

June 13, 2007

The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to comment on the Joint Commission's current Standards Improvement Initiative (SII) as it relates to the Infection Control Standards. General impressions and comments will be followed by comments specific to the individual standards and elements of performance.

SHEA was founded in 1980 to advance the application of the science of healthcare epidemiology. SHEA works to maintain the utmost quality of patient care and healthcare worker safety in all healthcare settings. It upholds its high success rate in infection control and prevention, while applying epidemiologic principles and prevention strategies to a wide range of quality-of-care issues. SHEA is a growing organization, strengthened by its membership in all branches of medicine, public health, and healthcare epidemiology.

Overall, the flow of the standards in the SII does not appear to be as logically progressive as the current standards. In addition, crucial deletions and movement of other standards to the Leadership, Human Resources, and Emergency Management chapters appear to weaken the Infection Control chapter significantly at a time when healthcare associated infections (HAI) are receiving increasing attention by legislators, payors and consumers. In addition, the standards as proposed do not speak to the integration of the infection control program into the organization's quality improvement and patient safety initiatives as strongly indicated in the CMS Draft Infection Control Interpretive guidelines. This deficit coupled with the removal of programmatic resources, influx of communicable diseases, and staff competency and training to other chapters tends to "silo" infection prevention and control activities. Finally, the proposed standards appear to be a significant departure from the DRAFT CMS Infection Control Interpretive Guidelines in content, emphasis, and phraseology, making it more difficult for an Infection Control program to comply with standards than if the two documents were harmonized, as is currently occurring within Joint Commission for the standards on the use of restraints recently released by CMS.

IC.1.10 EP 2

When the individual(s) responsible for oversight does not have expertise in infection prevention and control, he or she consults someone with such expertise in order to make knowledgeable decisions.

This element of performance should be deleted. It appears to dilute the authority of the Infection Control Professional (ICP) and the physician/hospital epidemiologist (HE) by implying that the administrative position to which infection prevention experts report should consult external experts if they themselves have no training or experience in

infection control. We would propose that if trained and competent individuals are appointed to direct the infection prevention and control program (IPC), there is no need for the individual who had administrative oversight of the program to seek external consultation. Ideally the leaders should also get some training themselves to be better prepared to lead infection control, quality and patient safety initiatives. If the ICP and or HE need additional help or consultation, the more direct route would be for them to seek external consultation from experts as necessary. This should be supported by the administration. We would suggest instead that JC reinforce the need for Leadership resources to support and delegate authority to the ICPs/HEs to act when conditions occur that threaten patient safety, and for ICPs/HEs to solicit additional expert consultation as necessary. The standard, as written, would also be difficult to institute; for example, in a small rural facility, who could the administrator turn to for consultation? The authority issue has been the backbone of successful IPC programs for decades and would not appear to serve to provide any gain. It is more important to foster ongoing partnership and effective relationships between ICPs/HE and senior leadership and not to fragment those relationships.

IC.1.30 EP 5

The [organization's] goals include the following: improving compliance with the Centers for Disease Control and Prevention (CDC) hand hygiene 1A, 1B, and 1C recommendations.

The Society for Healthcare Epidemiology of America is concerned about “codifying” CDC/HICPAC guidelines, and prefers that the Joint Commission instead revise the standard to “improving compliance with hand hygiene.” Guidelines by definition allow flexibility in implementation. SHEA applauds the Joint Commission for promoting improvement in hand hygiene; however, not all aspects of all CDC guidelines may be applicable to all facilities. In addition, tiered guidelines such as those for control of multidrug resistant organisms do not lend themselves to codification as the intensity with which they are implemented depends upon each facility’s outcomes based upon implementation of lower tiers. We support the Joint Commission's approach to enforcing the organization's policies based on CDC/HICPAC guidelines, but the guidelines are intended to be applied to a wide variety of settings and cannot be enforced prescriptively to be effective.

IC.1.40 EP 1

The [organization] uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus when developing infection prevention and control activities.

SHEA strongly supports this language as opposed to the codification of guidelines as proposed for hand hygiene as noted above. This EP could be strengthened even further by adding language such as that proposed in the CMS Infection Control Interpretive Guidelines requiring hospitals to have a:

“mechanism to periodically evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include documentation that

it has considered, selected, and implemented nationally recognized infection control guidelines. Examples of organizations that promulgate nationally recognized infection and communicable disease control guidelines, recommendations, and/or regulations include: the Centers for Disease Control and Prevention (CDC), the Occupational Health and Safety Administration (OSHA), the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Association of periOperative Registered Nurses (AORN).”

IC.2.10 EP 9

IC.2.10 EP 9 requires the organization to educate “*everyone* who enters the facility about their responsibilities in preventing and controlling infection.” We believe the use of the term “*everyone*” is too broad as it would include not only patients and staff {as defined by the CMS interpretive guidelines as “patient care staff, non patient care staff, including employees, contract staff and volunteers) but also “incidental” visitors such as restaurant delivery workers, staff of express package delivery services, process servers delivering papers to the legal department, and hundreds of other transient and one-time visitors who have extremely limited to no contact with actual patients. “Everyone” would include all patients entering the facility even briefly for reasons such as outpatient laboratory draw or outpatient radiologic procedures, creating an undue burden on infection prevention specialists and other hospital staff without adding any additional patient safety benefit. We therefore urge the Joint Commission to replace the word “everyone” with language consistent with the draft CMS Interpretive Guidelines.

IC.2.30

The [organization] works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.

The elements of performance in this standard refer to staff screening for exposure/immunity, care of staff infected with communicable diseases, and care of staff exposed to infectious diseases, but is worded in a way that suggests reaction to exposure rather than proactive protection and prevention from exposures, where ever possible. SHEA prefers adopting additional wording such as that in the CMS Interpretive Guidelines which state that Infection Control programs must address:

“measures for screening or evaluating immunization status for designated infectious diseases in employees and other healthcare providers and personnel as recommended by the CDC and it Advisory Committee on Immunization Practices (ACIP).”

Proposed IC.2.40 goes on to address influenza vaccination specifically, but without the addition of language such as that proposed above, other recommended healthcare professional vaccinations such as varicella, pertussis, and mumps, among others, could be overlooked.

IC.3.10 EP 6

Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program. (see LD.4.40 EP 1)

This standard as noted in the general comments tends to “silo” the infection control, quality, and patient safety programs. Annual reporting is not sufficient to develop and maintain an integrated program such as that required by CMS QAPI.

Current Standard IC.6.10

SHEA strongly disagrees with moving standards dealing with an influx of communicable disease patients to the Emergency Management Chapter. As indicated in this current standard and in current Environment of Care Standards, an integrated approach to emergency management, including involvement in local, state and national planning activities is key. Removal of this language from the Infection Control chapter dilutes the criticality of IC participation and fosters a silo approach. SHEA suggests instead a cross-reference here to leadership, medical staff, and environment of care standards as appropriate.

Current Standard IC.7.10 EP 2

SHEA strongly disagrees with moving standards on qualifications of infection prevention professionals to the Human Resources chapter. Infection prevention and control specialists are unique in that literature shows education/ specific are training necessary for reliable collection of data. This is especially necessary at a time when HAIs are receiving more and more public scrutiny, and mandatory reporting is required in at least 14 states. Having well trained and competent ICPs is integral to public reporting mandates whose goal is to provide comparative information on HAI that can be used by consumers to make healthcare choices. This standard should be retained with a cross reference to Human Resources.

Current Standard IC.9.10

SHEA strongly disagrees with moving the IPC program resource assessment and provision to the Leadership chapter. This dilutes the emphasis on IPC resources (IPC as non revenue-generator) at a time when HAI are receiving more public and payor scrutiny. This standard should be retained with a cross-reference to the Leadership chapter.

SHEA agrees with the Joint Commission focus on risk assessment based on geographic considerations, patient and employee populations, services provided in order to inform surveillance activities and programmatic planning and prioritization. However, the focus on written plans with written goals, objectives, and targets is too proscriptive and values form over substance. This focus may be especially problematic for smaller facilities with fewer resources secretarial resources.

In conclusion, the Society for Healthcare Epidemiology recommends that the Joint Commission harmonize content, emphasis, and phraseology of the standards with the CMS Infection Control Interpretive Guidelines in order to enhance hospitals' ability to comply with the standards. We do not believe codification of CDC guidelines into Joint Commission standards is an approach that allows the flexibility necessary for the broad diversity of hospitals to which Joint Commission standards apply, and urge the Joint Commission instead to focus on standards requiring hospitals to document that they have considered, selected, and implemented nationally recognized infection prevention and control guidelines as appropriate to their patient populations and geographic locations.

SHEA welcomes the opportunity to continue to work with the Joint Commission to further refine and improve the Infection Control standards.

Sincerely,

A handwritten signature in cursive script that reads "Victoria Fraser".

Victoria J. Fraser, MD
SHEA President