

APIC-GD Winter Board Report Feb 3 2006

1. HAI and public reporting—implications for Michigan,

Model legislation APIC, IDSA, SHEA developed model legislation on public reporting of healthcare-associated infections (HAI). This was released in a joint press release Jan 23rd. Judene Bartley has been a member of this coalition which also had input from CDC and provided Michigan's proposed legislation (a study bill). The final product is important & has 2 aims—

- 1) Proves a start for states that have no language at all;
- 2) Provides a message to Consumer's Union and the congressional committee that is investigating the status of HAI mandatory reporting (whether public or private) that the key stakeholders are working together on this issue.

HAI: MHA Patient Safety and Quality Compliance committee meetings. An extensive report on HAI and public policy implications was given by Judene in the December MHA committees. Dave Finkbeiner and Judene presented together and addressed related activities. These items review same information with updates:

- **National legislation and NHSN** Andrew Snowdon, General Counsel for the House Energy and Commerce subcommittee has been meeting with APIC, CDC and SHEA (among others) and has received detailed presentation on potential of NHSN (National Healthcare Safety Net) for collecting and reporting HAI using standard definitions. Snowdon has expressed the opinion that the state-by-state approach is problematic and is looking at potential federal legislation.
- **NHSN** CDC has approached Michigan on utilizing NHSN in next HAI Keystone initiative; National APIC is likely to partner with CDC to implement across all states (education/training on Web-based software via systems like Webex). MHA's Keystone Center has been asking/receiving input for forming a new advisory committee to plan this initiative. APIC-GD, MSIC, and MIDS have been contacted officially
- **National Quality Forum –NQF** is moving forward on formulating a steering committee and Technical Committees to develop/refine standard definitions; these are expected to include at least the current standardized definitions published by CDC for past 30 years. APIC, SHEA, CDC and other NQF members have submitted names for the steering and 4 Technical panels. Selection process is underway currently.
- **HAI-POA** Budget that will be taken up by Congress at the end of this month does have language that already calls for reduced payments for HAI infections in FY2008 (after CDC assists in identifying which HAIs have sufficient evidence to show ability to prevent) if the patient was “coded” as not having that specific HAI “present on admission”. This will be getting more attention in coming year as the HAI are selected.
- **CMS IC Interpretive Guidelines for acute care**
- The update/revision has resumed post Katrina hurricane crisis, and APIC and SHEA joint discussions resumed January 06. No deadline or definitive date is available for final version Judene has been working with CMS Office under auspices of APIC and SHEA to revise the current guidelines which appear to support total hospital surveillance. Much progress has been made to address this and modify interpretation of the “the log” regulation which has been the biggest source of contention regarding “house-wide surveillance.
- **SCIP publishes measure specifications and additional tools**
The Centers for Medicare and Medicaid Services (CMS) Surgical Care Improvement Project (SCIP) specifications (also called “measure information forms” or MIFs) for each SCIP measure are available on the SCIP Web site. SCIP is collecting information on 21

process or outcome measures in four major areas of surgical complication – infection, cardiac, venous thromboembolism and respiratory. Each MIF contains information relevant to each measure, such as the definition, rationale, included and excluded populations, and data elements. The specifications also describe references used to support the measure and the algorithm used to determine the numerator and denominator for each measure.

- SCIP measurement information forms or specifications,
<http://www.medqic.org/dcs/ContentServer?cid=1134322290027&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools>
- See HAI Appendix for Model legislation press release

2. TB Guidelines; Appropriations and impact on Michigan-MIOSHA

2005 TB guideline published 12/20/05 including support for QFT-Gold –TB blood test; 2005 Guideline for GFT - Gold published with other recommendations in a separate Guideline on 12/16/05.

- Fit testing – The CDC Guidelines call for use of N95 respirators with an initial and “periodic” (not annual) fit-testing based on specific criteria. Aside from the TB guideline, the use of N-95s is governed by OSHA’ Respiratory Protection standard.
- Prohibition on annual fit-testing in Michigan continues up to Sept 30, 2006. The prohibition on use of federal funds to enforce annual fit-testing continues into FY2006. OSHA has not yet announced this publicly but MIOSHA has updated their policy on their enforcement of the Resp Protection Standard as of Jan 15, 2006. We believe MIOSHA’s update in Jan 15 *MIOSHA News* which states they will extend the delay of annual fit-testing for TB is based on their receiving information shared with Dir of MIOSHA on Jan 6, shortly after President Bush signed HR3010 (HHS appropriations) into law. We speculate that MIOSHA does not reference the 2005 TB guidelines yet since they must be reviewed for any change to their current TB CPL which is administered under the General Duty Clause. (There is no specific OSHA TB standard)
- This delay only affects TB; however there is no other standard that address other airborne infectious agents. We believe from prior discussions with the Director that Michigan has no intention to pursue this issue if N95s are used for other purposes, but would be wise to word organization policies carefully.
- Concern remains for the current language in the CDC TB guideline for future congressional reference. A number of errata have been identified and hopefully there will be some clarifications/interpretations in future published interpretations
- **See Appendix TB for supporting information**

3. Alcohol Based hand rubs revisited – Foam and Gels treated the same ...

JCAHO made a new interpretation that caused consternation last month, applying specific distance rules (12” from center of dispenser) when installing both gels and foam products *AND* not permitting foam products to be installed in egress corridors. At this time revised language has been worked out with ASHE, APIC, JCAHO, NFPA and CMS re: JCAHO story in EC News referenced below. (See [ABHR Appendix](#))

VIP We cannot disseminate it in writing but JCAHO agreed they will NOT cite (nor will CMS—including Michigan) for *current* installations of foam in corridors or shorter distances of dispensers from electrical receptacles; they will not request foam dispensers be removed from

egress corridors—unless local ICC fire marshals insist... this new recommendation should apply only for NEW installations. CMS and NFPA are in agreement with JCAHO—they will not support placement of aerosolized foam in egress corridors in *new* installations until we have data demonstrating safety.

- ASHE –with APIC’s help—will identify companies who manufacture aerosol foams and gels- will request another modeling study from Gage Babcock/another TIA and try to settle the aerosolized foam issue for good....(or bad). APIC and other groups will need to support the clinical need for this access
- JCAHO *will* amend the January story in Feb—clarifying that it *will* change distances from electrical outlets from 12” to 6” (adjacencies only) – both in rooms and egress; but will not support placement of foams in corridors (*new* installations only)

Posting on APIC list serve

JCAHO Establishes Guidance on Alcohol Hand Rubs

In the January 2006 edition of *Environment of Care (EC) News*, the JCAHO provides their official stand on the use of alcohol-based hand rubs (ABHR). The *EC News* article is intended to provide clarification on JCAHO’s interpretation and enforcement of the amendment to the 2000 and 2003 editions of the Life Safety Code that specifically defines the requirements for safe use of ABHR in healthcare facilities. The *EC News* article explicitly discusses dispenser placement and permissible volume separately for gel ABHR and for foam ABHR. Since the article was released, questions have been raised by ASHE members on two key items within the article: the definition of adjacent and the prohibition of installing dispensers of foam ABHR in egress corridors. Because JCAHO’s stance has just been issued and may be further refined or modified based on the outcome of current industry efforts to perform fire modeling of foam products (similar to ASHE’s fire modeling study of gel products) it is unreasonable for JCAHO surveyors to expect immediate compliance with these expectations or to apply these expectations retrospectively. Therefore ASHE and APIC have worked together to offer the following plan of action:

- Hospitals should comply with these new expectations for new installations of dispensers only.
- If a hospital cannot meet these expectations for new installations because of space constraints, then they should perform a *product-specific risk assessment* to determine if manufacturer labeling indicates any product-specific hazards to be addressed in the usage or dispensing of the product. **ASHE believes that JCAHO’s concerns about foam products center on the use of an aerosol propellant (the liquefied or compressed gas that expels the contents from the aerosol container). If the foam product does not use a flammable propellant, the foam product may be dispensed in the same manner as gel products (i.e. no restriction from placement in egress corridors). (Modification 1/13)**
- This risk assessment, and usage according to manufacturer labeling, should be the basis for justifying any deviations from the JCAHO guidance for new installations and document the action taken.
- Hospitals should work with their local fire officials to determine compliance with local regulations.

Through observance and adherence to the requirements identified in the NFPA amendment, ABHR use can be effectively managed to allow ready access by healthcare workers and family members and minimize the potential risk of fire.

For more information on ABHR go to <http://www.ashe.org/ashe/codes/handrub/index.html>

- **See ABHR APPENDIX for *EC News* excerpt**

4. Michigan - Minimum Design Standards

Revisions continue: Michigan Dept of Community Health has completed initial draft and formal meetings to revise *Minimum Design Standards for Health Care Facilities in Michigan*. The review committee began in February 2005, included infection control representation (Betty Ann Esch (Midland) and Judene Bartley (AIA liaison) and concluded with its last formal meeting in January 2006. A final draft will be developed for MDS committee review and then will be posted for public comment on the Health Facilities Engineering Section Web site. MDCH will present “conceptual changes” at their MISHE meeting in March. After that a timeline be drawn up for putting through the legislative process. Following the final draft, we will attempt to develop a summary of proposed changes to share with the board and members so ICPs can provide individual comment on the proposed changes. At this point we are supportive of all changes made to date. ..including handwashing sinks and alcohol based hand rub use in hospitals and *nursing homes*...

5. CDC Guidelines and JCAHO standards

- CDC Isolation guidelines – These are not expected until late spring
- JCAHO has published proposed standard requiring the **offering** of Flu immunization each year. Comment period has been extended from Feb 9 to Feb 15. AHA has weighed in strongly already—has data that shows most hospitals already offer the vaccine free and this generally includes medical staff (JB: unpublished survey but this will be presented at the Flu summit in Atlanta this week.) Main issue of concern is ensuring such a standard is not prescriptive in *how* monitoring is done—how rates of success are measured---so that tracking forms does not take up resources better used for vaccination. Simple surveys could provide useful information without using up major labor resources
- See **JCAHO APPENDIX** for actual language
- Michigan may have a bill to offer flu vaccination to all inpatients >65 (MCare population) Not really different from current requirements but a tradeoff for good-will to a legislator important to MHA, APIC-GD and MSIC for other health policy support. T Lundstrom and J Bartley offered input and guidance in bill development as members of MHA PS committee.

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1. HAI APPENDIX—PRESS RELEASE

APIC, IDSA, SHEA DEVELOP MODEL LEGISLATION ON PUBLIC REPORTING OF HEALTHCARE-ASSOCIATED INFECTIONS

Washington, DC, January 23, 2006—Today, the Association for Professionals in Infection Control and Epidemiology (APIC), the Infectious Diseases Society of America (IDSA), and the Society for Healthcare Epidemiology of America (SHEA) released model legislation to assist patient safety initiatives by giving state legislatures a template to use when adopting legislation for the collection and reporting of healthcare-associated infection rates.

“Our organizations recognize the challenges to the states of public reporting,” said Michael L. Tapper, MD, chair of SHEA’s Public Policy and Governmental Affairs Committee. “Sound science and appropriate methodologies are integral to states’ successful institution of reporting requirements. SHEA, IDSA, and APIC have worked together to provide a comprehensive document based on these principles.”

"Currently, there is no uniform national standard for surveillance of healthcare-associated infections or standardized systems for collecting and reporting these infections when they occur," said APIC President Kathleen Meehan Arias, MS, MT, SM, CIC. "For the first time, states are armed with a tool to help craft legislation that will result in useful data by which facilities can benchmark their performance."

Healthcare-associated infections (HAIs) are a major public health problem in the United States, and are thought to be responsible for increasing mortality and morbidity, adding millions of dollars in healthcare expenditures by states and their taxpayers.

"It has been estimated that in the United States, HAIs account for 2 million infections and \$4.5 billion dollars in excess healthcare costs each year," added Arias.

The new model legislation was developed in response to a growing trend. At least six states (FL, IL, MO, NY, PA, and VA) now have laws mandating public reporting of infection rates, and one state (NV) mandates reporting infection rates to the state government. Similar proposals have been introduced in about 20 other states.

“States need a good model on which to base their systems,” said IDSA President Martin J. Blaser, MD. “It’s important that public reporting be done in a way that allows people to discern what the data actually mean, and—just as importantly—how the data can be used to prevent infections and improve patient care.”

The model legislation aims to ensure that state reporting systems adhere to recommended practices that have been shown to reduce the risk of HAIs, protect the confidentiality of medical records, and reflect the fact that some institutions treat more seriously ill patients. “People should be able to use this information to measure how well institutions perform. The model legislation makes certain that state reporting systems are based on reliable data,” said SHEA President Trish M. Perl, MD, MSc.

Although APIC is very pleased to have this document ready for the 2006 legislative year, the organization has not lost sight of the need to develop national standards.

"APIC continues to advance the national standards initiative that we've spearheaded in partnership with the National Quality Forum and we are excited to report the initiative will soon be launched," said APIC Executive Director Kathy L. Warye. "It is imperative to have a consistent approach to the collection and reporting of infection data. Without a national approach there will be more confusion than clarity."

2. TB APPENDIX

President Bush on Friday signed H.R. 3010, the appropriations bill for the Departments of Labor, Health and Human Services, Education and related agencies. H.R. 3010 contains a provision sponsored by Congressman Roger Wicker (R-MS), and input from APIC, prohibiting federal funds from being used to implement or enforce annual fit-testing for Fiscal Year 2006 (October 1, 2005-September 30, 2006).

Departments of Labor, Health and Human Services, Education and related agencies. H.R. 3010 contains a provision sponsored by Congressman Roger Wicker (R-MS Bill Language: *"Provided further, That none of the funds appropriated under this paragraph shall be obligated or expended to administer or enforce the provisions of 29 C.F.R. 1910.134(f)(2) (General Industry Respiratory Protection Standard) to the extent that such provisions require the annual fit testing (after the initial fit testing) of respirators for occupational exposure to tuberculosis."*

MIOSHA Extends Delay of Annual Fit Testing for Workplace Exposure to TB

During fiscal year 2005, MIOSHA delayed the requirement for annual fit testing of respirators for occupational exposure to tuberculosis (TB). **MIOSHA has extended the delay through fiscal year 2006, from October 1, 2005, to September 30, 2006.** This action follows the lead of federal OSHA, who received this direction from Congress.

During FY 2006, employers may not be cited for the requirement to do annual fit testing of respirators for occupational exposure to TB. No other provisions of MIOSHA Part 451, Respiratory Protection, are affected by this restriction.

MIOSHA will continue to cite the remainder of Part 451 as it relates to respirators, including the provisions for an initial fit testing, or whenever a different respirator facepiece is used, or when facial changes could affect the proper fit of the respirator.

In addition, the restriction affects only annual fit testing of respirators used for protection against TB. All requirements of the respiratory protection standard, including annual fit testing, will continue to be cited for respirator use against other hazards.

In addition to the requirements of the respiratory protection standard, employee exposures to TB are also addressed by **MIOSHA Instruction GISHD-COM-05-2, *Enforcement Policy and Procedures for Evaluating Occupational Exposure to Tuberculosis (TB)***. This instruction provides guidance on agency expectations for employers based on industry recognition that exposure to TB is a recognized hazard.

The instruction is on our website: www.michigan.gov/miosha. Left click on "Policies & Procedures," then click on "Search for Instructions," and type "tuberculosis" in the search box.

MIOSHA will continue its current enforcement policy of this instruction, through the General Duty Clause, when an employer has a confirmed or suspected case of TB and is not adequately addressing the hazard.

Occupational exposure to TB is a serious and recognized hazard, and feasible abatement methods exist. MIOSHA's instruction for TB exposure control methods is based on the CDC's 1994 "*Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities*."

Employers who have questions about TB enforcement and compliance issues may contact **MIOSHA TB Specialist, Gerry Dike, General Industry Safety and Health Division, at 248.888.8863.** ■

3. ABHR APPENDIX

Clarification on Alcohol-Based Hand Rubs (ABHR)

The Joint Commission's official stand on the use of alcohol-based hand rubs (ABHR) is described here. Use of ABHR is for topical bacteria only, not for gross soiling. Use of ABHR is not meant to replace hand cleansing.

ABHR Gel Product: Dispensers in Egress Corridors

The Joint Commission allows the installation of gel product dispensers in egress corridors, provided that the following conditions are met:

- The corridor width is 6 feet or greater, and dispensers are at least 4 feet apart.
- The dispensers are not installed over or directly adjacent to electrical outlets and switches. *Adjacent* is defined as being no closer than 12 inches from the center of the dispenser to either side.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted

surfaces are permitted only in sprinklered smoke compartments.

ABHR Gel Product: Permissible Volume

- Each smoke compartment may contain a maximum aggregate of 10 gallons of ABHR gel product in dispensers and a maximum of 5 gallons in storage.
- The maximum individual dispenser fluid capacity is 1.2 liters for dispensers in rooms, corridors, and areas open to corridors.
- The maximum individual dispenser fluid capacity is 2.0 liters for dispensers in suites of rooms.

ABHR Foam Product: Permissible Location

Note that the preceding criteria do *not* include ABHR foam product in the corridors, which is not to be dispensed in egress corridors. ABHR foam product may

be used inside patient rooms and suites, provided that the dispensers are installed safely, as per the following:

- The dispensers are not installed over or directly adjacent to electrical outlets and switches. *Adjacent* is defined as being no closer than 12 inches from the center of the dispenser to either side.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces are permitted only in sprinklered smoke compartments.

ABHR Foam Product: Permissible Volume

No studies have been conducted by the National Fire Protection Association (NFPA) or other related agencies to provide quantity guidance, so the Joint Commission would expect volumes to be the same as or less than those for ABHR gel product. ^{EC}

5. JCAHO APPENDIX

Standard IC X.X. The risk of influenza infection and transmission is reduced throughout the organization.

Rationale

Transmission of influenza from staff, students, volunteers, and licensed independent practitioners to patients, clients, or residents can create serious health care problems, especially among those who are at high risk for complications related to influenza. In addition, influenza among those in the workforce, especially during an epidemic, can compromise the ability of an organization to provide care for its patients, clients, or residents. Annual vaccination is an important method for preventing influenza and its severe complications. Only 34 -36 percent of staff and Licensed independent practitioners are immunized against influenza each year (unpublished National Health Interview Survey data, Centers for Disease Control and Prevention, 2003).

Elements of Performance

1. The organization identifies the kinds of patients, clients, or residents that are at high risk for influenza related complications.
2. The organization identifies staff, students, volunteers, and licensed independent practitioners who work with or near these patients, clients, or residents.
3. The organization establishes an influenza immunization program for these staff, students, volunteers, and licensed independent practitioners.

This program:

4. Provides access to influenza immunization at the worksite and at no cost, to these staff, students, volunteers, and licensed independent practitioners;
5. Educates these staff, students, volunteers, and licensed independent practitioners about the value of flu vaccination, non-vaccine related control, and the epidemiology, transmission, and diagnosis of influenza;
6. Maintains records of staff, students, volunteers, and licensed independent practitioners who have received vaccination;
7. Monitors influenza vaccination rates among staff, students, volunteers, and licensed independent practitioners who work with patients, clients, or residents that are at high risk for influenza and;
8. Implements enhancements to improve those rates.