We are writing as representatives of organizations which advocate for safe and accessible healthcare for vulnerable immunocompromised patients. The United States' current healthcare safety policies are untenable and are leading to preventable death and disability in immunocompromised populations.

Our healthcare system is faced with ongoing respiratory pathogens, including influenza, RSV and SARS-CoV-2. Influenza and RSV are seasonal. However, SARS-CoV-2 is not. The Centers for Disease Control and Prevention's (CDC) provisional SARS-CoV-2 death data has maintained a level of COVID-19 deaths above 450 per week. A rate which is currently rising.(1) Although cases are currently not tracked by the CDC, healthcare systems utilizing Epic medical record software have seen weekly cases rise from 17,360 in mid-June of 2023 to 58,283 in mid-August.(2)

Most, but not all, of these infections are mild in the general population. However, this is not the case in immunocompromised individuals. SARS-CoV-2 has broken through current vaccine protection against infection, so much so that in immunocompromised individuals the NIH recommends protection by vaccinating "all close contacts" for COVID-19.

> *"Vaccinating household members, close contacts, and health care providers who provide care to transplant and cellular immunotherapy candidates and recipients is important to protect these patients from infection. All close contacts are strongly encouraged to get vaccinated against COVID-19 as soon possible."(3)*

Thus, additional steps need to be implemented to assure the safety of immunocompromised individuals in the healthcare setting. Several commentators at the CDC's August 22, 2023 Healthcare Infection Control Practices Advisory Committee (HICPAC) meeting testified that patients were avoiding healthcare because of the lack of infection control.(4) One even stated "*The only COVID risks we are forced to take is when seeking out medical care*."

For the immunocompromised and patients with organ transplants, access to healthcare is key to their rehabilitation and treatment on unrelated diseases. The Americans with Disabilities Act (ADA) places a high value on safety for disabled individuals.(5) The lack of implementation of the needed mitigation strategies in healthcare facilities poses a *direct threat* to vulnerable patients.

1. Section 36.211 of the ADA requires maintenance of accessible features. One of these features is adequate and safe ventilation. There must be firm regulations enacted regarding HVAC system's air exchanges per hour based upon occupation, and for the use of HEPA filtration and UV-C germicidal lighting.

2. Section 39.301 states, "*A public accommodation may impose legitimate safety requirements that are necessary for safe operation*." Thus, mandatory masking and safe ventilation are within the purview of the ADA.

3. Section 36.208 of the ADA states a facility does not have to provide services to an individual "*when that individual poses a direct threat to the health and safety of others*." Individuals who frequent healthcare settings may carry respiratory pathogens and be asymptomatic carriers of SARS-CoV-2, as such they are "direct threats" to immunocompromised individuals. Therefore, mandatory universal masking with respirators should be implemented for all individuals who enter or work in any healthcare facility where immunocompromised individuals obtain needed care.

Examples of vulnerable patients who are considered disabled by Social Security include those who have received a heart (6) or kidney transplant(7) within one year of their surgery, and in patients undergoing peritoneal and hemodialysis.(8) The following guidance is given for patients with kidney transplant:

> *"If you receive a kidney transplant, we will consider you to be disabled under 6.04 for 1 year from the date of transplant. After that, we will evaluate your residual impairment(s) by considering your post-transplant function, any rejection episodes you have had, complications in other body systems, and any adverse effects related to ongoing treatment."*

Ironically, under the current reporting system, the abundant co-morbidities in the majority of transplantation and immunocompromised patients have along with the delayed and multi-system impact of SARS-CoV-2, may well prevent COVID-19 from being recorded as the cause of death. In addition, hospital acquired SARS-CoV-2 requires an onset 14 or more days after admission of a currently hospitalized patient (Dec. 15, 2022 definition).(9) As of June 11, 2023, reporting has changed to "optional".(10) There are no provisions for reporting of SARS-CoV-2 acquisitions in outpatient healthcare settings.

We would like request that the current process of revising CDC recommendations for infection control be mindful of the provisions of the ADA and the impact recommendations will have regarding vulnerable patients who are experiencing reduced access to healthcare because of unsafe healthcare environments.

Thank you for this consideration,

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