

APIC –Greater Detroit March 2009 - Advocacy Update

FEDERAL

Health and Human Services Healthcare-Associated Infection Action plan – February 2009

The long awaited HHS HAI "Action Plan" was released January 5, 2009 with comments on the plan due Feb 6, 2009. The plan sets up metrics and target HAI reductions –and many noted it is critical that HAI measures –developed by the CDC-led prevention workgroup --is aligned with the CMS-led reimbursement-incentives group, since CMS HAI measures affect payment and public reporting. Major stakeholder organizations including APIC, the Society for Healthcare Epidemiology of America (SHEA), AHA and Premier sent in comments and are located on the organizations' Web sites. There is general agreement that this internal HHS plan provided good background information, but it didn't constitute an actual plan with specific deliverables and timelines. The responses were reviewed by CDC/HICPAC on Feb 13, 2009 with Donald Wright, MD, MPH Principal Deputy Assistant Secretary for Health, HHS present for the discussion. According to Dr. Wright, there is every expectation that there will be meetings starting this spring to provide for more input and broader plan development. Follow-up action will be reported next quarter. See the links below for more information.

- HHS site: <http://www.hhs.gov/ophs/initiatives/hai/infection.html>
- The entire online plan: <http://www.hhs.gov/ophs/initiatives/hai/index.html>

HHS - CMS All-Day Listening session December 18, 2008

In late 2008, CMS began the 2009 process of considering additional Hospital-Acquired Conditions (HACs) including HAIs--for both inpatient (IPPS) and outpatient (OPPS) reimbursement in 2009-2010. Tammy Lundstrom MD, JD, offered comment in Baltimore last December on behalf of SHEA as many more stakeholders listened or commented by phone. Many groups reinforced the theme that no more HACs should be developed until we know more of the unintended consequences of the current set (see prior reports), and requested CMS to move HAIs into a risk-adjusted set of quality measures as CMS moves into Value Based Purchasing (VBP). See the following for more information:

- http://www.cms.hhs.gov/HospitalAcqCond/01_Overview.asp#TopOfPage And:
- www.premierinc.com/quality-safety/tools-services/safety/topics/guidelines/cms-guidelines-4-infection.jsp

Economic Stimulus Package – Impact on Healthcare Infection Prevention

The American Recovery and Reinvestment Act passed the House and Senate on Feb 13, 2009. Key issues affecting infection preventionists are highlighted here:

Prevention and Wellness Fund

The conference agreement includes **\$1 billion for a Prevention and Wellness Fund** down from the \$3 billion proposed by the House. This total includes **\$50 million to be provided to States for carrying out activities to implement healthcare-associated infections (HAI) reduction strategies**. The Prevention and Wellness fund also includes \$650 million to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act, as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates.

Comparative Effectiveness Research

The bill provides \$1.1 billion in funding for comparative effectiveness research. Of these funds, \$400 million is for the NIH and \$300 million to the Agency for Health Care Research and Quality to

conduct or support comparative effectiveness research. \$400 million is directed to the Secretary of HHS to accelerate the development and dissemination of comparative effectiveness research. Also establishes a Federal Coordinating Council for Comparative Effectiveness Research, chaired by the Secretary, to ensure optimum coordination of comparative effectiveness and related health services research supported by relevant Federal departments and agencies. The Conference Report language says: "The conferees do not intend for the comparative effectiveness research funding... to be used to mandate coverage, reimbursement, or other policies for any public or private payer. The funding... shall be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition."

Immediate Funding to Strengthen the Health Information Technology Infrastructure

The Secretary shall invest in the necessary infrastructure to allow for and promote regional HIT information exchange as outlined in the National Coordinator's strategic plan. Funds will be used for HIT meeting current standards until new standards are adopted. Funds will be distributed through the National Coordinator, Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and Indian Health Service (IHS) to support technology architecture, development and adoption of certified EHRs for providers not otherwise eligible, training, infrastructure, and overall expansion and promotion of technology. \$300 million is authorized.

Omnibus FY 2009 Appropriations bill (House)

Nearly \$22 million in additional funds for the U.S. Department of Health and Human Services (HHS) is included in the Omnibus Fiscal Year 2009 Appropriations bill passed by the House last week to begin implementation of the national action plan to prevent HAIs. This total includes a \$7.5 million increase for the National Healthcare Safety Network (NHSN) at CDC, \$5 million for the Office of the Secretary and \$9.3 million for the Agency for Healthcare Research and Quality (AHRQ). As of this writing, the Senate has not yet considered this appropriations bill.

APIC and SHEA leaders initiated discussions with key staff at HHS to convey their perspectives regarding the most appropriate use of these HAI prevention and reduction funds. Priorities include an emphasis on evidence-based practices, investment in training and education programs for hospital-wide personnel and patients/families, broad context for use of funds rather than pathogen-specific targets or mandates, and investment in hospital infrastructure and qualified personal for infection prevention and control.

Sustainability Aligned with Infection Prevention – New GGHC Operations released

National APIC is moving to better educate chapters on the alignment of 'sustainability or green' with infection prevention. Judene Bartley, as APIC's lead on green through the Practice Guidance Committee with team member Russ Olmsted, functions as a liaison between APIC and several groups such as the Global Health and Safety Initiative (GHSI) and Practice Greenhealth (PGH). PGH incorporates the former Hospitals for a Healthy Environment (H2E). Work was done with PGH on behalf of APIC and the Association of Healthcare Environmental Services (ASHES) to incorporate changes in the Green Guide for Healthcare -Operations (GGHC-Ops). The changes were approved by APIC and ASHES. The final version of *GGHC-Ops* was released in January 2009. This is different from the GGHC-Construction which should soon be released as "LEED-Healthcare." It is noteworthy that in many places of the GGHC-Ops, decisions on disinfectant or antimicrobial soap use depend on an ICRA and decisions by the Infection Control Committee (or comparable committee).

- Go to: <http://www.gghc.org/>

CDC Releases-Final Disinfection and Sterilization Guidelines

The Centers for Disease Control and Prevention (CDC) released updated guidelines for cleaning, disinfecting and sterilizing medical devices and cleaning and disinfecting the environment. The last version published more than two decades ago in 1985.

- http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf

Bleach dilutions clarified with household measurement terms

The glossary in the CDC D/S guidelines provides bleach dilutions using household measurement terms and equivalent parts per million (ppm) that can be used to translate recommendations for use in the patient care setting for environmental decontamination after cleaning, e.g., for *Clostridium difficile*. The Premier Safety Institute has expanded the information to include the use of chlorine bleach as a sanitizing agent in dietary settings consistent with EPA U.S Govt regulations (21 CFR Part 178). See the links below for copies.

Bleach Solution	Dilution Exact	Chlorine (ppm)	Dilution approximate	Household (ppm) Approximate	Application
5.25% - 6.15%	Concentrate	52,500 - 61,500	Concentrate	52,500 - 61,500	*Patient Care
5.25% - 6.15%	1:10	5,250 - 6,150	1.5 cups / 1 gallon	~6000	*Patient Care
5.25% - 6.15%	1:100	525-615	0.25 cup / 1 gallon	~600	*Patient Care
5.25%	1:200	263	1 tablespoon / 1 gallon	<200	Dietary
5.25% - 6.15%	1:1000	53-62	1 teaspoon / 1 gallon	~50	Dietary

- <http://www.premierinc.com/quality-safety/tools-services/safety/topics/cdad/cleaning.jsp>
- <http://www.premierinc.com/quality-safety/tools-services/safety/safety-share/12-08-full-txt.jsp#story-05>

TJC Must Include CMS Standards to Apply for Deemed Status – Impact on IC Standards

As of January 1, 2009 CMS required TJC to incorporate CMS language into its standards, challenging accredited hospitals with an increased prescriptiveness of standards in order to maintain deemed status. TJC has provided a cross walk of the old standards with the new CMS adapted standards

- www.jointcommission.org/Library/WhatsNew/Hospital_deeming+application_January_+2009_Update.htm

The recent change is in preparation for TJC's submission of its application to CMS for continuation of its hospital deeming authority. These changes are in effect now, but compliance with any requirements that are *completely new* will be reviewed by surveyors *beginning January 1, 2009, but*

will not be scored until July 2009. The changes require a grasp of the CMS's interpretive guidelines of the actual CMS Conditions of Participation (CoP) standards. **Consider IC Standard IC.01.01.01**

- **Infection control standards:** For example, the prior Infection Control standard states that the organization "identifies the individual(s) responsible for the infection prevention and control program." The CMS standard language from Medicare's CoP adds much more specificity. The good news is that it will ensure the program is guided by experts in infection prevention. However, the CMS standard states that this individual is also responsible for "maintaining a log of incidents related to infections and communicable diseases." This prescriptive statement appears to take a step backward to a prescriptive requirement of "line listings" and "paper logs."

Fortunately for infection preventionists, recent updates of the CMS IC Interpretive Guidelines, does permit this "log" rule to be interpreted more broadly. In this case the log may be a paper log or in electronic format. The intent is that "regardless of the format, the information must at all times be safe/secure from unauthorized access, up-to-date, and accessible and readily retrievable by authorized personnel." Although CMS always required this, TJC put less emphasis on documentation of this type. ***Compliance with these CMS changes requires familiarity with the CMS standards and interpretive guidelines (IC IG)***

MICHIGAN

EPA and Hospital/ Medical/Infectious Waste Incinerators; Proposed Rule Michigan Impact

The EPA released a proposed rule in the Federal Register Vol. 73, No. 231 72962 on December 1, 2008. Judene Bartley provided an assessment of the proposed rule to MHA Quality Compliance and Patient Safety Committee, noting that at the present time Michigan does not have *any* MWI so the rule has little immediate impact on MI. Michigan hospitals use alternative technologies or sends its RMW out of state. However, there are challenges, since MWI do not include Pathological waste and both Pathological and Chemotherapy waste must be incinerated.

Since hospitals do not require permits to operate autoclaves, several hospitals have built waste autoclaves to manage some RMW. MDEQ has concerns about hospital autoclaves since they may release mercury and may not be in compliance with the Clean Air Act (CAA). MDEQ has learned that autoclaves require some additional technology (grinding/agitation, etc.) in addition to time/temp and pressure, to achieve effective destruction of RMW, and autoclaves will get a closer look in the future. Healthcare systems seeking leadership in "green" and social responsibility need to consider autoclave emissions and community perception if there is a risk that they are not meeting the CAA.

Michigan HAI Legislation

HAI reporting legislation had been introduced in Michigan in early December, 2008; **SB 1651** was introduced on December 2, 2008 by Senator Dennis Olshove (D-Warren) and referred to the Committee on Health Policy. The bill would have required each hospital to submit an annual report to the state health department summarizing the number of HAIs contracted by patients. Specific information to be reported would be determined by the department, but would include a breakdown of the number of HAIs within each unit or department within the hospital. The department would be required to post on its Web site a summary of all hospital reports. The department would also be required to promote public awareness about HAIs and steps being taken by hospitals to prevent them. This bill died in the last session.

However on January 22, 2009, as anticipated, a similar bill, **HB 4010** bill was introduced by Representative Lesia Liss (D-28) and referred to the Committee on Health Policy, of which Rep. Liss is a member. This bill also requires hospitals to report annually to the state health department summarizing the number of HAIs. The reports would be broken down by unit or department in the hospital. The details of implementation would be developed by health department rules. There are no requirements for posting or promoting public awareness. MHA, APIC-GD MSIPC and MDCH are all monitoring this closely for any further action in the House or Senate.

- <http://www.legislature.mi.gov/documents/2009-2010/billintroduced/House/pdf/2009-HIB-4010.pdf>

MHA and Transparency -Voluntary Reporting of ICU CA-BSI

On a related note, MHA's Quality Compliance and Patient Safety committee formed a subgroup to determine how to voluntarily report Michigan's CA-BSI data in an effort to show transparency to the consumer. At the same time this transparency is also important e to legislators. The committee included reps from many large and small medical centers. Tammy Lundstrom and Judene Bartley were QCPS representatives. The final data display is under development and will be submitted to the MHA Board in 1st quarter 2009. The data is organized by ICU type and uses NHSN pooled means for comparison. How detailed the information will be in actual display remains under discussion. Updates will be provided when available.

MIOSHA Latex Glove Task Force

APIC-GD and MSIPC continue to provide input into the MIOSHA Latex Task force that has been underway since 2004, charged by MIOSHA's Occupational Health and Safety Commission to examine the issue to see if rules needed revision or special programs devised to address the hazard in healthcare and the hospitality industry (hotels etc). APIC-GD, MSIPC and MHA continued to seek a "latex-safe" versus "latex-free" environment. At the February 20, 2009 meeting consensus could not be reached so the March meeting is cancelled. The recommendations for Latex-Free and the Latex-Safe gloves will be made to the Occupational Health Standards Commission on May 13th, 2009.

The single dissenting vote was from MHA, with whom we share common goals and views and we have collaborated with MHA's representative on the committee. Anthony Burton, MD, the Technical Advisor, Co-chair and an Occupational Medicine physician is not a voting member. He provided this summary in a recent communication following the vote, regarding his own findings and recommendations that agree with APIC-GD and MSIPC:

I did a limited review of the glove barrier issue for the committee, and my conclusion was that although latex (and nitrile) tend to perform better, I could not state that this issue was sufficiently persuasive to use as the basis for the argument for using latex safe gloves rather than latex free. This is because all gloves tend to fail (despite the variability among material types) and because I am not aware of a literature that indicates an increased rate of health care worker infection (i.e. harm) secondary to using gloves with less barrier protection than latex.

I believe the argument for latex safe (and one that I have made) is that this is the intervention that has been studied and documented to have greatly decreased the degree of the problem, whereas there are no published studies that establish the added benefit of the latex free intervention.

This step occurs before any legislative action would occur and we hope to be present at the commission's meeting, since it is open to the public.

Regulated Medical Waste Rules and Medical Waste Directory Revision

Action just occurred with the Medical Waste Regulatory Act (MWRA) in late February in the House, with two bills being referred to the Regulatory Reform Committee for a hearing held March 4, 2009. The two bills, HB4458 and HB 4459 were re-introductions of last year's bills, only HB4458 was even worse in terms of creating a new category of medical waste "trauma waste." Due to one work-day notice, none of our professional groups could attend and provide testimony, but letters were drafted in the name of APIC-GD's president, as well as MSIPC. MHA Advocacy Dept delivered them to the hearing room on our behalf. The letters restated our lack of support for HB4459, full support for HB4459—but state that since they were tie-barred we could not support the bills as presented.

The hearing ended with the issue being voted out of committee, and completely along party lines. (7 Democrats/4 Republican) We expect the issue to be vote to the floor as early as next week. Although a number of members did have question and concerns, and the sponsor Rep Miller tried for amendments, there was still a party vote. If the process goes as it did last year, the vote will again follow party lines and then be referred to the Senate. Senator George is still chair of Senate Public Policy; he had problems with this last year, so we will be following up with letters to him and the Senate committee again, when the time is right. Updates will be provided on this and the *Medical Waste Directory Revision* as they occur.

Submitted by Judene Bartley, Chair, APIC- GD Advocacy Committee, March 13, 2009