



# NEWS

## Michigan Society for Infection Control

Promoting Healthy Communities Through Epidemiology

Winter 2004

Volume 29 - Number 1

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### Special Member News Alert:

#### Federal OSHA Withdraws Proposed Tuberculosis (TB) Rule & Applies Respiratory Protection Standard to TB

On December 31, 2003 the federal Occupational Safety & Health Administration (OSHA) published two actions in the U.S. Federal Register. The first, consistent with earlier public notice, involved withdrawal of OSHA's proposed TB Rule. The second was a revocation of an older standard for respiratory protection being applied to respirators for protection against occupational exposure to TB pending definitive action on their proposed TB Rule. The result of this latter action means that OSHA's General Industry Standard for Respiratory Protection is being applied to respirators provided for protection against TB infection. One notable requirement in this General Industry standard is both initial and annual fit testing of certain types of respirators such as N-95. More details are available from MSIC web <http://www.msic-online.org>

As this issue of the News went to press, discussions with officials with MIOSHA have indicated they likely will issue more information on impact of this federal action on Michigan. In the interim MIOSHA will continue to enforce the 1996 TB Directive which only requires initial fit testing of N-95 respirators. Also, MIOSHA's general approach is to provide notice and education related to changes in regulations first before widespread enforcement. The TB directive is available at: [http://www.michigan.gov/documents/CIS\\_WSH\\_CET\\_151\\_34470\\_7.doc](http://www.michigan.gov/documents/CIS_WSH_CET_151_34470_7.doc)

-MSIC Advocacy Committee

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### Presidents Message

2003 has been an exciting year for MSIC and I have enjoyed being able to serve the membership. The anniversary celebration this fall was a great success. I would like to express much appreciation to Betty Ann Eash, Paula Hoegemeyer, and Maggie Piehl and her team for devoting so much time and effort for planning our 30th anniversary celebration.

With the winter approaching, I hope everyone has taken the flu shot and remains healthy for the New Year. Many of us, however, may still have other viral illnesses as the season progresses. Just remember your tissues, don't take antibiotics, stay home and have a sip of tea while you rest!

The MSIC board meets in January with new leadership and ideas for 2004. Teri Lee Dyke will lead the board as President. Welcome also to Sue Lloyd as President Elect, Deb Leithauser, Professional Development, and Jenelle Thelan MIOSHA Liaison.

We are looking forward to seeing you at our 2004 conferences. The dates are April 22nd and 23rd and the fall conference will be October 7th and 8th. If you would like to consider a poster, visit the MSIC web to identify the chair for that session for more information. Posters are a good way to network with your peers and remain current in the practice of Epidemiology and infection control.

I wish you a happy and healthy New Year.

Regards, Elaine Flanagan, President 2003

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### Society Changes

It's that time of year again, and I'm not referring to flu season. It's the time of year when we have to stand up and give a big round of applause to our outgoing board members: Sue Burns-Organizational Promotions Chair, Paula Hoegemeyer-Professional Development Chair, Joan Wideman-Past President and Nella Davis-Ray-MIOSHA Liaison. MSIC would like to thank Joan, Paula, Sue and Nella for all their hard work and dedication.

And now a big WELCOME to the new MSIC board members who will take over the reigns in January 2004: Teri Lee Dyke-President, Jennifer Madigan-Organizational Promotions Chair, Deb Leithauser-Professional Development Chair, Sue Lloyd-President Elect, and Jenelle Thelen- MIOSHA Liaison.



Visit us On-Line at:  
[www.msic-online.org](http://www.msic-online.org)

**MSIC 2004  
Leadership Roster**

**PRESIDENT**

Teri Lee Dyke, RN,BSN,CIC  
Regional TB Consultant  
American Lung of Michigan  
(517) 484-7283  
Fax: (517) 484-2118  
terileedyke@voyager.net

**PRESIDENT-ELECT**

Sue Lloyd, MT (ASCP), CHSP, CIC  
Epidemiologist  
St. Joseph Mercy – Oakland  
(248) 858-3159  
Fax: (248) 858-3174  
finns@trinity-health.org

**PAST PRESIDENT**

Elaine Flanagan, RN,BSN,MSA,CIC  
Harper University Hospital  
DMC Manager Epidemiology  
(313) 745-1708  
Fax: (313) 745-1709  
eflanaga@dmc.org

**SECRETARY**

Rachelle S. (Ricki) Burk, BS,RN,CNA  
Patient Care Manager  
Clinton Memorial Hospital  
(989) 224-5607  
Fax: (989) 224-5680  
Ricki.burk@sparrow.org

**TREASURER**

Rosemary M. Ham,RN,MSN,CIC,FNP  
Nurse Practitioner  
(269) 781-3744  
rosemaryham@yahoo.com

**ADVOCACY CHAIR & MDCH  
LIAISON**

Linda Scott RN,BSN,CIC  
Bioterrorism Hospital Coordinator  
Office of Public Health  
Preparedness  
Michigan Department of  
Community Health (MDCH)  
(517) 335-8284  
Fax: (517) 335-9434  
scottlin@michigan.gov

**INFORMATION TECHNOLOGY**

Russell N. Olmsted, MPH,CIC  
Epidemiologist, Infection Control  
Services  
St. Joseph Mercy Hospital  
(734) 712-3158  
olmstedr@trinity-health.org

**MANAGING EDITOR, MSIC  
NEWS**

Jennifer Sweeney, MPH  
Clinical Information Analyst  
Infection Control & Epidemiology  
U of M Hospitals & Health Centers  
(734) 936-6355  
Fax (734) 763-7692  
Jenfur@umich.edu

**INTERNET DEVELOPMENT  
COORDINATOR & DATABASE  
SUPPORT**

Joyce Buerge, BSMT,(ASCP),CIC  
Consultant  
(989) 673-4626  
buerge@centurytel.net

## Immunization Update

Pediarix Correction: In the fall newsletter the minimum age for use of Pediarix was stated to be 6 months. According to the CDC guidelines, the minimum age for the first dose of Pediarix is 6 WEEKS. Additional information on Pediarix is available on the CDC website at <http://www.cdc.gov/nip/vaccine/pediarix/pediarix-faqs-hcp.htm> - R10

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## MSIC News Notes: November 2003

Judene Bartley, Advocacy committee  
**National News**

### CDC Environmental Infection

In late November, the Centers for Disease Control and Prevention (CDC) released the complete 235-page Guidelines on Environmental Infection Control in Health Care, that include background information, recommendations and appendices. CDC announced that the full document may be downloaded in its entirety from the CDC Web site. Only the recommendations (Part 2) had been published earlier this year in the June 6, 2003, MMWR. Go to:

<http://www.cdc.gov/ncidod/hip/enviro/guide.htm>

### 2004 National Patient Safety Goal and Infection Control – Update on Goal#7- HAI FAQs

On November 3, 2003, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) updated the frequently asked questions (FAQs) for the healthcare-associated infection-related (HAI) 2004 National Patient Safety Goals (NPSG). Earlier this year, JCAHO announced that it was retaining each of the six 2003 goals, with some modifications, and adding a seventh goal aimed at reducing the risk of healthcare-acquired infections. HAI Goal #7 requires that a patient suffering death, permanent injury or loss of function as the result of an HAI qualifies as a sentinel event and also requires compliance with the CDC Hand Hygiene Guideline. More information is now published on the JCAHO web site under ‘Frequently Asked Questions’

[http://www.jcaho.org/accredited+organizations/patient+safety/04+npsg/04\\_faqs.htm](http://www.jcaho.org/accredited+organizations/patient+safety/04+npsg/04_faqs.htm)

### Alcohol-based Hand Rubs – Update from National Fire Protection Agency (NFPA)

The Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene in healthcare settings (10/02) calls for the use of alcohol-based hand wash solutions (hand rubs) as an effective tool in reducing health care associated infections (HAI), but fire authorities have prohibited its use in specific areas of health care organizations based on fire safety regulations and perceived risk of fire hazards. Activities responding to the fire codes undertaken by the American Society for Healthcare Engineering (ASHE) and CDC were summarized in MSIC Fall news and can be located at CDC and ASHE Web sites listed below.

**NFPA meeting:** On November 19, 2003 the results of an ASHE-sponsored fire modeling study carried out by Gage-Babcock & Associate (GBA) were presented by Chris Leaver, PE, of GBA to a group of fire safety professionals involved in fire code setting activities. Judene Bartley, ASHE and AHA liaison to APIC, presented the infection control issues and the urgent need for increased accessibility. Following the presentations, Tom Jaeger PE, GBA, facilitated a panel discussion and questions from the audience. Panelists included ASHE Advocacy director, Dale Woodin; Dean Samet, JCAHO standards, and representatives from the VA and long term care facilities. There was increasing agreement by fire marshals and safety professionals to support the use of alcohol in patient rooms in the fight to reduce HAIs, but differences of opinion on the degree of risk in egress corridors remain within some groups. Others expressed their conviction that current codes do not prohibit dispenser use in corridors and several avenues are being actively pursued by ASHE and other members of the NFPA to resolve code issues to improve access. No definitive time line has been determined for final resolution, but approval processes for potential changes would not occur before January or February of 2004. In the meantime, all healthcare facilities are urged and encouraged to install these dispensers within patient rooms as appropriate for the population.

<http://www.cdc.gov/handhygiene> or [www.hospitalconnect.com/ashe/currentevent/abhi.html](http://www.hospitalconnect.com/ashe/currentevent/abhi.html)

**Note:** Michigan has specific regulations in place that must be followed. Michigan’s Office of Fire Safety encourages contact for questions regarding dispenser placement and should be contacted for direction. Although national codes may be reviewed or modified, any changes made will still require review and consideration for final interpretation by Michigan’s OFS.

See <http://www.msic-online.org> for contact information.

## Michigan News

### Blue Cross Blue Shield of Michigan (BCBSM): Infection measurement initiative

In late September, MSIC was invited by David Share, MD, Clinical Director of the Center for Health Care Quality at Blue Cross Blue Shield of Michigan to discuss potential infection-related performance measures pertaining to BCBSM hospital incentive program [Participating Hospital Agreement (PHA)]. Dr Share had solicited input from various clinicians, and discussions continued with a small committee of MSIC members: Judene Bartley, Russ Olmsted and Tammy Lundstrom, MD. The spe-

## PROFESSIONAL DEVELOPMENT

Debra Leithauser, RNC, MSN,  
NNP, CIC  
Henry Ford Health System  
(313) 876-8703  
dleitha1@hfhs.org

## NOMINATIONS

Judy Gula, RN,BSN  
Manager Infection Control  
Crittenton Hospital- Medical Center  
(248) 652-5219  
Fax: (248) 601-6021  
jgula@crittenton.com

## MEMBERSHIP ASSISTANCE (QUESTIONS, etc.)

Amy Mulonas  
Administrative Coordinator, MSIC  
(248) 693-3474  
Fax:(248) 693-3473  
e-mail: infectioncontrol@prodigy.net

## NETWORKING LIAISON

Betty Ann Eash, RN,BSN,CIC  
Infection Control Coordinator  
MidMichigan Medical Center  
(989) 839-3245  
Fax: (989) 839-1424  
bettyann.eash@midmichigan.org

## ORGANIZATIONAL PROMOTIONS

Jennifer Madigan, MPH, CIC  
Infection Prevention Specialist  
Henry Ford Health System  
(313) 874-4329  
Fax (313) 874-9515  
Jmadiga1@hfhs.org

## ASSISTANT – ORGANIZATIONAL PROMOTIONS

Jennifer Madigan  
Infection Control Specialist  
Henry Ford Health System  
(313) 974-4329  
jmadiga1@hfhs.org

## LIBRARY

MSIC Administrative Office  
C/O Amy Mulonas  
(248) 693-3474  
Fax (248) 693-3473  
infectioncontrol@prodigy.net

## MIOSHA LIAISON

Jenelle K. Thelen  
Consultation Education and  
Training Division  
MIOSHA  
Dept. of Labor & Economic Growth  
(517) 322-6595  
jthele@michigan.gov

**MSIC - Developing a  
knowledge network  
providing educational  
resources and  
promoting  
science-based  
practices in  
partnership with the  
community**

cific purpose was to provide input into the PHA that BCBSM has as part of its contract with Michigan hospitals. In conjunction with the Michigan Hospital Association, BCBSM has established performance measures pertaining to quality of care and medication/patient safety. For performance above set thresholds, hospitals can earn incentive payments.

Dr Share noted that one of the areas of focus at present involves the three JCAHO surgical infection prevention quality measures as part of the quality section of this incentive system. BCBSM is interested in expanding the focus on infection prevention and was looking for guidance in identifying aspects of hospital infection control practice for which providing a financial incentive could stimulate constructive activity on the part of hospitals. BCBSM would establish objective measures of performance (process or outcome) that are meaningfully linked to the activity, and hopefully, data collection wouldn't be overly burdensome. These indicators would be considered for 2005.

The committee refined the original ideas and a draft of process (not outcome) measures was presented to the MSIC Board November 12. The board unanimously supported the concept and reviewed the proposed draft. Feedback was given and each measure and process options were ranked in order of preference. The key areas of interest: Enhancing hand hygiene, urinary tract infection prevention and catheter management and prevention of central venous catheter-related complication. BCBSM already has an initiative addressing ICUs (including issues of ventilator-associated pneumonia) and surgical site infections, so these were not considered. The results of the assessment will be shared with the board and David Share. MSIC board also endorsed possibility of co-sponsoring a future BCBSM forum/conference re: emerging issues in hospital infection control. Updates on the project will be provided in future issues of MSIC News.

Tools and Tips - excerpted with permission from Premier Safety Institute Safety Share

### **CDC healthcare worker guide: Recognizing chemical agent exposure**

The Centers for Disease Control and Prevention (CDC) has issued a guide intended to help health care providers recognize exposure to chemical agents in the event of a covert chemical release. The agency said symptoms of exposure to some chemical agents might be similar to those of common diseases, making them difficult to identify. Immediate symptoms from certain chemical exposures may be mild or nonexistent, despite the risk for long-term effects, while exposure to contaminated food, water or consumer products may result in reports of illness over a long period and in various locations. <http://www.cdc.gov/exposurereport/>

### **NIOSH web resource: Indoor air quality**

Indoor air quality problems are preventable and solvable. The National Institute for Occupational Safety and Health (NIOSH) has announced an online resource that aids employers in addressing air quality concerns. The Indoor Environmental Quality topic page provides links to a variety of air quality topics, including how to identify, correct, and prevent indoor air problems; how to implement an effective air quality plan; and resources on mold, asbestos, asthma and allergies, and chemical safety. The NIOSH topic page is at [www.cdc.gov/niosh/topics/indoorenv](http://www.cdc.gov/niosh/topics/indoorenv)

### **OSHA tools: Fire threats and mold control**

The Occupational Safety and Health Administration (OSHA) announced the online availability of two new resources that may be of interest to environmental health, safety, and security managers. One, a matrix tool, provides information on how facilities can reduce vulnerability to and consequences of a terrorist attack that involves fire or an explosive device.

"Fire and Explosion Planning Matrix" is available from [www.osha.gov/dep/fire-expmatrix/index.html](http://www.osha.gov/dep/fire-expmatrix/index.html)  
"Brief Guide to Mold in the Workplace," [www.osha.gov/dts/shib/shib101003.html](http://www.osha.gov/dts/shib/shib101003.html), a health information bulletin, provides recommendations on preventing mold growth, proper use of personal protective equipment, and safe cleanup methods.

Judene Bartley 11 22 03 judenebartley@cs.com; or judene\_bartley@premierinc.com

### **JCAHO Announces Revised IC Standards for 2005** - Submitted by Russ Olmsted

The JCAHO released revised infection control standards that will become effective January 1, 2005 during the National Infection Control Conference that was convened on November 17-18, 2003 in Chicago IL. Pre-publication versions of these standards for ambulatory, behavioral health, and home health care, hospital, laboratory, and long term care are available from the JCAHO web site at: <http://www.jcaho.org/accredited+organizations/accredited+organizations+.htm#05ic>

The revised standards emphasize the performance improvement aspects of preventing health care-associated infections (HAIs), integration and collaboration with multiple disciplines and areas within a healthcare organization, and incorporation within a facility's overall performance improvement program. A rationale and elements of performance are incorporated under each standard. The standards applicable to hospitals seeking accreditation are as follows:

IC.1.10 The risk of development of a health care-associated infection (HAI) is minimized through an organization wide infection control program.

IC.2.10 The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

IC.3.10 Based on risks, the hospital establishes priorities and sets goals for preventing the development of health care-associated infections within the hospital.

IC.4.10 Once the hospital has prioritized its goals, strategies must be implemented to achieve the goals.

IC.5.10 The infection control program evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.

IC.6.10 Note: This standard is currently in field review. Please refer to Joint Commission Perspectives® for more information about this standard.

#### **Structure and Resources for the IC Program**

IC.7.10 The infection control program is managed effectively.

IC.8.10 Representatives from relevant components/functions within the hospital collaborate to implement the infection control program.

IC.9.10 Hospital leaders allocate adequate resources for the infection control program.”

**Source:** [http://www.jcaho.org/accredited+organizations/patient+safety/infection+control/05\\_ic\\_](http://www.jcaho.org/accredited+organizations/patient+safety/infection+control/05_ic_)

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## **The Experience of a Norovirus Outbreak in a Long Term Care Facility**

Submitted by Yvette Haddix, Evangelical Homes

Speaking from first hand experience as an Infection Control Coordinator in a long term care facility that has had to deal with this situation twice, I wonder if it was coincidence or bad luck? Call it what you want, but I would not wish these kinds of unfortunate events on any one.

The first time that our facility experienced a Norovirus outbreak we did not know exactly what kind of a GI problem we were dealing with. Symptoms included diarrhea, nausea, vomiting and low grade temperatures. One of the reasons that we were unsure was the residents with symptoms were sporadically located through out our facility. Within 24 hours, we had fourteen residents that were affected. It was not until I spoke with the local health department did I realize exactly what our facility was dealing with.

The second time we dealt with the Norovirus situation was exactly one year to the date that our first case had occurred. This time we knew exactly what we were dealing with. This time the residents that developed symptoms were all located on one unit. As soon as we realized these residents had the same symptoms of nausea, diarrhea, vomiting and low grade temperatures, we knew what we were dealing with. Seventeen residents were affected within 24 hours.

The most important thing to avoid during these times is the residents becoming dehydrated. We provided extra fluids any chance that we could; during medication pass and at all meals. Extra fluids, such as juices, jell-o, broth and Gatorade were also encouraged on the units throughout the day.

Secondly, we needed to stop the virus from spreading. We encouraged residents to stay in their rooms and closed the unit doors to keep residents on their units. This was helpful for wandering residents. We closed the dinning rooms, so that residents had to eat in their rooms and cancelled group activities. All of these things were important factors in stopping the spread of the virus.

Staff in- servicing was also important to remind staff how crucial hand washing was to stop the spread of the Norovirus. We reminded staff to change and wash their clothes as soon as they got home. Employees were encouraged not to show up for work when they were sick and to try to remain at home for 48 hours after their symptoms had ceased. By far, this was one of the biggest challenges.

Visitors were made aware of what was occurring in the facility by the signs that were posted on all entrances to the building. The signs alerted the visitors that the facility was experiencing a high volume of residents that had gastro-intestinal symptoms. They were instructed to speak with the nurse before entering the resident room. We also included a reminder to the visitors that they should wash their hands well before leaving the facility.

Random stool cultures were also obtained on approximately five residents to confirm that this indeed was Norovirus and all cultures did return positive. Between both outbreaks, greater than fifty percent of our residents and staff were affected.

During these times as the Infection Control Coordinator I contacted the Medical Director of our facility and the county health department. They were great resources during both outbreaks. The Internet was another great source of information. We all learned a lot from both outbreaks in our facility. Hopefully some day this virus will be prevented by a simple vaccine like the influenza vaccine.

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## **MDCH UPDATES**

### **Emergency Preparedness**

It is an exciting time as MDCH moves forward with this years CDC and HRSA Cooperative Agreements supporting emergency preparedness activities. We hope all MSIC members and their facilities are working within their regional structure and with their community partners to develop a solid, integrated emergency response plan. Each region received additional funding to support the priority activities outlined by our Federal partners. Highlighted below are several new initiatives you should be aware and involved in.

A wonderful system has been up and running across the state called MI-HAN. This stands for the Michigan Health Alert Network. This network is designed to establish and maintain a network that will support exchange of key information by linking public health and private partners on a 24/7 basis. It is a redundant system, that contacts by email, office phone, cell phones etc...however, each facility sets up their alerting process.

Each hospital with an Emergency Department was allocated 5 licenses to participate on the system. It was suggested that Infection Control be one of those designated licenses. Much of the training has been done through the regions, but more will be offered soon.

Another premier learning resource system is up and running and has great benefit for our members as well as healthcare professionals across the state called MI-TRAIN. MI-TRAIN is an affiliate of the Public Health Foundation's TRAIN (Training finder Real-time Affiliated

Integrated Network) system. MI-TRAIN can be accessed via the web site <http://mi.train.org/>. Through this site, healthcare professionals can quickly find and register for many courses, track learning with personal online transcripts, access valuable materials, course reviews and discussions and stay informed of the latest public health trainings. Again, additional information on this system will be available at your regional advisory committee meetings in the months ahead.

Do you know whom to contact to find out more? The first place to start is with your Regional Bioterrorism Coordinator –

**Region 1**

Jim McCrone  
D1RMRC-BTC@sbcglobal.net

**Region 2N**

Gary Canfield  
gcanfig@aol.com

**Region 2S**

Ann Maher  
amaher@co.wayne.mi.us

**Region 3**

Steven Cardinal  
scardinal@synergymedical.org

**Region 5**

Bob Dievendorf  
dievendorf@kcms.msu.edu

**Region 6**

Tim Bulson  
tbulson@kcms.org

**Region 7**

Tres Brooke  
lbrooke@mhc.net

**Region 8**

Jim Tritten  
jstritten@mgh.org

Additional information can be obtained from your MSIC MDCH Liaison, Linda Scott at [scottlin@michigan.gov](mailto:scottlin@michigan.gov) or 517-335-8284.

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## **On the Flu Front** - Submitted by Sally A. Bidol, MPH - Michigan Department of Community Health / Bureau of Epidemiology **2003-04 Influenza Season**

As of early October, the Centers for Disease Control and Prevention (CDC) have reported the appearance of influenza activity in several states, including school outbreaks of laboratory-confirmed influenza A infections in Texas. Preliminary laboratory analyses conducted at the CDC on influenza A (H3N2) isolates from Texas have shown that while most are antigenically similar to the current vaccine strain, some are antigenic drift variants. This coincides with analyses of influenza A (H3N2) viruses isolated worldwide between February and September showing that about a third have also drifted antigenically from the current A (H3N2) vaccine. According to the CDC, while vaccine protection against the A (H3N2) drift variants may be lower, the vaccine is expected to provide some degree of effectiveness.

To view real-time information on influenza activity in Michigan, please visit the Michigan Department of Community Health (MDCH) website at <http://www.michigan.gov/mdch>. This information is updated regularly throughout the flu season. National influenza surveillance summary information for the current week is available at the CDC website <http://www.cdc.gov/ncidod/diseases/flu/weekly.htm>

### **Enhanced Surveillance for Emerging Influenza Strains**

While it is atypical for persons to contract influenza infections directly from animals, sporadic human infections and limited outbreaks caused by avian influenza A viruses have been reported in the world in recent years. As recently as this past winter (2003), there were separate reported occurrences of human infections with avian influenza viruses in two countries. The Netherlands reported more than 80 confirmed cases of human H7N7 influenza virus infections among poultry workers and their families following an outbreak that began in chickens. The majority of these human illnesses were mild and were characterized by clinical signs of conjunctivitis; however several persons experienced respiratory symptoms and one person died. In another discrete occurrence, two human cases of influenza A (H5N1) infection were confirmed in a single family of Hong Kong residents who had traveled to mainland China. Both patients were hospitalized and one died.

The above scenarios illustrate the ongoing potential for emergence of avian or other animal influenza viruses that are capable of causing illness in humans. If these viruses are subsequently able to spread efficiently person-to-person, an influenza pandemic could arise.

In response to these situations, the CDC has recommended enhanced influenza surveillance for state health departments to rapidly identify an importation of a novel strain of influenza A virus into the United States. As part of this effort, Michigan along with other states have continued laboratory and sentinel provider surveillance activities year round, uninterrupted. Currently there are 40 sentinel physician sites established throughout Michigan that provide weekly information on influenza-like illnesses among their patient populations.

In addition, physicians and hospitals are asked to perform viral culture on all patients meeting both of the following criteria: Patient hospitalized with unexplained pneumonia, acute respiratory distress syndrome (ARDS), or severe respiratory illness AND Travel to Asia within ten days from onset of symptoms.

For more information on the Michigan sentinel surveillance system or to inquire about becoming a sentinel site, please contact MDCH at 517-335-8159

### **Severe Influenza-Associated Illness and Deaths in Children – Jan-Feb 2003**

During the first quarter of 2003, MDCH worked with the CDC and several Michigan local health departments to investigate a series of severe illnesses or unexplained deaths among children following a brief upper respiratory syndrome. Fourteen such occurrences among previously healthy children were identified and investigated, 4 of which were deaths. Eight of the children (57%) had evidence of encephalopathy and one case had evidence of myocarditis. The children ranged in age from 14 months - 14 years of age, most resided in the southeast region of the state. There were no recognized common exposures or epidemiologic links among the cases.

Following extensive laboratory studies, influenza virus was detected in all 14 of the cases, including influenza A (n=13) and influenza B (n=1). Of those viruses antigenically characterized, H1N1 isolates and H3N2 isolates were similar to the 2002-03 influenza vaccine strains. One H1N2 isolate was similar to the H1 antigen from the H1N1 vaccine strain, and the N2 antigen from the H3N2 vaccine strain. The influenza B isolate was most similar antigenically to a minor variant of the B vaccine strain.

The four fatalities associated with influenza occurred in healthy children considered low risk for influenza complications, and for whom influenza vaccination was not encouraged or recommended. None of the four children had received vaccine. Per the current recommendations of the Advisory Committee on Immunization Practices (ACIP), influenza vaccination of healthy children aged 6--23 months continues to be encouraged when feasible [1]. Vaccination of children aged >6 months who have certain medical conditions continues to be strongly recommended.

The complete study can be found in the Morbidity and Mortality Weekly Report CDC. Severe morbidity and mortality associated with

influenza in children and young adults - Michigan, 2003. MMWR 2003;52(35):837-40.

§ Defined as altered mental status of any duration, including seizure but not including simple febrile seizures

#### References

[1] CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2003;52(No. RR-8).

### **Testing for Mycobacterium Tuberculosis - What Should You Expect from Your TB Laboratory**

Michigan Department of Community Health

Dale E. Berry - TB Lab Manager

Laboratory testing for M.tuberculosis plays an integral part in diagnosis and management of tuberculosis cases. However, when a patient's specimen is sent to the laboratory for testing, information is already known which assists the physician to diagnose tuberculosis (TB). The physician may have recognized signs and symptoms typical of pulmonary TB. The patient may have indicated exposure to another person known to have TB or that they had a history of past exposure to TB. Chest X-rays or skin testing may have also indicated TB infection or exposure. Laboratory testing usually provides secondary information which assists in confirming the clinician's suspicion of TB and which also aids in determining appropriate therapy and subsequent tuberculosis case management. It is essential that laboratories provide accurate and useful test results, as rapidly as possible, so that there is minimal delay in case detection and management. This is especially important in cases when TB has not been previously suspected. It is also essential that recipients of TB laboratory test reports understand when to expect lab reports and what kind of information that these reports convey.

The Centers for Disease Control and Prevention (CDC) recommends standards for mycobacterial laboratory testing to all clinical laboratories, which attempt to perform mycobacterial testing services. (Reference: Styr, B.A., T.M. Shinnick, J.C. Ridderhof, J.T. Crawford, F.C. Tenover. 1997. "Turnaround Times for Mycobacterial Cultures". J.Clinical Microbiology. 35,1401.)

To accomplish these requirements, physicians, public health departments, treatment clinics and hospitals must seek mycobacteriology laboratory services which satisfy all CDC recommendations. We must expect that our TB laboratory be able to report microscopic slide examination results on the same day that the specimen was received in the laboratory. We must expect our TB laboratory to perform primary culture using a "rapid broth" AFB growth detection system, which can determine culture positive specimens within two weeks of receipt of an AFB smear positive specimen. We must expect that our laboratory provide "rapid identification" testing, using either genetic probe or high performance liquid chromatography (HPLC) on AFB positive cultures to determine whether the culture is M.tuberculosis complex or NOT M.tuberculosis) within 21 days of receipt of the clinical specimen. A report of "TB" or "Not TB" should be expected within two days of the positive AFB culture report. New TB isolates must be tested for susceptibility to primary anti-tuberculosis antibiotics (Isoniazid (INH), Rifampin (RIF), Ethambutol (EMB), Streptomycin (ST) and Pyrazinamide (PZA)). Susceptibility results are to be reported within 28 days of receipt of the clinical specimen, usually about one week after a positive TB identification report. This can only be accomplished by employing the use of a rapid broth susceptibility test system. Subsequent testing must be arranged to provide confirmation of the TB identification, as well as, secondary antibiotics susceptibility results, when required for alternative antibiotic therapy. A "direct specimen amplified genetic probe" is also offered by some laboratories and can provide identification of M.tuberculosis complex within one day of an AFB positive slide examination report. This test provides the most rapid identification of M.tuberculosis complex; however, it is limited for use on pulmonary specimens from patients with no previous history of M.tuberculosis infection.

It is advisable for laboratories which decide to perform acid-fast microscopic examination and primary isolation of M.tuberculosis to also perform a rapid identification test to differentiate acid-fast growth as either M.tuberculosis or NOT. Otherwise, culture isolates have to be sent to a reference laboratory to perform the differentiation and may require additional days or weeks, an unacceptable delay which may negatively impact patient isolation, treatment and infection control decisions.

So, we must consider our laboratory service provider wisely, to assure that the best TB laboratory services are selected, services which meet CDC recommendations and provide rapid and accurate AFB test results to enhance the ability of TB case managers to provide the best health care and TB case management possible.

### **State of Michigan Guidelines to Reduce the Transmission of Perinatal HIV, Hepatitis B and Syphilis**

Each year in the state of Michigan, newborns are perinatally infected with the human immunodeficiency virus (HIV). Newborns are also exposed to hepatitis B and syphilis.

Guidelines have been developed based on Michigan's Public Health Code and other recommendations from the Michigan Department of Community Health to reduce the incidence of perinatal transmission of HIV, hepatitis B and syphilis. The entire document can be viewed at: [http://www.michigan.gov/mdch/0,1607,7-132-2944\\_5320\\_5331---,01.html](http://www.michigan.gov/mdch/0,1607,7-132-2944_5320_5331---,01.html) or [http://www.michigan.gov/mdch/0,1607,7-132-2942\\_4911\\_4914-71223---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_4914-71223---,00.html)

### **FDA Approves New Rapid HIV Test Kit - OraQuick**

The U.S. Food and Drug Administration has approved a new rapid HIV diagnostic test kit that provides results with 99.6 percent accuracy in as little as 20 minutes. Using less than a drop of blood collected, this new test can quickly and reliably detect antibodies to HIV-1, the HIV virus that causes infection in most cases in the U.S. Unlike other antibody tests for HIV, this test can be stored at room temperature, requires no specialized equipment, and may be considered for use outside of traditional laboratory or clinical settings. The newly approved HIV test is called The OraQuick Rapid HIV-1 Antibody Test, manufactured by OraSure Technologies, Inc., Bethlehem, Pennsylvania. Even though the test is called "OraQuick" it has nothing to do with the collection of oral exudate like the OraSure test.

Each year, approximately 8,000 HIV-infected people in the US who come to public clinics for HIV testing do not return later to receive their test results. With this new test, in less than a half an hour they can learn preliminary information about their HIV status, allowing them to get the care they need to slow the progression of their disease and to take precautionary measures to help prevent the spread of HIV.

The Centers for Disease Control and Prevention (CDC) has estimated that one fourth of the approximately 900,000 HIV-infected people in the U.S. are not aware that they are infected. Because of the potential public health benefits of rapid HIV testing, the CDC and the Centers for Medicare and Medicaid Services (CMS) are working with state and other health officials to make the test widely available and to offer technical assistance and counseling training for its use.

A Fact sheet about the OraQuick can be found at: <http://www.fda.gov/cber/faq/oraquickfaq.htm>

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## **SARS - A Brave New World** Submitted by Jennifer Sweeney / Managing Editor MSIC News

Health Care was hit hard by the 2003 global outbreak of Severe Acute Respiratory Syndrome (SARS) but it also proved an essential element in eventual containment of this newly emerged disease. The first laboratory confirmed case of SARS in 2004 was recently detected in China. As many of us attempt to batten-down-the-hatches for the possibility of a resurgence of SARS, the CDC and WHO websites have a plethora of helpful information for healthcare institutions. Below is information summarized from the CDC's SARS Public Health Guidance Document- SARS Preparedness and Response in Healthcare Facilities. The entire document is available at <http://www.cdc.gov/ncidod/sars/pdf/sarshealthcareprep-oct2003.pdf>

One of the big lessons learned in 2003, was that unprotected exposures to unrecognized SARS cases accounted for significant transmission in healthcare facilities. Strict adherence to infection control practices and preparedness planning are essential to limiting the impact of future SARS outbreaks. Early identification of cases, prompt isolation of cases, implementation of effective infection control measures, and a plan to manage SARS cases are just a few of the items outlined by the CDC as elements on which healthcare facilities should focus their attention in anticipation of reappearance of SARS.

A system for SARS surveillance is important to diagnose and detect cases before transmission occurs. Surveillance is focused on known risk factors.

1) Travel to previously affected areas 2) Contact with healthcare facilities 3) Contact with other patients with unexplained pneumonia  
In the absence of SARS, it is recommended that patients with pneumonia be evaluated as usual with the addition of SARS risk factor questions. Additional information on surveillance and clinical evaluation in the absence of SARS is available at: <http://www.cdc.gov/ncidod/sars/absenceofsars.htm>. In addition, the Michigan Department of Community Health (MDCH) has posted two updated documents on their web site; a SARS screening form and guide to collection and arranging testing of specimens from potential cases of SARS. These are available at: [http://www.michigan.gov/documents/finalmiscreeningform\\_62405\\_7.pdf](http://www.michigan.gov/documents/finalmiscreeningform_62405_7.pdf)  
[http://www.michigan.gov/documents/SARSlabguidelines\\_80103\\_7.pdf](http://www.michigan.gov/documents/SARSlabguidelines_80103_7.pdf)

In the event a case of SARS is detected, it is recommended that surveillance be expanded to include screening all patients with fever or respiratory symptoms for known SARS risk factors, especially travel to an area where SARS cases are or contact with potential SARS patients. The CDC has on-line SARS clinical algorithms to aid in evaluating patients with SARS risk factors that can be found at: <http://www.cdc.gov/ncidod/sars/clinicalguidance.htm>

As infection control professionals, what can we do to prepare? Make sure that basic infection control practices like handwashing and proper isolation procedures are fresh in the minds of staff. Ensure that staff is aware of the criteria for evaluating potential SARS cases and that they have access to and training with personal protective equipment. Your facility may want to consider adopting a "respiratory hygiene/cough etiquette" strategy to control respiratory secretions thus potentially reducing SARS transmission in addition to other respiratory pathogens. Establish a plan of communication between your facility and the health department. They will be an important ally in the event of an outbreak.

SARS transmission can be prevented so start planning NOW! For all of the latest SARS information visit the CDC website at <http://www.cdc.gov/ncidod/sars>

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## **PROFESSIONAL DEVELOPMENT** - Paula Hoegemeyer

The memories linger from the educational and exhilarating Fall Conference "Strong Roots...Steady Growth" held November 13 & 14. Many thanks to Maggie Piehl and her hard working Program Committee who designed the curriculum that led us from immunization policy to emerging pathogens, outbreak investigation, construction issues, wound care, and patient safety. Attendance at this timely and practical conference was 222. Presentation summaries may be found on the MSIC website: . A Conference highlight was the gala banquet celebration of MSIC's 30th Anniversary with Gina Pugliese emceeding a fun Hollywood style evening. Betty Ann Eash and Teri Lee Dyke planned and carried out a marvelous program that culminated in the presentation of Germie Awards to selected nominees. The creative costuming of the guests, gala decoration of the banquet hall, great music of the DJ, and program laughs made for an evening that will not soon be forgotten.

Get your bags packed because we are going "traveling" in 2004! "All Aboard" is the title for the Spring Conference which will take us on a train ride with an emphasis on quality issues. Karen Foley Frahm is the "conductor" for this Conference which will be held on April 22 & 23 at the Sheraton in Lansing. On October 7 & 8 we will board a ship at the Sheraton in Lansing for "Anchors Aweigh – Cruising Along with MSIC" with Joan Wideman serving as our "cruise director". Topics will include medical waste, water systems, and patient devices. Information and dates will be available on the MSIC website.

The Fundamentals of Infection Control workshop held October 22-24 was attended by 55 participants, six of whom were from the Upper Peninsula of Michigan. The three days of intensive learning and networking gave these participants much information to implement in their work sites across the continuum of care. Thanks to Joan Kirkwood, Ruth Anne Rye, Judene Bartley, and Jan Jennings for their hard work on this workshop. The dates for the 2004 Fundamentals workshop are October 27-29.

It has been my privilege to serve MSIC as Professional Development Chair for the past four years. Thank you for the opportunity.

## Out with the Old, In with the New

The Bureau of Safety and Regulation has changed its name to the Michigan Occupational Safety and Health Administration (MIOSHA). The MIOSHA website can still be accessed through [www.michigan.gov/miosha](http://www.michigan.gov/miosha)

MIOSHA is sponsoring three Bloodborne Infectious Diseases half-day workshops, throughout the state, in 2004. These workshops will bring together 3 State of Michigan agencies:

MIOSHA - BID Overview;

MDCH - Hepatitis A-E Overview and CDC Post Exposure Management Review;

MDEQ - Update related to the Michigan Medical Waste Regulatory Program.

Workshop Locations:

Escanaba - Jan. 28, 2004 at M-TEC at Bay College Contact: Jayne Szukalowski (906) 786-5802 ext. 1510.

Grand Rapids - Feb. 10, 2004 at the Dominican Center Marywood Contact: Lansing Area Safety Council (866) 423-7233.

Southfield - March 16, 2004 at the Safety Council of S.E. Michigan. Contact: (248) 557-1281

The cost of the workshop is \$25. Please contact Jenelle Thelen at <mailto:jthele@michigan.gov>

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## LATE BREAKER: - Submitted by, MSIC Advocacy Committee

Governor Jennifer Granholm establishes the new Michigan Department of Labor & Economic Growth (DLEG)

The Governor's Executive Order 2003-18 renamed MI Department of Consumer & Industry Services (MDCIS) as DLEG. DLEG officially opened for business on Dec. 8, 2003. Of note for ICPs, this order transferred the Bureau of Health Services (licenses and regulates health professionals) and Bureau of Health Systems (licenses and regulates healthcare facilities, EMS, and nursing homes and reviews health facility construction plans) to MDCH. You can visit MDCH and DLEG web sites for more details at:

<http://www.michigan.gov/mdch> & <http://www.michigan.gov/dleg>

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## Marketing News

APIC CIC Review Study Guides are still available at \$49.00 plus \$4.00 shipping.

Contact Amy Mulonas for orders at 248-693-3474.



# NEWS

## Michigan Society for Infection Control

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Amy Mulonas

MSIC Office

724 Lawson

Lake Orion, MI 48362