



1275 K Street, NW, Suite 1000
Washington, DC 20005-4006
Phone: 202/789-1890
Fax: 202/789-1899
apicinfo@apic.org
www.apic.org

December 19, 2011

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-3244-P: Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; proposed rule

Dear Ms. Tavenner:

The Association for Professionals in Infection Control and Epidemiology (APIC), an international association comprised of greater than 14,000 infection preventionists (IPs), wishes to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide input into its proposed reform of the Medicare and Medicaid Programs Conditions of Participation for Hospitals and Critical Access Hospitals. We are very pleased that CMS continues to demonstrate its commitment to quality by reducing unnecessary regulatory burden on hospitals and critical access hospitals (CAHs). Our comments primarily reflect the views of our members who oversee infection prevention and control programs (IPC) in hospitals and CAHs as they have a vested interest in the effective use of infection prevention practices that are evidence-based and produce positive outcomes. We will provide comments on the proposed elimination of the infection control log requirement, the use of standing orders as they relate to immunizations, and Physical Environment Life Safety Codes with impact on IPC programs and practice.

Nursing Services (§482.23)

APIC supports the use of standing orders specifically as they relate to the improvement of immunization rates. We commend CMS for the inclusion of “improving immunization rates,” as an area identified by the standing order literature. APIC members have long advocated for the importance of vaccination to prevent the acquisition and transmission of infectious diseases.¹ Our members are active in developing processes to ensure vaccine delivery to our patients. The use of standing orders has been beneficial during this process.²⁻³ The ability to expand standing orders into this arena will certainly provide positive patient outcomes.

APIC Recommendation: APIC supports the expansion of standing orders for immunization.

Infection Control (§482.42)

APIC supports the proposed recommendation to eliminate the requirement for an infection control log as a Condition of Participation (CoP). Newer methodologies have enhanced the ability to provide useful and precise surveillance processes that are targeted, in real time, and based on the epidemiology of the area being monitored.⁴ Elimination of this requirement will allow IPs to better focus their efforts on useful data that will drive timely decisions to keep our patients and staff safe.



APIC Recommendation: APIC supports the elimination of the “infection control log” as described in rule §482.42.

Physical Environment (§482.41)

Adopting the latest edition of the *Life Safety Code (2012 LSC)* has the potential to save hospitals billions of dollars, and APIC urges CMS to strongly consider this. APIC is closely aligned with the American Society for Healthcare Engineering of the American Hospital Association (ASHE/AHA), and together they recognized the key relationship between the physical environment and the prevention and control of healthcare-associated infections (HAIs). Infection Preventionists are impacted by these codes due to issues related to design of new spaces/facilities as well as renovation and construction. The environment plays an important role in preventing infections and use of special procedures to protect patients during construction is critical to safe patient care. As will be seen, the adoption of the 2012 LSC is necessary to effect needed changes given its significant impact on other codes that affect IPC programs, broad patient safety needs, and related costs and savings.

Impact of codes: The use of outdated LSCs siphons significant resources away from patient care. We applaud CMS in recognizing the importance of the 2012 LSC, given that it was adopted in September 2011 along with the National Fire Protection Association (NFPA) 99 and other key codes related to the 2012 LSC. We wish to add our support as well to other organizations that stand ready to assist CMS in working towards starting the rulemaking process. CMS’s adoption of the 2012 LSC will have a major impact on patients and their care in multiple ways including HAI reduction.

The impact of outdated codes on infection prevention

- *The 2000 LSC references more than 50 other technical codes and standards.* When the 2000 edition was written, these reference codes were current. Reference standards have been updated over the years, with some having undergone major changes. Yet hospitals must use reference codes from as far back as 1995 because they are mandated by the 2000 LSC. Permitting hospitals to comply with the latest 2012 version would save facilities significant amounts of money by using more cost effective materials and installation methods not permitted by the older codes.
- *New hospitals are built to comply with up-to-date codes,* such as the 2012 *International Building Code (IBC)* used by most local municipalities and code officials to regulate the design/construction of healthcare facilities. Ninety eight percent of U.S. jurisdictions use the IBC. However, when hospitals undergo opening surveys they must use the 2000 LSC, adding costs of wasted equipment and re-design and do not include the updated 2012 codes. Examples include areas such as ventilation, isolation rooms, etc.
- *New codes conflict with old costly codes.* Hospitals spend more than \$4 billion a year and suffer lengthy delays in bringing new and updated spaces online because of conflicting codes and standards, overregulation, unjustified code enforcement, and misinterpretations. Current estimates of annual health care construction range from \$40 billion to \$60 billion; savings of 6 to 10 percent could be realized while maintaining the same levels of safety.⁵⁻¹¹
- *The 2012 edition of the Life Safety Code is more closely aligned with the International Codes* published by the International Code Council, (ICC) including the IBC. As noted, the IBC is adopted and enforced by the vast majority of state and local agencies. Adopting the 2012 LSC will save hospitals money and time because they will have to deal with fewer instances of conflicting codes.



Examples of increased patient safety and reduced HAI risk with the use of 2012 codes: The 2012 LSC is superior to LSC 2000 because it permits:

- *Placement of alcohol-based hand rubs (ABHR) in corridors and patient rooms.* The 2000 edition allowed this through an amendment that was recognized by CMS but not by all local jurisdictions. The 2000 edition said ABHRs could not be “adjacent” to electrical outlets, leading to citations due to conflicting interpretations. Other issues relate to the amount of ABHR that can be stored on hospital units, per smoke zone so that more dispensers can be made available than now permitted. These improvements were clarified in the 2012 edition.
- *Lower range of relative humidity (RH) in the operating room (OR) and similar controlled areas.* ASHE, American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), and NFPA published changes that permit the lower range of 20% RH in controlled, short-term spaces such as operating rooms. These updated documents became effective as of September 2011. The changes were accomplished through collaboration with additional groups including APIC, the Association of periOperative Registered Nurses, the National Institutes of Health and others. APIC members have collaborated with others in doing investigative work that proves there is no HAI risk and in fact the lower humidity is an advantage.⁵⁻¹¹ CMS however, has two different CoPs on RH, which reference LSC 2000 and a defunct version of NFPA 99. As a result, CMS continues to cite hospitals for the 1 or 2 days of the year when hospitals cannot hold lower RH values (30% or 35%) as they are currently obliged to enforce LSC 2000. Expediting the process for LSC 2012 is needed to prevent the need for hospitals to purchase and use equipment that is only necessary to comply with outdated CMS humidity guidance. This unnecessary use of resources obtained by facilities to comply with old humidity requirement and prevent CMS citations on the few days of the year that they may be out of this range (despite being in compliance with the new NFPA 20% standard). In addition, the efforts and time expended by hospital personnel could be used in implementing more updated scientific intervention in the healthcare environment

APIC Recommendation: APIC, strongly recommends adoption of the 2012 LSC and urges that the federal rulemaking process be expedited.

In conclusion, APIC appreciates CMS’s thoughtful approach to improving the quality of healthcare for patients. We support the elimination of the infection control log, the use of standing orders to improve immunizations and the adoption of the 2012 LSC. Finally, we appreciate the opportunity to express our comments to the CMS proposed rule for Reform of Hospital and Critical Assess Hospital Conditions of Participation.

Sincerely,

A handwritten signature in black ink, appearing to read "Russell N. Olmsted", written in a cursive style.

Russell N. Olmsted, MPH, CIC
2011 APIC President



1. Greene LR, Cox T, Dolan S, et al. APIC position paper: influenza vaccination should be a condition of employment for healthcare personnel, unless medically contraindicated. January 2011. (Available at: http://www.apic.org/Content/NavigationMenu/GovernmentAdvocacy/PublicPolicyLibrary/APIC_Influenza_Immunization_of_HCP_12711.PDF).
2. Eckrode C, Church N, English WJ. Implementation and evaluation of a nursing assessment/standing orders–based inpatient pneumococcal vaccination program. *Am J Infect Control* 2007;35(8):508-515.
3. Wroten K, Piper J, Couch K. Improving influenza vaccination rates among adults in acute care using a standing order form by exception. *Am J Infect Control* 2005;33(5):e148.
4. Greene LR, Cain TA, Khoury R, et al. APIC position paper: the importance of surveillance technologies in the prevention of healthcare-associated infections. May 29, 2009. (Available at: http://www.apic.org/AM/Template.cfm?Section=Surveillance_Technology_Resources&CONTENTID=16713&TEMPLATE=/CM/ContentDisplay.cfm).
5. ANSI/ASHRAE/ASHE. Addendum to American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. ASHRAE/ASHE Standard 170-2008. Ventilation of Health Care Facilities 2010;1-4. Available at: <http://www.fgiguilines.org/2010guidelines.html>. Accessed November 2011.
6. The American Society for Healthcare Engineering of the American Hospital Association (ASHE). Briefing for CMS: Reduced design criteria for relative humidity levels for short-term patient care areas. September 2010 and April 19, 2011;1-29. Available at: <http://www.ashe.org/advocacy/research/> or http://www.ashe.org/advocacy/research/pdfs/briefing_cms_humidity-04-19-2011.pdf. Accessed November, 19, 2011 [Note: This document includes many referenced articles but difficult to access.]
7. Bartley J, Olmsted RN. Behind the change in the ASHRAE/ASHE Standard 170. *Engineered Systems* 2;2011:26-29. Available: <http://www.esmagazine.com/publications/3/editions/1180>. Accessed November, 2011.
8. Bartley J, Olmsted RN. Examining the evidence: APIC and AORN endorse a change in the ASHRAE/ASHE design standard for relative humidity in the OR and other spaces. *Prevention Strategist*. Autumn 2010;18-19.
9. Memarzadeh, F. Literature review: effect of temperature and humidity on viruses that cause epidemics and pandemics. 2010: 1-23. Edited by APIC members Bartley J and Olmsted RN. Available from ASHE upon request. [Also in ASHE Briefing – see ref 6]
10. Memarzadeh, F. The Environment of care and health care-associated infections: an engineering perspective. Facility Guidelines Institute and the American Society for Health care Engineering of the American Hospital Association. 2011: 1-80. Edited by APIC members Bartley J and Olmsted R. Available from http://www.ashe.org/resources/management_monographs/. Accessed November 2011.
11. Rosenberg J, Jackson M. Infectious Disease Risk from Low Humidity. American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc. 2008;1-6. Available from APIC upon request. [Also in ASHE Briefing ref 6].