

# Hospital Infection Control & PREVENTION

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June 2012

Volume 39, No. 6

Pages 61-72

## CMS draws generally favorable reviews as it hones infection control survey

*IPs have 'more leverage, more pressure'*

By **Gary Evans**, Executive Editor

The Centers for Medicare & Medicaid Services (CMS) continues to develop an infection control survey slated for use in the nation's hospitals later this year, using expert feedback and "pre-testing" results from the field to create a 42-page tool that assesses a wide breadth of program issues.



**Ruth Carrico**

Now in a "pilot-testing" phase, the survey has the potential to be the most significant and far-reaching of a series of infection control initiatives undertaken by the CMS in the last few years as health care associated infections (HAIs) became a national issue. Created in partnership with the Centers for Disease Control and Prevention, the CMS survey has generally received favorable reviews for its design and attention to detail by infection preventionists contacted by *Hospital Infection Control & Prevention*. Indeed, some see it as a potential

game-changer for infection prevention, particularly if CMS strengthens its ties to conditions of participation and ultimately links survey results directly to reimbursements. That would get the attention of senior hospital administrators and possibly empower infection prevention programs.

"It brings the force — the 'seriousness' — of CMS behind it," says **Ruth Carrico**, PhD, RN, CIC, an associate professor at the School of Public Health and Information Sciences at the University of Louisville, KY. "Some people may say well it's only an infection prevention risk assessment. But we're saying, 'Seriously,

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**Insert:** Patti Grant's popular *IpNewbie* column



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this is important. It comes from CMS.' I think it will garner a lot of attention, and really I'm thrilled."

The CMS has created a survey tool for a broad assessment of infection prevention, using a "patient tracer" approach in some areas to focus on key issues and connections through the care process. The survey includes such areas as infection control program and resources, quality improvement programs, multidrug resistant organisms, antibiotic stewardship, employee health, hand hygiene, needle use, environmental services, cleaning and reprocessing equipment, and infection prevention in the surgical suite. Concerning the latter, two surgeons expressed doubt that a regulatory inspection approach will do much to address the complex issues that give rise to surgical site infections. (See box, p. 63; related story, page 66.)

Some have also questioned the inclusion of areas like antibiotic stewardship, which cannot be cited under current CMS regulations. For the most part, however, the pilot survey instructs inspectors to cite various sections of the CMS conditions for participation in infection control if deficiencies are discovered.

"We are still trying to emphasize the basics. We are having surveyors spend more time at the bedside," says **Daniel Schwartz**, MD, MBA, chief medical officer of the CMS Survey and Certification Group in Baltimore, MD. "But

there are some things that we want to emphasize that we know are not in the regulations — that we are not able to cite."

Indeed, as we recently reported, some infectious disease groups have even asked the CMS to begin regulating antibiotic stewardship to help reduce multidrug resistant organisms. While clarifying that the survey is not a "pay for performance" initiative — a move many see as inevitable — Schwartz also stressed that it is designed to be more than an educational tool.

"This is what the surveyors will eventually use as part of their survey process," he tells *HIC*. "As we are developing this tool we are also very cognizant that hospitals will want to take a look at this. We think it will be a good self-assessment for hospitals, and to that extent it is very educational. But after we finish the pilot phase and we put this out in its final form then we are going to be expecting CMS surveyors to use this tool to assess infection control compliance."

The latest version provided to *HIC* by CMS did not include the open-ended questions to IPs included in an earlier draft. That "instructions" portion was used in recent training of CMS inspectors, but was not included in the pilot survey going forward.

"We restructured it and put it together in a way that is perhaps easier for surveyors to use," Schwartz says.

**Hospital Infection Control & Prevention**<sup>®</sup>, including **Infection Control Consultant**<sup>™</sup> and **Healthcare Infection Prevention**<sup>™</sup> (ISSN 0098-180X), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to **Hospital Infection Control & Prevention**<sup>®</sup>, P.O. Box 105109, Atlanta, GA 30348.

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This activity is effective for 36 months from the date of publication.

Target audience: Infection control practitioners and infectious disease physicians.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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**Subscription rates:** U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$78 each. (GST registration number R128870672.)

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The tool may continue to be refined as warranted based on the pilot testing, with the final product targeted to debut in all 50 states in October 2012. The CMS has developed similar surveys on discharge planning and quality assessment/performance improvement (QAPI). States are being asked to pilot at least one of the surveys in some of their hospitals in the coming months, he says. The CMS is expected to post all of the surveys on their websites in the near future, he adds.

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### ***Tie to CMS funding coming?***

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The CMS is expected to eventually tie the survey process more directly to reimburse-ment and financial incentives, experts tell *HIC*.

"I think it is going to have to be," says Carrico. An IP for some 20 years before a move into academia, she recently won the prestigious Carole DeMille Achievement Award from the Association for Professionals in Infection Control and Epidemiology. Increasing CMS regulation is likely because HAIs have such a devastating impact on individual patients and the health care system as a whole, she says. Moreover, as the scope of the CMS document makes it abundantly clear, it takes an organization-wide effort to prevent HAIs.

"For example, I don't think you can really

have a good medication administration program without having a good infection prevention and control program," she says. "Issues like safe injection practices, medication preparation are tied together. It really shows that infection control is a program — not just an initiative or a department. It has to really be embraced organization wide."

In that sense, the CMS survey reflects and quantifies to some extent the increasingly broad job description of the IP.

"You can't possibly 'own' infection prevention and perform all of these activities," she says. "Our job is to find the best people, the right people to do all of these different components. It really helps take our job to a very different level, a place where we know our [career future] lies."

That said, having detailed requirements for antibiotic stewardship — citable or not — in an infection control document, is a little disconcerting to some. The perception is that medicine and pharmacy would have to be directly involved in this aspect of a CMS



**Connie Steed**

## **What hospital areas are CMS surveyors targeting?**

*About all of them it appears*

A draft Centers for Medicare and Medicaid Services infection control survey slated for use in unannounced inspections of hospitals later this year includes the following major sections:

- Section 1.A. Infection control/prevention program and resources
- Section 1.B. Hospital QUAPI systems related to infection prevention and control
- Section 1.C. Systems to prevent transmission of MDROs and promote antibiotic stewardship, surveillance
- Section 1.D. Personal education system/infection control training
- Section 2.A. Hand hygiene
- Section 2.B. Injection practices and sharps safety (medications, saline, other infusates)
- Section 2.C. Personal protective equipment/Standard precautions
- Section 2.D. Environmental services

- Section 3.A. Reprocessing of semi-critical equipment
- Section 3.B. Reprocessing of critical equipment, sterilization of reusable instruments and devices
- Section 3.C. Single-use devices (SUDs)
- Section 4.A. Urinary catheter tracer
- Section 4.B. Central venous catheter tracer
- Section 4.C. Ventilator/respiratory therapy tracer
- Section 4.D. Spinal injection procedures
- Section 4.E. Point of care devices (e.g., blood glucose meter, INR monitor)
- Section 4.F. Isolation: Contact precautions
- Section 4.G. Isolation: Droplet precautions
- Section 4.H. Isolation: Airborne precautions
- Section 4.I. Surgical procedure tracer
- Section 5.A. Protective environment (e.g., bone marrow patients)

inspection, but it's an unsettling section of an otherwise strong CMS effort, says **Patti Grant**, RN, BSN, MS, CIC an infection preventionist in Addison, TX.

"Where it is assigned is where the responsibility lies," Grant says. "I'm just saying that before this is finalized this section should really be strongly considered for movement to another area — to a discipline that actually has control over antibiotic use through prescriptions."

While noting that the list of requirements may be "a little overwhelming" for IPs, **Connie Steed** RN, BSN, CIC, stresses the importance of taking a collaborative approach from the onset.

"The IP should not be doing this alone," says Steed, manager of infection control at the Greenville (SC) Hospital System. "It should be collaborative in nature. It is not just IPs that are responsible for these programs. It's a pretty extensive survey, as I look at, but a good program has all of this. It shouldn't be that they have to go out and create a bunch of new stuff. If they do — then they need to. Because everything that CMS has here are key components of a program."

Having alerted administration about the CMS initiative, Steed is preparing to break down the requirements and begin meeting with key staff as the CMS moves toward a final version of the survey.

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### ***Use survey tool for risk assessment***

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As a starting point, the CMS survey can be used as part of annual risks assessments already done as a Joint Commission requirement, several IPs noted.

"The key is to look at this with the same type of multidisciplinary approach that you use when you perform a risk assessment," Carrico says. "Who are the right people who need to be involved in all of these different areas? You've got to get together on the same page. We are not talking about having the 'illusion' of compliance. We need to have hard compliance with these requirements."

A member of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), Carrico says the panel has been briefed and is advising on the project but the CMS has clear ownership.

"This is a CMS document," she says. "I hope that one of the results is that it really gets the attention of those who are responsible for

resource allocation."

That has not always been the case with other CMS programs targeted at infection control. A recent analysis of CMS policies linked to reimbursement cuts for certain HAIs in 2008 found that only 15% of IPs reported increased funding for infection control as a result of the CMS policy.<sup>1</sup> A few IPs actually had budgets cut, though the majority (77%) reported stable funding levels. Respondents reported faster removal of urinary (71%) and central venous (50%) catheters as a result of the CMS policy, but the study also found some questionable testing policies on admission and "resource shifting" away from HAIs not targeted by the CMS policies.



"The positive impact has been on hospital leadership and awareness of the importance of infection prevention, which I think really helped a lot of the IPs in terms of how the 'C-suite' feels about the importance of their mission," says

**Grace Lee**, MD, MPH, lead author of the study and associate medical director of infection control at Children's Hospital in Boston. "That was extremely helpful. It also really enhanced efforts in surveillance education and prevention on the HAIs targeted by CMS policies. They did report improvements as a consequence of a policy such as removing urinary catheters as soon as possible in order to minimize the risk for CAUTIs."

Though it's something of a work in progress, the CMS is aligning its regulations with quality improvement strategies and infection prevention recommendations like those issued by the CDC.

"I think that is the goal. CMS wants to align quality with financial reimbursement," Lee says. "They are making steps in that direction, but I don't know when that will officially be triggered."

Other observers concur. "That is the way I read the writing on the wall," says **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University School of Medicine in Nashville. "This [CMS



William Schaffner

survey] is impressive for both its breadth and depth — the precision with which it raises and addresses the details of infection control. I think it can only enhance the role of infection control in an institution, but that will take various forms. They will have more leverage, but it will

put more pressure on infection control. And as we know, it doesn't necessarily mean that infection control will get more resources."

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### ***Whither the Joint Commission?***

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There has been some question about whether the Joint Commission, which accredits organizations under its "deemed status" from the CMS, will adopt all or part of the survey tool for its own inspections.

"This is much more detailed than any Joint Commission survey or any state survey that we have undergone at Vanderbilt," Schaffner says. "This will be a more trenchant review, and I would imagine that if Joint Commission and individual states take this on there is going to be an awful lot of training of surveyors. It will take more time for the Joint Commission surveyors to do the infection control part than in the past."

In response to a request for comment from *HIC*, the Joint Commission released the following statement via email: "The Joint Commission is aware of this important infection control activity by the CMS and has been working with them to refine the infection prevention tool as well as the other surveyor tools that they are developing. While CMS is still in the process of developing these new tools, The Joint Commission believes that its current requirements align closely with each of the tools and their specific areas of focus."

The CMS was under considerable pressure to act on HAI prevention after several key developments in recent years. For example, all of the agencies in the Department of Health and Human Services (HHS) were called on the carpet after a scathing 2008 federal report cited a lack of HHS leadership and coordination to reduce "needless suffering and death" caused

by HAIs.<sup>2</sup>

That same year a hepatitis C virus outbreak at a Las Vegas endoscopy clinic resulted in a massive follow-up and testing effort for tens of thousands of patients. As we reported at the time, CMS inspectors had actually been to the clinic in question, but apparently were not adequately trained in assessing needle safety practices. (See *HIC*, Dec. 2008, cover.) As a result, the CDC worked with the CMS to develop an infection control survey tool for ambulatory care, forming a partnership that eventually led to the development of the current hospital survey. The collaboration with CDC is likely to continue in other areas, as the CMS puts its regulatory power behind the CDC's voluntary guidelines.

"The tools would have to be tweaked for the various services that are provided and the specific locations, but I think that is certainly a major possibility," says **Carolyn Gould**, MD, a medical epidemiologist in the CDC Division of Healthcare Quality Promotion. Gould has been a key liaison with the CMS in creating the infection control survey.

The tool is still subject to revision, she says, noting that she has heard some of the quibbles and questions about both what is in the survey — and what is not. For example, though generally praising the scope of the effort, Schaffner questioned why there is no mention of the Tdap, MMR and varicella vaccines in the employee health section. Though the survey is presumably not designed to be all inclusive, "if you don't put it on the exam, students won't study for it," he observed.

It may come down to a question of regulatory authority, but Gould says "we may add additional elements to reflect more vaccinations. Whether those are going to be citable or not is up to CMS. But I think as HICPAC continues to review this and we get feedback from the states we are probably going to be adjusting it and that may be one of the things we add."

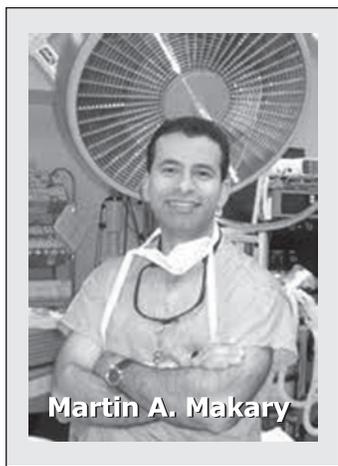
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# Surgeons: CMS survey won't lower SSI rates

*More minimally invasive procedures needed*

Memo to the Centers from Medicare & Medicaid Services (CMS) from two leading surgeons on the literal cutting edge of infection prevention in the OR: Hospitals and federal regulators should encourage the use of newer and safer types of surgery and more transparency with patients on procedure options and possible outcomes. That would do more to reduce surgical site infection (SSI) rates than inspections by CMS and other government regulators.



Martin A. Makary

"My prediction is that most hospitals will be found compliant with these measures that CMS is going to check, yet wide variations in surgical site infections will continue," says **Martin A.**

**Makary**, MD, MPH, an associate professor of surgery and health policy at the Johns Hopkins

Hospital in Baltimore, MD. "Unfortunately, these metrics, while important, don't capture the variation and complexity in care, and they don't capture the variation in surgical practice."

While conceding that much of its effort is to emphasize "the basics," the CMS has developed a draft hospital survey that includes a surgical procedure tracer to monitor infection control elements in the OR. The CMS survey, which is currently in a pilot testing phase, advises inspectors to assess essential infection control measures in the surgical area, including:

- Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using either an antimicrobial surgical scrub or an FDA-approved alcohol-based antiseptic surgical hand rub;
- Surgical masks are worn (and properly tied, fully covering mouth and nose) by all personnel in restricted areas where open sterile supplies or scrubbed persons are located;
- Traffic in and out of OR is kept to minimum and limited to essential staff;
- Cleaners and EPA-registered disinfectants,

when in use, are labeled, diluted according to manufacturer's instructions, and are dated;

- Anesthesia equipment is cleaned and disinfected between patients; and
- All surfaces, including but not limited to floor, walls, and ceilings have cleanable surfaces, are visibly clean, and there is evidence that all surfaces are cleaned regularly in accordance with hospital policies and procedures.

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## ***Too rudimentary to have impact?***

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The proposed guidelines outline strategies that have been around for at least the last 10 years, says **Ramon Berguer**, MD, general surgeon at Contra Costa Regional Medical Center in Martinez, CA.

"I can't say I was impressed at how far-reaching the CMS guidelines were," he says after reviewing the survey for *Hospital Infection Control & Prevention*. "I was not impressed they were pushing the envelope at all."

Makary concurs, saying, "It doesn't push to any new ground like antibiotic sutures, skin closure devices, minimally-invasive surgery. It's pretty much run-of-the-mill, and it won't make any difference in infection rates."

Another omission in the CMS surveyor guidelines involves scalpel safety and sharps handling, though that may be beyond the agency's regulatory reach.

"Sharps safety items have been considered to be out of the scope of Medicare," Makary notes.

The Occupational Safety and Health Administration generally takes responsibility for that area. While a rare risk to patients, sharps injuries exposed OR personnel to the risk of infection by HIV, viral hepatitis B and C, and bacterial infections in as many as 15% of operations, according to a 2007 report by the American College of Surgeons.<sup>1</sup>

Hospital ORs have considerable room for improvement in how they handle sharps safety, particularly with regard to newer recommended practices, such as double gloving, blunt tip suture needles, and the hands-free technique, Berguer says.

While the CMS surgical procedure tracer standards are silent on sharps safety, they pay considerable attention to documentation compliance, Berguer says. Any hospital with an infectious diseases nurse and that complies with existing IC standards will have no difficulty passing the CMS inspection, he says.

One change CMS could encourage that would

result in much better outcomes involves requiring transparency and improved methods of informed consent, suggests Makary, author of a book in press for publication, "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care."

Patients who are considering surgery need to be fully informed and educated about the most realistic benefits and risks they face and learn about all available options — including not having surgery at all, he says.

"In my career and training, I've seen unnecessary operations that result in infections," Makary says. "Those preventable harms or infections are not at the level of hand washing or sterile technique; they're at the level of choice to do the procedure and informed consent that overstates benefits and understates risks."

When health authorities quote infection and mortality rate statistics they often use data that comes from some of the largest health centers, and these rates could be significantly lower than what patients might find at their own local hospital.

For instance, pancreas surgery may be listed as having a 1% mortality rate, while in the real world the mortality rate is in the 7% to 9% range, Makary says. Other infection rates may be similarly downplayed, he adds.

"We are doing a research study now and are finding providers at a hospital are not aware of their hospitals' infection or complication rates, so how can they be providing patients with accurate information?" he says. "This is the basis for a new movement — a shared decision-making movement."

Shared decision-making would be possible only with transparency and publicly-available data, such as having hospitals publish their local complication and infection rates online, he adds.

"What's going to work better?" Makary says. "A regulation where you send in government inspectors to check the things most people are doing, or empowering consumers to go to hospitals where there is good information on their performance?"

Few hospitals will lead this effort without some government requirement or incentive, he adds.

"Right now, the only things reported publicly are what Medicare is requiring, and that includes very few outcomes," he says. "In fact, surgical site infections are one of the only outcomes that Medicare requires in public report-

ing, and that will start this summer."

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### ***Maximize minimal invasive surgery***

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Another change that Medicare has not promoted but which would make a huge difference in surgical infection rates is the move to minimally invasive surgery (MIS) whenever possible and clinically indicated, he adds.

"There's a vast underutilization of minimally invasive surgery in the United States," Makary says. "MIS is associated with infection rates of approximately 1%, which is remarkable."

The overall surgical site infection rate in the United States is 1.9%, according to Centers for Disease Prevention and Control data from 2006-2008. However, this rate can range as high as 10% to 40% depending on the hospital and type of procedure, Makary says.

MIS incisions are small, allowing little space for infections to set in. A number of studies have shown great results from the use of MIS, yet it's underused because of culture, finances, lack of peer review, and understating options to patients, he says. MIS also results in decreased pain and shorter hospitalization rates, but patients are instead told they should have the traditional surgical procedure because that's what many surgeons prefer, Makary says.

Health systems could improve their own surgical site infection rates by changing the culture to encourage MIS and by making several other changes, such as making it easier for doctors and staff to do the right thing, Berguer says.

"Often you go into a hospital and they can't get the surgeon to wear eye protection," he says. "This is because the eye protection equipment is in a closet down the hall."

The solution is to make it easier for doctors to pick up the gear by simply putting the equipment where they can more easily reach it.

Another strategy would be to place video cameras next to the sinks so doctors are observed while washing their hands. This has been shown to improve compliance and lengthen the time spent washing hands, Makary suggests.

One institution that installed cameras noticed dramatic improvements in hand washing rates, like a speed-trap camera at an intersection, he adds.

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# Will CMS survey enforce OSHA regs?

## *Linking worker safety, patient safety*

As the lines blur between patient safety and worker safety, employee health professionals — including those “two-hat” infection preventionists with dual responsibilities — can expect much more scrutiny from regulators who traditionally focused on patient care.

A new, draft survey tool from the Center for Medicare & Medicaid Services (CMS) sounds a bit like an inspection checklist from the U.S. Occupational Safety and Health Administration. Is your bloodborne pathogen program up to date? Are you fit-testing at-risk employees every year? Did you document offering the hepatitis B vaccine?

Those are just a few worker-related questions on the new survey tool, which is in its final stages of pilot-testing. The final tool is expected in October.

“The government’s catching on that there’s a connection between employee safety and patient safety,” says **Bill Buchta**, MD, MPH, medical director of the Occupational Health Service at the Mayo Clinic in Rochester, MN. “But it just seems odd that you have Medicare and Medicaid, where the primary goal is patient safety and getting the best value for your dollar, [asking about] providing hepatitis B vaccine.”

In most cases, CMS isn’t actually proposing to cite hospitals for worker safety issues. The survey tool contains items that are subject to citation (such as using single-dose vials with more than one patient) and those that aren’t subject to citation (such as failure to empty sharps containers). But the tool is also intended for self-assessment by hospitals, says **Daniel Schwartz**, MD, MBA, chief medical officer of the CMS Survey and Certification Group in Baltimore, MD. “We felt it was important to include those questions that weren’t in the standards but that we felt were very important for basic infection control and to prevent the transmission of infections in hospitals,” he says.

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### ***OSHA worked with CMS***

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The greater CMS focus on worker safety is no accident. OSHA has been working with CMS to build awareness around the safety culture and

work environment, says **Dionne Williams**, MPH, senior industrial hygienist and a specialist in bloodborne pathogen exposure.

“We’re happy to know they’re incorporating worker safety in their survey,” she says. “Those are the collaborations we’re doing behind the scenes to get others involved in fighting the fight for worker safety. “It’s an effort to get people thinking that patient safety and worker safety shouldn’t be separate. “It needs to be considered all a part of how you’re going to improve infection control in the health care setting.”

CMS has authority and precedence for expecting hospitals to protect both patients and personnel from infectious diseases. The Conditions of Practice (CoPs) include the stipulation: “The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.”

CMS also expects hospitals to follow universally accepted guidelines, notes **Karen Hoffmann**, RN, MS, CIC, FSHEA, infection preventionist with the CMS Survey and Certification Group. “[The provisions of the Bloodborne Pathogen Standard] have been in place since 1991, so that’s not beyond minimal standards,” she says.

The survey tool includes a catchall requirement for the hospital to demonstrate “general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.” As with other CoPs, failing to do so can result in a citation, the need for a plan of correction — and potential impact on reimbursement.

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### ***EH boost from survey items***

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Whether CMS cites or not on certain items, the inclusion of worker safety on a survey tool could have a significant impact on employee health. Among other infection control items, the tool asks if hospitals:

- provide job-specific training in infection control, including bloodborne pathogen training for those employees with the potential for exposure.
- address sharps injuries and follow up on bloodborne pathogen exposures and TB conversions.
- replace sharps containers when the fill line is reached.
- have a respiratory protection program and annual fit-testing for appropriate personnel.
- have non-punitive work exclusion programs when employees are ill.
- provide hepatitis B vaccine to those with the

potential for exposure, offer influenza vaccine and screen appropriate personnel for TB.

At Tampa (FL) General Hospital, **JoAnn Shea**, MSN, ARNP, director of employee health and wellness, plans to go over each employee-related item with a task force. "We're going to address each of those elements and how we comply," she says.

She anticipates putting the appropriate policies and other information in an easily accessible binder. For example, nurses in the employee health clinic must clear employees for work if they've been absent for three days or more due to illness.

At the Marshfield (WI) Clinic, **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety, asks managers to conduct monthly safety checks or their departments. They observe employees to make sure they're performing hand hygiene, and they peer into sharps containers to make sure safety features have been activated.

Bottom line: Hospitals should already be complying with the items on the CMS infection control assessment, he says. "If you're doing what you should be doing as a health care facility, you've got most of these programs in place," he says.

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### ***Be aware of CMS, OSHA differences***

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It is also interesting to note some things that are missing in the CMS survey tool. An earlier version specifically suggested talking to an employee health professional. The current version instructs the surveyor to talk to "the most appropriate staff person(s) for the items of interest."

That change came as the tool was shortened and streamlined, and wasn't intended to de-emphasize anyone's involvement, says Hoffmann.

The CMS tool does not completely mirror OSHA's Bloodborne Pathogen Standard, notes **Pamela Dembski Hart**, CHSP, BS, MT (ASCP), principal with Healthcare Accreditation Resources in Boston. For example, it states, "The hospital infection control system trains healthcare personnel that are in contact with bloodborne pathogens on the bloodborne pathogen standards upon hire and when problems are identified."

OSHA requires bloodborne pathogen training upon hire and at least annually, and "when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure."

The assessment tool will be helpful, but won't ensure compliance with OSHA regulations, she notes. "There's definitely overlap with OSHA [in the CMS survey tool]," says Hart. "I think that's

great as long as the hospital understands that CMS's goal is not to address OSHA standards in their entirety."

Interestingly, the CMS tool mentions influenza immunization and hepatitis B vaccination, but not MMR, Tdap (pertussis) and varicella. This year, there has been a pertussis outbreak in Washington state and a measles outbreak in Indiana.

CMS may still be revising the tool, notes Schwartz. "We've invited comments from a wide range of organizations. We'll take into consideration any feedback we get," he says.

Beyond the details of the tool, the inclusion of worker safety raises the profile of employee health. And that has been welcomed by employee health professionals.

"CMS has the potential for making change in hospitals," says Cunha.

The Joint Commission accrediting body is likely to follow the CMS lead and focus on the same areas, says Shea. And that means employee health will become a greater priority for hospital administration, she says.

"I don't think we always get acknowledged for what we do to protect the hospital from infections," she says. "Employee health works behind the scenes to make sure our health care workers practice safely, don't have infectious diseases and are treated for exposures." ■

## **Hard lessons learned: VA develops 'look-back' model**

### *Patient notification a complex issue*

The Veterans Health Administration has developed best practices in handling large-scale epidemiologic look-back investigations, including finding a way to explain a potential exposure of bloodborne viruses to a large number of people who likely were not impacted by the incident.

The VA developed the processes after a 2009 discovery of incidents in which improper endoscope reprocessing procedures occurred at four VHA facilities over a six-year period, impacting more than 10,000 patients.<sup>1</sup>

"We had to do look-back investigations in a short period of time," says **Gina Oda**, MS, CIC, associate director of the office of public health surveillance and research at the VA Palo Alto (CA) Healthcare System. "We learned the hard way

because we didn't have all the processes and procedures in place. So we learned the right and wrong ways of doing these kinds of large-scale look-back programs, then we developed a manual and key things to make it go smoothly."

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### *Five key steps*

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Here are the five main steps the VA developed for a look-back investigation:

#### **1. Identify and notify affected patients.**

"The VA now has a large-scale process involving many offices in which we determine in the beginning whether this event involves exposure to patients and places them at risk," Oda says. "Look-back means we go back and look at their medical histories and perhaps bring them back in for additional lab testing to see if they developed some sort of infection from exposure."

The VA determines which pool of patients is involved and then carefully decides how to make the notification to the potentially impacted individuals.

"You have to be very careful because you don't want to notify someone who wasn't involved and scare the person," Oda says. "You have to weigh the risks with benefits and make sure there is enough of a risk that it is worth going back and testing that patient to find out if they are infected."

The VA determined that calling patients on the telephone, while ideal, is not practical in all cases.

"Patients appreciate a personal call, but that can take a long time, so it depends on how serious the problem is," Oda explains. "We don't send out emails; we send out certified letters or make telephone calls."

It's also a good idea to keep track of the people who were contacted, how they were contacted, and whether they came in for testing.

#### **2. Provide services to patients responding to notification.**

It's important to standardize the response.

The VA set up call centers and trained people to answer veterans' phone calls to inform them further of the exposure event, Oda says.

The call center staff needs to know the basics of what happened and what the health system is doing. It's important the people answering calls can provide reassurance and explain how there is no immediate concern or risk of further infection. They also should provide practical information about when local clinics would be open and what the person needs to do to be tested and learn the results.

"The exposures we've had were not the type of exposures where you knew immediately that something happened," Oda notes.

Usually the risk was minimal, resulting from medical equipment that was improperly reprocessed, but the problem wasn't identified for a long period of time.

However, when the notified patients returned for testing, a number of positive test results were found.

The VA conducted further testing of the viruses to see if there was a link to any potential VA reprocessing exposure and found no connection, Oda says.

"If we had found the virus was the same we could say with high probability that the patient with newly-identified virus actually got an infection from the procedure," she explains. "In none of the cases we tested did the patient have the same virus, so the likelier explanation was the patient got infected some other way."

The problem was that patients were unconvinced that they had contracted HIV or hepatitis from another source, and often they had not been tested previously for the viruses, she notes.

"Unfortunately, we uncovered the underbelly of care, which is that people are not getting tested when they should be tested," Oda says.

"You uncover all these people who are newly positive, and they think they got it from the procedure," she adds. "So we had to deal with quite a few people who were upset and thought they had gotten the virus from the VA, even when we told them it was unlikely."

The VA provided care and follow-up counseling to all of the patients.

#### **3. Follow laboratory testing strategies.**

When patients visited clinics in response to notifications, they were tested for HIV or hepatitis C. One lesson the VA learned from this experience was that they needed to provide better instructions to clinics about how they needed to have these blood samples taken.

For instance, local clinicians collected the blood samples, ran the basic screening tests, and if a test came back with positive results they'd call the patient and ask the patient to return for a follow-up blood test, Oda explains.

"It would have been easier if they had saved the blood on all of the patients, so they wouldn't have had to call some patients back for further testing," she says.

The VA learned from this experience and had clinicians collect extra blood samples the next time there was a look-back investigation.

The follow-up blood tests were necessary to determine whether or not patients had obtained their viral infection from the reprocessing procedure, and the VA informed patients upfront of this investigation.

"We informed them that if they were positive we would like to do a test to determine if they got their virus from the procedure, and that was why we saved blood to use for testing," Oda says. "They signed a consent to agree to do that."

#### **4. Disclose test results and provide clinical follow-up.**

Clinicians set appointments to discuss the results with patients, whether the results were positive or negative.

"If the results were positive, we set them up with appropriate clinical care," Oda says.

Those testing positive for hepatitis C were referred to a hepatitis C clinic where they received treatment. Patients who tested positive for HIV were sent to the HIV clinic.

If patients refused to go to the clinic where they were initially referred, clinicians found another VA clinic where they could receive care, Oda adds.

#### **5. Conduct an epidemiologic investigation of patients with newly identified infection.**

This investigation occurred through the saved blood samples. Once the VA learned that clinics were not conducting the blood sampling as efficiently as desired, the VA developed a testing protocol for them.

"We ended up having them send the samples to us so we could be responsible for additional testing," Oda says. "We're still evolving that process; it gets a bit complicated."

In some cases, the event occurred recently enough that patients would have to return for a second blood test because the first negative test might have been within a window period for the virus, she adds.

The VA's look-back process also resulted in development of a VHA Lookback Program Operations Manual, which still is in rough draft form. When it's completed, the VA will make it available to others, Oda says.

## **REFERENCE**

1. Oda G, Schirmer P, Lucero C, et al. Development of a standardized process for conducting large-scale epidemiologic lookback investigations following improper reprocessing of reusable medical equipment. Abstract 127. Presented at the 38th APIC Annual Educational Conference & International Meeting. June 27-29, 2011, Baltimore, MD. ■

## **CNE/CME Instructions**

To earn credit for this activity, please follow these instructions.

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2. Log on to [www.cmecity.com](http://www.cmecity.com) to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
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## **CNE/CME Objectives**

Upon completion of this educational activity, participants should be able to:

- Identify the clinical, legal, or educational issues encountered by infection preventionists and epidemiologists;
- Describe the effect of infection control and prevention issues on nurses, hospitals, or the health care industry in general;
- Cite solutions to the problems encountered by infection preventionists based on guidelines from the relevant regulatory authorities, and/or independent recommendations from clinicians at individual institutions. ■

## **COMING IN FUTURE MONTHS**

■ Full coverage of APIC in San Antonio

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## CNE/CME Questions

1. The Centers for Medicare & Medicaid Services (CMS) infection control survey includes which area that cannot be cited under its current regulations?
  - A. infection control program and resources
  - B. antibiotic stewardship
  - C. hand hygiene
  - D. environmental services
2. A recent analysis of CMS policies linked to reimbursement cuts for certain infections resulted in what percentage of infection preventionists reporting increased funding to address the changes:
  - A. 8%
  - B. 15%
  - C. 49%
  - D. 77%
3. Martin A. Makary, MD, MPH, a surgeon at Johns Hopkins, said the CMS requirements for surgical procedures were particularly demanding and would lead to citations at the majority of hospitals.
  - A. True
  - B. False
4. The Veterans Health Administration developed comprehensive policies to handle large-scale epidemiologic look-back investigations after discovery of incidents of improper endoscope reprocessing. In general, investigators concluded that the majority of patients infected with bloodborne pathogens:
  - A. were infected via contaminated endoscopes
  - B. were infected prior to receiving care at the VA
  - C. were seen at the same outpatient clinic
  - D. A and C

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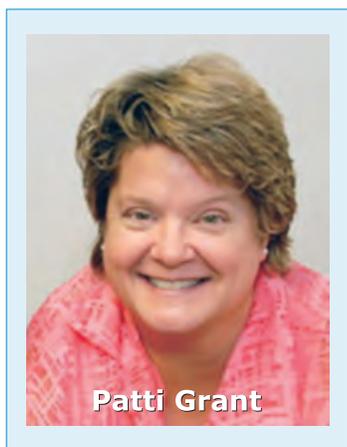
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## A new challenge for an 'old' newbie

*Stepping out of the comfort zone*

By **Patti Grant**, RN, BSN, MS, CIC, Infection Preventionist, Addison, TX.



Recently I've chosen a major change in job responsibilities. For the second time I'm the sole Infection Preventionist (IP) for a facility, but this time the realm of 'Quality' is included, and my facility is a 32-bed surgical hospital including a four-bed ICU. It was time to challenge myself to keep learning new approaches to age-

old problems surrounding patient safety. Talk about moving out of the comfort zone!

This experience has brought a fresh perspective to the term Newbie as some days I'm feeling like a fish out of water. From a generic standpoint the process improvement portion of this new experience is familiar. After all, IPs were some of the pioneers in healthcare investigations and data presentation from an infectious viewpoint. Despite the similarities, there are new acronyms to learn, including SCIP (Surgical Care Improvement Project) and CART (CMS Abstraction and Reporting Tool), just to name a couple. Along with unfamiliar abbreviations are databases I must 'gain access to' for data entry and extraction, all accompanied by a "Specifications Manual" that requires a 4-inch binder to house. The Quality portion of this new job parallels CDC/NHSN, which is familiar and comfortable. Still, I can only hope — soon — these quality-driven databases and definitions will become just this side of routine as well.

This experience is shared in such embarrassing detail because it has challenged me to return to the days of the first *iPNewbie* column in December 2008 to provide 'in the trenches' advice for the new IP as a mentoring tool. Now I am in the trenches of another aspect of governmental web-based reporting which has acutely reminded me that no matter how proficient we are in our area(s) of expertise, there

remains the reality that there is *way* more that we do *not* know regarding other topics in healthcare. Please know this is true, though you may forget, and be hard on yourself for 'not knowing everything' about infection prevention and control. This too shall pass.

You will gain expertise as you actively educate yourself through reading, networking, conference attendance, and accessing the resources available through APIC (The Association for Professionals in Infection Control and Epidemiology, Inc. ([www.apic.org](http://www.apic.org))). You and others will know you have arrived when you earn your first "CIC" (Certification in Infection Control ([www.cbic.org](http://www.cbic.org))) and join the ranks of IPs taking a stand for professionalism and strengthening their discipline through formal certification.

That debut column shared the message about a newly dubbed term "Infection Preventionist" which united a 40 year-old discipline so multiple undergraduate and graduate professionals could be encompassed into a single term that actively described a mission in two words. That initial piece also included the offer to share a list of favorite websites I'd accumulated over 20 years of practicing infection prevention and control. Since sharing that list there are many excellent new (free) web-based tools. But I asked myself, as a "new" IP what would I find that could quickly be useful to share the infection prevention message?

So as not to overwhelm, I forced myself to pick only two free resources that are grounded in credibility. The two listed below are easy to use, designed to also include those outside the formal IP occupation, and share a clear message with minimal jargon:

- <http://www.cdc.gov/CDCTV/HandHygiene/index.html> (Hand Hygiene Saves Lives). This resource is a short 'talk' with anyone who is entering the healthcare system so they know to watch and ask their providers to clean their hands before patient care.

- <http://www.hhs.gov/ash/initiatives/hai/training/> (Partnering to Heal: Teaming up against healthcare-associated infections). This is an inter-active learning opportunity to view, and make decisions regarding, infection prevention techniques from the "eyes and thoughts" of a nurse, physician, medical student, IP, and visitor.

These two internet-based resources provide you with many ways to accomplish your infection prevention message for several audiences and without a formal budget. Also, please e-mail me at [sngsmart@verizon.net](mailto:sngsmart@verizon.net) or [pgrant@methodistsurg.com](mailto:pgrant@methodistsurg.com) if you'd like that list of 'favorite bookmarks' I've accumulated over the years that make my life easier to access resources quickly. ■

### ***Nominate a Newbie!***

Do you know someone relatively new to infection prevention that would be a good candidate for one of our IP Newbie profiles? Drop us a line and tell us why you think their story may be of interest to *HIC* readers. Send nominations to [gary.evans@ahcmedia.com](mailto:gary.evans@ahcmedia.com).