses.

Sarah Liebman
Beaverton OR
Patient, Mom, Daughter, Wife, Advocate for safety, Tech Instructional Designer

Dear Healthcare Infection Control Practices Advisory Committee,
I am a scientist who works in healthcare and public health at Columbia University and the COVID Advocacy Initiative. I am writing to express my outrage at your new proposed guidelines which will weaken infection control in healthcare settings. The draft guidelines will put many healthcare workers and patients at greater risk, and significantly and adversely impact the quality of healthcare in our country.
Your updated infection control guidelines in health care settings dangerously fail to adequately address airborne transmission of SARS-CoV-2 and other respiratory pathogens.
Your new guidelines do not recommend the use of N95 respirator masks in routine settings, where airborne transmission is common. Your claim that surgical masks are sufficient is based on a flawed review and will lead to workers and patients getting sick because they aren't using an adequate standard of PPE.
Your new guidelines do not lay out much needed filtration and ventilation standards to remove pathogens from the air. This is an unacceptable omission, as cleaning indoor air is one of the most effective tools we have for reducing nosocomial infections.
Your new guidelines incorrectly try to pigeonhole COVID-19 as just a seasonal virus, when data shows us that there is a high baseline level of SARS-CoV-2 transmission for most of the year. As such we need to *increase*, not reduce, the layers of protection against airborne pathogens throughout the year.
I am also greatly disappointed by the lack of transparency and community participation in this process. This is inexcusable, as your guidelines will affect the lives of millions of healthcare workers, patients, and their communities. Your guidelines should absolutely not be approved until nurses, direct care healthcare workers, patients, community members, and many others whose lives are significantly and directly impacted by your recommendations have a central and meaningful role in drafting them.

The guidelines as currently drafted are a serious violation of "do no harm." They will result in more patients, especially those most vulnerable, being excluded from getting healthcare because it's too dangerous. They will result in a decline in the quality of healthcare due to worker shortages. They will result in many more healthcare workers and patients dying and becoming seriously ill.

I urge you all to do the right thing and please reconsider.

Sincerely,
Lucky Tran, PhD
Director of Science Communication
Columbia University
New York, NY

Hello HICPAC!
Please take steps to make sure healthcare settings are safe for folks that really can't get COVID. Please have strong guidelines masks in hospitals and other care facilities, both for the protection of those who work there as well as the patients.

My partner has a lot of health challenges which requires numerous visits to hospitals and other care facilities. Every time she goes and the care providers and other patients aren't masking, she is putting herself at risk. Please do the right thing and make sure people are able to safely get the help they need.

Thanks, Andrew Matsuoka
Brooklyn

---

Hello,

My name is Abigail Henderson and I am a middle school STEM teacher.

My sibling is immunocompromised and has long COVID. Because the government is no longer enforcing masking and other proven methods of safety, my sibling is unable to travel (and I am unable to travel to see them without risking exposing them). They feel like the world has left them behind while COVID rages on, and I really feel for my sibling and the many others. Our people should not have to do this work alone, without the support of their government. In the absence of solid public policy, I fear that conspiracy theories and misinformation may run rampant. My sibling and others are working hard to find trusted data sources, but those are getting fewer and fewer, thanks in part to the actions of the CDC. Please do your part to ensure the health and safety of our most vulnerable!

Best,
Abigail

---

My name is David Kronig, I reside in Whitehouse Station, NJ, and I am not affiliated with any organization. I submit these comments on my own behalf as an immunocompromised individual with complicated health issues that require frequent medical care. I am dismayed that HICPAC is considering revised infection control guidance that would make receiving medical care even more dangerous than it already is.

It is unthinkable that the CDC could conclude that, especially in this most critical of settings, surgical masks provide the same level of protection as N95s. Abundant evidence (https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0723_HICPAC_experts_letter_background_combined_FINAL.pdf) and common sense make clear that N95s are dramatically superior at preventing the wearing both from contracting respiratory illnesses and passing them on. As an immunocompromised person at high risk of poor outcomes from COVID and other respiratory disease, it is imperative that healthcare providers be taking all reasonable measures to keep me from getting sick or making me sicker. High quality respirators are an easy way to do that.

Moreover, the CDC should recommend improved ventilation standards for healthcare settings. With mask mandates dropped in most places, ventilation is the only remaining tool to clean the air and lower the inhalation dose of infectious particles in the air.

It seems like it should go without saying, but the agency's name is the Centers for Disease Control and Prevention. By lowering standards, the CDC is doing the opposite of its name--it's increasing the likelihood that I contract an infection in a hospital or other healthcare setting that could be avoided by simple and inexpensive means.

I'm a lawyer by training, so I think of relationships through the lens of attorney-client relationships. Please remember that your clients are not industry groups, hospital conglomerates, trade associations, and the like. Your clients are the public, and what we need from you is to keep us safe from preventable disease.

Thank you,
David Kronig

---

August 25, 2023

I am writing to express my strong opposition to HICPAC's proposed weakening of infection control measures in healthcare settings. I am the mother of an immune-compromised child (Immunoglobulin Gamma deficiency). Even before COVID, she was regularly quite ill from common cold viruses that would nearly always progress to pneumonia or bronchitis. By early 2020, when she was 6 years old, she had been on antibiotics a stunning 30 times and had been hospitalized at the Children's Hospital of Georgia for 3 days on IV antibiotics for a multidrug resistant pneumonia. All from "mild" cold viruses that her body could not fight off.

With the ongoing and interminable COVID pandemic, my family has had to be extremely careful not to let her get infected since she is at high risk for adverse outcomes. We have switched to homeschooling, masking 100% indoors, and bringing HEPA air purifiers with us to necessary medical appointments. We have thus far been able to stay uninfected, but it is getting more and more difficult as apathy and willful blindness have taken hold in even the medical community.

As infection control specialists, you are all familiar with the studies that list the horrors of even "mild" acute infections of COVID. You should know about the immune system dysregulation, the lymphopenia, the increased risks of blood clots and strokes, the brain damage, the endothelial damage, and the persistent inflammation leading to debilitating POTS and ME/CFS. You all have heard of Long COVID and the terrifying statistics indicating that something like 1 in 10 people will end up with Long COVID– and that reinfections up that risk substantially.

And yet, HICPAC is proposing *weakening* infection control guidelines in medical settings. What happened to "do no harm"? These decisions to drop the use of respirators during an ongoing airborne pandemic are NOT supported by data, and are leading to COVID infections being acquired by the most medically vulnerable in the ONE place they should be safe and protected as they receive necessary care.

I'd like to let you know some of the impacts of these disastrous decisions, as a member of the public.

1. My children and I cannot get medical care without making serious calculations about the risk of COVID infection against the severity of the health concern.
2. Every time we have to walk into a medical setting– as the only masked people in N95s– and beg medical providers to keep us safe, it sets up a volatile encounter with some providers, many of whom refuse.
3. Many providers refuse to honor the ADA reasonable accommodation requests for masking. We literally are at the mercy of being infected and killed or disabled by the people we depend on for care.
4. My divorced coparent believes that I am overreacting to COVID since medical professionals are no longer masking. As a result, he is threatening to take me to court and take my children away from me… because I am the only one trying to keep my kids safe during an ongoing pandemic, I am being painted as a hysteric. And I have no one in

authority backing the use of airborne protective equipment during an AIRBORNE PANDEMIC.

5. This week, a hospital worker in Indiana exposed 500 patients to Tuberculosis. That could have been prevented with respirators. Also, COVID has surpassed TB to become the deadliest respiratory infection, according to the WHO. Why is it that there are no required airborne PPE measures in place, given all that we know about COVID?

HICPAC's infection control guidelines must recognize that adopting effective prevention measures is critical for the health of patients and healthcare workers. There is no room for compromise on safety and **there is no justification for adopting non-airborne precautions for airborne pathogens.**

Guidelines should be based on the precautionary principle, which emphasizes the need for policy makers to prioritize risk reduction. I demand that HICPAC codify the established science of airborne transmission and its prevention. This includes using effective masking including N95 respirators, elastomeric respirators, and PAPRs.

HICPAC needs to be on the right side of medical history. It is your duty to protect patients and healthcare workers during this ongoing, deadly and disabling airborne pandemic– and, by extension, our healthcare system, economy, and national security.
Sincerely,
Megan J. Cunningham
World Health Network committee member
Grovetown, Georgia

---

Please improve infection control, not weaken it as you are considering.
Please realize that the covid pandemic is ongoing and we need to do everything we can to protect ourselves.
Please understand that immune system damage from covid is making people more susceptible to other infections.
Please make health care a safe place. People who are sick should not be afraid to seek care.
Health care workers are an asset, please help protect them.
I do not understand why weakening infection control is being considered, especially at a time like this. Please do the right thing and do all in your power to control disease. It's the whole point of the existence of your organization.
G. Dunkle

---

My name is Jeanne Seidel and I'm a member of the general public. My address is Philadelphia, PA

I'm writing to ask that the CDC implement accurate protective healthcare measures in ALL medical care settings, including Dr. offices, urgent care settings and hospitals, with regard to Covid-19.

It is scientific FACT that both high-quality air filtration systems and specifically high-quality N95 masks are necessary to prevent the spread of Covid. If the CDC only requires surgical masks in healthcare settings, Covid will continue to spread to the most vulnerable people including the immunocompromised, the disabled and the elderly.

This would simply be a willful act of negligence given that it is a proven FACT that covid can be spread with use of surgerical masks. N95s are necessary to reduce tramsmission. I'm not sure

why the CDC would make a choice that is not based in science, unless it's simply bc the U.S. is too cheap to pay for N95 masks.

My husband is a quadriplegic and it is a FEDERAL LAW under the ADA that his medical requirements are accommodated any time he is receiving medical care. My husband is also a well-respected academic employee of Temple University for over 23 years. He is a pillar of his community and this blatant disregard for both his life AND all the lives of people receiving medical treatment is completely unsciectific, irresponsible and unacceptible.

Please use your common sense. Do you really want future lawsuits on your hands for willfully spreading a dangerous, life-threatening, contagious virus to people like my husband? I know that protecting people's health doesn't seem to be the goal any longer, but you may want to consider wrongful death lawsuits that could become more common in medical settings in the future. Since it seems money is more important to the CDC than preventing disease.

To use only surgerical masks is willful ignorance and a complete disregard for science. Literally the opposite of what the CDC is supposed to stand for. There is no excuse to ignore the science of a life-threatening, disabling airborne virus.

Sincerely,
Jeanne Seidel

---

Amanda Goad
[no organizational affiliation]
Los Angeles, CA
August 25, 2023
Healthcare Infection Control Practices Advisory Committee (HICPAC)
Centers for Disease Control and Prevention
Re: Public comment on infection control and isolation precautions
Dear Healthcare Infection Control Practices Advisory Committee (HICPAC):
I am writing to urge you to limit the spread of SARS-CoV-2 and other pathogens by imposing common-sense parameters for indoor air quality in health care settings.

It is important for the well-being of health care workers as well as patients to address indoor air quality, including both ventilation and filtration, in health care facilities. This is particularly true given the range of health conditions impacting immunity that are present among those populations, and the necessity for patients to remove masks for some medical encounters even if they are masking for other indoor interactions.

It is also important for regulation (and guidance efforts) in this realm to accurately characterize the costs and benefits of different masking strategies. This week’s meeting slides, in justifying the recommendation of merely surgical masks in routine circumstances, seem to overplay the downsides of wearing an N95 respirator by failing to consider the diversity of N95 respirators on today’s market. They also do not seem to acknowledge the reality that if merely surgical masks are required, in practice most surgical masks will be worn loosely so as to provide little source control
benefit.

On behalf of my friends, family members, and clients who are immunocompromised and/or disabled, I urge you to reconsider the portions of the isolation precautions guideline proposal that are weak on masking and ventilation/filtration.

Sincerely,
Amanda Goad

---

To Whom it May Concern:

I am not high risk for covid. No one in my immediate family is. However, the risk to the average person like me is still long covid, which is a debilitating lifelong condition, as well as diminished heart, lung, and brain function. For my extended family, which includes elderly and immunocompromised people, the risk is death. I am not willing to sacrifice them for the privilege of doing nothing. I ask that the CDC implement more strict air quality standards for public buildings, including both better ventilation and filtration, because right now we are still wearing respirators and keeping non-essential trips inside public buildings to a minimum. I want to be able to take my kid to a toy store without worrying he'll infect and kill my grandparents. I want to be able to have a meal in a restaurant again. I haven't eaten in a restaurant since February 2020 unless they have outdoor seating. I haven't gone shopping for fun in the same amount of time. I miss my old life, and I'm not even worried about dying. I'm just inconvenienced. But I'm also not going to put my convenience over the health of my loved ones or my community, and being a vector for covid would do just that. For most of us, we can't choose not to be in public. Doctor's offices, grocery stores, veterinary clinics... These are places we cannot choose to avoid. We need to improve so public buildings so that everyone feels safe going in. On top of that, the norm of getting sick multiple times a year isn't necessary. With improved air quality, we'll all stay healthier and reduce the amount of people who suffer from colds and flu and other airborne viruses every year, not to mention improved quality of life for people with allergies. Filtering the dust, pet dander, pollen, and have scents from the air would be so welcome to millions of us. Keeping people healthier is good for everyone and studies have proven that ventilation and filtration save lives. Please take this simple step and improve air quality for all of us.

Adrianne Covino
Canterbury CT

---

To: CDC HICPAC 8/25/2023
From: Matthew Cortland, Silver Spring MD
Organization Affiliation: None

**SARS-CoV2 Is Airborne, We Know How To Mitigate Airborne Transmission**

The evidence is in:

> The most common way COVID-19 is transmitted from one person to another is through tiny airborne particles of the virus hanging in indoor air for minutes or hours after an infected person has been there.

That simple, clear, direct sentence was written by Dr. Alondra Nelson while she was serving as the Director of the White Office of Science and Technology Policy and it was published by the White House.[1] WHOSTP's assessment that airborne transmission is driving spread of COVID-19 is extremely well supported in the scientific literature. [2, 3, 4]

Dr. Nelson went on to point out that we are not powerless to stop airborne transmission of SARS-CoV-2:

> In fact, research shows changing the air in a room multiple times an hour with filtered or clean outdoor air – using a window fan, by using higher MERV filters in an Heating, Ventilation, and Air Conditioning (HVAC) system, using portable air cleaning devices, and even just opening a window – can reduce the risk of COVID-19 transmission – with studies showing five air changes an hour reduce transmission risk by 50 percent. And, improving indoor air has benefits beyond COVID-19: it will reduce the risk of getting the flu, a common cold, or other diseases spread by air, and lead to better overall health outcomes.

WHOSTP's assessment that improving Indoor Air Quality (IAQ) through increased ventilation and/or filtration mitigates the spread of SARS-CoV-2 is extremely well founded in the scientific literature – it is so well founded that EPA and CDC already recommend IAQ interventions to help mitigate the spread of SARS-CoV-2. [5, 6, 7]

[1] White House Office of Science and Technology Policy. Let's Clear The Air On COVID. The White House. Published March 23, 2022. Accessed April 26, 2023. https://www.whitehouse.gov/ostp/news-updates/ 2022/03/23/lets-clear-the-air-on-covid/

[2] Duval D, Palmer JC, Tudge I, et al. Long distance airborne transmission of SARS-CoV-2: rapid systematic review. *BMJ*. 2022;377:e068743. doi:10.1136/bmj-2021-068743

[3] Greenhalgh T, Jimenez JL, Prather KA, Tufekci Z, Fisman D, Schooley R. Ten scientific reasons in support of airborne transmission of SARS-CoV-2. *The Lancet*. 2021;397(10285):1603-1605. doi:10.1016/ S0140-6736(21)00869-2

[4] Rabaan AA, Al-Ahmed SH, Al-Malkey M, et al. Airborne transmission of SARS-CoV-2 is the dominant route of transmission: droplets and aerosols. *Infez Med*. 2021;29(1):10-19. PMID: 33664169.

[5] McNeill VF. Airborne Transmission of SARS-CoV-2: Evidence and Implications for Engineering Controls. *Annual Review of Chemical and Biomolecular Engineering*. 2022;13(1):123-140. doi:10.1146/annurev- chembioeng-092220-111631

[6] United States Environmental Protection Agency. Air Cleaners, HVAC Filters, and Coronavirus (COVID-19). Published June 18, 2020. Accessed April 26, 2023. https://www.epa.gov/coronavirus/air- cleaners-hvac-filters-and-coronavirus-covid-19

[7] Centers for Disease Control and Prevention. Ventilation in Buildings. Centers for Disease Control and uary 11, 2020. Accessed April 26, 2023. https://www.cdc.gov/coronavirus/ munity/ventilation.html

**CDC Has Imposed Disproportionate Risk And Suffering On Disabled Americans By Refusing To Issue Indoor Air Quality <u>Targets</u> For Healthcare**

CDC's *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic* document ("IPC Recommendations") is guidance promulgated by CDC that applies to U.S. settings where healthcare is delivered. CDC's IPC Recommendations do not contain any actionable Indoor

Air Quality targets for healthcare facilities, i.e. CDC does not currently set out Indoor Air Quality standards for healthcare, like '12 air changes per hour or equivalent.'

We have known for quite some time, based on HHS' own data, that SARS-CoV-2 is being spread from healthcare personnel and patients who have active COVID-19 infections to healthcare personnel and patients who are COVID-19 negative.[8] In other words, we know that healthcare facilities are infecting chronically ill, disabled, and immunocompromised Americans with COVID-19, even though HHS has resisted calls to disclose per-hospital nosocomial transmission rates.[9] Furthermore, scientists have done the direct work of proving infectious SARS-CoV-2 is floating in the air of healthcare facilities.[10, 11, 12]

> CDC itself has recognized that disabled Americans are at higher risk from COVID-19.[13] CDC and FDA have also recognized that immunocompromised Americans (who are disabled, e.g., within the meaning of relevant federal disability civil rights laws and regulations – including laws HHS is charged with enforcing and regulations promulgated by HHS), are at particularly higher risk from COVID-19 – most notably when revoking the Emergency Use Authorization for EvuSheld (to date, the only pre-exposure prophylaxis product for immunocompromised people) because it was no

[8] Levy R, Vestal AJ. Nowhere is safe: Record number of patients contracted Covid in the hospital in January. POLITICO. Published February 19, 2022. Accessed April 26, 2023. https://www.politico.com/ news/2022/02/19/covid-hospitals-data-00010283

[9] Levy R. Biden officials to keep private the names of hospitals where patients contracted Covid. POLITICO. Published June 25, 2022. Accessed April 26, 2023. https://www.politico.com/news/ 2022/06/25/biden-officials-to-keep-private-the-names-of-hospitals-where-patients-contracted- covid-00042378

[10] Rufino de Sousa N, Steponaviciute L, Margerie L, et al. Detection and isolation of airborne SARS- CoV-2 in a hospital setting. *Indoor Air*. 2022;32(3):e13023. doi:10.1111/ina.13023

[11] Grimalt JO, Vílchez H, Fraile-Ribot PA, et al. Spread of SARS-CoV-2 in hospital areas. *Environmental Research*. 2022;204:112074. doi:10.1016/j.envres.2021.112074

[12] Stern RA, Koutrakis P, Martins MAG, et al. Characterization of hospital airborne SARS-CoV-2. *Respiratory Research*. 2021;22(1):73. doi:10.1186/s12931-021-01637-8

[13] Centers for Disease Control and Prevention. People with Certain Medical Conditions. Centers for ssed April 26, 2023. https:// /need-extra-precautions/people-with-medical-conditions.html

longer effectively providing protection against newer variants of SARS-CoV-2.[14]

And, importantly, COVID-19 doesn't just present an increased risk of death and of hospitalization-requiring-ventilation to disabled Americans. According to CDC's own data, disabled Americans are at increased risk of long COVID:

> Long COVID is no trifling matter. In a study of patients at a long COVID neurology clinic, MRI scans showed reduced blood flow to frontal, parietal, and temporal regions of the brain and long COVID patients experienced deficits in executive function, attention, language, and

memory.[15] More than 200 symptoms of long COVID have been identified with impacts on multiple organ systems.[16] COVID-19 also carries with it a "substantially increased risk of developing a diverse spectrum of new-onset autoimmune diseases." [17] To be clear, it isn't just disabled Americans who care about the health impacts of COVID-19 beyond death and hospitalization. CDC, as part of HHS, has been directed by the Presidential Memorandum of April 5, 2022 entitled "Addressing the Long-Term Effects of COVID-19" to address the "debilitating, long-lasting effects…often called 'long COVID."[18]

[14] Ducharme J. Without Evusheld, Immunocompromised People Are on Their Own Against COVID-19. Time. Published January 31, 2023. Accessed April 26, 2023. https://time.com/6251474/ immunocompromised-covid-19-evusheld-fda/

[15] Ajčević M, Iscra K, Furlanis G, et al. Cerebral hypoperfusion in post-COVID-19 cognitively impaired subjects revealed by arterial spin labeling MRI. *Sci Rep*. 2023;13(1):5808. doi:10.1038/ s41598-023-32275-3

[16] Davis HE, McCorkell L, Vogel JM, Topol EJ. Long COVID: major findings, mechanisms and recommendations. *Nat Rev Microbiol*. 2023;21(3):133-146. doi:10.1038/s41579-022-00846-2

[17] Sharma C, Bayry J. High risk of autoimmune diseases after COVID-19. *Nat Rev Rheumatol*. Published online April 12, 2023:1-2. doi:10.1038/s41584-023-00964-y

[18] President Joseph R. Biden, Memorandum on Addressing the Long-Term Effects of COVID-19. The ww.whitehouse.gov/briefing- emorandum-on-addressing-the-long-term-effects-of-covid-19/

In a 2022 meeting with CDC, I told CDC that patients – including disabled, chronically ill, and immunocompromised patients – seeking medical care were being told by hospitals to remove their highly protect masks (e.g. N95) and replace with a facility issued surgical. I was told by a high ranking CDC official that 1) that wasn't happening and 2) even if it was happening, it wasn't CDC's fault. CDC's intransigence essentially made me prove that claim up in the press.[19] After my doing so, CDC acknowledged reality and issued a "clarification" to CDC materials. [20] Today, I'm telling CDC that masks – i.e. source control – are being gleefully abandoned in acute care hospitals, including children's hospitals.

Today, I'm telling CDC that like many disabled, chronically ill, and immunocompromised Americans the choice I have to make is stark: without the kind of healthcare that is only available in clinics and hospitals, I die. Today, I'm telling CDC that this is an opportunity for CDC to reverse course, to abandon the refusal to issue actionable Indoor Air Quality targets (in the form of, e.g., N ACH or N CFM per person) for healthcare facilities. Today I'm telling CDC that continued failure to issue actionable IAQ targets is an affront to health equity and an assault on the rights of disabled Americans to receive healthcare – HHS has a duty to uphold disability civil rights laws

[19] Levy R. Some hospitals ask patients, visitors to remove N95s, citing CDC. POLITICO. Published March 16, 2022. Accessed April 26, 2023. https://www.politico.com/news/2022/03/16/hospital-mask-cdc-covid-00017556

[20] Levy R. CDC updates Covid-19 guidance to allow patients wear N95s. POLITICO. Published March 24, ps://www.politico.com/news/2022/03/24/cdc-updates-covid-19-patients-wear-n95s-00020342

that guarantee the full participation of disabled Americans in public life, including, importantly, in healthcare. CDC must act.

Finally, I'm telling CDC that CDC leadership should expect any attempt to circumvent the Freedom of Information Act, 5 U.S.C. § 552 et seq., and the Federal Advisory Committee Act, specifically §10(b), relative to these proceedings to be met with litigation.

Matthew Cortland

---

Hello, I am Lila Someshwar, submitting this public comment for HICPAC regarding preventative safety measures in healthcare.

My address is Germantown MD. I am a member of COVID Safe Maryland.

HICPAC must strengthen protections to prevent infectious disease spread in healthcare, not weaken them. COVID-19 still poses a serious threat to healthcare workers, patients, and our communities. Universal masking protections, particularly the use of N95s, and improved ventilation are powerful tools to control the spread of COVID and other infectious diseases, and need to be mandated in healthcare settings. We need universal masking back in healthcare, and CDC must mandate use of N95 respirators by all healthcare providers. The weakening of infectious disease control measures in healthcare is making healthcare inaccessible for so many people, particularly disabled and immunocompromised people. Universal masking protections, mandated use of N95s by healthcare providers, and proper ventilation standards will protect and benefit everyone in our communities. Thank you.

---

I am writing to voice my endorsement of bringing back Covid protections and prevention measurements. It is very apparent that it is not over, and causing lobg-lasting conditions. It is obvious that without these protections the disease has been allowed to creep through the population and become more varied and harder to diagnose by conventional methods. Considering the lack of access most people who are at risk have, specifically the younger working class- "essential workers"- who cannot afford the care needed, it is vital to strengthen prevention. Access to tests is difficult, even in major cities, sometimes costing $30 or more for a single test as testing clinics are now scarce. Weakening infection control standards is absolutely unacceptable.
Olivia Baker

---

Greetings,

I'm reaching out to encourage HICPAC to make evidence-based recommendations to the CDC as they consider revising isolation precautions in healthcare settings. I am concerned that HICPAC's workgroup on the Isolation Precautions Guidance has proposed taking a more

"flexible" approach to standards. We know COVID is airborne. Politics should not be considered here. It should be recommended that the CDC incorporate best practices for protection against transmission of airborne infection, like is required for BSL-3 labs that handle such viruses. A protective approach should include assessments that measure the level of exposure, select appropriate control measures for a given job (like PPE), and offer a written exposure control plan following the hirarchy of controls. Not doing so puts both healthcare workers and those that seek care at unnecessary risk for illness, disease, and even death. Over the past 3.5 years, we have seen enough of politics influencing healthcare, and it has led to a rampant pandemic that has killed about 7 million people and left more than 65 million people with long COVID, a disease that is poorly understood and can be very debilitating. Those of us that already have health issues that put us at higher risk for poor outcomes have increasingly been left behind by many institutions as well as our neighbors. Many people are uninformed and many organizations are not equipped to ensure safe and accessible spaces for all. Please don't add to the problem. Encourage the CDC to make healthcare settings trusted, safe spaces for all who need to access them.

Thank you,
Megan Lizik, writing in a personal capacity
Glen Ellyn, IL

---

Hello CDC,

I am currently a cancer patient and I had considered skipping chemotherapy to prevent recurrence out of fear of the long-term consequences of being temporarily immunocompromised. If I had trusted the healthcare system to protect me, it would have been a much easier decision. I am still deeply concerned about the risk that while immunocompromised, I will contract COVID-19 and develop some of the less common, but well-known, serious disabling long-term consequences from COVID such as cardiac damage, elevated stroke risk, and cognitive issues.

I request that CDC take the following actions to protect the most vulnerable patients in healthcare settings from currently known and any future airborne pathogens by:

1) Issuing indoor air quality targets for all healthcare facilities to ensure that all healthcare facilities are required to have ventilation that provides 12 fresh air changes per hour and/or an equivalent level of HEPA filtration.

Please consider even higher standards for facilities where patients cannot mask and in fact do deep inhalation and exhalation as an essential part of the exam or treatment, such as pulmonologists, asthma care centers, and oncology radiation treatment areas. (It is common for breast cancer patients receiving radiation to the left breast to be instructed to breathe deeply to reduce the radiation that reaches the heart.) Higher indoor air quality standards would protect more patients.
2) Requiring source control in healthcare facilities where a high proportion of the patient base have weakened immune systems (for example, facilities dedicated to treating patients with cancer or HIV/AIDS) and places where patients must be unmasked as part of the procedure (surgeries and colonoscopies, for example).
Early in April, I arrived one Friday afternoon to the cancer care building to find that they had made masking optional without notifying the patients. I was incredibly angry. The healthcare workers do mask upon request, but that's inequitable due to the power imbalances in the provider-patient relationship.

Managing a health condition like cancer is by itself a part-time job and it's incredibly dismaying and exhausting to know that healthcare facilities are placing the burden on me, the sick patient, to do even more work to protect myself while I receive care. To protect myself during treatment, I researched and purchased a portable air filter to take to my infusion appointments as well as masks with even tighter seals and higher filtration rates than I already own. While I was incredibly privileged to have the knowledge and resources to do so, it's still also true that the time to do that research was time I should have spent resting or with loved ones. If I could be confident that my healthcare workers were masking to protect patients like me and that the building's air was regularly refreshed and filtered to greatly reduce the risk of virus transmission, I could relax and focus on healing.

Thank you,
Trina Grieshaber
Chicago, IL

---

Dear HICPAC Committee and CDC,

I have multiple medical conditions that place me at risk for poor outcomes if I were to become infected with COVID-19. My children are also at high risk due to a genetically shared medical disorder. Unless common sense, scientifically sound COVID precautions are adhered to, medical facilities are a risky ecosystem, and our risk of contracting COVID and a subsequent bad outcome is significant.

COVID is an airborne BSL-3 pathogen. Even one-way respirator use is insufficient to guarantee protection against COVID exposure in crowded indoor settings, like waiting areas, tight unventilated spaces like patient exam rooms, and during treatment which require us to unmask.

We can't use virtual appointments for everything. I am behind in yearly echocardiograms, pulmonary functions tests, mammograms, pap smears. These are required for basic monitoring of my general health and chronic medical conditions.

Recently hospitalizations for COVID are up 22% (https://covid.cdc.gov/covid-data-tracker/#maps_new-admissions-rate-county). Nearly a third of COVID-19 hospital cases in England were hospital-acquired (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/). Hospital-acquired COVID-19 has a 10% mortality rate (https://ozsage.org/media_releases/immediate-action-is-needed-to-reduce-hospital-acquired-covid-19-infections-and-deaths/). A recent study indicates that up to 27% of healthcare workers in the study developed Long COVID-19, with repeat infections a contributing factor (https://www.cidrap.umn.edu/covid-19/study-finds-27-rate-long-covid-infected-health-workers).

Covid is a vascular disease (https://www.science.org/doi/10.1126/science.368.6489.356) that causes multi- systemic injury and risk of organ damage, especially repeat infection (https://www.scientificamerican.com/article/do-repeat-covid-infections-increase-the-risk-of-severe-disease-or-long-covid/). According to the CDC, there is a 20% risk of developing Long COVID with each infection (https://www.forbes.com/sites/madelinehalpert/2022/05/25/1-of-5-with-covid-may-develop-long-covid-cdc-finds-though-vaccination-may-offer-some-protection-study-suggests/?sh=7ae00eea5704) and can disable anyone. Surgical masks and cloth masks (https://www.ama-assn.org/delivering-care/public-health/what-doctors-wish-patients-knew-about-wearing-n95-masks) have never adequately protected from COVID infection. N95 respirators or better (https://www.cmaj.ca/content/188/8/567) have always been the most effective and required form of respiratory shielding against Sars-Cov-2. A multilayered approach

(https://www.nytimes.com/2020/12/05/health/coronavirus-swiss-cheese-infection-mackay.html) is vital in stopping the cycle of unmitigated spread and mutation.

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. Source control (limiting outward emission of infectious aerosols) is not adequately considered in the context of personal protection from inhalation.

Robin Saunders
Rio Rancho, NM
HICPAC Meeting Comment

---

Dear members of HICPAC,
Thank you for giving members of the public the opportunity to express our thoughts. This is much appreciated.

My name is Louise D*. I am a caregiver, helping two persons requiring assistance in their tasks. In the last year, both of these persons have been infected with COVID-19, this happened while being treated in healthcare for other ailments, one even infected more than once during different hospital stays. Not only is this detrimental to their personal recovery from their main health issues, it also burdens the healthcare system. These persons required longer stays in hospital, more treatment and this situation put at risk healthcare workers, visitors and carers. This is unacceptable. Healthcare workers, be it nurses, doctors, technical, maintenance or administrative personnel should not be put in face of such dangerous pathogens in their every day work duties.
Therefore
I ask you to
Pause
for a Moment

Please take time to read the transcripts of the fourteen persons from the public that presented their views on Tuesday, August 22nd,
Please take time to read all the other letters sent to you recently concerning this important topic.

Please take time
To listen
To what these persons are saying

Please take time
To reflect

Please take time to integrate specialists from other fields of expertise in your work group: Engineers, Aerosol specialists, Industrial and Occupational hygienists, just to name a few.

Please listen to the science behind airborne spread of pathogens
Please put aside your learnings and the EBM littérature that was forwarded to you.

And I ask

You
To be
A beacon of light

You have the ability
You have the power
To make decisions
That will impact
The course of this pandemic and those to come

We must
Limit the transmission of pathogens using thorough airborne precautions
Such as:
Mandating the use of N95 respirators or better in healthcare settings and LTC (and not just for AGPs),
Upgrading ventilation and filtration of buildings to ASHRAE Standard 241,
Educating the public and healthcare personnel on this topic.

The sooner the facts are recognized,
The sooner the means to stop transmission are implemented,
The sooner this crisis will be resolved.

That is why
I call on you,
Members of HICPAC,
To be
A beacon of light

And, even though I am a resident of a neighboring country, I truly believe the decisions you take will impact not only Americans but also citizens living elsewhere like me.

Please take your time,
Do your work with a truly open mind
Be a beacon of light for all.

Thank you for your time.

Louise D
Concerned citizen
and Former math teacher

Note:
I include a KAVLI Science Award-winning article that illustrates magnificently the spread of airborne particules and pathogens in closed settings;
Please take two minutes of your time to look at these infographics.
Although I have a background in science, I am not a specialist in the field of physics;
However these visual illustrations explain clearly and without any doubt the dissemination of aérosols in indoor settings — settings like hospitals, LTC.
Please also consider reading this article.
Thank you.

Reference :
EL PAÍS visual feature on aerosol spread of coronavirus wins Kavli Science Award, the 'Pulitzer' of scientific journalism
https://english.elpais.com/science-tech/2021-11-10/el-pais-visual-feature-on-aerosol-spread-of-coronavirus-wins-kavli-science-award-the-pulitzer-of-scientific-journalism.html
https://elpais.com/especiales/coronavirus-covid-19/a-room-a-bar-and-a-class-how-the-coronavirus-is-spread-through-the-air/

*Louise Desrochers
Montréal (Québec)
CANADA

---

It is a grave error to downgrade masking to mere surgical masks in healthcare settings.
With COVID on the rise again, healthcare providers and patients need better protection.
The CDC's attitude of "let's move on"is putting so many people at risk.
We now know COVID is much more than a respiratory virus. It is also a virus that affects the immune system, and many other systems in the body. Why would you downgrade your advice?
Please help our healthcare providers and at risk populations.
Thank you,
Therese Miller
A former RN

---

I am deeply concerned and dismayed about the loosening of public health proposed in the Draft Isolation Precautions Workshop. I am immunocompromised and have elderly and immunocompromised family members and we have had to delay needed healthcare because of the risk of nosocomial COVID infection after the removal of mask requirements in healthcare facilities. Without increased air exchange and air quality requirements, receiving emergent medical care has become even more stressful because of the risk of hospital-acquired infection, which could be life-threatening because of my preexisting conditions and could result in long COVID. Patients who acquire COVID in hospital settings have higher risk of mortality than patients who do not.

As the body of research about the importance of aerosol transmission of viral and bacterial diseases grows, so should our standards for masking with fitted N95 respirators and ventilation and air purification (eg, HEPA filtration and UV).

In addition, multidrug-resistant bacterial and fungal infections are a growing threat, especially in the hospital setting. Maintaining or increasing the current masking and PPE standards and providing increased air quality guidelines can help curb the spread of these healthcare-acquired infections, preserve the efficacy of our current antibiotic and antifungal medications, and improve patient outcomes.

Sincerely,
Amy Tyszkiewicz
Parlin, NJ
No organizational affiliation

---

**Name**: Emily Reynolds
**Address**: Madison, WI

**Organizational affiliation:** I am a dues paying rank and file member of the Wisconsin University Union for the University of Wisconsin-Madison.

**Comments on HICPAC proposal for new infection control protocol:**

In 50 years the world will look back at the CDC of the 2020s and place it in the same breath as the arrogant doctors who belittled Ignaz Semmelweis, the Hungarian doctor who discovered handwashing with a chlorine solution improved patient outcomes. The CDC of the 2020s will be seen as a direct extension of the countless doctors in the mid-20th century who insisted smoking was safe, as they took payouts from the tobacco industry behind closed doors.
Your oath to do no harm has been broken, time and time again, during this pandemic. You had the chance to be forward-thinking, innovative, compassionate, history-making. You have instead caved to corporate and governmental pressures insisting on profit over health. The refusal to include better air ventilation and filtration systems and required masking with respirators (which countless observational studies prove more effective than surgicals against airborne illnesses) is just another in a long line of medical professionals in power valuing their power more than the lives of the people they are supposed to care for, and believing themselves incapable of making a mistake.

You still have a chance to walk back these new weakened infection control protocols. You have a chance to be on the right side of history. You have a chance to not be the laughingstock of the world in 50 years, to not have millions shake their head in disbelief at the choices you made. You have a chance to set aside hubris and embrace progress. Please, recommend improved air ventilation and filtration and required masking with respirators like N95s.

Emily

---

The draft does not give adequate attention to key preventive measures such as proper ventilation, UV disinfection, HEPA filtration, and the use of NIOSH-approved respirators, lacking the detail needed for public health guidance. It is imperative to consider and evaluate the extensive research on these measures for effective public health guidance for aerosol transmission control.

A Technology is available today that can stop the spread of any harmful pathogen continuously, safely, with people present, and with a high degree of efficacy. Far-UV 222nm light deactivates all microorganisms. Far-UV destroys all known viruses, bacteria, and spores, all airborne Sars-CoV-2 variants, RSV, HAIs, and allergens. Far-UV is the only technology that can destroy airborne pathogens that does not require air movement or air exchanges. Far-UV is safe for humans and does not damage materials. There are now dozens of studies that have proven the efficacy and safety of Far-UV.

You don't have the luxury of waiting for an air exchange to shield other people from the aerosolized viral particles if one person in the room is coughing or expelling viral particles with each breath.  Far UV when arranged appropriately, can give that degree of security.

*The one thing we're NOT doing to mitigate the spread of COVID-19*
By Paul Taylor, former FEMA director
https://bit.ly/32R4OIB

"The Centers for Disease Control and Prevention (https://www.cdc.gov/) (CDC (https://venturebeat.com/2020/09/09/combatting-covid-19-misinformation-with-machine-

learning-vb-live/)) have consistently recommended that masks and vaccines are only part of a comprehensive protection strategy to combat the dangerous pathogens in the air and on surfaces all around us. Because their effectiveness is impacted by human error and/or compliance, masks and vaccines, without other complementary methods of disinfection and mitigation, can only limit the spread of disease so much.

The reason these two tactics alone can never completely prevent the spread of disease is that they do nothing to eliminate or remove pathogens from our occupied spaces. We have known for some time now that the primary means of transmission of COVID-19 and many other serious infectious diseases is through the air. Consequently, the CDC recommends providing clean air (https://venturebeat.com/product-comparisons/best-air-purifier-reviews/) in enclosed, occupied areas as the best means for controlling infections. So far, there are only three evidence-based methods for doing this: increasing ventilation to swap indoor with outdoor air more frequently, using HEPA filters to repeatedly filter the air inside of spaces, and using UV lights (https://venturebeat.com/2020/11/09/dynamics-nanowave-air-zaps-the-coronavirus-with-uv-light/) to constantly disinfect air and surfaces. Of those options, UV disinfection technology (https://venturebeat.com/2020/03/03/how-people-are-using-ai-to-detect-and-fight-the-coronavirus/) is highly effective and much less costly, and yet is one of the least utilized mitigation strategies, likely due to misplaced concerns over safety.

The recent game-changer in UV technology that makes it such an effective tool in stopping the spread of infectious disease is that Far UV utilizes even narrower wavelengths of UV light (around 222 nm), allowing it to operate safely in a room with human occupants while killing any airborne and surface particles before they can spread from an infected person to anyone else.

Far UV technology has already been installed in some government buildings for over three years, giving it a long track record of success in preventing spread within enclosed high occupancy spaces. Now is the time for school officials and employers to think comprehensively about the infectious disease threat inside their buildings and utilize a layered approach to mitigation and disinfection. The U.S. taxpayers have already provided ample funding to state and local governments, businesses, schools, and other organizations to provide more than just PPE and simple disinfection. They should use this funding to implement a more sophisticated risk mitigation strategy designed to improve the safety of our indoor spaces and protect U.S. citizens now and into the future.

While scientific, cost, and safety arguments (https://venturebeat.com/2021/05/01/data-science-in-a-post-covid-world/) are all compelling reasons to implement far UV technology as broadly as possible, common sense provides the most important reason: If a far UV light on the ceiling of a room can provide more protection to the occupants than each one of them wearing an N-95 mask, then why shouldn't that technology also be in our hospitals, schools, buses, offices and waiting rooms?"

Cheerfully,
*John Neister*
*Sr. VP Marketing*
*Co-Founder*
Sterilray, Inc.
Somersworth, NH

---

Healthcare Infection Control Practices Advisory Committee Members,

I am writing to implore you to maintain and increase infection safety precautions for healthcare workers. Please issue guidance that recommends increasing indoor air quality in healthcare facilities and the use of high-quality well-fitting respirators (e.g. N95s). The evidence for both is strong and clear.
I am a disabled/chronically ill person who is at high risk for Covid complications and I am a parent of a kid who is at higher risk for Covid complications. Additionally, my children and I have worked hard to completely rebuild our lives after fleeing domestic violence in 2021. I am acutely aware of the tenuousness of our newly rebuilt lives and the fact that the safety of myself and my children is inextricably tied to my ability to stay healthy enough to remain employed. If I get Covid and experience long-term health effects that impact my ability to work, I won't be able to keep us housed or safe. This adds complexity to weighing decisions about when accessing in-person healthcare is worth the substantial risks of infection that those visits carry when there is not source control (respirators) or effective ventilation/filtration.
Healthcare is necessary and should be as safe as possible to access. For a number of types of visits, it is not possible for high risk people to mask 100% of the time--you have to take your mask off to get dental care, for surgery, some ENT visits, etc. In addition to routine healthcare, for my family, part of rebuilding has included catching up on healthcare that we weren't allowed to access prior to fleeing. We need dental care and we also need that care to come without a huge risk of potential exposure to infectious disease. With the sudden removal of mask mandates in most local healthcare facilities this past spring, accessing care has become significantly more difficult and carries much higher risks of infections.

Please work to reduce the negative impacts of Covid-19, particularly for high risk populations, and require the use of respirators (e.g. n95, KF94, KN95, elastomerics) in healthcare facilities and issue Indoor Indoor Air Quality targets for all healthcare facilities (e.g. 12 or more air changes per hour and/or an equivalent level of HEPA filtration.). Source control (respirators), ventilation and filtration are important, effective measures to prevent the spread of all airborne diseases including Covid. Please issue this guidance for all healthcare providers including hospitals, clinics, dentists, optometrists, physical therapy, occupational therapy, mental health providers, etc.

Sincerely,
Kelsie Onyango
Saint Paul, MN
No organizational affiliation

---

I live a 15 hour drive from my aging parents. Making that drive when my dad was hospitalized due to an infection in 2020 lives amongst my worst memories. The science at the time was lagging, but restrictions were tight at the hospital - and neither he nor my mother nor I came down with Covid at that time.

This summer, he was hospitalized due to COPD presenting like a heart attack. My mom, who has dementia, was allowed to stay at the hospital with him. She caught Covid before they went home. She passed it to my dad.

It is unconscionable that my aging parents, one of whom was hospitalized for LUNG PROBLEMS were exposed to a dangerous respiratory infection in a healthcare facility.

“High risk” individuals have been forced to retreat from public life so that the rest of us aren’t inconvenienced by having to remember a mask. This is an utter failure of civic life. But the last

remaining spaces where those at most risk should be protected need to be the healthcare facilities that they go to for help.

Please don't make Covid - and other respiratory infections- an unavoidable outcome of requiring healthcare. Please do what you can to shield my parents, even if the risk is only mitigated rather than eliminated. Please protect them the way I can't from 15 hours away.

Thank you for requiring high quality masks (beyond surgical masks) and high standards for ventilation in healthcare settings.

Ginger Kautz
Raleigh NC
No organizational affiliation

---

Hello HICPAC,

I am writing to urge you to increase your protocols to protect patients in the hospital.

As much as we all wish Covid had just gone away, it didn't.
We are seeing more sub variants and variants and people are continuing to get sick every day.

Earlier this year, one of my friends lost her father after he acquired Covid while in the hospital for an entirely unrelated surgery. My friend and her brother also got it while visiting him, but then stayed home to try to protect other patients and staff.
Unfortunately, her father struggled to recover after the surgery, because is anyone surprised an older patient is struggling post-surgery while fighting a hospital-acquired virus?
Unexpectedly, he aspirated vomit and his heart stopped. Covid is a known vascular virus that increases cardiac events. I firmly believe had the hospital protected their patient from Covid, he could very well still be here, being a grandparent and parent.

This is but one story of countless stories about how hospital acquired infections impact our families and our communities.

We know that well-fitting respirators, improved ventilation and filtration, testing, and other layers of protection can help reduce the spread of respiratory pathogens. It is unconscionable to be attempting to weaken protections after the past three years. So many people have died or become disabled or developed some chronic condition because of this virus, and we are still only beginning to understand the impacts it can have on our health long-term.

"Do no harm" is pretty clear to me, and weakening infection control protocols when folks are still dying every week is harm.

Please stand for public health and community care. Please work to make hospitals sites of as little transmission as possible. Please protect your patients and their families. Please protect your workers.

Honor the dead.

Protect the living,

-Adam Hettler.

Dear HICPAC,

As a healthcare worker, I was quite shocked to hear that your committee tasked with infection control planning for healthcare facilities in the US has chosen to advise the CDC to lessen our standards against respiratory viruses. This is dangerous, unethical, and devastating when so many health care workers, their family members, and patients died during our current pandemic from health care setting exposures.

The ideas proposed by your committee in draft that infection control may not be as rigid when considering infections that don't cause morbidity and mortality at high rates. This clearly cannot be referencing covid-19 that has shown us how a "benign" illness, for which we have great population level immunity by vaccine or infection, many times sweeped through long term care facilities, hospitals, and clinics disrupting health care, causing multiple days of significant illness for workers, widespread transmission within the facility, and so many deaths. This is an ongoing pandemic.

As a society we share the air we breathe with others when we go about our normal lives. For infection control purposes, as proven by the many aerosol scientists who have already reached out to HICPAC, this means infections acquired outside healthcare facilities transmit inside simply when we share the air we breathe. This should be the main consideration when making recommendations on respiratory virus precautions updates.

As a nurse I do not wish to get covid-19 or flu at work or spread illness to my patients or my loved ones. I know my patients wish to get care without risk of getting infected in a health care facility. I know my colleagues do not wish to see progressibe short staffing due to workplace acquired infections. HICPAC has an ethical obligation to represent what the public and front line workers need and want when making recommendations to the CDC. Your recommendations should aim to prevent transmission of respiratory viruses in health care settings by promoting better adoption for clean air standards for hvac in all health care facilities, mask mandates for patients and staff recognizing that respirators clearly work better than surgical masks. These interventions have proven themselves in aerosol research and world wide during respiratory infection pandemics and we should be strengthening these standards not weakening them. I simply cannot imagine any reasons HICPAC would even question the life saving protection offered to a health care worker or patient from a respirator other than health care industry executives attempting to promote agendas of cost cutting and decreasing their responsibility/liability for outbreaks in their facilities. We can not forget the deadly impact from not having this PPE available in the spring and summer of 2020. How could you set a standard for inferior pathogen filtration from a surgical mask when we already learned they don't work for covid 19 as well as respirators on such a large scale in 2020 that no study could match the numbers of exposures ethically?

I urge you to consider the major impacts to our society of weakening guidelines that we need to access healthcare safely. Those who are vulnerable cannot be sacrificed to death; those who seek care and work in healthcare facilities cannot physically or financialy withstand repeated infections just so that healthcare facilities can save money. You have such a big responsibility to use the science that exists to protect people's wellbeing and their lives. I hope the committee makes a choice to protect the right interests by advancing clean air standards, promoting universal mask mandates in health care facilities with standards for respirators at the forefront of precautions.

Thank you for accepting public comment,
Nisha Patel RN, FNP
Santa Rosa Community Health

---

Hello, I am writing to express my opinion about masking in healthcare facilities. As someone with blood cancer who receives chemotherapy, I am immunocompromised. Because of this health status and because healthcare facilities have dropped masking requirements, every time I need to visit a healthcare facility, I need to think long and hard if that visit is important enough for me to put myself at risk of Covid. When I go for health care, I should have the right to experience SAFE health care and not run the risk of catching Covid from healthcare providers and other patients. Considering that many people have asymptomatic cases of Covid, screening patients for symptoms and asking staff to stay home when not feeling well not nearly enough to protect vulnerable patients. We could easily catch Covid from people with asymptomatic cases. Additionally, it is known science that two-way masking is much more effective over time than one-way masking. Plus, N95's are much more effective at preventing the release of exhaled aerosolized virus than surgical masks. So please, reinstate the requirement for mandatory masking in healthcare facilities to help the millions of vulnerable people in the USA obtain healthcare more safely.
Kim Eckhoff

---

Name: Jessica Donley
Address: Cleveland, Ohio
Affiliation: Concerned high risk citizen
Topic: infection control guidance

Please strengthen infection control guidance and require N95 respirators or better, as well as air purification and ventilation to protect patients and healthcare workers. One way masking, only masking for known infection, and wearing surgical masks is not enough. Sometimes a patient can not stay masked so they're left with no protection. It is horrific that people are getting sick or dying because they needed medical care, especially when it is so easily preventable. The entire burden of preventing Covid19 infection should not be on the patient. I have some of the medical conditions that are being triggered or worsened by Covid19, and I have risk factors that the CDC says make me high risk. If nothing else the ONE place that I expect precautions to be taken is in medical settings, and right now my biggest risk for Covid is getting medical care. I don't want to risk illness, disability, or death because I went to the doctor. I don't want to keep avoiding necessary medical care. I shouldn't have to choose between these terrible options. We shouldn't have to beg for the bare minimum. Please protect us. Thank you.

---

Hello,

My name is Michelle Chang, and I am a member of the public, residing in Los Angeles County, California. I am urging you to NOT replace the previous precautions with laxer alternatives. Two safety procedures in particular are necessary:

1. The usage of N-95 masks (instead of surgical masks);
2. Having a proper air filtration system in place.

Please protect our healthcare workers, as well as the public who relies on their hard work and dedication.

Thank you,
Michelle Chang

---

Dear all,

I'm writing as a member of the public to ask you to return N95 respirators to all healthcare settings and to strengthen, not weaken, guidance for infection controls and protections.

I was appalled to listen in on the 22 August HICPAC meeting and hear public commenters who were more aware of current research than the experts on the committee's panel only to have the video disappear mere hours after it was made public.

The evidence is clear that Covid is airborne and that N95 respirators work to protect wearers from Covid and other respiratory pathogens.

Healthcare workers deserve a safe work space.

Patients deserve to seek out healthcare without the risk of acquiring a life-altering disease like Covid.

On a personal note, it has been exhausting to navigate hospitals and doctor's offices, school and public transportation with an injured child who required testing, diagnosis and follow up care while doctors, teachers and classmates have refused to mask, even after our family submitted ADA requests. A Covid infection would delay her care and put her at risk of further complications.

I work in the tv/ film industry, which kept masks, testing, and contact tracing in place until the strike started, and if you had told me at the start of the pandemic that society would do more to protect actors than children and the elderly, I would have said that was ridiculous, but here we are.

With no updated vaccines, no communication of cases, no viable treatments, and still no reliable tests, it is past time to take action. I would like to read Dickens' novels, not live in Dickens' novels.

*Do your jobs* - protect public health and return N95 respirators to healthcare settings.

Yours,
Alixandra Englund

---

Hello,
I am writing to express my opinion about masking in healthcare facilities. As someone with Follicular Lymphoma, a blood cancer, who receives chemotherapy, I am immunocompromised. Because of this health status and because healthcare facilities have dropped masking requirements, every time I need to visit a healthcare facility, I need to think long and hard if that visit is important enough for me to put myself at risk of Covid. When I go for health care, I should have the right to experience SAFE health care and not run the risk of catching Covid from healthcare providers and other patients. Considering that many people have asymptomatic cases of Covid, screening patients for symptoms and asking staff to stay home when not feeling

well  is not nearly enough to protect vulnerable patients. We could easily catch Covid from people with asymptomatic cases. Additionally, it is known science that two-way masking is much more effective over time than one-way masking. Plus, N95's are much more effective at preventing the release of exhaled aerosolized virus than surgical masks. So please, reinstate the requirement for mandatory masking in healthcare facilities to help the millions of vulnerable people in the USA obtain healthcare more safely.
Kim Eckhoff
Avondale, AZ
Member: Immunocompromised People Are Not Expendable

---

Just wanted to express my concern for the way healthcare workers are no longer masking. I believe that the biggest learning from the pandemic is that we don't have to respiratory illnesses so readily. N95 masks should be a basic standard of care in healthcare settings in the same way as HIV moving us to gloves as a basic standard.

No one should have to worry about healthcare workers who are unmasked. Yet medical facilities are causing a great deal of spread. This is dangerous and unacceptable.

Please ensure masking becomes a basic standard for the future.

Thank you.
Kathryn Kelly-Leary
Elkton MD
Vexteo

---

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 increased 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

---

Precautions that include HEPA filtration and N95-or-better masks on all employees and visitors to healthcare facilities should be the standard, not an emergency measure. We lost a lot of healthcare workers over the past four years, and we'll never have enough if we don't take protective measures now. Our nation's most vulnerable are delaying or forgoing medical and dental care to avoid infection. Please keep protections, especially masking, in place.

Thank you.
Jane Lorenzen

---

To the Healthcare Infection Control Practices Advisory Committee:
I am writing in response to your invitation for public comment on your August 22 meeting. My interest in your work is both professional and personal: I am a medical librarian, and multiple family members and I have recently dealt with infectious diseases.

Due to my work, I am constantly immersed in the medical literature. Particularly since the outbreak of COVID-19, I have closely followed public health developments. I am concerned that your committee's recent work ignores some of the relevant science regarding COVID-19. These are the science-based measures that I believe HICPAC and the CDC need to take to reduce additional human suffering caused by the pandemic.

· Recognize that COVID-19 is spread primarily through airborne transmission (Tang et al., 2021 (https://doi.org/10.1016/j.jhin.2020.12.022)). Communicate this clearly to the public.
· Return to universal masking in health care settings. Nosocomial COVID-19 infections are far too frequent, leaving many immunocompromised people unable to access care without serious risks to their health. Further, these masks need to be N95s or higher quality. While surgical masks are helpful in certain settings, they are not nearly as effective at preventing the transmission of airborne diseases (Royal Society, 2023 (https://royalsociety.org/topics-policy/projects/impact-non-pharmaceutical-interventions-on-covid-19-transmission/), p. 60).
· Promote increased attention to improved air filtration and ventilation (Liu et al., 2021 (https://doi.org/10.1177/01945998211022636)).
· Communicate the risks of post-COVID conditions. Many people are unaware of these and believe that the only danger of COVID-19 is the acute infection, when post-COVID conditions are usually the greater risk, even when the acute infection is mild or asymptomatic (Davis et al., 2023 (https://doi.org/10.1038/s41579-023-00896-0)).
· Increase the scope of data collection back to what it was before. It is difficult for nonprofessionals to understand what the risks are when official data are not provided.

While COVID-19 and post-COVID conditions remain significant threats to public health, the CDC seems to be downplaying these risks, and your committee seems poised to recommend reducing the already inadequate mitigation measures against them. I appreciate that the pandemic has lasted a long time and that we would all love to move on, but the science simply does not justify removing yet further public health measures. I also recognize that there are economic and political factors that push against the interests of public health, but those factors are not the guiding principles of HICPAC. (In the long run, preserving people's health will be better for the economy anyway.) I plead with you to put public health first.
Sincerely,
Lee Crowther

---

To Whom It May Concern:

I write regarding the effort now underway by the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) to revise the agency's *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. In particular, I wish to express my alarm at how the HICPAC's draft revision fails to fully recognize the scientific evidence concerning aerosol transmission of pathogens such as SARS-CoV-2, the virus that causes COVID-19, and erroneously proposes that standard surgical masks offer equivalent protection against inhalation of infectious aerosols as do fit-tested N95-type respirators.

If formalized as official agency guidance, these revisions are likely to aggravate rather than prevent the serious problem of ongoing nosocomial transmission of airborne infectious agents like SARS-CoV-2 in healthcare settings, which continues to be the cause of substantial mortality and morbidity [1,2]. This in turn will ensure that medical facilities continue to be places where patients are unnecessarily exposed to heightened risks of contracting serious illnesses when seeking needed care. In addition, failure to institute effective mitigations against airborne disease will further undermine the healthcare workforce and guarantee that recurrent labor shortages among medical workers due to both acute COVID infections and disabling chronic/post-acute sequelae remain a fact of life for the foreseeable future [3].

There is abundant evidence in the peer-reviewed literature that establishes airborne transmission as the dominant mode of spread for the SARS-CoV-2 virus [4,5], and for other infectious diseases as well [6]. The proposed category of "air" transmission in HICPAC's draft revision of the 2007 guidelines does not properly account for the crucial role of inhalation of aerosolized infectious particles in propagating disease spread. As a result, the associated recommendation that ordinary surgical masks should be used to protect against such transmission is critically flawed, as only well-fitted N95-type respirators are capable of providing meaningful protection against harmful aerosols for any meaningful length of time.

Moreover, the committee's review of the evidence on masks and respirators unduly prioritizes the results of randomized controlled trials to conclude that there is no significant difference between surgical masks and N95 respirators. In reality, laboratory studies and other relevant data clearly demonstrate that the former offer inadequate protection against inhalation of infectious aerosols [7,8].

Worse still, HICPAC has inexplicably failed to address the need for engineering controls that would operate in synergy with the use of well-fitted respirators to effectively control the spread of airborne pathogens. There are no recommendations on ventilation in the draft revision and the proposals regarding airborne infection isolation rooms or alternative isolation strategies are extremely limited. Professional associations such as the American Society of Heating,

Refrigerating and Air-Conditioning Engineers (ASHRAE), which recently proposed a new standard on “Control of Infectious Aerosols,” ought to be consulted as part of the revision process and their relevant expertise incorporated into any updated guidelines [9].

As the SARS-CoV-2 pandemic continues to kill thousands of Americans each week and disable many more, I hope that the HICPAC will take seriously its mandate to prevent the transmission of infectious disease in healthcare settings as it looks to complete the process of revising the 2007 guidelines. The committee's recommendations must align with the available scientific evidence and the imperative to protect public health and not be tainted by a desire on the part of special interests to protect their own profits at the expense of patients’ and workers’ lives.

I thank you for your consideration and thoughtful attention to this vitally important issue.

Sincerely,

Matt Mazewski, Ph.D.

---

Name: Nick Barry
Address: Decatur, GA
Organizational affiliation: None- independent (concerned citizen)
Topic: INFECTION CONTROL/ISOLATION PRECAUTIONS

HICPAC / CDC:

I am writing to voice my concerns around and disappointment in the suggestions made by the HICPAC Work Group regarding Infection control. Specifically, I'm disheartened by the politicization of SARS-CoV-2 and the group leveraging that position to weaken infection control across the full spectrum of infection disease. While many are (rightly) focused on SARS-CoV-2, further concern should be expressed regarding the impacts of these changes across other highly infectious diseases, including but not limited to tuberculosis, HIV/AIDS, and ebola. 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.

Furthermore, 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 requesting that, at a minimum, HICPAC vote against the Work Group's full slate of recommendations and ideally review how the preexisting 2007 guidelines can be further strengthened following the overwhelming evidence of need presented by the SARS-CoV-2 pandemic.

Regards,
Nick Barry

---

Andrew Collins

The science is clear. Do not equate surgical masks with N95 respirator masks. Thank you.

---

To all members of the CDC involved in this matter:

My name is Heather Petit. My address Newark DE

I am a fan of The People's CDC and I am pursuing credentialing as a religious professional in the Unitarian Universalist Association.

I am also disabled, and while I am working, long COVID has been part of my life for more than three years now.

Given current research and the data we already have, we know that not masking increases transmission risk, and that transmission means both acute and long-term sequelae are going to impact people who are simply attending their doctor's appointments. People who have existing risk may have more appointments, more time spent in those environments, and more accumulated risk as a result.

First do no harm is essential to medical ethics. People who are high risk are not less human, less worthy, less beloved, less important. We know the outsize death rate from COVID-19, we know the organ damage, vascular damage, cognitive impairment. There is no ethical way we should have dropped mask mandates in medical settings in the first place. We didn't entirely know but suspected, then. We know more now.

Please reinstate mask mandates in healthcare settings. Disabled people, people at medical risk, and people who are not yet at risk but could become so due to one more infection with COVID-19 are all in need of your good judgment. Don't let more people fall into this hole.

Regards,
Heather Petit
Candidate for ministry

---

The stories I have to share are I'm sure familiar to the committee by now. As a disabled person, part of a community that makes up over a quarter of the country and together with our friends and family 73% of consumers, universal n95 masks in healthcare settings and beyond makes a massive difference in my quality of life and care. Mask optional has meant mask abandonment in my healthcare settings, leading to lack of access to providers, unacceptable risk when I do see them, and distrust in their clinical decisions if they are willing to put me at risk by not masking. I have to ask myself questions like, "Should I delay this echocardiogram, risking my

heart health, or expose myself to COVID during an echocardiogram with an unmasked doctor in an unmasked building, risking my heart health?"

Many people I know are in the same position, delaying dental care, MRIs, surgeries, bloodwork, and more because catching COVID would cause or exacerbate the very health issues we are trying to manage. It is hard for us to trust the advice of doctors who do not wear n95 masks and a medical system that does not require it. The CDC's abysmal leadership has led to worse infection control behaviors than before the pandemic began. At two recent unavoidable appointments, doctor offices did not even have n95 masks in stock for staff to wear at my request, despite how poorly the US fared without an adequate supply of PPE in early 2020.

The tide will turn on the disinformation against n95 masks. When it does, the US and the CDC will be laughingstocks for trying to suggest surgical masks would be equivalent to respirators. You can change that by instituting universal respirators in all healthcare settings.

Thank you,
Anna White

---

Hi there,

I am immunocompromised and have some concerns about the new policies the CDC has shared and would like to provide feedback.

Let me first explain that I am 34, and have been taking immunosuppressants since I was 19 due to an autoimmune. I work full time from a home I recently purchased (for the first time!).

I have been advised to "socially distance," wear a mask around those outside of my household and "consider avoiding crowded spaces that aren't well ventilated" for the last 3 years according to the CDC's recommendations for immunocompromised people. And since masks were no longer required in healthcare settings, even going to get a checkup or the quarterly blood tests my doctor requires has become a "risky" and stressful event.

High-risk people should not have to risk our health (and livelihood) to go to the doctor. Please issue Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration). And please require the use of masks in healthcare facilities. Or at least require hours of the day that provide covid mitigation and accommodations to immunocompromised patients so we are not sitting in crowded waiting rooms next to coughing and contagious people.

We have been isolating for more than 3 years now, enduring talking points about "only the high risk are dying of COVID" as a positive. But we have the right to exist safely in society.

Thank you,
Megan O'Neal

No org affiliation

---

To HICPAC:

I am writing as a concerned citizen regarding the presented revisions to the current isolation precautions guidance. However the guidelines presented are set to weaken current infection

control protocols. Over 900 public health experts have come out to formally express the clear and serious problems with these weakened guidelines.
I am a former public health investigator. I have served thousands of State of Georgia residents in multiple social service and public health capacities. In my time working for the State of Georgia, especially during this CURRENT pandemic, I have witnessed the horrors of completely avoidable death and unnecessary disability due to improper infection control. The proposed guidelines ignore the irrefutable science on how best to protect patients, staff, and healthcare professionals. I, a citizen and seasoned public health professional, insist that the HICPAC take into account aerosol transmission in the proposed guidelines for 2023.

Below are some points to consider:

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.

On 8/25/2023, Dr. Mandy Cohen of the CDC shared a video on social media of her answering questions about Covid-19. She explicitly did not discuss high quality respirators, ventilation, and air filtration: the three most critical layers of infection control to address aerosol pathogens. This can only be described blatant misinformation with a goal to mislead the public.
SARS-Cov-2 is AIRBORNE. We demand guidelines that address actual science for proper infection control protection in healthcare spaces. Weakened guidelines with kill and disabled countless patients. Covid-19 has taught us that we need to have better guidelines for infection control and any efforts to weaken and mislead patients and healthcare workers are unacceptable.
Thank you for your consideration,
Robin Gillis

---

Dear CDC HICPAC,

The COVID-19 pandemic is a fixed material reality and will not yield to any attempts to wiggle around the safety measures necessary to prevent infection by an airborne diseases transmitted by both short and long range aerosols produced by breathing, speaking, coughing, sneezing, or singing as is the consensus of the scientific community and the World Health Organization. We condemn the influence of venial political and economic interests that have prevented CDC and HICPAC from grappling with this reality and enabled the consideration of weakening protections for workers as noted by National Nurses United. COVID-19 remains a very serious, highly transmissible disease, and healthcare settings are one of the most sensitive environments in

existence as they are places where COVID-19 patients, workers, and the most vulnerable people in our society are forced to congregate. It is essential to clearly communicate the severity of the situation and protect all of these stakeholders.

The mass trauma and forced infection with COVID-19 due to the planned and intentional reduction of mitigations is a public health failure of such epic proportions that it is difficult to find words to describe it. This policy is conducive to nothing but furthering dysfunction in our communities, and frankly it is counterproductive to producing a healthy economy, which we understand to be the goal of this policy. How can our economy function as it did in 2019 with over a million dead and millions more disabled with Long COVID, with few options for treatment? How can this forced infection policy do anything other than run the economy into the ground over time? From both a humanistic and economic perspective, this is a lose-lose.

The solution is not to cover one's eyes and ears, but to fearlessly fight for COVID-19 protections. CDC HICPAC is chartered to provide advice regarding the practice of infection control strategies. The charge vested upon this body demands that integrity and science be the standard for decision making. Time and time again, the science shows that the use of respirators, ventilation, air cleaning, and frequent testing is necessary to keep a healthcare system functional during a pandemic.

At the CDC HICPAC meeting’s public comment section, the human cost of reduced mitigations was made evident by numerous expert and impacted speakers. Reports of deaths and hospitalizations occur every day as this crisis continues, regardless of what the White House declares. Do the right thing. Make the use of respiratory protection mandatory in healthcare settings.

We regard anything less as a blatant and deadly attack on the public, disabled and medically vulnerable people, and the working class.

Sincerely,

William Silversmith
Executive Board Member (on behalf of the Executive Board)
Disability Working Group
Democratic Socialists of America

---

Please forgive the tone of my letter, but I value a strong public health infrastructure and at this point in our ongoing pandemic have lost patience with the CDC and HICAP.

It is my understanding that the Centers for Disease control is relying on a single flawed study to determine the effectiveness of masking with an n95 respirator in a hospital setting.The majority of the public realizes that, like Tuberculosis, the SARS-CoV virus is airborne. An airborne virus lingers in the air for hours before it dissipates.This is particularly alarming indoors - especially in a hospital environment.

The idea that a "baggy blue" surgical mask could protect anyone from airborne particles is absurd.These masks are not NIOSH approved for a reason - they do not provide any seal and allow the spread of aerosols. Flimsy surgical masks are antiquated in today's hospital settings and should not be promoted as an effective option for safety in healthcare.

A patient in a hospital is in a vulnerable position no matter how good their health status. It is the job of the CDC to make clear recommendations that protect the public. I hope that HICAP and the CDC will listen to scientists and the general public and make the n95 respirator mask the gold standard and a requirement in healthcare settings.

Again, I apologize for the angry tone of my letter. I have always looked to the CDC for guidance in health matters. It is beginning to look like the CDC might have a serious conflict of interest when the interests of for profit healthcare is prioritized over the well being of patients.

Thank you for your consideration,
Lisa Herzig

---

Dear Honorable HICPAC Committee:

I called a welfare check on my friend who didn't return calls the first time in 22 years, and found her dead Feb 2020 and got severely sick myself, still sick with dizziness and other long covid symptoms, unprotected and unknowingly exposing myself on top of a very demanding minute to minute lifelong condition, type 1 diabetes. She was symptomatic but didn't qualify for a test not traveling to China. My primary condition is type 1 diabetes with many complications--and it is a severe condition. I've had to manage it daily 12 shots a day for decades and I love my life even more for all I have to do to protect it, and it gives me empathy to care for others short changed of health privilege. We were put almost ast in line for vaccines by the CDC, the only Western country to do that to us and with no explanation when we died at 2/3 the rates over t2 approved earlier, once hospitalized. We are well aware public health is political. Nevermind that a t1 discovered MRNA vaccine. My control is worse because pharmacy charged me hundreds for vials of insulin over years, they knew I needed to survive, unlike any civilized western country. I sometimes had to short myself. Twelve shots a day, and my medicine that keeps me alive and can also kill me every day every day, and I didn't do this much work to survive to be killed by a person's breath. And I love my life, through all of this. I love your life. I want you well. I have empathy and desire for fairness. Doctors judge that I have poor quality of life and aren't worth saving, and said that in surges. They have acted on that. They misperceive our own lived experience that we love our live, and instead treat us disposably nor creating safe medical settings. Please direct them with the best science and remind them to do no harm. We wonder Why do public health care providers, Biden's CDC, and too many providers care so little about the public's safety with this virus? Your decisions will impact millions of lives, your little group. Please know us as humans and worthy as you are. Please recommend what CDC FDA already knows--universal n95, ventilation, far UV, filtration, the same care Mr. Biden gets and you likely enjoy with the privilege of your positions.

This is America, not CHINA where they killed millions in lockdown depriving food and medicine and let people die when it was totally preventable outside of lockdown. But we are china now, the disposable patients dying and getting in for seeking medical care. It's so cruel. Can you put yourself in our position? Disabled got Biden elected because he promised to protect the vulnerable on election night. Disabled are the largest voting minority and now many don't want to vote for Biden. Either party's CDC is voting for death, they think. I still like Biden more and just want him to live up to his promise to protect us. Give accurate information to the public Give the kind of guidance in medical centers you want for yourself, your loved ones, your friends, the future. More pandemics are expected, Prepare us. Millions of lives are in your hands. Please do the right thing. The human thing. Issue undebatable guidance.

My mother died of untreated t1 diabetes and I witnessed her death. It was preventable. She was a democrat and helped expand medical access for people before she tragically died, neglected in medical care and wishes to live not honored. She would not recognize this democratic party, throwing the most vulnerable under the bus in medical settings. Please restore our confidence in the CDC and the President and issue correct guidance. The moral injury is severe, many feel Biden's abandonment of the most vulnerable and the medical system and workers and their families. We hope he listens. All of us vote. He is not popular in the polls they say. He should ensure health care policy protects the public and vulnerable and medical providers if he wants reelection and the largest voting majority in America (disabled) to show up. He is creating more disabled through long covid and policies they say, and they say they are so abandoned and at risk for reinfection. I have to get a biopsy. They quote CDC why they don't follow science. Protect me and them and the health care system. Protect the nation. Proven science. My life is in your hands. And I'm a cool person. You'd like me, if you met me. I'm even kind of funny, good heart. Thanks for protecting me like you would protect your own. .

Thank you.
Joanne Jansen

---

Dear HICPAC,
My name is Stephanie Contino, and I am a disabled chronically ill patient with long Covid, Myalgic Encephelomyelitis and other chronic conditions who is at high risk of severe COVID-19 illness and death. I have family and friends who are severely immunocompromised and also at high risk, whose safety I am deeply concerned about. I'm also concerned about healthcare workers' occupational safety. This is why I'm writing in support of increasing, not decreasing current infectious disease control standards. I will share two personal stories that I hope will demonstrate the importance of increasing infectious disease control standards.

In 2021, my therapist's employers eliminated their facility's universal masking requirement (in violation of state regulation at that time). Two weeks later, my therapist and other therapists working there contracted COVID-19 through the workplace, and then again a second time. Every time, it disrupted my mental health care, and that of other patients, for weeks at a time: my therapist wasn't well enough to see patients for 2-3 weeks each time she was infected for instance. And she experienced symptoms lasting months that lowered the quality of care she could provide during those times.

Two months ago, June 2023, I contracted cellulitis and had to get in-person urgent medical care. Due to my disabilities, I needed my partner's assistance to get to an urgent care clinic at a local hospital. At the clinic, I was treated by a nurse and a doctor neither of whom wore any type of mask while they treated me. I was in so much pain from the cellulitis that I didn't feel strong enough to advocate for my own safety by asking them to please put on masks before treating me. I was also afraid that asking for that might lower the quality of care I received. I was wearing a N95, as was my partner while they waited for me. One staff member, at the front desk, was wearing a blue surgical mask and disinfected the tablet and digital stylus for signing consent forms. But no other staff members, patients or people waiting wore any masks. I also saw no HEPA filters anywhere (same in the exam room). Two days later, my partner became ill with COVID-19, and I became ill with it a week later. (Neither of us had any known COVID-19 exposures nor been in any other indoor public spaces except for this clinic during the two weeks' prior.) This is what I had feared would happen, and why I had put off medical care for so long (for 5 days). By the time I received care for the cellulitis, the cellulitis had grown dangerously large and fast. Fortunately I received treatment just in time to avoid its potential serious complications. If I had not been afraid of contracting COVID-19 or another airborne

infection, I would have gotten in-person care much sooner - 3 or 4 days earlier.

I still have not fully recovered from this most recent COVID infection and I do not feel safe obtaining other in-person medical care that I need right now, which includes cancer screenings. Patients should not have to risk contracting COVID-19 or another preventable infectious disease every time we need in-person medical care. Hospitals and other healthcare facilities are where people go to receive care and get better - not to get sicker. Similarly, healthcare workers deserve to have as safe workplaces as possible. I therefore ask HICPAC to take into account the role of aerosol transmission in many airborne diseases like COVID-19 and to improve infectious disease control standards accordingly by recommending standard use of layered precautions like improved indoor air quality with better ventilation and filtration, masking with N95 or better respirators, and pre-procedure and admission testing. These kinds of layered mitigations are especially important for a disease like COVID-19 with such a high amount of asymptomatic and pre-symptomatic transmission (estimated to be around 40-50% of all COVID-19 infections).

Thank you.
Stephanie Contino, Patient

---

As a medically vulnerable patient, and an advocate for post-infectious neuroimmune conditions, I urge the CDC to create concise infection control guidelines that recognize transmission characteristics of SARS-CoV-2 based on up-to-date scientific evidence. This means having a publicly transparent process for establishing these guidelines that prioritizes science over profit.

COVID-19 is not over for millions of immune-compromised Americans. Many of us have spent three years sacrificing normalcy in order to simply survive. We are able to avoid going to restaurants and crowded indoor recreational events, but we cannot avoid getting medical care. In fact, vulnerable people make up a disproportionate percentage of patients at any given time because our conditions require ongoing management.

Without adequate aerosol infection control, we are asked to either risk catching a potentially disabling virus or forgoing critical medical care. In short, without guidelines backed by aerosol scientists and hygiene professionals, people like me will die—either due to healthcare-acquired infections or due to missed healthcare.

I urge the CDC to not leave behind millions of Americans like me. I urge the CDC to prioritize the health and safety of healthcare workers. Reinstating universal masking with respirators, creating ventilation standards, and implementing regular COVID-19 testing will go a long way towards accomplishing this.

Sincerely,

Shelby Lock
B.S., B.M., Belmont University, *summa cum laude*
Community Advisory Board Member, Neuroimmune Foundation

---

Hi,

I would like to speak to the update of the CDC's *Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* guidelines. The EPA has recognized that Covid-19 is

spread via aerosolized particles and that those particles "can remain airborne for hours (https://www.epa.gov/coronavirus/indoor-air-and-coronavirus-covid-19)" and accumulate in indoor spaces (and has documented science and technical resources, key references and publications for technical information on their website). It's a known scientific fact that other diseases are transmitted via aerosolized particles as well. And the FDA has clearly stated that surgical masks "do not provide a reliable level of protection from aerosolized particles because of the loose fit (https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/face-masks-barrier-face-coverings-surgical-masks-and-respirators-covid-19)". The updated guidelines must include the use of N95s and improvements to air filtration and ventilation to prevent healthcare-associated infections from aerosolized particles. These measures will reduce the transmission of a number of infectious diseases.

This issue is also personal to me. My mother lives in the US and she has been infected with Covid twice in healthcare facilities. My mother is vulnerable, she has been diagnosed with Primary Immunodeficiency, and she has new health issues that have shown up since she had Covid. The first time she was infected by another patient while waiting to get her blood drawn for tests at UCLA. The second time was this past April when she was seeking medical care at an Urgent Care facility where none of the staff were masked. She's in hospital right now and has been there for the past 3 weeks. It's not clear, if she's going to recover. While in hospital, she has found that the burden is on her to remind staff to wear masks around her, and to remind them to change their gloves between handling bathroom tasks and touching her or changing the sheets. The burden for making sure staff are wearing proper PPE and following proper procedures to prevent disease transmission should not be falling on patients! I think it's important to make sure the updated guidance is very clear and detailed about the precautions that are needed to protect healthcare workers and patients from infectious diseases and prevent disease transmission. This should include clear guidance on how to select the appropriate control measures (including PPE) for each job, task and location.
Healthcare facilities should be a safe place to seek care and a safe place to work, instead healthcare facilities have become a risky place to breathe due to the high risk of getting infected with Covid and other diseases that are spread through the air. A survey by British Medical Association released last month shows that 18% of UK doctors "reported that they were now unable to work due to their post-acute Covid ill-health (https://www.bma.org.uk/bma-media-centre/first-major-survey-of-doctors-with-long-covid-reveals-debilitating-impact-on-health-life-and-work-and-wider-implications-for-workforce-and-health-services)". We need to keep patients and staff as healthy as possible. One of the goals of HICPAC is to prevent healthcare-associated infections. Clean air is vitally important for patient safety and to protect our doctors, nurses and other healthcare staff. Clean air is central to the goal of preventing healthcare-associated infections, as it will reduce the spread of all diseases that are transmitted via aerosolized particles.

Thank you for considering my comments.

Sincerely,
Lalena Whitcombe
Artist/Entrepreneur (no other organizational affiliation)
Vancouver, Canada (dual-citizen of the US and Canada)

---

Michelle Jones, PhD

I am a PhD biomedical scientist by training and the mother of a medically complex 9-year-old boy. I am writing to urge HICPAC to recommend that the CDC reenact universal masking in healthcare settings to protect all patients, including my son.

One of my son's many medical conditions is epilepsy. A typical seizure looks like him waking up in the middle of the night, wearing snug-fitting blue pajamas with astronauts or trucks on them, his arms shaking uncontrollably. My husband, sleeping next to him for his safety, is startled awake, and as soon as he realizes that the shaking is a seizure, he yells out for me.

I spring out of bed and rush to my son's nightstand to grab his emergency anticonvulsant medication. His seizures never stop on their own, and his neurologist has advised us to give him his emergency med ASAP to try to stop them. We administer the med, then wait a couple of minutes. He's still shaking, and he's looking to the left, eyes locked in place. He's still seizing. "Call 911," one of us says.

The ambulance arrives. Three or so paramedics come into our home, ask us questions---*What's his name? What medications does he take? When did the seizure start?*---and examine him. They transport him to the back of the ambulance. I grab our emergency backpack from near our front door, always packed with meds, snacks, and clothes *just in case*, and rush out to the ambulance, where I climb up into the front passenger seat. In the back, two paramedics place an IV in my son's arm and give him more meds, trying to stop the seizure.

Soon we arrive at the closest ER. The doctor gives my son even *more* meds. The shaking slows to a stop, and my son finally looks at me. This time, thankfully, the seizure has stopped. The doctor directs us to go to the nearest children's hospital for further monitoring, which means another ambulance ride with a new set of paramedics, followed by a new set of hospital staff.

My son can't wear a mask during any of this due to the emergency anticonvulsant meds he's taken that could affect his breathing. He's at the mercy of all of the people who come in contact with him to protect him---*the paramedics from the 1st ambulance. The staff at the 1st ER. The paramedics from the 2nd ambulance. The staff at the 2nd ER. Any visitors that happen to be walking past his ER room.* Any one of these people could be infected with SARS-CoV-2 and transmit it to my son, especially if they aren't wearing proper PPE such as N95 respirators.

The thought of my 9-year-old contracting an airborne viral illness such as SARS-CoV-2 that could exacerbate his medical conditions---or worse---is absolutely terrifying. The thought of my **9-YEAR-OLD** contracting such an illness **FROM UNMASKED MEDICAL PROFESSIONALS WHO COULD HAVE PREVENTED IT BY MASKING** is absolutely despicable. Not all patients can wear masks. They deserve to be protected by the very medical professionals whose care they seek---and by all other patients and visitors who are able to mask.

For the protection of all, I urge the HICPAC to recommend universal masking in healthcare settings, including N95s for medical professionals (regardless of local prevalence data, which is inaccurate due to limited testing). People's lives depend on it.

---

Hello,

I am Ifunanya Okoroma, an undergraduate student at the University of California, San Diego. I reside at San Diego, CA. I am writing to address the CDC HICPAC's weakening of practices used to control infections in healthcare spaces. I would like to note that it is beyond disturbing that a proposal is being made that strips the power of designated places of recovery from

illnesses, making it easier for people to become infected with the illnesses that will put them in that same place. Moving forward with weakening these policies is incredibly unintelligent, knowing that this will perpetuate a vicious cycle. If people become sicker in the spaces where they are supposed to get better, this debilitates our healthcare system.

Thank you.

---

My name is Cristobal Palmer. I'm reachable at Carrboro, NC, and I'm writing as an individual rather than in my professional capacity as a systems administrator at UNC-CH.

I urge CDC to recommend improvements to indoor air quality through filtration and ventilation, as this is the evidence-based choice, and the direction that will improve public health.

Further, clear guidance on the relative efficacy of mask types that acknowledges the benefits of well-fitted N95 masks is a foundation upon which future state institutions' funding requests can be built. Please give us the tools we need to make our institutions safer for everyone.

Thanks,
CMP

---

To Whom It May Concern,

I recently had to go to the emergency room. I live in an area that's supposed to have the best hospitals and medical care in the world. I was shocked when, after a long wait in a crowded waiting room filled with unmasked patients, I was brought to a gurney in the hallway with no barrier between myself and others, no privacy, and nearly no masks to be seen.

An already stressful situation was magnified by the lack of infection control practices, particularly airborne infection control. The state of medical care in the US is shocking. It became clear that the hospital and its employees were not protecting the patients or themselves appropriately.

During the pandemic, I learned of the benefits of a high quality, well fitting mask. I thought to myself, "I hope masking stays in healthcare settings." I'm shocked and scared that infection control requirements are not being improved as a result of what has been learned during the pandemic, but instead weakened.

I fear that rolling back or leaving space to roll back infection control practices will have a long term negative impact on not only individuals who need to seek care (including possibly discouraging people from seeking necessary care, which could have long term negative consequences), but also long term negative impact on healthcare workers and the state of healthcare in this country overall. We already have a shortage of healthcare workers. The answer is not having healthcare workers have less protection and be encouraged to come to work sick, but rather to maintain or even increase infection control measures to keep healthcare workers healthy and at work at 100%.

In conclusion-- I hope HICPAC will revise it's recommendations to stress the importance and superiority of N95 masks over surgical masks, encourage their consistent usage, roll back the "flexibility" and maintain clear guidelines, add in material recognizing aerosol spread of infections, and add guidelines that underscore the importance of ventilation.

Thank you for your consideration.

Sincerely,
Melanie Walter
Boston, MA

---

Dear Committee,
My name is Melissa Steele-Ogus and I am a postdoctoral researcher at Stanford School of Medicine. I am also a chronically ill person who is high risk for infection. I am writing to urge you to update your guidance for healthcare facilities to include air filtration systems and air quality standards as well as requiring N95 masks for hospital employees. I receive weekly infusions to manage my health at the hospital. It's bad enough that I risk my life when I go to work. It's worse that I have to do so in a place that I go to maintain my health, a place that is supposed to protect me.
Thank you for your time.
Melissa Steele-Ogus
PhD

---

Hello, my name is Leora Matison. I have been in recovery from a mild traumatic brain injury, the most debilitating symptom of which is brain fog. Brain fog can prevent me from being able to read and write more than a paragraph and hold conversations when it is at its worst, and even when less bad still greatly interferes with my quality of life. Since a study by the NIH's RECOVER initiative has shown that 10% of Covid cases result in long Covid even after vaccination, and one of the most common symptoms of long Covid is brain fog, I would very much not like to risk Covid infection and therefore further brain injury during essential medical appointments that I cannot avoid (or even non-essential ones).

Recently, I made a medical appointment with my PCP for health concerns related to the recent wildfire smoke in the Northeast. My PCP commented on my mask and told me Covid wasn't around anymore and we didn't need to mask, and she was only wearing her surgical mask since she had a cold, then made comments pathologizing me for masking. Now, as other public commentators to HICPAC have stated, studies have shown that Covid and other airborne pathogens are mainly transmitted through aerosols, not droplets, a surgical mask is not enough to prevent aerosol transmission, and that N95 level respirators (or better) are much more effective. I also wondered how my doctor knew she had a cold and not Covid, whether she had taken a PCR test or whether she just assumed so, since prominent organizations such as the CDC had chosen to stop talking about it and stop tracking it. Note that in our area, Covid transmission was still at moderate levels when the CDC had stopped tracking case counts in May, and wastewater data in our area from Biobot.io had not shown Covid levels to have gone down since then, unlike flu and RSV levels, which genuinely do go down to near nothing during the summer. And a doctor's office is, needless to say, a lot more likely to contain someone with Covid than other public spaces. Since my doctor had assumed Covid wasn't around, she could have falsely assumed she could not have Covid and put me and other patients at risk of long Covid. Even if all she had was a cold, it is still concerning that she was willing to go to work sick and likely pass a cold onto her patients. Many of her patients were elderly and medically vulnerable, and all deserved not to get sick when going to the doctor.

I was uncomfortable with my doctor's lack of knowledge on the issue of aerosol transmission and appropriate respiratory projection, as well as her lack of knowledge of the moderate levels

of Covid that were still in our area and more likely than average to show up in a doctor's office, and her carelessness regarding transmitting any illness to her patients (whether covid or just a cold). However, her ignorance was understandable, she was just following CDC guidance. I now no longer feel safe going to her for medical care, especially care that involves taking my mask off (the test I had gone to the doctor for that day required taking my mask off, and since I did not wish to do that and risk getting long Covid from her I left empty handed). While I would very much like to switch to a doctor who is more familiar with appropriate respiratory protection for aerosol-transmitted diseases and with the levels of Covid transmission in our area, and who is interested in protecting patients from it, it is difficult to find one, since most doctors follow CDC guidelines and CDC guidance in this area is woefully inadequate. With Covid in the wastewater across the country having only increased since then and since we are now in a new surge, I am currently putting off seeing a doctor for various minor health issues since I do not want to risk obtaining further brain injury from doing so. (To say nothing of the dental care I have also been putting off, considering I must be maskless for it.) I dread a minor health issue turning into a more serious health issue and having to choose between treatment and the risk of long Covid. And with climate change causing increased wildfires and smoke events, among other hazardous weather conditions, the risk of health issues for myself and other members of the public is only increasing. I call on HICPAC to release guidance that: 1) Recognizes aerosol transmission of Covid and other illnesses. 2) Follows the science and recommends universal N95-level masking (or even safer options such as p100 elastomeric respirators or PAPRs) for healthcare workers to protect against aerosol-transmitted diseases, and masking for patients able to do so (preferably providing free N95 masks), so I could finally go to the doctor safely, and finally get medical tests that require taking my mask off. 3) States that healthcare workers with symptoms of any aerosol-transmitted infection should not enter healthcare facilities and should be given paid leave, or remote work if appropriate. And 4) Recognizes the importance of ventilation and filtration in preventing the transmission of Covid and any aerosol-transmitted disease, and states that healthcare 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.

Sincerely,
Leora Matison

---

To all members of the CDC involved in this matter:

My name is Adrian Ballou. My address is Brockton, MA. I am a supporter of The People's CDC, and I am a Unitarian Universalist religious professional focused on community ministry and support for trans and nonbinary people living through anti-trans hate legislation sweeping the nation. This anti-trans hatred and violence is wreaking havoc in my communities. Many are dying, and hundreds of thousands are fleeing for their lives. Those of us who are in support roles--or volunteering for them--are showing up to help keep our community alive and thriving.

There is currently not a similar news or community focus on another state-sanctioned onslaught on the rights of a marginalized community: disabled people. I'm disabled, chronically ill, and have many conditions that make me high risk for severe complications of acute COVID-19, including higher likelihood hospitalization and death. In addition, I already have medical conditions that mirror many that Long Covid are experiencing, and I am hoping to avoid adding to the symptoms I'm experiencing.

To be clear: I am a proud member of the disability community. I know that we deserve more than experiencing continued injury and forced infection and death. We deserve access to

medical care. I had two healthcare providers refuse to mask when I was at an appointment the other day--it took three people to take my vitals because they would not provide this reasonable accommodation that had already been promised when I called ahead. I have a surgery coming up in a few weeks, and I'm concerned that the lack of universal masking will have me leaving the hospital sicker than I came in--with a COVID infection that could mean another permanent disability for me, or threaten my life. There is nothing wrong with being disabled, but there is a lot wrong with forcing disabled people to acquire more disabilities. Forced infection is not freedom or safety.

Our healthcare professionals right now are violating their oaths to do no harm. They are violating basic principles of science and how an airborne virus that is at a BSL-3 level of contagion containment in a lab setting, that's extremely contagious and devastates all systems of the body, should be handled. Medical settings are sites of universal harm without universal masking. And for those of us who are high risk--which, at this point, is most of us, given that a previous COVID infection is also a risk factor--it is a death sentence.

Many people I know in similar situations have been denied access to care--including lifesaving surgeries, including getting hung up on when they ask healthcare providers to mask, including avoiding healthcare in the first place whenever possible.

This is inhumane. It is violent. And it needs to stop. Bring back masks in healthcare. Save all our lives.

Adrian Ballou

---

Name: Jossie J. Yashinskie
Topic: Weakening of infection control guidelines
Affiliation: Concerned citizen & cell biologist

People go to hospitals to receive care, not for nosocomial infections! HICPAC/CDC 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/CDC must increase transparency and public engagement in the process to update the 2007 Isolation Precautions guidance. I urge HICPAC/CDC to strengthen, not weaken, infection control guidance! People over profits!!

---

Hello,

I'm writing to submit my feedback on HICPAC's Isolation Precautions Guidelines. As an unlucky person who developed Long Covid (or PASC) after my first covid infection in, it alarms me to hear that infection control measures in healthcare settings may potentially be loosened as a result if your recommendations. I've been told by physicians that I am at high risk of complications if I am reinfected.
Some procedures commonly indicated for people with PASC are impossible to complete while wearing the N95 respirator I wear to protect myself. When I got an MRI, I had to remove my mask because it was metallic. Two-day serial cardiopulminary exercise tests (CPETs) are one of the only tests that can provide proof of ME/CFS-like fatigue symptoms in people with Long Covid as part of applications for SSDI – these tests can not be completed while masked. Even

tilt table tests used in diagnosing orthostatic intolerance, a common post-acute sequela of COVID-19 often requires a Valsalva test, again something that cannot be done masked.

The pandemic has shown the power of NPIs in preventing disease transmission, whether COVID-19, flu, or RSV. Let's learn from our successes and ensure that healthcare environments are safe for our most vulnerable community members – not hotbeds of disease transmission that harken back to the 1854 Broad Street cholera outbreak.

Thank you for your consideration,

Ezra J Spier
Oakland, California

---

My name is Christelle Vincent and I live at Burlington VT. I am speaking in my own capacity and I am not affiliated to any organization.

Please promptly design and implement Indoor Air Quality Standards for all health care facilities, equivalent to 12 changes of air per hour. Your current suggested guidance is out of step with the reality we are facing. Health care facilities should be safe. As President Biden says, we have the tools, and this includes the highest air quality standards in health care facilities.

Best,
Christelle

---

To Whom it may concern,

I am concerned about health care facilities not having universal masking with high quality masks like n95s. Covid is still present and while almost all spaces have no masking, I would think health care settings would keep it to keep us, the most vulnerable, SAFE. Covid is still very present and long Covid is still very much a threat to the public. I am immunocompromised and so is my family and it has been a nightmare to navigate health care facilities being at risk. Also, the lack of acknowledgment of needing proper air filtration in these spaces needs to be addressed! It honestly deters me from going to get help for my health issues.

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.

Sincerely,
Heather Boyer

---

Hello,
My name is Ursula Floden. I live in Richmond, CA.

I am writing to urge HICPAC/CDC to strengthen, not loosen, healthcare infection control practices for the safety of both healthcare workers and the patients they interact with. We, the public, the patients, the loved ones of those at higher risk of COVID-19s adverse affects, and so many who work in healthcare settings, deserve to feel safe when accessing/providing healthcare. Proactive measures such as N95 respirators (not surgical masks, which have been proven much less effective), HEPA purifiers that help to clean the air of aerosols (like COVID-19 and other infectious diseases), and proper testing/isolation of infected folks should be basic protocol.

I personally cannot afford to get COVID. I have two high-risk elderly parents, a high-risk husband, and an autistic son who relies heavily on me everyday. The science has been telling us for years now that SARSCOV2 is a vascular disease. It does not matter how mild your initial case may be. Reservoirs in the body can make Long Covid a disabling probability for so many—especially with subsequent reinfections. It is a gamble I do not want to take.

I, and so many like me, have put off routine health care services in order to avoid possible infection. This is unacceptable. We deserve the comfort of not having to worry about a disease that labs treat with Biosafety Level 3 practices whilst at our medical appointments. The medical community and Public Health should be doing MORE, not less, in the midst of a pandemic. Please listen to our pleas for the support we all deserve. Thank you.

Very sincerely,
Ursula Floden

---

As a disabled/immunocompromised individual, I am imploring the CDC to *not* weaken protections on infection control. We need to limit the spread of SARS-COV-2 in healthcare facilities by increasing indoor air quality AND educating the public on why a respirator is much better protection than a surgical mask (there are numerous studies that prove the efficacy of a respirator such as N95 or P100 over a surgical mask, some that the CDC has even shared in the past. To claim otherwise now is to betray science and the general public for profit). People should not be at risk of contracting deadly diseases in medical centers, especially those of us who rely on medical care to survive. Weakening the already weak protections is akin to forcibly infecting, disabling, and killing people.

I ask you to issue Indoor Air Quality targets for all healthcare facilities (e.g. all healthcare facilities must have ventilation of 12 air changes per hour or an equivalent level of HEPA filtration).

Hannah Martin

---

I ask that you issue new guidelines which recommend increasing indoor air quality via ventilation and/or filtration inside healthcare facilities.

Additionally I understand you plan to claim that surgical masks are just as good as N95s, and numbers do not back that claim. Please do not make it.

Daria Brashear

---

Good evening!

My name is Chelsea Williamson, and I am currently a pre-medicine student at Asnuntuck Community College in CT. My address is Omaha, .

I have many concerns over HICPAC considering weakened rules that will allow the transmission of airborne infectious diseases like SARS-COV-2 to happen in health care settings such as hospitals without precautions that are simple, inexpensive, and effective.

My concerns are congruent with the majority if not every single spoken public comment given air time during the meeting.

Our public health messaging, including these updated guidelines, needs to be clear about not only the airborne nature of viruses including SARS-COV-2, but also the significance of prevention methods such as masking with N95 or better respirators (not just surgical masks) as well as the need for air cleaning/filtration.

Given the significant risks of a single acute infection, let alone long covid, it's ridiculous that anyone — particularly vulnerable individuals like cancer patients — is forced to choose between accessing health care in a setting where transmission and infection is unchecked, and avoiding care altogether.

The CDC and HICPAC have the power to raise standards, not lower them, and a moral duty to do so.

Thank you for your time.
Chelsea

---

From: Robin-Ann Klotsky, PhD

- Respirators need to be mandatory for all health care. COVID-19 is airborne and we are entering yet another surge. This includes N95 respirators, elastomeric respirators, and PAPRs. Air quality must also be improved via HEPA filtration, ventilation, and UV.

- As the government has pushed "you do you" precautions, that leaves people who are vulnerable and/or aware of COVID risks to desperately scramble to protect themselves.

- One-way masking is insufficient protection. One can choose to not go to many places, but people eventually *need* health care. "data show that one way masking can be fifty times less effective than two way masking at preventing infection of the masked individual (Bagheri et al., 2021) 1"

- We should not be setting up people to get sick when obtaining healthcare. People have no choice, they must go, or get sicker, or die, if they do not get the healthcare they need. It is unconscionable to not protect people from getting infected in healthcare settings.

- More needs to be done with mandating proper respirators, improving air quality, utilizing ultraviolet light, in both healthcare and all public and private locations. We also need to better educate the public about the true transmission of Covid and its dangers both short and long term.

- It is important that HICPAC bring air quality engineers in to be part of the decision making committee. Physicians do not understand air quality the way that IAQ engineers understand air quality. Frontline nurses or health care workers must also be included.

1 https://whn.global/letter-from-disability-organizations/

---

OSHA Guidelines saying N95 or better, ventilation and Filtration are the only evidence based options for Deadly pathogens like Covid 19 and other airborne spread illness.

The impact of your unproven guidance is allowing our local hospitals and Dr offices to abandon their masking guidelines and because of this policy it is not allowing my wife, who is chronically ill with a number of different ailments, to get the testing she needs to improve her quality of life. Knowing that if my wife gets any illness let alone Covid 19, her quality of life would be worse than it is now, which consists of going from our bed to the couch with the help of a walker, scares me every day. By allowing Dr offices and hospitals to no have any masking requirements make is impossible for us to attend Dr appointments in person and does not allow us to go to hospitals for any testing. When you watch the person you love go from a Strong women to someone who needs help getting up from the Couch to go to the bathroom is hard to watch, and with the lack of any safety precautions where she can get additional testing to try and improve anything is hard to deal with some times. I urge you from a caregiver, husband and friend to other people in our same situation, Please recommend N95 or better masking requirements and air ventilation and Filtration systems for all Dr offices and Hospitals who are there to keep and help people get healthy, not make them sicker. Thank you.

James Nehmer

---

To whom it may concern:

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.

I'm deeply concerned and appalled by these actions. We are three years into a pandemic that is transmitted by aerosols and it's as though the CDC has learned nothing. It's been extremely disappointing to have the mask mandate in hospitals dropped. Reducing additional measures that we know are needed to protect workers and patients is outrageous. I don't want to be scared that I'm going to contract additional illnesses when I seek care, putting me at greater risk.

Please change these policies and show that the CDC cares for people over profits.

Thank you for your time,
Mercedes Klein

---

OSHA Guidelines saying N95 or better, ventilation and Filtration are the only evidence based options for Deadly pathogens like Covid 19 and other airborne spread illness.

The impact of your unproven guidance is allowing our local hospitals and Dr offices to abandon their masking guidelines and because of this policy it is not allowing my wife, who is chronically ill with a number of different ailments, to get the testing she needs to improve her quality of life. Knowing that if my wife gets any illness let alone Covid 19, her quality of life would be worse than it is now, which consists of going from our bed to the couch with the help of a walker, scares me every day. By allowing Dr offices and hospitals to no have any masking requirements make is impossible for us to attend Dr appointments in person and does not allow us to go to hospitals for any testing. When you watch the person you love go from a Strong women to someone who needs help getting up from the Couch to go to the bathroom is hard to watch, and with the lack of any safety precautions where she can get additional testing to try and improve anything is hard to deal with some times. I urge you from a caregiver, husband and friend to other people in our same situation, Please recommend N95 or better masking requirements and air ventilation and Filtration systems for all Dr offices and Hospitals who are there to keep and help people get healthy, not make them sicker. Thank you.

James Nehmer

---

To whom it may concern,

I am writing to you as a disabled, immunocompromised person, imploring you to reconsider the new recommendations you are proposing for healthcare facilities. Firstly, it is irresponsible to advise against improving indoor air quality when we are dealing with a resilient and still mutating virus that is transmitted via the air. Secondly, it is purposefully and maliciously misleading to say that standard surgical masks are as effective as N95 masks at protecting against transmission of an airborne virus when that assertion is patently false.

It is clear that the CDC, and indeed the federal government, have decided that endangering the lives of disabled citizens (and in some cases condemning them to death) is an acceptable risk. This is the end stage of ableism, deciding that if a virus primarily affects disabled persons, that we as a country should "learn to live with it". We still don't know or understand all of the long-term effects of COVID on the human body, but we DO know that COVID has a profound effect on people whose immune systems are already compromised. The US Centers for Disease Control and Prevention have effectively abdicated their responsibility to control the spread of this virus, or to enact any clear guidance to prevent the spread of this virus.

You should be ashamed of yourselves.

Jen Jones (they/them)

---

Hi there,
I know organizations like to think they can pretend COVID is over however it very much is still ongoing and each variant creates a new problem. We NEED all health care workers in N95

masks. We need better filtration and infrastructure. I find it cruel and vile that disabled and immunocompromised try to protect themselves and everyone else has decided that they don't matter and are expendable. DO YOUR JOB TO PROTECT US.  I can only do so much on my end to protect those in my home.
Heather Martin

---

Name: Chandler Louisell
Topic: aerosol transmission standards and practices to ensure safety of patients and healthcare workers
Comment:

The proposed updated guidelines for aerosol transmission of infectious diseases in the newest guidelines by HICPAC do not meaningfully address how the transmission occurs and how to mitigate it. One of the main ways the updated guidelines are not properly addressing aerosol transmission is through the lack of recommendation for wearing proper respirators. HICPAC is currently referencing a flawed data study on the efficacy of surgical masks and N95 respirators or better as not having any meaningful difference. The current guidelines only potentially recommend wearing medical masks. We need guidelines for medical staff and patients to be wearing N95 respirators or better to stop the transmission of viral respiratory viruses such as Covid19 or bacterial respiratory infections such as tuberculosis. Currently patients who are vulnerable to severe outcomes from Covid19 must go into medical facilities that do not require masks and/or respirators and be put at risk for leaving sicker than when they arrived at the facility they are seeking treatment from. One way masking is not sufficient and in cases where patients are going into facilities for a diagnosis such as oral cancer they have no choice, but to remove their mask to receive care. If all doctors and staff are not wearing proper N95  respirators the cancer patient is at risk for disease and severe outcome simply for seeking treatment. My partner has been battling oral cancer since 2021 and this is a risk we have to take everytime we go to the doctor to seek treatment from people who are knowledgeable experts in their field. The doctors and staff need HICPAC to create solid guidelines to inform them of best practices for both the patients, and the staff. Medical staff safety matters too. We need medical staff to be healthy and able to save patients' lives, not repeatedly getting sick from repeated mitigatable illnesses such as Covid19 because of poor guidelines on N95 respirator usage. I urge HICPAC to write strong guidelines requiring N95 respirator usage by medical facility staff and doctors in all medical facilities. Disability and death from Covid19 is preventable and we have the science to know respirators work in preventing the spread.

---

I'm a scientist and 20+ years neuroscience scholar. I'm also a survivor of West Nile Virus (WNV) Meningoencephalitis in 2013. In 2022 I was the single WNV survivor from the US to be invited to the WHO world zoom conference on Encephalitis, which included the CDC. My contribution to the panel was to encourage hospitals to include education on diagnosing and treating WNV Encephalitis in routine CMEs since my experience following several thousand other survivors indicates that knowledge about WNV among physicians is woefully lacking.

I'm writing to advocate for a CDC mandate for rigorous infection control in all medical settings due to the present pandemic. I included the above background because that past illness history (as well as senior age, being male, and balding) places me in a very high risk group for covid-19 infection. In June of this year a seminal study entitled **Autoantibodies neutralizing type I IFNs underlie West Nile virus encephalitis in ~40% of patients** was published in Journal of Experimental Medicine (https://rupress.org/jem/article-pdf/220/9/e20230661/1453733/jem_20230661.pdf). These autoantibodies neutralized type I

Interferons of around 40% of cases of West Nile virus (WNV). This research also found autoantibodies against IFN in patients with severe covid infection. It's highly likely that this autoantibody presence played a part of my encephalitis and validates my risk situation and demands that I should avoid all possible agencies of infection. My previous brain insult could be exaggerated with a new infection.

In 2020 our local hospital was desperate for PPE with infections of staff and a tsunami of covid patients. They appealed to the public to help by making cloth masks to help them avoid covid while treating patients. Our community turned out scores of volunteers who made hundreds (if not thousands) of these masks, dropping them off daily in a box in front of the hospital. Now, after mandates have been lifted, these same medical professionals are turning their backs on the most vulnerable of their patients by refusing to wear any kind of mask, or requiring it in the hospital building. It is a slap in the face for those who worked so hard to help protect them in their time of need. I personally know two women who went to the hospital's attached physician clinics (while wearing their own masks) for needed health appointments (CHF) and were astonished to find that no personnel or other patients were masked during their visit. Though they visited no other location, three days later they became ill and tested positive. I recently took my seriously ill wife to a clinic where I saw *one* nurse with a mask and the doctor verbally belittled our personal masking, knowing well the critical state of illness.

It's time for the CDC to rise to the present urging of the **National Nurses United** to fully recognize aerosol transmission and protect health care workers and patients! I urge the **CDC HICPAC to follow CDC's own FDA, NIOSH, OSHA guidelines** saying N95 or better universal respirator masking are the only evidence based options, not surgical, not cloth, not no masks.
--
All the best,

William Alford