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Robert A. Malson
President

November 26, 2008

Pierre Vigilance, MD, MPH
Director
District of Columbia Department of Health
825 North Capitol Street, NE, 4th Floor
Washington, DC 20002

Dear Dr. Vigilance:

Thank you for giving the District of Columbia Hospital Association (DCHA) the opportunity to provide comments on the proposed reporting requirements and procedures for minimizing patient infection by methicillin-resistant *Staphylococcus aureus* (MRSA). Our hospitals appreciate your efforts to put forth a rule that will provide additional guidance to providers as they work to ensure the best possible care. After a comprehensive review, our hospitals believe that there are significant problems with parts of the rule as written. We urge you to reconsider the language of the following sections of the proposed rule:

Section 207.1
While we appreciate the Administration's efforts to garner comprehensive data regarding the incidence of MRSA, the language in Section 207.1 is vague and administratively burdensome. It will be very time consuming to research every MRSA bloodstream infection that comes into a hospital. Smaller hospitals would quite feasibly have to create new full-time employee positions in order to collect the data, a move that would also be financially burdensome. Furthermore, categorizing an infection as "healthcare acquired" is not feasible because it would require the individual making the determination to construct previous exposures at other organizations. Questions also surround the use of the phrase "relevant denominator data." The regulation does not define which denominator should be used, nor does it ensure that all hospitals will use the same denominator. For these reasons, we recommend that the current language in Section 207.1 be stricken and replaced with the following: "*Each healthcare facility shall report the number of patients with MRSA bloodstream infections on an annual basis as an aggregate number*." This more specific language would provide the Department with the data needed to track the burden of MRSA infections, without creating new administrative and financial burdens for hospitals and nursing facilities.

Section 207.3
Hospitals agree, based on recent CDC guidelines, that active surveillance along with Contact Precautions should be used as a prevention tool more than in the past. However, the current language in the proposed MRSA regulations contains very general reporting language with no defined time frame. For these reasons, we recommend that the first sentence in the current language of the proposed regulations be changed to: 'Each healthcare facility shall conduct active surveillance testing and *annually* report *the findings of that surveillance as* the percentage of MRSA isolates in relation to all *Staphylococcus aureus* isolates for *the patient population or* areas identified as at-risk for MRSA."

Amendments to Section 299.1
We recommend a more complete definition of MRSA that would include bacteria with a resistance to all relevant beta-lactams. For this reason, we recommend that the second sentence in the current language of the proposed regulations be changed to: "These antibiotics include methicillin, amoxicillin, *oxacillin*, and penicillin."

We also recommend, for the sake of consistency, that both VISA and VRSA be defined using their full, unabbreviated names. These would be Vancomycin-intermediate *Staphylococcus aureus* and Vancomycin-resistant *Staphylococcus aureus*, respectively.

We further recommend that the definitions of VISA and VRSA be changed so that the regulations would always be consistent with the most current CDC guidelines at all times--without having to undergo another rulemaking process--as research and best practices regarding these organisms continues to evolve. We recommend that the current definitions be stricken and the new definitions be listed as follows:

"*Vancomycin-intermediate Staphylococcus aureus (VISA)*—a bacterium that is *intermediate to vancomycin as per current CDC guidelines.*

Vancomycin-resistant Staphylococcus aureus (VRSA)—a bacterium that is resistant to *vancomycin as per current CDC guidelines."*

Sections 2038.3 and 3267.3
Every hospital in the District currently follows national CDC guidelines, DOH standards, OSHA regulations and the Joint Commission standards regarding infection prevention that are required for the facility to be licensed and accredited. Over the past 25 years, all DC hospitals have designed programs to control MRSA and have regularly updated their programs based on the most current literature and CDC guidance. As best practices regarding MRSA will continue to change over time and with updated research, it is essential that we are not forced to undergo a new rulemaking process each time there is a new discovery. It is also essential that the language

in the regulations not restrict hospitals and nursing facilities to out-of-date practices because the regulations have not kept pace with the latest research. For these reasons, we request that the following treatment recommendation be stricken from both of the above-referenced sections: "*A patient requiring "Contact Precautions" shall be placed in either a private room or in a semi-private room with another patient infected or colonized with MRSA (cohorting).*"

Sections 2038.6 and 3267.6

We recommend striking the following language from both of the above-referenced sections as unnecessary: "*This practice will expedite the use of proper precautions and reduce possible spread.*"

Sections 2038.7 and 3267.7

We understand and appreciate that it is the Department's intent in these sections to require hospitals and nursing facilities to have current, accurate and complete worker education programs. However, the proposed language does not require that the education programs be appropriate or in line with current guidelines, only that the programs exist. In addition, use of the phrase "Contact Precautions" does not require that the education programs include information on airborne or droplet transmission. For these reasons, we recommend the following replacement language for both of the above-referenced sections: "Each hospital/nursing facility shall have *appropriate* worker education *requirements* regarding modes of transmission, use of personal protective equipment, disinfection policies and procedures, and other preventive measures in accordance with *current* CDC guidelines on the use of "Standard Precautions" and "*Transmission-Based* Precautions."

Section 2038.99

All long-term care facilities in the District are not hospital-based. The definition of long-term care facility in the proposed language does not acknowledge this fact, thereby leaving many facilities whose patients would benefit from these regulations unaffected. For these reasons, we recommend the definition of long-term care facility in the proposed language be changed to the following: "a *facility* intended for the treatment of patients who require extended stays."

Sections 2038.99 and 3299.1

Again, we recommend a more complete definition of MRSA that would include bacteria with a resistance to all relevant beta-lactams. For this reason, we request that the second sentence in the current language of the proposed regulations in both sections be changed to: "These antibiotics include methicillin, amoxicillin, *oxacillin*, and penicillin."

Additional recommendation

Even with the recommendations above, the implementation of these proposed regulations would increase the administrative and financial burden on hospitals and nursing facilities. It is our hope that the Department would be willing to revisit these regulations in two years to see if they have

accomplished their desired intent and are still in line with best practices, or if they need to be rewritten or repealed. We recommend inserting such language into the regulations to keep them as current as possible.

DCHA strongly believes that the proposed MRSA regulations must be a useful and credible document that reflects the Department's desire to collect needed data and ensure the quality of care for all hospital and nursing facility patients. In its current state, however, the rule fails in several respects to provide enough flexibility for the regulations to keep abreast of the most current guidelines and research. It also uses vague language to place unnecessary administrative and financial burdens on hospitals and nursing facilities. We urge you to reconsider the sections outlined above before releasing the next iteration of this rule.

Sincerely,

Robert A. Malson
President

cc: Rudolf Schreiber, Assistant Attorney General, Office of the General Counsel
Robin Diggs, MPH, Epidemiologist, Bureau of Epidemiology and Health Risk Assessment, District of Columbia Department of Health