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***Mandated Infection Prevention Staffing Ratios in N.J.***

**Kathy Horn, RN, CIC**  
Director of Infection Prevention Services  
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 **Hunterdon Healthcare**  
Your full circle of care.

(There are no financial disclosures.) 2

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## Objectives

- Discuss opportunities to influence regulations by partnering with state health departments to achieve common goals.
- List important factors to consider in setting Infection Preventionist staffing ratios.
- Describe the impact of IP staffing regulations in N.J.

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## Is there an expert in the house?

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**Is there anyone  
 who doesn't think  
 this is an important issue?**

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**A Brief History of IC&P Programs**

- 1950-60s: JC & AHA
- 1970s
  - CDC recommendation for IC programs in hospitals
  - SCENIC Study
    - Benefit 1:250 ICP
- 1980s
  - Science more complex
  - Technology more complicated
  - Recognized that WH surveillance was too much surveillance with too little impact

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**More History**

1990s

- 'Targeted surveillance'
  - Focus on high-risk patients in ICUs, select surgical procedures, resistant organisms
  - Data was risk-adjusted & more comparable
- Time management studies
  - 48.5% of ICP work was clerical
  - ICPs working at 130% utilization
  - 50% of days with 'quality gap'
  - Not linked with outcomes

Measurement of IC Dept Performance. Haas J. AJIC 11/06; Workload Measurement Tool for IC nurses Trundle CM JHospInf 2001; Rec for optimizing ICP effectiveness in amb setting. Haim L, Boothj. J Hosp Qual 1994

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## NNIS Hospitals Survey 1999

- 1 ICP per 115 beds (median)
- 40% of ICP time spent outside of traditional inpatient job specs

Characteristics of hospitals and IP participating in NNIS system 1999 Richards C et al, AJIC 2001

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## Canada

- “Crises-motivated influxes of resources”
  - SARS 2003
  - CDAD 2002-04
- Recommendation for 1 ICP FTE/100 beds
  - 22.6% of hospitals (2005)

A comparison of IC program resources, activities and antibiotic resistant organism rates in Canadian acute care hospitals in 1999 and 2005. Zoutman D, Ford B, AJIC 12/08

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## 21<sup>st</sup> Century Infection Prevention

- Bundles, i.e. attention to details
- Electronic surveillance
- Direct (real) observation of practice
- It's not the knowledge, Stupid

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## Delphi Project

- “Competing responsibilities and lack of adequate resources were the most frequently cited reasons for non-performance of essential infection control tasks.”
- “Staffing recommendations must consider beds, scope of program, complexity of facility, patient population & unique/urgent needs of community.”

O’Boyle c, Jackson M, Henley S. Staffing Requirements for IC programs in US HC facilities AJIC 10/02

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*Tipping  
Point*



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## *Infection Control Update 2006*



**At the Tipping Point**

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## It's not just about the technology...



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## Tipping Point > 'Always'

- In epidemiology: small changes will have little or no effect on a system until a critical mass is reached.
- Then a further small change "tips" the system & a large effect is observed.
- 'Tipping point': sociology term that refers to that dramatic moment when something **unique** becomes common.

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## Revolution from 'Blameless Culture' to 'Era of Accountability'

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### Things were changing for the better.....

- Hand hygiene rates were rising
- Environmental cleaning recognized as important
- New resources being put into improving care
- Fostering a culture of
  - ‘positive deviance’
  - ‘Tell me, don’t tell on me’
  - ‘Tell on me & something will be done’

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### How about Quality Improvement?

- QI as a field has grown
- QI departments have grown
- QI staff monitor
  - don’t have a shoe leather approach
  - don’t ‘DO’ improvement
  - historically, not action oriented

### Why we have a new specialty, ‘Patient Safety’?

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### Infection Prevention Departments

- Have not grown
- ICP/IP
  - monitorAND
  - proactively seek improvement



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## Some NJ History.....

2004 hospital licensure regulation went into effect mandating

- 1 ICP per 200 adjusted occupied bed
- Certification of all ICP within 5 years of employment

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## There shall be a ratio of at least...

One full-time ICP to every 200 adjusted occupied beds, where the bed occupancy has been adjusted both for an outpatient factor & for the hospital's all-payer case mix index (CMI), using the most recent complete data set available to the Department & the following formula:

$$\text{Adjusted Occupied Beds} = \frac{(\text{Annual Inpatient Days}) \times (\text{Inpatient Charges} \times \text{Outpatient Charges}) \times \text{All Payer CMI}}{365 \times \text{Inpatient Charges}}$$

For every hospital, there shall be at least one half-time infection control professional.

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## Why did they do that.....?

- Recognized our importance
- Allies in raising the standard for our profession

'The only way this is going to happen is if it's legislated.'

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### What Does an IP *DO* These Days?

- Infection prevention
- Employee health
- Administration
- Public speaking
- Public health
- Education
- Policy writing
- Mandatory reporting
- Emergency preparedness
- Oops, I've run out of room....
- Antibiotic stewardship
- Vaccines
- Flu shots, TSTs
- Needle safety
- OSHA compliance
- Cajoling, convincing, consulting
- Arm-twisting
- Hand-holding
- Gnashing of teeth
- Wringing of hands
- Wringing of necks.....oops

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### Historical Role of State DoH

Most State DoH

- Licensing teams license
- No routine inspections
- No licensing standards
- Broad statements of what is required of IP Program

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### *Perspective*

#### Writing Rules & Regulations

- Time-consuming
  - Social impact statement
  - Economic impact statement
  - Comments
    - respond
  - Expertise

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## Symbiotic Relationship with The JC

- JC accreditation
- State then licenses facility
  - Charges licensing fee
  - Politically correct
  - Burden on the JC

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## ***NJDHSS & IP: Happy Together***

- Work together on Infection Prevention courses
  - State sends new inspectors to our Course
    - Scholarship
- Historically, inspections every 3 years
- Committees
  - Expert panels
    - Licensure revision
    - Mandatory reporting
    - Emergency preparedness, latex allergy, etc., etc., etc.

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## ***Bill Dealing with IP***

Introduced in Senate or Assembly

- Goes to Health Committee
- IP lobby sponsors for desired changes
- NJHA looks at all introduced legislation
  - Relationship with APIC Chapters
- Lobby NJDHSS to submit comment reinforcing
- IP-related bills go to NJDHSS Epi, Licensure and/or Quality Divisions for comment

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## Bill into Law

- Passes Health Committees in both Houses
- Passed by both houses
- Signed (or vetoed) by governor

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## The 'New Law'

- Legislation not clear or specific?
- NJDHSS called upon to write Guidance Document or Rules/Regs
  - Another opportunity to influence
  - Expert working groups convened
    - Multidisciplinary group

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## The Law is the LAW

.....but regulations can be changed.

or they sundown.....

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## Mandatory Reporting in N.J.

- HAI law, effective January 1, 2009
  - Pilot year, data not available to public
    - Central line-associated bloodstream infections in ALL critical care units (adult, pediatric, neonatal)
    - SSI following abdominal hysterectomy
    - SSI following CABG
  - NHSN is reporting mechanism
- MRSA law, March 2009
  - Hospital-onset MRSA BSI incidence based on clinical cultures
  - MRSA admission screening compliance
  - Via NHSN MDRO/CDAD Module

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## Mandates for Reporting HAI

Healthcare-Associated Reporting Laws and Regulations



- States with study laws
- Mandates public reporting of infection rates
- Mandates reporting only to state government
- Voluntary

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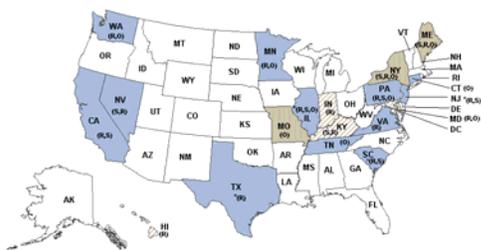
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## MRSA Laws & Pending Legislation - 2009



- Enacted MRSA Law
  - Pending MRSA Legislation
  - Enacted MRSA Law & Pending MRSA Legislation
  - Legislature Adjourned Without Enactment
- R – Reporting Laws or Bills  
 S – Screening Laws or Bills  
 O – Other Laws or Bills (e.g., studies, pilots, other infection control requirements)

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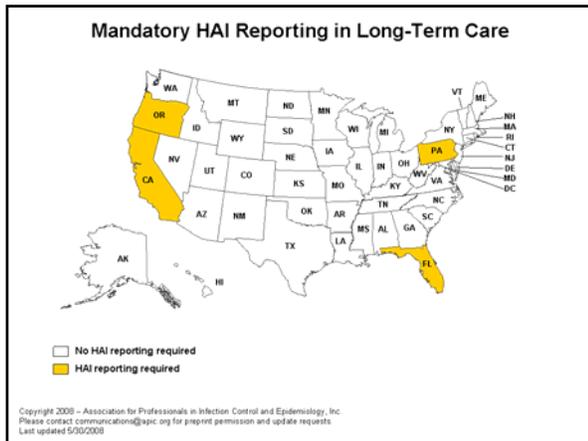
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## HAI Reporting 2010

- Reconvening HAI Technical Work Group, June 2009
  - To determine reportable events for 2010
  - SSI following hip, knee, colon & vascular procedures being considered
- Reporting to public to begin 2010

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## NJ Hospital Licensure Regs IP Program Staffing Ratios

- Draft revision completed in December 2008
  - Still needs impact statements
  - Approval process ~18 months
  - Retirements
- Staffing
  - IP ratio: average daily census/100 x 1.1 FTE
  - Data entry position
    - 0.5 FTE if <200 beds
    - at least 1.0 FTE if >200 beds

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# Minimum Standard

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## What are Other States Doing?

Massachusetts

- Motivated by public concerns, new statute for HAI data collection
- Convened Technical Advisory Panel (Epi, ID, IP)
- Strong recommendation by expert panel that hospitals have 1–1.5 IP per 100 occupied beds
  - Not mandated

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## Massachusetts, cont

- Started using hospital assessment tool, Jan '08
- Newly funded DoH IP staff doing consultative visits
  - Well received
  - Asking
    - Other responsibilities
    - Administrative support
    - Technical support
    - Help with data collection
    - Support of data analyst

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## Massachusetts, cont

Summer '09

- New Licensing Reg adopted
- Mostly do validation surveys
- If find a problem, will refer to Recommendations

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## Pennsylvania

- PHC4, 2004
  - Must report all infections
  - No IP input
- Act 52, Feb 2008
  - Reporting through NHSN
- Impact
  - Less staff education
  - Less visibility of IP
  - Less prevention
  - No more staff



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## New York

NY State Dept. of Health Hospital Survey (222 of 224)

- Average full-time ICP is responsible for
  - 151 acute care beds
  - 1.3 Intensive Care Units (average 16 beds each)
  - 21 LTCH beds
  - 0.6 dialysis centers
  - 0.5 ambulatory surgery centers
  - 4.8 outpatient clinics
  - 1.1 private physician offices
  - 'Other duties not mentioned in job description!'
- 45% of time on surveillance

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## Disclaimers

Objective #1

- Describe the impact of IP staffing regulations in N.J.

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## 2008 Staffing Survey

- Northern & Southern NJ APIC Chapters
- 39 respondents
- Acute care hospitals

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## NJ APIC Chapters' Survey

- Current regulation
- Draft regulation

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## Staffing Survey Results

Do you use the NJDHSS-mandated staffing formula?

Yes – 28 (76%)  
No - 9

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## Who do you report to?

Director of Quality	12 (27%)
VP, Patient Care Services	11 (24)
VP, Medical Affairs	4 (9)
Other	8 (18)

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## What was the last years data you used to calculate your staffing needs?

2008 - 2	2005 - 3
2007 - 13	2004 - 3
2006 - 3	

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### Are you over, under or right on?

Over: 5 (14%)  
Right on: 14 (40%)  
Under: 16 (46%)

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### Have you increased, or do you plan to increase, staffing due to the new (draft) mandatory reporting requirements?

Yes – 16  
No - 16

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Regulations don't always result in the desired outcome.

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**Do you have a secretary or data analyst?**



Yes – 16 ('shared' to 1 FTE)  
 No - 13

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**Do you have responsibility for things other than IP?**

**Lots!**

- Pandemic Flu
- E-Prep
- Core Measures
- Environment of Care
- TST
- Flu vaccine
- Cover for Oc Health & Safety

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**Timing is Everything!**

- State budget
  - Retiring DoH staff
  - Diminished inspection schedule
- Hospital finances

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## Disclaimer

Objective #2

- Discuss opportunities to influence regulations by partnering with state health departments to achieve common goals.

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## \_\_\_\_\_ *the Opportunity*

- Recognized the opportunity
- Seize the opportunity
- Create the opportunity

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## Help our infection preventionists transition from benchmarking & bean-counting to zero tolerance & accountability.

The Lowbury Lecture. U.S. approach to strategies in the battle against healthcare-associated infections, 2006: transitioning from benchmarking to zero tolerance and clinician accountability. Jarvis, WR 60

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1. No single intervention prevents any HAI; a "bundle" approach, with multiple interventions, based on evidence & implemented by a multidisciplinary team is needed.
2. Benchmarking is inadequate; a culture of zero tolerance is required.
3. ....a culture of accountability & administrative support

***'With that approach, much greater levels of HAI prevention can be accomplished than ever estimated in the past.'***

Jarvis WR. The Lowbury Lecture. US approach to strategies in the battle against HAI, 2006: transitioning from benchmarking to zero tolerance & clinician accountability. J Hosp Infect. 2007;65(Suppl 2):3-9 61

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## ZERO Tolerance

Zero tolerance for **behaviors** that contribute to infections

- a culture in which HCW no longer believe HAIs are an inevitable outcome of care.

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## Culture Change is Difficult

Patience

Wisdom

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## Can We Really Do MORE??



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## Something's Gotta Give



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## Evidence is Lacking

Increased Healthcare Spending

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Increased Quality

Hosp staffing and HAI review. Stone P et al, CID 2008

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## IP Extenders?



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## More than One Way to Skin A Cat

- Infection Prevention Liaisons
- Clinical Nurse Leaders
- Trade an FTE for a software program?
- Trade an IP for a DA (data analyst)?

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## 'Tired *Unsung* Superheroes'



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**Things are not always as they seem.....**



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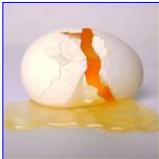
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*Tipping Point*



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**Find that Balance**

*Adequate staffing*



*Patient Safety*

**At the right cost.**

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## A New Vista



- HHS Action Plan to Prevent HAI
  - Washington, DC June 30
- Impact our state Plans
- Healthy People 2020
  - HAI prevention new target area

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## Thank You!

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