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Docket ID: OSHA-2008-0005
Docket Title: *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*
Document ID: OSHA-2008-0005-0001
Document Title: *Request for Comments on Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*

The Society for Healthcare Epidemiology of America (SHEA) appreciates this opportunity to comment on *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza*. SHEA is an organization representing over 1,400 physicians and other professionals who direct the infection prevention and control programs in our nation's healthcare facilities. As such, we are vitally interested in evidence-based, effective means of reducing the transmission of infectious agents, including pandemic influenza, in healthcare facilities, other workplaces, and in the community. We are, therefore, concerned about the appropriate use and supply of personal protective equipment, such as facemasks and respirators.

We commend the Department of Labor for continued responsiveness to workers' concerns about the utility and use of respiratory protection. The current guidance extends the previous guidance, while addressing questions about stockpiling of respiratory and barrier protection devices. Advanced planning is necessary, and stockpiling facemasks and respirators prior to the influenza pandemic makes sense as long as industry can maintain supplies for current healthcare needs. However, too extensive stockpiling, by too wide a variety of employers may lead to current and future shortages.

Use of respiratory protection is quite appropriate in very high exposure risk situations, where aerosols of respiratory secretions are generated. However, it is the situation of exposure, not necessarily the occupation of the potentially exposed, which determines the level of risk. Overreliance on respiratory protection for pandemic influenza in situations of lesser risk is an ongoing concern. For non-healthcare and non-first responder employees the prime focus should be on reducing opportunities for exposure by scrupulous use of droplet barrier precautions, adherence to hygiene recommendations, proper disposal of secretions, and by assuring adequate source control by providing the patient, if not contraindicated, with a surgical mask. Pandemic influenza, as a human-adapted viral infection, would be overwhelmingly transmitted directly or indirectly by wet respiratory droplets in a similar fashion as seasonal influenza. The evidence of true airborne (droplet nuclei requiring filtration of particles of 2-5 microns size) transmission of influenza is very limited and the evidence of droplet transmission strong. We feel that more focus should be directed to the instruction in and the encouragement of the use of surgical type masks,

except at the very high exposure risk level. For example, emergency medical service employees will not face continuous exposure at a high-risk level, and can and should use droplet precautions and barrier mask protection for much of their work shift. In the guidance, it is assumed that they will always be using respirators.

Recommendations for respirators at lesser levels of potential exposure diminish the emphasis on the droplet precautions that have proven most useful for containment of influenza in healthcare facilities over the past 30 years. In the workplace, a normal person would have difficulty wearing respirators beyond 2 hours. Many people have a misconception that respirators can be worn for the full duration of an extensive period of possible exposure. It is unrealistic to assume that first responders and workers in home health will be able to tolerate the prolonged use of respirators implied by the stockpiling assumptions. Also, standard precautions and procedures should be sufficient for performance of autopsies since there are no data to suggest that performing autopsies on persons who die with influenza presents any special risk.

There is also an inconsistency in recommending isolated respiratory protection for influenza in healthcare and other workplaces. In the healthcare setting, the use of respiratory protection at the level of N95 respirator or higher usually requires concomitant engineering controls including an airborne isolation room (AIR) to protect other staff and patients. The application of airborne infection isolation consists of negative pressure relative to the rest of the facility and direct exhaust air to the outside and, if the air from the room has to be recirculated, passing the air through a high efficiency particulate air (HEPA) filter. If the pandemic influenza guidance implies use of respiratory protection for the potential for droplet nuclei as a means of transmission, then this would lead to the presumption that these droplet nuclei are suspended in the air and ventilation engineering controls would also be necessary. In the past, SHEA and the Infectious Diseases Society of America (IDSA) have questioned the basis for measures, such as respirators or airborne infection isolation for influenza infection control in the healthcare setting since they are poorly supported by the scientific evidence, and potentially counterproductive to patient care and to protecting healthcare workers using evidence-based measures. Since the evidence of a significant contribution of droplet nuclei in influenza transmission is weak, the implication of applying such a standard to a wider variety of work settings is of even more concern.

Recommendations for level of protection should be based on the risk and nature of the occupational exposure, not on societal need for the workforce maintenance. During an influenza pandemic, infectious people (symptomatic and pre-symptomatic) will be ubiquitous in the community, so promotion of a universal and realistic approach to respiratory hygiene and cough etiquette is vitally necessary to limit transmission in both occupational and non-occupational settings. Risk of non-occupational exposures may predominate over occupational risk of exposure in many work settings. Workers in many sectors that might be addressed in this guidance are unfamiliar with the use of respirators, have no experience with fit testing, and are not trained in the proper handling of facemasks and respirators that may become contaminated. Pandemic influenza plans should also include plans for the deployment of those who have recovered from

pandemic influenza. These individuals should be immune to re-infection for several years, reducing markedly the risk from further exposure. This should be made clear to employers and others.

There remains a critical need for research on prevention of transmission of influenza by the use of respiratory and barrier protection. Resources need to be brought to bear to accomplish this research agenda as soon as possible. Seasonal influenza offers the opportunity to pursue this research goal each year and this research would offer an inherent incentive of potentially reducing the impact of these predictable epidemics and their resulting morbidity and mortality. This research should be a major priority.

These proposed guidelines are a welcome refinement of earlier guidance and we recognize the difficulties of making recommendations in the absence of scientific evidence. However, we remain concerned about the impact recommendations have on how workers in many workplaces may be directed or not directed toward the most effective means of protecting themselves and their loved ones in the most realistic way. Respiratory hygiene, cough etiquette, and hand hygiene are key strategies to prevent transmission of pandemic influenza and these should be stressed in all recommendations for the workplace and the general community. Guidance that unduly stresses respiratory protection utilizing either disposable or non-disposable respirators over barrier (droplet) protection for pandemic influenza can lead to diminished reliance on the more evidence-based droplet precaution procedures to the overall detriment of programs to protect workers and the public. Also, preparedness and response capacity require the assurance of adequate supplies of personal protective equipment where they are of proven value. Excessive stockpiling and use of either respirators or facemasks can lead to shortages of this personal protective equipment and these medical devices for those circumstances for which they provide a critical function of protecting healthcare personnel and other critically necessary first responders.

SHEA appreciates the opportunity to offer these comments in response to the proposed Department of Labor guidance on the use of respiratory protection by the public during an influenza pandemic, and looks forward to continued collaboration with federal, state, and local governmental agencies on these important issues related to pandemic preparedness.

Sincerely,

A handwritten signature in black ink that reads "P.J. Brennan". The signature is written in a cursive, flowing style.

Patrick J. Brennan, MD
President of SHEA