The President’s Message

Dear Members of MSIC,

I trust that everyone had a fun and safe summer! It always amazes me how quickly the weeks and seasons just fly by, especially when we’re having fun. It certainly seems as if we just had our Spring 2002 conference a short time ago, but it was in April. Our Fall “Adding Pieces to the Puzzle” program is just around the corner on September 19th and 20th in Lansing. A Certification for Infection Control (CIC) Review course will be offered the evening before the conference for those wishing to take the examination in November. Consider that we have 100 certified ICPs in our organization and hope to increase that count, as this form of official recognition helps to bring value to the organization.

As you read this issue of the MSIC News, you may wish to review the latest information on immunizations, keeping in mind that as we swing into fall, influenza vaccination program recommendations have changed from previous years. In acknowledgment to the success and to focus attention on vaccines – August 2002 was National Immunization Awareness Month and October includes National Adult Immunization Awareness Week.

This issue’s Advocacy Committee Report contains the latest information in the Infection Control and related healthcare disciplines that will help keep you up-to-date on state and national issues. As I’ve mentioned in previous columns, it really helps me to get a snap shot view of the many evolving areas within the healthcare arena. In particular the information provided by MIOSHA, with special thanks to Jenelle Thelen and Nella Davis Ray from MDCIS, on reuse of blood tube collection holders will be of interest to all.

Of Note the lead story in this issue highlights the first isolate of vancomycin-resistant Staphylococcus aureus (VRSA) in the U.S. ICPs will be needed more than ever to assist with appropriate response to strains such as these that continue to keep one step ahead of the antibiotics developed to treat them. On behalf of MSIC I’d also like to thank Dawn Sievert for her contribution on VRSA for this issue of the News.

West Nile Virus (WNV) is near – there was a dead crow in my backyard on July 2 and I reported it appropriately. See also MDCH Update for information on WNV activity as this issue went to press. I was very disappointed that the county didn’t want my crow sent to the state lab for testing but the article under MDCH Updates provides more background on this. Unbeknown to me, there were additional crows found about the same time in our little 2-square mile city of Clawson in Oakland County. From those that were submitted for testing by our city animal control officer, we were notified that some tested positive for WNV. After being on ice in a cooler for several days, my crow went bye-bye with the weekly trash pick-up. Moral of the story, keep reporting them dead crows, but help me to figure out how to clean and disinfect my cooler! [I don’t recall seeing that in Rutala’s draft Guidelines].

So… in consideration of the ups and downs we may experience in our careers and personal lives, I’d like to share a short prose that I find motivating, entitled It's Up to You, by Linda E. Knight:

This life is the only one you're given.
Look for opportunities to grow, and never be discouraged in your efforts to do so.
Replace your weaknesses with positives; take life's broken pieces and re-create your dreams.
Never measure the future by the past; let yesterday become a memory and tomorrow a promise.
Begin each day by focusing on all that is good, and you'll handle whatever comes along.
Take responsibility for your actions; never make excuses for not being the best you can be.
If you should slip, be comforted by the thought that we all do at times.
Determine your tomorrow by the choices you make today, and you'll find yourself living in joy and triumph.

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Hope to see you in Lansing at our upcoming Fall Educational Conference!

Regards,
Joan Wideman, MS, MS, MT(ASCP)SLS, CIC
President of MSIC, 2002

PS: Do you also wear a safety / security hat? If so, you may wish to check out this new document the is FREE to you - NIOSH Publication Number 2002-101 (April 2002) Violence: Occupational Hazards in Hospital NIOSH Publication Number 2002-101. The purpose of this brochure is to increase worker and employer awareness of the risk factors for violence in hospitals and to provide strategies for reducing exposure to these factors. Available as a pdf (acrobat reader) file for download by following instructions found at the website address http://www.cdc.gov/niosh/2002-101.html.

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Vancomycin-Resistant Staphylococcus aureus, Michigan 2002

Submitted by: Dawn Sievert, MS - Communicable Disease Epidemiologist, Michigan Department of Community Health (MDCH)

The first clinical case of vancomycin-resistant Staphylococcus aureus (VRSA) in the United States was detected and investigated in June 2002. The case patient was a 40-year-old, Michigan resident with diabetes, peripheral vascular disease, and chronic renal failure. The patient had been receiving dialysis at an outpatient facility since August 1999, and since February 2001 had undergone three toe amputations on the right foot and had been treated for chronic toe ulcerations. For intermittent infections of the ulcers, as well as those in various hemodialysis catheter and graft (shunt) sites, the patient had received several courses of antimicrobial therapy, often including vancomycin.

In April 2002, the patient was hospitalized and underwent surgery for removal of a gangrenous toe. Subsequently, the patient developed methicillin-resistant S. aureus bacteremia caused by an infected arteriovenous hemodialysis graft. The graft was removed and the infection was treated with vancomycin and rifampin. In June 2002, the patient presented for a dialysis session with a suspect catheter exit-site infection. The catheter was removed, the exit-site was cultured, and blood was drawn. The catheter tip was sent to one hospital-laboratory in the area, and the exit-site culture and blood were sent to another for testing. Within a few days, both laboratories had grown and identified S. aureus resistant to oxacillin (MIC>16 ug/mL) and vancomycin (MIC>128 ug/mL). These results were immediately reported to the Michigan Department of Community Health (MDCH) and the Centers for Disease Control and Prevention (CDC). The cultures were forwarded to the laboratories at both institutions for confirmatory testing. Meanwhile, one week later, while the patient's catheter exit-site appeared healed, the chronic foot ulcer appeared to be infected. At this time, cultures were taken from the exit-site wound, the foot wound and the patient's nares. In the subsequent days, the exit-site wound and nares cultures did not grow VRSA, however, the foot wound grew VRSA, vancomycin-resistant Enterococcus faecalis (VRE), and Klebsiella oxytoca. Results from the confirmatory testing at MDCH and CDC laboratories revealed VRSA (MIC>128 ug/mL) from the catheter tip, the original exit-site and foot wound cultures.

As soon as VRSA had been confirmed, a comprehensive epidemiologic contact investigation was begun to assess the possibility of transmission beyond the patient to healthcare workers, other patients, family members, friends, and community contacts. At the same time, infection control practices were assessed in all healthcare facilities where the patient had been seen between April and June of 2002. All facilities were following standard precautions consistent with CDC guidelines. At the facilities that had continuing contact with the patient, all healthcare workers were informed of the situation and more stringent infection control measures were initiated. Staff was assigned for one-on-one direct patient care, contact isolation procedures were utilized, dialysis equipment and non-critical care items were dedicated, and the patient received treatment in an area separated from other patients and during the last shift of the day. The patient continues to receive aggressive care for the foot wound infection and will be cultured until three consecutive weeks of VRSA negative cultures are obtained. The dedicated staff will also receive weekly nasal swabs during this time. To date, there has been no documented transmission of this VRSA organism to any other individuals.

Preliminary laboratory analysis of this VRSA organism has indicated that resistance to vancomycin was acquired through the transfer of the vanA gene from vancomycin-resistant Enterococcus faecalis. This emphasizes the importance of stringent infection control practices, accurate laboratory testing, and vigilant surveillance of resistant organisms.

The CDC has published guidelines for the prevention and control of staphylococcal infection associated with reduced susceptibility to vancomycin (MMWR 1997; 46(27):626-8, 635). These guidelines are currently under revision to include information gained from this VRSA investigation. All healthcare facilities in the United States should make it a priority to implement strategies to improve adherence to current guidelines to prevent transmission of antimicrobial resistant organisms.

You may contact the Michigan Department of Community Health with any questions regarding antimicrobial resistance. For questions about infection control practices or surveillance of resistant organisms, please contact the antimicrobial resistance epidemiologist, Dawn Sievert at (517) 335-9001. For laboratory testing questions, please contact the quality assurance microbiologist, Martha Boehme at (517) 335-9654.

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5126a1.htm

MDCH Press Release:
http://www.michigan.gov/mdch/0,1607,7-132-8347-43226--,00.html

# Editorial Note: For ICPS who become aware of a report of VRSA reinforce with your laboratory the need to confirm presence of true vancomycin resistance by contacting MDCH Laboratories.
Q & A On Blood Tube Collection Holders

Prepared by MSIC Advocacy Committee #

Illustrative Examples of Application of the Federal Interpretation Prohibiting Reuse of Blood Tube Collection Holders -

Question #1: Does the federal OSHA interpretation prohibit the removal of sharps from blood tube holders that are engineered to allow mechanical release of the phlebotomy needle from the holder?

Answer: Yes, removal by any means, regardless of the design of the blood tube holder, is prohibited under both federal OSHA’s Bloodborne Pathogens Standard (29 CFR 1910.1030, paragraph (d)(2)(vii)(A)) and OSHA’s Bloodborne Pathogens Standard and Michigan Bloodborne Infectious Diseases Rules unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure. In addition, the blood drawing/phlebotomy needle is rarely, if ever, required by a medical procedure. Because such devices involve the use of a double-ended needle, such removal clearly exposes employees to additional risk, as does the increased manipulation of a contaminated device. In order to prevent potential worker exposure to the contaminated hollow bore needle at both the front and back ends, blood tube holders, with needles attached, must be immediately discarded into an accessible sharps container after the safety feature has been activated.

RE: Federal OSHA Standard Interpretations 06/12/2002 - Re-use of blood tube holders.

The following excerpt was taken from the Federal OSHA letter of interpretation related to the reuse of blood collection tube holders.

Question: What is OSHA’s position regarding the use of blood tube holders specifically removing a needle in order to reuse a tube holder? Must each blood collection device be disposed of with the needle attached each time they are used?

OSHA’s Bloodborne Pathogens Standard (29 CFR 1910.1030, paragraph (d)(2)(vii)(A)) provides: “Used needles and other contaminated sharps shall not be sheared, bent, or broken and shall not be recapped or resheathed where other disposal methods are practical. Used needles and other sharps shall not be recapped, resheathed, or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.”

In Michigan, the MIOSHA Part 554 Bloodborne Infectious Diseases Standard R 325.70007 Work Practices Rule 7. (2) (e) states, “Used needles and other contaminated sharps shall not be sheared, bent, or broken and shall not be recapped or resheathed where other disposal methods are practical. Used needles and other sharps shall not be recapped, resheathed, or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.”

The MIOSHA compliance directive for Bloodborne Infectious Diseases is currently under revision. When completed, copies may be requested in accordance with the Freedom of Information Act (FOIA) through the Michigan Department of Consumer and Industry Services, Bureau of Safety and Regulation, Occupational Health Division, 7150 Harris Drive P.O. Box 30649 Lansing, MI 48909-8149.

Sincerely,

Jenelle K. Thelen
Industrial Hygienist
MIOSHA Consultation Education and Training
Prepared for MSIC News on August 5, 2002

# Reviewed with MIOSHA Consultation Education & Training Division for accuracy.
Date of Release: August 16, 2002

West Nile Virus Common-Sense Precautions Key to Prevention
Two Probable Human Cases Await CDC Confirmation

Michigan Department of Community Health (MDCH) Director, James K. Haveman, Jr., and Michigan Department of Agriculture Director Dan Wyant, today urged individuals to continue to take common-sense precautions to minimize exposure to mosquitoes to protect themselves from West Nile virus. To date, two probable cases among residents of Southeast Michigan are in the process of being confirmed by the CDC. A case in a horse in Washtenaw County has been confirmed. Crows in over 40 counties in Michigan to date in 2002 have been found to have WNV infection.

“Confirming West Nile virus in crows in Michigan is not cause for panic or alarm, it simply reinforces the importance of minimizing exposure to mosquitoes,” said Haveman. “We encourage individuals throughout the state to follow simple, common-sense precautions to protect themselves from mosquito borne illness.”

The most sensitive indicator of West Nile virus activity is the presence of dead crows. Citizens are encouraged to report dead crow sightings to the West Nile virus toll-free hotline at 1-888-668-0869 or through a website at www.michigan.gov/mda and by clicking on “West Nile virus” and on “2002 Specimen Collection and Submission Instructions.” Selected crows will be sent to the Animal Health Diagnostic Laboratory at Michigan State University for testing.

“There is also no need for individuals to panic if they find a dead crow,” said Wyant. “If the bird is found in a county where West Nile has already been detected and has been reported by calling the toll-free hotline or through the Internet, the crow can simply be properly disposed of.” Individuals should always avoid barehanded contact when handling any dead bird. Use disposable gloves to put the dead bird in a double plastic bag. If gloves are not available, invert a plastic shopping bag and scoop up the bird with the bag. Once the bird has been reported, place the bagged carcass in an outdoor garbage can for disposal.

Additional crows will not need to be submitted for testing from the 24 counties—Bay, Berrien, Branch, Charlevoix, Clinton, Genesee, Gratiot, Ingham, Kent, Lapeer, Lenawee, Macomb, Midland, Muskegon, Oakland, Oscoda, Ottawa, Saginaw, St. Clair, St. Joseph, Shiawassee, Tuscola, Washtenaw and Wayne—where West Nile has been detected. Individuals from these counties are still urged to report the presence of dead crows through either the toll free hotline or website.

The virus is NOT transmitted from person-to-person or from crows to people. You cannot get it from touching or kissing a person who has the virus or from a health care worker who has treated someone with it. West Nile virus is transmitted to people by the bite of an infected mosquito. There are many ways to reduce the risk of becoming infected. They include:

• Applying insect repellent that contains the active ingredient DEET to exposed skin or clothing, always following the manufacturer’s directions for use on the label.
• Avoid applying repellent to children under 2 years of age, and to the hands of older children because repellents may be transferred to the eyes or mouth potentially causing irritation or adverse health effects.
• Maintaining window and door screening to keep mosquitoes out of buildings.
• Draining standing water in the yard. Empty water from mosquito breeding sites, such as flower pots, pet bowls, clogged rain gutters, swimming pool covers, discarded tires, buckets, barrels, cans and similar sites in which mosquitoes can lay eggs.
• Wearing light colored long-sleeved shirts and long pants when outdoors.

Mosquitoes become infected with West Nile virus when they feed on infected birds that carry the virus in their blood. After 10 to 14 days, the mosquitoes salivary glands become infected and those infected mosquitoes can then transmit the virus to humans and other animals while biting them to take blood. During blood feeding, the mosquito injects the virus into the animal or human, where it multiplies and may cause illness. Crows are very susceptible to infection with West Nile virus and will die within two to three weeks of infection. Because of this, dead crows are the most sensitive indicator for the presence of West Nile virus in an area.

Most people infected with the West Nile virus have no symptoms of illness, but some may become ill three to 15 days after the bite of an infected mosquito. Health authorities believe about one in four infected persons will have mild illness with fever, headache and body aches, sometimes with skin rash and swollen lymph glands. Encephalitis is less common and may include headache, high fever, stiff neck, stupor, disorientation, coma, tremors, muscle weakness, convulsions and paralysis. In a few cases, mostly among the elderly, death may occur.

Horse owners are encouraged to contact their local veterinarian to discuss appropriate preventive measures. Prevention tips for horses include:

• Using approved insect repellants to protect horses.
• Placing horses in stables, stalls or barns during the prime mosquito exposure hours of dawn and dusk, and other times when mosquitoes are present, if possible.
• Eliminate standing water and drain troughs and buckets at least two times a week.
• Consulting with local veterinarian about using the recently developed vaccine to help control this disease in horses. The vaccine has been shown safe for use, and is expected to prove to be effective in studies.
The Michigan Departments of Community Health, Agriculture, and Natural Resources, Michigan State University Animal Health Diagnostic Laboratory and Michigan State University Department of Microbiology and Molecular Genetics all work cooperatively on surveillance activities for West Nile Virus in Michigan. Information on West Nile virus can be found at http://www.michigan.gov/mda, http://www.cdc.gov or by calling the West Nile virus toll free hotline at 1-888-668-0869. The most recent listing of counties where West Nile virus has been detected can be found at http://www.michigan.gov/mda and by clicking on “West Nile Virus,” located along the right “Quick Links” bar. 

PS: The August 6, 2002 issue of Annals of Internal Medicine contains a timely article entitled “West Nile Virus: A Primer for the Clinician”. It is available online at www.annals.org

Submitted by, Mary Grace Stobierski, DVM,MPH,DACVPM
Chief, Infectious Disease Epidemiology Section and State Public Health Veterinarian
Michigan Dept. Community Health

Advocacy Committee Report

Chicago Tribune Series on Hospital Acquired Infections Grabs National Media Attention

According to the Centers for Disease Control and Prevention (CDC), hospital-acquired infections are adverse patient events that affect approximately two million people each year. This issue has been highlighted in a series of articles published in the Chicago Tribune (July 21-23), which also addressed challenges related to calculating accurate rates of infection because of incomplete reporting. Although most agree that these reports have increased public awareness of a serious issue, critics say this focused on past problems without sufficiently recognizing current efforts to control infection. The American Hospital Association has noted that the process of controlling infection requires constant attention and new technologies. For example, waterless hand cleansing agents, which many hospitals have adopted, have been shown to improve hand hygiene practices because of their ease of use and accessibility. As a result, they help reduce infections spread by hand contact.

Following the media stories CDC sent out a bulletin highlighting the importance of monitoring hospital-associated infections as critical adverse events, and describing their plan to expand its current infection surveillance system for identifying and reporting infections. The CDC’s Division of Healthcare Quality Promotion (DHQP) has monitored infection for more than 25 years using the National Nosocomial Infections Surveillance System (NNIS). NNIS has standardized definitions and reporting processes that permit comparisons and measurement of improvements. NNIS is undergoing expansion and will become an Internet-based knowledge system network, called the National Healthcare Safety Network (NHSN). It will monitor the reporting of adverse events, including healthcare-associated infections and disseminate information on prevention. When NHSN has been implemented, any healthcare facility will be eligible to participate.

For DHQP educational materials (video conferences, slide sets, etc.), and for prevention strategies, including preventing antimicrobial resistance, go to: http://www.cdc.gov/drugresistance/healthcare. For DHQP priorities to reduce healthcare-associated infections and other adverse events, go to: http://www.cdc.gov/nic id/hip/challenges.htm

Smallpox Immunization Update

As this issue of the News went to press estimates are that HHS/CDC should make their final decision re: the Advisory Committee on Immunization Practices (ACIP) Smallpox vaccination utilization update (pre-event) no later than mid-August. Reliable sources indicate that the number will be well beyond the ACIP recommendations to date. (ACIP projections could be to target offering vaccine to 20,000 health care and other personnel; other projections have been as high as 500,000. The reason for the higher estimate is the fact that patients deliberately exposed to smallpox who then seek care would go to the closest hospital, not necessarily a “designated” facility and more hospital staff need to be protected.

A recent story (USA TODAY) reported that in Texas (Baylor U) volunteers are rolling up their sleeves for science, letting themselves be immunized with smallpox vaccine that has been sitting in lab freezers for 40 years. At the National Institutes of Health in Maryland, researchers are planning to test old stocks of smallpox vaccine on children ages 2 to 5. More studies are underway to test a new vaccine being made as fast as possible under a contract with the U.S. government.

CDC has been soliciting input on the vaccination initiative from many groups but has learned that after an initial enthusiasm about vaccination, interest wanes as they consider the hazards. For complete information go to http://www.cdc.gov/hip/smallpox/supp_rec.htm

Influenza Vaccine Reminder

In addition to other immunization news elsewhere in this edition of the MSIC News, ICPs and Occupational/Employee Health staff should be aware of the plan this year from CDC/NIP to promote the efficacy of influenza vaccine even after October-November. There will be sufficient vaccine to gear up for the usual October promotion, but even after Thanksgiving organizations might be wise to plan for a “catch-up” Influenza immunization day, working to get the highest number of workers immunized as possible. Flu outbreaks do occur in early winter and later immunization is effective. For planning information go to: http://www.cdc.gov/hip/flu/default.htm
**OSHA and Emphasis Programs**

Hospitals in at least one part of the country recently found inspectors at their front doors checking for compliance with the bloodborne pathogens standard. The Occupational Safety and Health Administration’s (OSHA) Region 8 office -- which covers Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming -- began what is known as a “local emphasis program” that looks at how hospitals stay in line with the requirements of the bloodborne pathogen standard (29 CFR 1910.1030).

Inspectors will focus on key provisions of the Needlestick Safety and Prevention Act including recordkeeping, the hospital’s exposure control plan, a key requirement of the bloodborne pathogens standard and the organization’s needlestick injury log. Go to [http://www.osha.gov](http://www.osha.gov) and search on “needlestick.” Michigan has its own state-specific OSHA plan but this emphasis initiative may signal interest in assuring similar adherence by providers here in Michigan.

**IMPORTANT: MICHIGAN-SPECIFIC UPDATE ON BLOOD TUBE COLLECTION HOLDERS** – See the special report on the impact of the federal interpretation that prohibits reuse or removal of sharps from blood tube collection holders elsewhere in this is sue of the News.

**JCAHO Approves Six Patient Safety Goals Based on Sentinel Events & Other News**

The six patient safety goals developed from reported sentinel events have been finalized by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO Board of Commissioners approved the six National Patient Safety Goals, representing 11 recommendations for improving the safety of patient care, for implementation effective January 1, 2003. The recommendations were developed by the Sentinel Event Alert Advisory Group through an intensive review process of all past Alert recommendations published by JCAHO. The 2003 National Patient Safety Goals are to:

1. Improve the accuracy of patient identification.
2. Improve the effectiveness of communication among caregivers.
3. Improve the safety of using high-alert medications.
5. Improve the safety of using infusion pumps.
6. Improve the effectiveness of clinical alarm systems.

The recommendations for each goal are provided in the JCAHO’s July edition Joint Commission Perspectives available online. The recommendations will be subject to survey beginning January 1, 2003. Organizations may implement alternatives to the recommendations if they are determined, upon review by the Sentinel Event Alert Advisory Group, to be at least as effective as the published recommendations. Organizations that fail to implement the recommendations or acceptable alternatives will receive a single special Type I recommendation related to the particular patient safety goal. The process for reviewing alternative recommendations will be communicated to accredited organizations in a future issue of Joint Commission Perspectives and will be posted on JCAHO’s Web site. [http://www.jcaho.org](http://www.jcaho.org)

**JCAHO PRESS RELEASE & NEW REPORT ON RISKS ASSOCIATED WITH NATIONWIDE NURSING SHORTAGE** – JCAHO issued a press release and held a news conference to highlight the risks to patients associated with the current shortage of over 126,000 nursing positions and expectations of continued growth of this shortage. “The need for solutions to this problem is particularly urgent,” says Dennis S. O’Leary, M.D., president, JCAHO. “We must as a country understand not simply what needs to be done, but who specifically is responsible for getting each task done. Otherwise, we face a future in which patient safety and health care quality will be significantly compromised.” Additional details and the JCAHO’s new report, “Health Care at the Crossroads” are available online at: [http://www.jcaho.org/news+room/press+kits/nursing+shortage+press+kit.htm](http://www.jcaho.org/news+room/press+kits/nursing+shortage+press+kit.htm)

**President Signs Nurse Reinvestment Act**

President Bush signed the Nurse Reinvestment Act (H.R. 3487) August 1, following the compromise achieved by House and Senate negotiators during the week of July 22. Major provisions of the act include nurse recruitment through public service announcements and expansion of the National Nurse Service Corps, nurse retention through internships, residency programs and career ladders, improved retention by enhancing collaboration with other professionals, programs to increase geriatric education, nurse faculty loan programs, and “magnet facility” patient safety grants to support greater provider and care activity coordination. The approved compromise legislation can be viewed [http://thomas.loc.gov](http://thomas.loc.gov) and search on: **H.R. 3487**. For a related story on the workforce go to: [http://blogs.hrsa.gov/healthworkforce/emp/](http://blogs.hrsa.gov/healthworkforce/emp/)

**Anthrax Detection Technologies Found Unreliable**

The Office of Science & Technology in collaboration with the Office of Homeland Security have determined that anthrax detection devices, including handheld monitors are unreliable and should not be used to investigate locations where intentional release of anthrax is suspected. Specifically, *Bacillus anthracis* detection thresholds for these devices are well above the minimum level that can infect personnel, and are not suitable for determining biological contamination of personnel, rooms, or pieces of equipment. Many devices also have been shown to give a significant number of false positives, which could cause unnecessary medical intervention with its own risk. Microbiological culture in a CDC-validated laboratory is the “Gold Standard” for determining the presence of anthrax spores. Field testing solely using commercially available polymerase chain reaction or handheld immunoassays for the detection of *Bacillus anthracis* is not recommended and should not be used.

Submitted by,

Judene Bartley, Doris Neumeyer, Mary Parston, Nella Davis Ray, and Linda Scott.
Influenza Vaccine Bulletin #3

Issued July 3, 2002 for Influenza Season 2002-03

-Submitted by, Mary Parston

The National Immunization Program (NIP) of the Centers for Disease Control and Prevention (CDC) has developed this bulletin to update partners about recent developments related to the production, distribution and administration of influenza vaccine for the 2002-2003 influenza season. Excerpts from this will be reprinted in this issue and future issues, as appropriate, of MSIC News.

Influenza Vaccine Distribution and Administration

CDC published an erratum in the June 28 MMWR to address an inconsistency in the recommended timing of vaccination of target groups in the 2002-03 influenza vaccine recommendations of the Advisory Committee on Immunization Practices (ACIP). The erratum is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5125a4.htm.

- Vaccination of the following groups should begin in October: persons at increased risk of influenza-related complications (persons 65 years of age and older; persons 6 months - 64 years of age with certain medical conditions, and healthy children 6-23 months of age); health care workers; household contacts of persons at increased risk of influenza-related complications (including contacts of infants less than 6 months old who are not eligible for influenza vaccine); and children aged 6 months - 9 years of age receiving influenza vaccine for the first time. All others should be vaccinated beginning in November.

- Vaccination efforts undertaken before November should focus on the October priority groups to the extent feasible, but providers should not turn away other individuals seeking influenza vaccination.

- There are no changes to groups of children eligible for influenza vaccine under the Vaccines for Children (VFC) program for the upcoming 2002-03 influenza season. Beginning with the 2003-04 influenza season, VFC coverage for influenza vaccine will be extended to healthy children aged 6-23 months and children aged 2-18 years who are household contacts of children < 2 years.

Influenza vaccine for the 2002-03 influenza season is still available for purchase. Health care providers who have not ordered influenza vaccine should do so as soon as possible to ensure timely receipt of vaccine.

- Aventis-Pasteur (1-800-822-2463) has indicated that all of its influenza vaccine for the 2002-03 influenza season has been prebooked, but the company=s waiting list remains open.

- The Evans Vaccines brand of influenza vaccine is available from Henry Schein and its GIV and Caligor divisions (at 1-800-772-4346, 1-800-521-7468, or 1-888-225-4467, respectively). In addition, Evans Vaccines has added two distributors. FFF Enterprises (1-800-843-7477 by phone, online at www.fluvaccine.net or by fax at 1-800-418-4333) is accepting orders for small quantities of 10-dose vials and is still pre-booking single-dose syringes. Bergen Brunswich has prefilled syringes available through two of its subsidiaries. Hospitals, home infusions pharmacies, and dialysis clinics should calls ASD Specialty Healthcare at 1-800-746-6273. All others may contact Besse Medical Supply at 1-877-462-3773 or email to flu@besse.com.

- Wyeth Vaccines (1-800-358-7443) has prebooked all of its projected production but they are accepting names on a waiting list.

Influenza Vaccine Communications

The American Medical Association (AMA) and the CDC co-sponsored the 2002 National Influenza Summit in Atlanta, Georgia on May 22-23, 2002.

- For additional details on this summit visit the following web address: http://www.ama-assn.org/ama/pub/article/1826-6268.html

CDC has new education materials for this season available on the CDC influenza website.

- New flyers on the timing of influenza vaccination for this season and myths concerning influenza vaccine are available on the CDC influenza website at http://www.cdc.gov/nip/flu.

REMINDER – October 14-20, 2002 is Adult Immunization Awareness Week

OSHA Launches Electronic News Memo

WASHINGTON – On March 1, 2002, the Occupational Safety and Health Administration (OSHA) unveiled the premiere issue of its new electronic communication tool which will be e-mailed on a regular basis to subscribers.

Called QuickTakes, the e-news memo contains a snapshot of OSHA=s activities that support safety and health in the workplace, including news and announcements, background information and other information of interest to stakeholders. Within the summaries, OSHA will often include links to the agency=s website, as well as other sites related to safety and health that provides additional information on specific items.

“QuickTakes will deliver short and concise information of the agency=s activities to safety and health stakeholders,” said OSHA Administrator John Henshaw. “The e-mail, which will come directly to your electronic mail box if you subscribe, will cover just the highlights of important OSHA issues. Readers can then get additional information on a subject they would like.”

Readers can receive the news memo by clicking on the QuickTakes icon on OSHA=s homepage and following the subscription instructions. If readers choose not to receive QuickTakes automatically, they may view it on OSHA=s website.

Note: you may view back issues (from March 1, 2002 to date) and/or subscribe to QuickTakes at URL http://www.osha.gov/as/opa/quicktakes/index.html

-Submitted by Joan Wideman
Another exciting conference coming up… ‘ADDING PIECES TO THE PUZZLE’ on September 19 and 20 at the Sheraton in Lansing. Brochures have been mailed. Doris Neumeyer and her able committee have planned an agenda that will appeal to ICPs across the continuum. Topics include interventional epidemiology, urine culturing, sexually transmitted illnesses in women, TB and Hepatitis updates, dialysis, and home care infection definitions. Come and network with practitioners across the state and continuum of care.

Certification in Infection Control Preparation Course will be offered on September 18 at the Sheraton in Lansing. Led by Joan Wideman and Elaine Flanagan, this course will prepare participants for the Certification Board of Infection Control & Epidemiology, Inc. exam. See brochure for details or contact Amy Mulonas.

Fundamentals in Infection Control will be offered on October 23, 24, and 25 at the St. Francis Retreat Center in Dewitt. Designed for new infection control professionals in all areas of health care and taught by an expert team of MSIC members, this course is a must for people new to the area of infection control. Contact Amy Mulonas or Joan Kirkwood, Program Coordinator at her e-mail address: jmkirkwood5@attbi.com for more information or to receive a brochure.

Mark your 2003 calendar… MSIC Spring Conference dates have been set for April 10 and 11 at the Sheraton Lansing. Maggie Piehl and her team have preparations well underway for another exciting conference. Fall Conference in 2003 will celebrate 30 years of MSIC excellence. Dates are pending for this gala event. Check our website information.

Submitted by Paula Hoegemeyer, Chair- Professional Development

Marketing News!

The following new resources were added to the MSIC Library in July, 2002. Contact the MSIC librarian, Chris Schemansky to borrow items for review – you only have to pay for shipping back to the librarian. (Note: you must be a MSIC member)

Bioterrorism Toolkit – set of three CD-ROMs
Everything you wanted to know about bioterrorism and how to prepare for it!

Barnes Jewish Infection Control Modules – CD-ROM
Three excellent educational programs to prevent ventilator associated pneumonia, line related bloodstream infections, and surgical site infections.

Submitted by Sue Burns, Organizational Promotions Chair

New Products

New products will be available at the MSIC Conference Marketing Table at Fall 2002 Conference and by order! Please contact Amy Mulonas for pricing list and orders at 248-693-3474 or check the website at www.msic-online.org

These new products include:

APIC Text Supplement $49.00
Edited and additional chapters to supplement the original APIC Text of Infection Control & Epidemiology.

APIC Handbook of Infection Control – 3rd Edition $35.00
New edited edition of the original handbook – a “must have” for new IC professionals.

Home Care Handbook of Infection Control $29.00
Handbook directed for infection control in the home setting

Ready Reference to Microbes $ 39.00
The best reference guide to microbiology organisms – a "must have" for all IC professionals – even if you are a microbiologist!

Strategies for Pandemics and Disasters Toolkit $ 75.00
Disaster plan design

Michigan Society for Infection Control
Amy H Lawn, RN, MS, CIC
8301 Cowan Lake Dr.
Rockland, MI 49341