



**American Hospital
Association**

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John Howard, MD
Director
National Institute for Occupational Safety and Health
Centers for Disease Control
Atlanta, Georgia

Dear Dr. Howard:

Hospitals take the responsibility of protecting its caregivers, their most precious resource, very seriously. All hospitals have multiple protocols and procedures in place to protect their caregivers from the hazards they face by virtue of their job.

Fit-tested N-95 respirators are one of many tools hospitals have available to protect their caregivers. In this H1N1 pandemic, hospitals are utilizing the full hierarchy of controls of an effective infection prevention and control program in healthcare settings, including engineering controls (e.g., patient placement, room air handling), administrative or work practice controls (e.g., respiratory hygiene/cough etiquette, hand hygiene, disease recognition protocols, disease surveillance, seasonal and pandemic influenza vaccination, antiviral treatment and prophylaxis, environmental cleaning, healthcare worker education), and personal protective equipment (PPE). Current CDC guidance, issued this past Spring before the severity or mechanism of transmission was fully understood, conservatively recommends the use of N-95 (or higher) respirators for routine patient care. However more recent data suggests that the virus has not changed to become more severe and studies suggest that it transmits much the same way as seasonal influenza. These facts along with supply concerns regarding N-95 respirators contribute to AHA's request that CDC reconsider its recommendations for healthcare facility infection control for H1N1 influenza.

The AHA is concerned about the conflicting recommendations regarding PPE. As you know, on July 23rd, the CDC's own expert advisory committee, the Healthcare Infection Control Practices Advisory Committee, taking into consideration more recent information on H1N1 influenza transmission, recommended that CDC update their guidance for infection control in healthcare facilities for H1N1 influenza to use standard and droplet precautions, including recommending the use of surgical/procedure masks for routine patient care of H1N1 suspect or confirmed patients and recommending the use of fit-tested N-95 respirators for selected "aerosol-generating" procedures. This recommendation was also supported by the President's Council of Advisors on Science and Technology. However, a special committee convened by the Institute of Medicine,

whose charge did not permit them to take into account logistical or economic considerations, recently recommended that healthcare workers (including those in non-hospital settings) who are in close contact with individuals with H1N1 influenza or influenza-like illnesses should use fit-tested N95 respirators or respirators.

The AHA believes that it is critical to strike an appropriate balance in considering recommendations for healthcare facility infection control. Given the limited supply of N-95 respirators (even if one considers the supply contained in the CDC's Strategic National Stockpile) and the uncertainty of the duration of a H1N1 outbreak, the AHA believes that the Federal government must take a responsible stance and carefully determine how to best use this limited resource. We know there are not enough N-95 respirators available to protect all hospital workers who may come in contact with an individual who has suspected or confirmed H1N1 influenza infection. If the IOM's recommendation of N-95s is finalized, hospitals will be forced to limit the number of staff who are available to care for patients at a time when the volume of patients is expected to rise precipitously.

It is important to take a reasonable stance as soon as possible in this round of the pandemic; otherwise the supply of N-95s will be rapidly exhausted. In addition, as we've seen in other situations of resource shortages, hospitals are already seeing an increase in "non-brand name" N-95 respirators of questionable quality being advertised.

Further, the IOM recommendation to use N-95 respirators would also apply to non-hospital settings, such as physician offices. Given that physician practices are unfamiliar with the use of fit-tested N-95 respirators and the difficulty they will face in obtaining adequate supplies, we are concerned that this would be another disincentive for physicians to treat patients with flu-like symptoms in their offices, resulting in a further surge of individuals being inappropriately sent to hospital emergency departments for care.

It is also important to note that the recommendation for N-95 respirators use in healthcare settings puts the CDC's recommendations at odds with recommendations for infection control in the community and at home, where both facemasks and respirators are recommended. It also is inconsistent with the SARs experience in which facemasks worn by healthcare professionals provided adequate protection to prevent and reduce the spread of the disease. Finally, it is inconsistent with the H1N1 experience in the Spring where caregivers wearing facemasks were not infected.

While the AHA will continue to advise our member hospitals to follow CDC's hospital infection control guidelines, we strongly recommend that HHS adopt a set of recommendations that takes into consideration the supply of N-95 respirators and the most recent epidemiologic data on how H1N1 infections transmit. We support the use of hierarchy of controls, that surgical or procedure masks should be used for most patient contact and that N-95 respirators be recommended primarily for aerosol-generating procedures.

We also continue to urge HHS to increase funding for research on influenza transmission and personal respiratory protection and for the development of a better respirator that is designed for use by healthcare workers, with consideration on the factors of protection, comfort and ability to communicate.

For additional information or discussion, please contact either Roslyne Schulman (telephone 202-626-4631 or email rschulman@aha.org) or James Bentley (telephone 202-626-4631 or email jbentley@aha.org).

Thank you.

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