

## 9-23-24 Weekly Clinical Update

Dr. David Gifford, Chief Medical Officer for AHCA recently addressed the LTC Nation Infection Prevention Forum with guidance on vaccines.

“for CMS billing for vaccines try this [www.cms.gov/files/document/...](http://www.cms.gov/files/document/...)

or Google CMS "CMS fact sheets respiratory virus reimbursement"

For Fact sheets from Moderna and Pfizer they are on the FDA website.

if you Google "FDA fact sheets Moderna COVID vaccine" or "FDA fact sheets Pfizer covid vaccine" and look for the FDA webpage link (below all the sponsored sites). The links are repasted below.

[www.fda.gov/vaccines-blood-biologics/...](http://www.fda.gov/vaccines-blood-biologics/...)

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Courtney Bishnoi sent out the following information. I would STRONGLY recommend we have some facilities from our state to have a voice in revisions to MDS. Let's stop sitting back and letting others decide our fates.

“As many of you are aware, the MDS is a standardized, interdisciplinary assessment to develop the person-centered care plan. However, the MDS is used for more than care planning and has a significant impact on our industry, including reimbursement and quality measures. Despite this, the MDS presents a significant challenge to nursing homes due to its expanding size and complex regulations/direction in the RAI Manual.

Due to these challenges, AHCA recently conducted a workgroup focusing on MDS burden reduction. This workgroup compiled examples of burden and shared with AHCA to better assist in determining focused areas of advocacy.

As this workgroup is nearing its conclusion, we still would like to support members regarding the MDS to determine what resources may be needed and ongoing advocacy efforts. Therefore, we are looking to create an MDS Focus Group. This will be a small, ongoing workgroup that will meet quarterly beginning late October.

We are seeking people at the provider level, who participate in coding the MDS and have expertise in the MDS and the overall RAI process. Participation in the workgroup would not be limited to committee members. Those interested should contact Amy Miller by close of business on October 4<sup>th</sup>. The people selected will be sent a follow-up email to arrange the first meeting shortly after.

Questions regarding the focus group may be sent to Amy Miller at [ammiller@ahca.org](mailto:ammiller@ahca.org). “

CDC recently (9-10-24) updated their tool, “Viral Respiratory Pathogens Toolkit for Nursing Homes”. Here is a link to the updated tool. <https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html>. In response to appropriate infection control practices, if you scroll down the page to the section titles, “ACTION: RESPOND when a resident or HCP develops signs or symptoms of a respiratory viral infection” the tool documents about applying appropriate TBP for symptomatic residents based on their infection and goes on to state:

- *“Symptomatic residents should not be placed in a room with a new roommate unless they have both been confirmed to have the same respiratory infection.*
- *Roommates of symptomatic residents – who have already been potentially exposed – should not be placed with new roommates, if possible. They should be considered exposed and wear a facemask for source control around others.*

You should always co-hort based on "like" residents-meaning they both have the same microorganism or virus.”

I know this weekly update frequently addresses Infection Prevention & Control issues, but that seems to be an important issue with multiple revisions recently. AND IPC continues to get multiple deficiencies on surveys, both standard and complaint surveys.

Cathy Ciolek, from AHCA posted on the Forum this week related to EBP:

“Over the last several months we've been working with Project Firstline experts to update the sample Enhanced Barrier Precautions Policy and Procedure document to reflect some of the updated FAQs and clinical situations we've heard from members. Our goal was to clarify (where possible) situations and also give discretion to the IP/team within the P&P for situations that are not explicit in either CDC guidance or CSM regulations.

In several places you will see red italic indicating where your facility should consider reviewing and/or expanding based on your risk profile for MDROs, resident/patient types, etc... Adaptations in other areas should clearly specify the facility/home's rationale for adaptation.

Please remain aware adopting this means the home/facility needs to be prepared to train staff so they regularly provide EBP in accordance with this policy. Many of the early citations from CMS that we have seen are related to not following the facility/home's Policy and Procedure document.”

On the following pages is a copy of the policy AHCA has developed named, AHCA Sample EBP Policy and Procedure

Template was developed by AHCA in conjunction with CDC Project Firstline- any modifications from original should be noted as such.

***NOTE: THESE POLICY AND PROCEDURE TEMPLATES ARE MADE AVAILABLE FOR YOUR USE BUT ARE NOT ALL INCLUSIVE. They are consistent with current CDC guidance as of Aug XX 2024. This template should be reviewed and modified to meet YOUR FACILITY NEEDS. STATE AND LOCAL AUTHORITIES MAY HAVE ADDITIONAL CONSIDERATIONS THAT NEED TO BE INCLUDED.***

\*\*\*Recommendations for Enhanced Barrier Precautions are being reviewed as part of updates to the 2007 Guideline for Isolation Precautions. Once a draft is finalized by the Healthcare Infection Control Practices Advisory Committee (HICPAC), it will be posted in the federal register for a public comment period before being returned to HICPAC for additional review. Further information about HICPAC, the guideline development and public comment process, and future meetings is available at: [Healthcare Infection Control Practices Advisory Committee \(HICPAC\)](#).\*\*\*

**Title: Enhanced Barrier Precautions**

**Effective Date:**

**Approved By:**

**Review/Revised Date:**

**Definition:**

The Centers for Disease Control and Prevention (CDC) defines Enhanced Barrier Precautions (EBP) as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and glove use during high-contact resident care activities for residents at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling devices as later defined in the policy) as well as those known to be colonized or infected with a MDRO.

**Purpose:**

EBP are recommended by the CDC and required by CMS to reduce the risk of transmission of multidrug-resistant organisms (MDROs) in the facility while allowing those most likely to become colonized or those known to be colonized or infected to participate in group activities that might otherwise be limited if they were required to be maintained on Contact Precautions.

**Responsibility:**

All staff and external consultants that perform high-contact resident care are responsible for following EBP policies and procedures.

**Policy Statement:**

Enhanced Barrier Precautions are implemented based on an evaluation of the resident's risk of acquiring an MDRO (i.e., having an indwelling medical device or wound present as described by this policy) OR the resident's history of known colonization or infection with a targeted MDRO.

Routine screening for colonization with an MDRO is not performed but may be considered based on changes in local epidemiology, patient risk factors, facility characteristics, and intended purpose of screening.

The decision to transfer a patient from one level of care to another should be based on clinical criteria and the ability of the accepting facility to provide care, not solely on the presence or absence of MDRO infection or colonization.

*NOTE: Facilities must include CDC targeted list of MDROs in this policy but at their discretion or per state or local public health guidance may also want to incorporate targeted MDROs into this policy*

**Procedure:**

1. At admission nursing staff will evaluate the resident's status to determine if EBP are indicated based on the MDRO risk to the resident or other residents in the facility.
  - a. Resident with any one of the risk factors listed below will have EBP applied:
    - i. Wound as listed in the glossary
    - ii. Indwelling medical device as listed in the glossary
    - iii. Colonization or infection with targeted MDROs or any MDRO of epidemiologic concern specific to the facility.
  - b. EBP may be implemented any time after admission if a resident develops one of the risk factors above.
  - c. Implementation of EBP due to clinical criteria not listed above will be reviewed on a case-by-case basis by the Medical Director and Infection Preventionist. Consultation with state and local health departments may be needed when criteria is unclear, or novel MDRO are detected.
2. If EBP is indicated, notify the following individuals that the resident has been placed on EBP and update the care plan and any other communication tools for daily care:
  - a. Resident
  - b. Resident representative (if applicable)
  - c. Infection Preventionist
  - d. Unit nurse
  - e. Rehabilitation Therapy (if applicable)
3. Room placement: Room placement restrictions are not necessary with Enhanced Barrier Precautions.
4. Place EBP signage outside the resident's room (e.g., door/wall) that clearly indicates the high contact resident care activities that require the use of a gown and gloves. *If your facility determines an alternative effective way to communicate the need for EBP to all individuals performing high contact tasks, adapt this section as appropriate.*
5. Ensure accessibility of alcohol-based hand sanitizer, gowns, and gloves for use during **high contact resident care activities** done in a resident's room, and in selected common areas such as bathing or wound care procedure rooms and rehabilitation services requiring high contact care.
6. To determine if EBP could be discontinued. Assess If...
  - a. The reason EBP was started is due to wound or indwelling device. If those wounds are healed or device is removed EBP can be discontinued.
  - b. The reason for EBP was known colonization or following infection with an MDRO continue Enhanced Barrier Precautions for the duration of a resident's stay in the facility, do not repeat screening results to discontinue EBP. Should a subsequent test occur do not stop EBP in response to a subsequent negative test.

7. Residents on EBP are permitted to leave their room to participate in activities, meals, visits to the hairdresser, and for any other reasons. Do not restrict residents to their room or from participation in group activities.
8. Ensure environmental surfaces (e.g. countertops in resident rooms and mobile medical equipment) are cleaned and disinfected with an EPA-registered hospital disinfectant that has a label claim against the organism of interest. Ensure adherence (e.g. contact time) with the label instructions for use.

### Resources:

CDC Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, Last Reviewed: May 20, 2024. <https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html>

CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), Last Reviewed: April 2, 2024. <https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html> [C EBP – Observations Tool https://www.cdc.gov/long-term-care-facilities/media/pdfs/Observations-Tool-for-Enhanced-Barrier-Precautions-Implementation-508.pdf](https://www.cdc.gov/long-term-care-facilities/media/pdfs/Observations-Tool-for-Enhanced-Barrier-Precautions-Implementation-508.pdf)

[CDC EBP – Pre-implementation Tool https://www.cdc.gov/long-term-care-facilities/media/pdfs/Pre-Implementation-Tool-for-Enhanced-Barrier-Precautions-508.pdf](https://www.cdc.gov/long-term-care-facilities/media/pdfs/Pre-Implementation-Tool-for-Enhanced-Barrier-Precautions-508.pdf)

CDC Infection Control- Fundamental Elements Needed to Prevent Transmission of Infectious Agents in Healthcare Settings. Last Reviewed November 22, 2023. <https://www.cdc.gov/infection-control/hcp/isolation-precautions/prevention.html>

### Glossary:

**Enhanced Barrier Precautions** are an infection prevention and control measure that involves gown and gloves use during *high-contact resident care activities* for residents who have *wounds or indwelling medical devices regardless of MDRO* colonization or have a known colonization or infection with a MDRO (when Contact Precautions do not apply).

**High Contact Resident Care Activities** requiring gown and gloves for EBP

Examples of activities include (but are not limited to):

- Dressing
- Bathing/Showering
- Transferring
- Providing Hygiene
  - brushing teeth, combing hair, and shaving.
  - hygiene is often bundled with other activities that necessitate EBP
- Changing Linens
- Changing Briefs or Assisting with Toileting
- Device Care or Use: Central line, urinary catheter, feeding tube, tracheostomy/ventilator
- Wound care and dressing changes

*There may be activities the facilitate specifically designates as non-high contact activities that can be covered in this policy. For example, CDC Guidance indicates that medication administration including via enteral feeding tubes is generally not considered a high contact care activity when done alone. You may have examples where it becomes high contact due to resident characteristic or when bundled with other high contact activities. Add to this policy and procedure as needed.*

Examples of common areas in which high-contact resident care activities necessitate the use of EBPs:

- Common showers and bathing areas
- Therapy gyms
- Wound care procedure rooms

Examples of common areas in which activities like transfers and provision of hygiene do NOT necessitate EBP:

- Common dining areas
- Beauty salons

**Indwelling Medical Devices** An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. Devices that are fully embedded in the body, without components that communicate with the outside, such as pacemakers, dialysis shunts, port-catheters, vascular stents would not be considered an indication for Enhanced Barrier Precautions. CDC does not currently consider peripheral I.V.s (except for midline catheters), continuous glucose monitors, and insulin pumps as indications for Enhanced Barrier Precautions. An ostomy in a resident without an associated indwelling medical device would not be considered an indication for Enhanced Barrier Precautions.

**Personal Protective Equipment (PPE)** PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission. PPE includes gloves, isolation gowns, and/or face protection (masks, goggles, face shields).

**Targeted MDRO** A MDRO is a germ that is resistant to most or all available antimicrobial agents and with the potential to spread widely. A targeted MDRO is one that requires intensive public health actions to slow the spread of disease. See CDC website for a list of targeted [MDROs](#).

**Current Targeted MDROs from CDC as of June 2024**

- Pan-resistant organisms,
- Carbapenemase-producing carbapenem-resistant Enterobacterales,
- Carbapenemase-producing carbapenem-resistant *Pseudomonas* spp.,
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and
- *Candida auris*

***Note: CHECK WITH YOUR STATE AND LOCAL HEALTH DEPARTMENT AS WELL AS YOUR MEDICAL DIRECTOR IF YOU SHOULD EXTEND THIS POLICY TO INCLUDE SOME OR ALL OF THE EPIDEMIOLOGIC IMPORTANT MDROS.***

*For epidemiologically important MDROs the infection preventionist, facility, and local or state public health jurisdictions have the flexibility to also use EBP. When determining whether to apply EBP in the presence of these organisms, the infection preventionist, facility, and jurisdiction should consider such factors as local epidemiology, presence of ongoing or past outbreaks, propensity for transmission in healthcare facilities, association with severe outcomes, or targeting for local prevention efforts.*

Examples of MDROs that might be epidemiologically important locally:

- *Methicillin-resistant Staphylococcus aureus (MRSA),*
- *ESBL-producing Enterobacterales,*
- *Vancomycin-resistant Enterococci (VRE),*
- *Multidrug-resistant Pseudomonas aeruginosa,*
- *Drug-resistant Streptococcus pneumoniae]*

**Wounds** This includes residents with chronic wounds or large wounds that will take time to heal (e.g. open surgical wound that needs to granulate in), and not those with only shorter-lasting wounds, such as skin breaks, or skin tears covered with a Band-aid or similar dressing. This also does not apply to well approximated new surgical wounds that are healing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions. When question if a wound would trigger the use of EBP, seek input from the infection preventionist or medical director.