Simpson, Karin 2623

From: Susan J. Navish [sjn@mspittsburgh.org]
Sent: Friday, August 15, 2008 5:18 PM
To: Simpson, Karin
Subject: Home Care Regulations-Comments from Health Policy Board meeting

Dear Karin,
After having reviewed the home care regulations that were discussed at the Health Policy Board meeting on July 30, 2008, I have some areas to comment on.

1) The term SPECIALIZED CARE poses difficulties when non-medical services is a vague definition of services. It could be a vast area that any surveyor could decide that a service falls into. This needs more clarification.

2) Under the section on Provisional hiring, #6 on page 31: Requiring a home care agency or roster to have a person who has been employed or rostered **FOR MORE THAN ONE YEAR** accompany a provisionally hired applicant may be impossible for many agencies, new or existing.
I understand and concur that the provisional staff must be accompanied by another person while providing care to someone less than 18, but to impose that the person must have been with the agency for one year will most assuredly render new agencies unable to comply. Existing agencies could have a problem due to the high turnover rate in these positions.

Please review the need to define this time period.

3) Under the definition of Qualified health professional:
Not including Registered Nurses to perform services that they are covered under the Nurse Practice Act in Pennsylvania is problematic.

This will be a specific problem as it relates to TB testing. The agency may have an RN who could do TB test for their workers. This would be a cost effective way to achieve the TB testing requirement. Forcing workers to go somewhere else will pose access and cost issues

4) Under Health Evaluations:
Requiring workers to have **annual** TB testing, even if the previous test was negative is a problem. The CDC guidelines do not call for annual testing. This will pose access and cost issues.
Please review this area again.

As I said on the conference call, it is evident that great attention was paid to the comments received from the last draft of the regulations. You are all to be commended for addressing and making changes as you could within the law.

Please contact me if you have a question regarding any of the above comments.

Thank you,
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Member, Health Policy Board

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and maintenance of optimal environmental controls (particularly ventilation). Depending on the a and the environmental control systems of a particular setting, AII rooms might be grouped either (e.g., a wing of a facility) or vertically (e.g., the last few rooms of separate floors of a facility);
- perform diagnostic and treatment procedures (e.g., sputum collection and inhalation therapy) in a
- ensure patient adherence to airborne precautions. In their primary language, with the assistance o medical interpreter, if necessary, educate patients (and family and visitors) who are placed in an / about *M. tuberculosis* transmission and the reasons for airborne precautions. For assistance with l interpretation, contact the local and state health department. Interpretation resources are available http://www.atanet.org; http://www.languageline.com; and http://www.ncihc.org. Facilitate patien by using incentives (e.g., provide telephones, televisions, or radios in AII rooms; and grant speci requests) and other measures. Address problems that could interfere with adherence (e.g., manag withdrawal from addictive substances, including tobacco); and
- ensure that patients with suspected or confirmed infectious TB disease who must be transported t area of the setting or to another setting for a medically essential procedure bypass the waiting are surgical or procedure mask, if possible. Drivers, HCWs, and other staff who are transporting pers suspected or confirmed infectious TB disease might consider wearing an N95 respirator. Schedul procedures on patients with TB disease when a minimum number of HCWs and other patients ar and as the last procedure of the day to maximize the time available for removal of airborne conta (see Environmental Controls; Tables 1 and 2).

Diagnostic Procedures

Diagnostic procedures should be performed in settings with appropriate infectioncontrol capabilities. Tl recommendations should be applied for diagnosing TB disease and for evaluating patients for potential infectiousness.

Clinical Diagnosis

A complete medical history should be obtained, including symptoms of TB disease, previous TB diseas treatment, previous history of infection with *M. tuberculosis*, and previous treatment of LTBI or exposu persons with TB disease. A physical examination should be performed, including chest radiograph, mic examination, culture, and, when indicated, NAA testing of sputum (*39,53,125,126*). If possible, sputum with aerosol inhalation is preferred, particularly when the patient cannot produce sputum. Gastric aspir be necessary for those patients, particularly children, who cannot produce sputum, even with aerosol inl (*127--130*). Bronchoscopy might be needed for specimen collection, especially if sputum specimens ha nondiagnostic and doubt exists as to the diagnosis (*90,111, 127,128,131--134*).

All patients with suspected or confirmed infectious TB disease should be placed under airborne precaut they have been determined to be noninfectious (see Supplement, Estimating the Infectiousness of a TB Adult and adolescent patients who might be infectious include persons who are coughing; have cavitati radiograph; have positive AFB sputum smear results; have respiratory tract disease with involvement o pleura or airways, including larynx, who fail to cover the mouth and nose when coughing; are not on antituberculosis treatment or are on incorrect antituberculosis treatment; or are undergoing cough-induc aerosol-generating procedures (e.g., sputum induction, bronchoscopy, and airway suction) (*30,135*).

Persons diagnosed with extrapulmonary TB disease should be evaluated for the presence of concurrent TB disease. An additional concern in infection control with children relates to adult household member visitors who might be the source case (*136*). Pediatric patients, including adolescents, who might be inf include those who have extensive pulmonary or laryngeal involvement, prolonged cough, positive sput smears results, cavitary TB on chest radiograph (as is typically observed in immunocompetent adults w disease), or those for whom cough-inducing or aerosol-generating procedures are performed (*136,137*).