

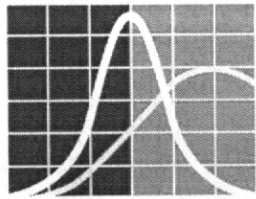
**Miller, Diane M. (CDC/NIOSH/EID)**

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**From:** Young, Melanie [myoung@shea-online.org]  
**Sent:** Friday, February 11, 2011 12:34 PM  
**To:** NIOSH Docket Office (CDC)  
**Cc:** Young, Melanie  
**Subject:** SHEA comments on Infectious Diseases and 42 U.S.C. 300ff-131  
**Attachments:** SHEA comments\_ERE-NIOSH ID notification rule\_FINAL (021111).pdf

Attached please find comments from the Society for Healthcare Epidemiology of America (SHEA) on Infectious Diseases and 42 U.S.C. 300ff-131. Thank you for your consideration.  
Melanie Young

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# SHEA

The Society for Healthcare  
Epidemiology of America

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February 11, 2011

NIOSH Docket Office

Robert A. Taft Laboratories

MS-C34, 4676 Columbia Parkway

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Re: Centers for Disease Control and Prevention [Docket Number  
NIOSH-219]

Implementation of Section 2695 (42 U.S. C. 300ff-131) of Public  
Law 111-87: *Infectious Diseases and Circumstances Relevant to  
Notification Requirements*

To Whom It May Concern:

The Society for Healthcare Epidemiology of America (SHEA)  
appreciates the opportunity to provide input to CDC regarding the  
proposed rule, *Infectious Diseases and Circumstances Relevant to  
Notification Requirements*.

SHEA was founded in 1980 and represents a growing and active  
membership of physicians and other healthcare professionals  
responsible for patient safety and quality improvement. The Society  
works to maintain the utmost quality of patient care and healthcare  
worker safety in all healthcare settings, applying epidemiologic  
principles and prevention strategies to a wide range of quality-of-  
care issues.

Our members are critical to efforts that protect emergency response  
employees (EREs) from potentially life threatening infectious  
diseases and are integral to the notification process requirements.

- **Definitions**

CDC clearly outlines the various methods of disease  
transmission that are utilized in determining the risk of exposure  
to EREs. SHEA agrees with these definitions and appreciates  
the thoroughness and clarity in which they are written.

This will permit our members to implement the revised requirements with accuracy and consistency in an effort to protect and notify EREs accordingly.

- **Part I. List of Potentially Life-threatening Infectious Diseases to Which Emergency Response Employees May be Exposed.**

SHEA appreciates the thorough and comprehensive list of diseases noted in each of the categories below and generally agrees with the list of diseases noted in each of the categories. This helps provide guidance for which workers are potentially exposed based on their patient interactions and route of transmission of the organism. For example, there may be situations where an ambulance driver may or may not have been exposed depending on the route of transmission and/or the driver's interaction with the patient.

- A. *Routinely Transmitted by Contact or Body Fluid Exposures*  
SHEA agrees with the disease entities as listed.
- B. *Routinely Transmitted Through Aerosolized Airborne Means*  
SHEA agrees with the disease entities as listed.
- C. *Routinely Transmitted Through Aerosolized Droplet Means –*  
**Addition recommended**

SHEA believes it is important to add pertussis (*Bordetella pertussis*) to this list. Clinical characteristics and complications in adults have been well described and can result in hospitalization in some cases. (1) Importantly, adults with pertussis pose an increased risk in the community if they have contact with young infants/children for whom morbidity and mortality from the disease are well documented. (2) For example, an ERE may be exposed and incubating the infection, resulting in potential exposures of young infants/children to a life-threatening disease during the ERE's work or at home.

Consideration of newly emerging infectious diseases to this existing list is essential and SHEA appreciates the document's incorporation of such language, permitting list amendments in the future as warranted.

- **Part II. Guidelines Describing the Circumstances in Which Such Employees May be Exposed to Such Diseases**

- A. *Exposure to Diseases Routinely Transmitted Through Contact or Body Fluid Exposures*  
SHEA has no additional comments.
- B. *Exposure to Diseases Routinely Transmitted Through Aerosolized Airborne or Aerosolized Droplet Means*  
SHEA has no additional comments.

- **Part III. Guidelines Describing the Manner in Which Medical Facilities Should Make Determinations for Purposes of Section 2695B(d) [42 U.S.C. 300ff-133(d)]**

SHEA is in agreement with the proposed criteria for making determinations of exposure or non-exposure in which the medical facility responds to appropriate requests by the employer, but *how* it is done is critical, since the determination of no, possible, or actual exposure requires additional information from the ERE's employer. Although the Act states that the request to the facility must contain a "statement of the facts collected" only the ERE's employer knows and is able to interpret the occupational protocols and activities that their EREs use on the field-- not the medical facility. Additionally, companies are required to comply with OSHA's bloodborne rule but may, and hopefully do, offer other key vaccinations important to EREs. The infection prevention and control program (IPCP) staff at the medical facility in response to the request, interface with the ERE's employer representative to provide information if the transported patient has or is suspected to have a disease warranting exposure workup and prophylaxis (gained from standard diagnostic or treatment of the patient). Such interaction can result in the best determination by the ERE's employer regarding the risk for exposure.

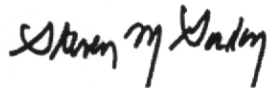
SHEA member organizations have comprehensive IPCPs that include basic components addressing the follow-up of infectious disease exposures among staff and contract workers, as well as responses to ERE requests with the required information as noted. These programs involve multiple personnel, including hospital epidemiologists (HE), physicians, infection preventionists (IPs), employee health staff and other clinicians.

In addition to the guidance provided in this document, HE/IPs currently utilize relevant guidelines and literature in their existing practice to assist in determining exposure events in the medical facility. But, as noted earlier, when presented with an ERE's employer's request, an exposure determination requires communication with the ERE's employer representative to ensure all the right information has been provided. As noted, only the employer knows the protective protocols used by the ERE in the field, as well as other preventive procedures they may require such as vaccinations. HE/IPs assist in gathering the transported patient's information if a suspected/known communicable illness has been determined and if that diagnosis has potential for exposure to the ERE. All pertinent information must be factored in during communication with the employer representative for the final exposure determination by the ERE's employer. The employer can then inform the ERE, providing for appropriate follow-up care.

The forms and documentation of the protocols and communication processes are necessarily organization-specific and include any additional state regulations if required. The documentation of processes has been incorporated as standard program requirements by healthcare organizations and as the final, updated CDC/NIOSH list becomes available, they will be revised and communicated as well.

We would like to commend CDC/NIOSH on the thorough review and update of this list which better responds to today's needs. As key participants in this important process to protect ERE, we are pleased to share our views and appreciate consideration of our suggestions for the final rule.

Sincerely



Steven M. Gordon, MD  
SHEA President

**References:**

1. CDC. *Preventing tetanus, diphtheria, and pertussis among adults: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine: recommendations of the advisory committee on immunization practices (acip) and the hospital infection control practices advisory committee (HICPAC)*. MMWR 2006; 55(RR17);1-33. See Tables 2 and 3
2. Cortese MM, Baughman AL, Ronping Z et al. *Pertussis hospitalizations among infants in the united states, 1993 to 2004*. Pediatrics. 2008; 121(3): 484-92.