Cathy Barry-Ipema: Welcome to today’s telephone conference call on the new influenza vaccination standard for licensed independent practitioners and staff. This call is targeted to organizations accredited under the ambulatory care, home care, laboratory, Medicare/Medicaid certification-based long term care, and office-based surgery programs. This is Cathy Barry-Ipema, chief communications officer for The Joint Commission. I’m very pleased to introduce our speaker from the Division of Health Care Quality Evaluation, Dr. Kelly Podgorny, who is the project director. Also joining Kelly, is Dr. Robert Wise, who is our medical advisor, and Linda Kusek, our associate project director. They will be available to answer questions. Standard IC.02.04.01 has been expanded to include LIPs and staff at ambulatory care, home care, laboratory, Medicare/Medicaid certification-based long term care and office-based surgery accreditation programs. When today’s formal remarks are concluded, we will take questions from the audience. It is now my pleasure to introduce Kelly Podgorny.

Kelly Podgorny: The Joint Commission has approved the revised Standard IC.02.04.01 on influenza vaccination for licensed independent practitioners and staff for all accreditation programs. The approval occurred in September 2011. So, if you go to page 3 of the PowerPoint, there is a list of all the programs that we’re going to be addressing today. On Slide 4, we have the objectives for today, and the outline for today’s program is on Slide 5. We will
be talking about the rationale for adding the standard applicable to all organizations and some of The Joint Commission’s actions. We are going to address concerns that we’ve learned about, regarding mandating and paying for the influenza vaccinations. We will then review Standard IC.02.04.01 and the nine elements of performance. We have an educational tool on vaccination myths and realities that we are going to review with you, and also resources, contacts and references that we will go through fairly quickly. If you turn to Slide 6, we will start. The slide gives information from the 2010 action plans from the Department of Health and Human Services on influenza vaccinations for health care personnel. I recommend that everyone take the time to read this action plan. It’s very informative about influenza vaccinations, and the most important part that I want to emphasize is that this action plan speaks at vaccination—that it remains the single most effective preventative measure available against influenza, and can prevent many illnesses, deaths and loss of productivity. So, this is the information that came out in 2010, and in that action plan, there was a recommendation that HHS actually encourage The Joint Commission to apply Standard IC.02.04.01 to programs other than just hospitals. So, this is the beginning of the rationale on why we decided to move forward with this. We then started our own research, as we do with any standard and National Patient Safety Goal, to really learn and understand the science behind the influenza vaccination. And, in starting that research process, one of the things that we learned is that the scientific organizations and the professional organizations all recommended influenza vaccinations for all staff and licensed independent practitioners in health care, and that includes APIC, the CDC, IDSA, NFID and SHEA. Something that I would like to point out is that APIC has yet to recommend that influenza vaccinations be a condition of employment. So, there is a lot of information supporting that we move this to all of the settings, and the
science clearly supports that influenza vaccinations should occur for health care personnel. So, if we can move to Slide 8, The Joint Commission completed its research, and then we took some actions. We just want you to be aware of these, that we revised Standard IC02.04.01 for the organizations that already have a standard. We strengthened it, and then we aligned it with some of the requirements with the HHS action plan that I’ve already mentioned. We then applied it to all the accreditation programs and conducted a field review. We conducted the field review from April 5 through May 17, 2011. We had a tremendous amount of response. We made some revisions you will see today, based on the field review, and then we took it back to our Board. On September 21, 2011, The Joint Commission’s Board of Commissioners approved the standard for all programs. So, if you turn to Slide 9, I would like to review some information that we have from the field review. The first graph is about the percentage of respondents to the field review who indicated that their organization has offered influenza vaccinations for five years or more. And what is interesting is that even organizations that don’t have the standard have been offering influenza vaccinations for over five years, which is support for moving forward with the standard. If you look at the next graph, on page 10, here we really wanted to understand how many organizations have been measuring the influenza vaccination rate for five years or more, and you can see that this is actually a lot less, when compared to the previous slide. So organizations are offering, but they’re not as consistently measuring, and that’s identified as an educational need to us. We will be addressing this somewhat in today’s presentation. So, on slide 11, based on all of the research that we have done, The Joint Commission determined that a phased approach was going to be necessary for implementation in all of the programs that we have there. So, for ambulatory, BHC, home care, labs, long term care, Medicare/ Medicaid certification, and office-based surgery, there are
six elements of performance that will go into effect in July 2012, and three that will go into effect on January 1, 2013. And we will very clearly delineate that to you later on in the presentation. What I would like to do now is move to slide 12, and just clear up some information. There was some confusion that the standard was now *mandating* influenza vaccinations for staff and licensed independent practitioners. If you look at the second bullet, The Joint Commission wants to be very clear that Standard IC.02.04.01 does not mandate influenza vaccination for LLPs and staff. On slide 13 there is information about payment. While we have the standard, that does not mean that organizations are required to pay for influenza vaccinations for staff and licensed independent practitioners. We are aware that there are some organizations that are very small and that this may be a burden. There are many organizations that have learned how to get the influenza vaccination for staff and licensed independent practitioners through working with their local pharmacy or working with their local health departments. So, now we actually move into review the actual standard and the elements of performance. Slide 15 is a summary of the goal and intent of this particular standard. And it is, as follows, the three bullet points here. We’re requiring organizations to establish an influenza vaccination program that will address staff and licensed and independent practitioners; and we want organizations to set incremental goals for meeting the 90 percent target in 2020. I will talk about that more specifically in a few minutes. And then also, to measure and improve their influenza vaccination rate to staff and licensed and independent practitioners. So all of the EPs that are going to go through elements of performance are related to these three goals. Slide 16 includes more information. When we were developing this standard for all accreditation programs, we really had to look at the language and make sure that not only were the concepts being similar across all of the
accreditation programs or their equivalent, but we also had to have language that was specific to the actual setting. So we do have very specific language. The EPs may have some different language, and that’s why it’s really important in that second bullet that if your organization is accredited under one or more accreditation programs, you need to make sure that you really review the actual language of each accreditation program. Slide 17 is the actual standard that an organization offers vaccination against influenza to licensed independent practitioners and staff. The standard is applicable to staff and licensed and independent practitioners only when care, treatment and services are provided on-site. So when care, treatment and services are provided off-site, such as with telemedicine or telephone consultation, the standard is not applicable. So, if you are contracting with an organization to provide you with telephone services, and those individuals you consider to be either as staff or licensed independent practitioners, you’re not required to offer it or get information on their influenza vaccination status. The note is a little bit different for home care, so to the home care people, I recommended that you read it; it’s a little bit more concise, because everything that you provide is off-site; you don’t have to necessarily have an on-site place, except for your office. And then there’s an additional note for labs that the standard is only applicable to laboratories that are not included in a hospital’s influenza program for staff and licensed independent practitioners. All right, Elements of Performance 1 is on Slide 18, the organization establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff. There’s not any documentation that will be required here, and the scoring is an A, so you get scored whether it exists or it doesn’t exist. And the way that we’ll get this information is through the system tracer on Infection Prevention and Control. The implementation date for this is July 1, 2012. Slide number 19 focuses on Elements of Performance 2. The organization
educates licensed independent practitioners and staff about, at a minimum, the influenza vaccination, non-vaccine control and prevention measures, and diagnosis transmission and impact of influenza. We also have a link there to HR.01.04.01EP4, and that’s an Element of Performance in the HR chapter that says that you are responsible for educating staff about infection control issues during orientations. There’s not going to be documentation required here. We are not going to go through the individual records, but we will be interviewing staff about this, and so the scoring of this means we will be using frequency based scoring, and the implementation date will be July 1, 2012. Moving to Slide 20 then, this is where we have some language differences. For ambulatory, BHC and office-based surgery, the EP states that the organization offers the influenza vaccine on-site to licensed independent practitioners and staff, or facilitates obtaining the influenza vaccination off-site. One of the things that we learned from the field reviews is that there are some organizations that have said that they were very, very small, and it just made sense for them to facilitate the vaccination outside of their site, so that’s why we have this different wording. All other programs, except home care, says that the organization provides influenza vaccinations at sites and times acceptable to licensed independent practitioners and staff, and in a home care version, that term, “times” is removed, because home care only occurs on the patients. So, for EP 3, there’s no documentation required. The scoring is going to be A, and the implementation is going to be in July for 2012. Element of Performance 4 is about the fact, on slide 22, that the organization includes in its infection control plan the goal of improving influenza vaccination rates. And we have a link there to Standard IC.01.04.1, that actually addresses that organizations identify their risk, and develop goals, so here, we’re actually saying that you have to have a goal on influenza vaccination for staff and licensed independent practitioners. Documentation is
required, so you will want to be looking at your infection prevention plan. The scoring is an A, and the implementation date will be July 1, 2012. So, I am going to move now to slide 23, and this is the first EP that is of the SHEA approach, we are wanting you to be very aware that we will have a couple of slides on this Element of Performance, and the EP reads that the organization sets incremental influenza vaccination goals, consistent with achieving the 90 percent rate established in the national influenza initiatives for 2020. And I would like to be very clear that The Joint Commission did not establish the 90 percent rates in isolation. This was a goal decided by the government and HHS, and we are supporting that goal and aligning with it, by developing this requirement. So, you can get the information about that through the link that is provided and is available for you. So, if we turn to slide 24, I just want to point out a few other things regarding this particular Element of Performance. It has a lead-in statement that tells you when it will be implemented, and all the phased-in 2013 EPs have that lead-in, so I would just like you to be aware of that. Documentation will be required here. The scoring will be an A, and the implementation will be July 1, 2013. So, one of the things that in preparing for this presentation that we were thinking about is some of the questions you may have. We’re trying to anticipate them. So, if you turn to slide 25, you can see an example of how we would be looking at organizations that are meeting the intent of this Element of Performance and organizations that would not be. And I want to be very clear that this is about setting goals. It’s not about the actual performance. So, on the very first bullet, we have Organization A. They have a current influenza vaccination rate for staff and licensed independent practitioners of 50 percent and in being in line with this particular Element of Performance, they developed some goals. In 2012, they wanted to be at 60 percent At 2014, they wanted to be at 75 percent and 2016, their goal was 85 percent So we would really recommend doing something like this,
because it really shows that the organization is planning to move forward to achieve 90 percent in 2020. If you look at Organization B, they also start out at 50 percent influenza vaccination rate, and they come up with a goal of 52 percent for 2012, 54 percent for 2014, and 55 percent for 2016. We would say that we are not recommending that you do that, and that’s really not meeting the intent of the standard, because it’s not showing real movement toward that 90 percent in 2020. So, this was just a little example. Please don’t take these percentages verbatim. All right, now we’re going to go into Elements of Performance 6. It says that the organization has a written description of the methodology used to determine influenza vaccination rates. And we’ve developed this EP while there has been a lot of other work nationally going on about the influenza vaccination rates. There is a link there to the standard that we’re currently talking about, EP 1, and the reason why we made that link, is that we wanted you all to think about the fact that the written methodology should be part of your entire influenza program. It shouldn’t be someone else who is responsible for that. It should all be integrated as one entire approach. So, what was going on while we were actually developing this standard is that the National Quality Forum and the CDC were conducting research on developing a measure for influenza vaccination rates. And that’s because it was being done so differently; there was no consistency in the country. So, if you take that link and copy it and put it in your browser, it will take you to the NQF site, so you can actually see the numerator and denominator and the measure rate. It’s very interesting information, and it’s very good. If you turn to the next slide, we’re now actually going through some of the issues in the second bullet. We want you to understand what the note is all about. So, the note goes on to say that The Joint Commission recommends that organizations use the CDC/NQF proposed performance measure to calculate the influenza vaccination rate. That’s the wording in the note. We’re
recommending that because it is the most researched methodology for calculating the rate that is out there today. Even though it’s still in the proposed state, it has a very clear numerator and denominator, and the CDC has reported to us that the measure can be used in all health care settings, even though it wasn’t tested in all settings. So, that’s an important point to make. We really do recommend that you use it, and also, it will be the measure that will be used for CMS for organizations that will be reporting in the future. However, if you turn to slide 28, the CDC/NQF influenza vaccination measure does not include all contracted staff. It was very clear that the data on contracted staff was very difficult to obtain, and that it was inaccurate and not necessarily reliable, and so that unreliable data could actually inadvertently alter the influenza vaccination rate. If you go to slide 29, this is actually The Joint Commission’s position. We want to be very clear with all of you that the influenza vaccination is to be offered to all contracted staff, even though they are not included in the measure that we are recommending that you use. Additionally, The Joint Commission is recommending that the influenza vaccination rates for contracted staff be tracked separately by the organization, and that you could use that information as part of your quality monitoring, and that when you’re looking at making improvements for Element of Performance 8, you can actually use that information. I know this is a little bit complicated. If you go to slide 30, we have the actual final sentence in the note that says, The Joint Commission recommends that organizations do track influenza vaccination rates for all individuals providing care treatment and services, since contracted individuals also transmit influenza. The measure actually does state that contracted licensed independent practitioners are counted in the measure, but other contracted staff, like maybe agency staff, would not be, and so we have communicated our concern about that, and this is the information we can give you at this time. All right, so for EP 6, that indication will be
required, and the scoring will be A, and the implementation date for this will be July 1, 2013. So, now we’re going to move into Element of Performance 7, the organization collects and reviews the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This collection and review occurs at least annually. This EP does not require that a declination form be signed. However, we are aware that several states do require the declination form, so in those instances, we would also require you to have it. And that would be “X”’d in the system’s tracer on whether or not a declination form is required by your state. But The Joint Commission standard is not requiring that. All right, moving to slide 33, for Element of Performance 7, there is no documentation that is required. The scoring will be an A and will be discussed in the system’s tracer, and the implementation will be on July 1, 2012. Element of Performance 8, we will review that, starting on slide 34, and this is the last of the phased approach EPs. This will also be applicable or implemented in 2013. It says that the organization improves its vaccination rate according to the established internal goals, at least annually. We have actually given you some of the PI standards to look at regarding presenting data and analyzing data. However, we do have a note for lab, OBS and home care because some organizations are very small, and presenting the data in a rate, that doesn’t necessarily make sense. So, in those circumstances, when basically, you have a staff of 10 or less, it’s fine if you present the data using raw numbers. For Element of Performance 8, documentation will be required. We’ll be looking to see your improvement rates over time. The scoring will be an A, and the implementation will be done on July 1, 2013. So again, you do really have some time to prepare for this. Element of Performance 9 does have some language differences. For laboratory, long term care Medicare and Medicaid certification, and home care it states that the organization provides influenza vaccinations rate data to key stakeholders, which may include
leaders, licensed independent practitioners, nursing staff and other staff at least annually. But for ambulatory and office-based surgery, these are organizations that sometimes are very small. We wrote the EP to say that the organization provides influenza vaccination rate data to organizational leaders at least annually, and you determine who your leaders will be. There will not be any documentation required for EP 9. The scoring will be an A, and the implementation will be July 1, 2012. So, if you turn to slide 38, this is an important slide, because it gives you information about when the EPs go into effect, some will go into effect in July 2012 and those in July 2013. This is basically a summary of the Elements of Performance for Standard IC.02.04.1. Earlier, we talked about the fact that we had conducted a field review last spring. We received a substantial amount of qualitative data, which we asked for, and as we were analyzing it, it become very clear to us that there is a lot of semi-accurate information from people who were responding to this field review about the influenza vaccination. And it’s interesting that these inaccuracies have already been documented in the literature and by other organizations, so all those myths, as they’re called, were actually substantiated in our very recent field review. So, The Joint Commission has developed an educational tool; my colleague Linda Kusek, who is here, wrote it, and it was developed as an educational tool that you all can use to deal with individuals or just supply education about the influenza vaccination. And we have a summary of it on the next two slides. So, the first myth is that the influenza vaccination can cause influenza. The second column has the reality and the fact in it. And that is that the flu vaccination does not contain the live virus, so it’s impossible to get influenza from the vaccine. Now, we do know that there are sometimes some redness and some uncomfortableness in the injection site, but that is not the same thing, as getting influenza. The second myth is that the flu shot doesn’t work. The data really supports that even
thought the influenza vaccination isn’t perfect, it’s effective between 79-90 percent depending on how well the circulating viruses match those in the vaccine. So, we know it’s not perfect, but yes, what’s written in the HHS action plan is that it is the most effective measure that we have available to us today. The third point was really concerning, when respondents said, “Our staff follows standard precautions with good hand hygiene and practices and uses appropriate gloves and masks. And, therefore, we don’t need the vaccinations.” And, so the reality is that the influenza is spread by respiratory droplets, generated when talking, coughing and sneezing, and I think a really important point here is that adults shed the influenza virus at least one day before any signs of symptoms. And if you read the HHS action planning, as we talked about individuals who have actually had the virus, it confirms your blood culture, but they had no symptoms whatsoever, and did not know that they had influenza and never had any symptoms. On slide 41, similar information where staff responded that we don’t need the vaccination, and the reality is very much the same as what I just stated. Number 5, there is no evidence to support that influenza vaccination of staff improves patient outcomes. That’s incorrect. Influenza transmission and outbreaks have been recognized for many years and has been associated with substantial morbidity, mortality and costs. And if you go to the actual document that has all of this information in more detail, there are several references there. There are actually 17 references on that document, and you can go back and look at that on that information for everything if you would need to. And then finally, number 6, that the influenza vaccination is too costly, what I will tell you is that we had several organizations with several respondents who stated that they have saved so much money by having the program and offering the influenza vaccination, and they documented that over time. So we know that there is some cost associated with this, but you should also really be getting the cost savings
from implementing the influenza vaccination program. So, with that said, we have that
document available for you at one of the resources that we are providing to you, that we want
you to be aware of, that’s on slide 42. On slide 43, we want you to know about another
resource that we have. It’s a monograph that was written a few years ago on influenza
vaccination for staff and licensed independent practitioners. There’s a wealth of information in
there that can be very helpful to all of you, particularly if you don't have a program set up yet.
If you go to slide 44, another resource that we have is from one of our other companies, Joint
Commission Resources. It’s called the Flu Vaccination Challenge. We just want you to be
aware of it. If you go to slide 45, you’ll see that there is actually the link to it. There is a
tremendous amount of resources that are available to help you through this process if you
need that information. So, the very last slide has my contact information and Linda’s contact
information. The last slide is about the references that we used for this presentation. I just want
you to know that if you have a question, you can also send it to our Standards and
Interpretation Group’s on-line questions format, which is www.jointcommission.org/Standards/,
and that will get you to the page where you can actually write a question, and then, we will
respond.

**Caller:** Do you have a plan for how we can handle a vaccine shortage, if that will be affected
with this standard?

**Bob Wise:** There is an expectation that there won’t be a vaccine shortage. Obviously, if we
have a national issue that makes certain things impossible to deal with, then that would be
taken into consideration, and obviously at that point, we would expect the organization to be
thinking through how they would handle influenza. This is about how to protect your patients from influenza, with vaccine being the first tier, so if it isn’t available, you should figure out how to deal with that and how you can take that into consideration in the survey.

**Kelly Podgorny:** I would just like to mention that there is a SHEA position paper that came out a couple of years ago that actually gives some guidance on how to manage influenza during a season when there is a shortage in vaccine, and we can make that available on our website, too.

**Caller:** I have a question about the extent of the staff that are required. Are these only staff that have direct patient contact, in other words, what about the staff that works in the administration office?

**Kelly Podgorny:** The standard is really that you are offering influenza vaccination to all staff, whether they are direct patient care or not.

**Caller:** We are an HME, home medical equipment company, and this particular standard is not listed, the IC Standard 02.04.01 is not listed in our manual, so I am assuming that it would be addressed during survey through the HR and Infection Control standards and the PI standards that you mentioned.

**Kelly Podgorny:** Standard 02.04.01 is actually the standard we’re talking about today, and the reason why it’s not in your manual is because it hasn’t been formally published yet. In
January, it will go up on the prepublication page. So that’s why it isn’t there. As we relate to the previous question, this standard is applicable to all employees, so it would be applicable to a home DME.

**Caller:** So the book I just received from you was the 2012 standards. It’s not listed in that, but it will be as of January? Is that what you’re saying?

**Kelly Podgorny:** Yes. We just recently approved it, so it’s not going into effect until July 1, 2012. The manual that you have is January 2012. It will be included in the update.

**Caller:** Can you revisit the contracted staff for the home care requirement?

**Kelly Podgorny:** Yes. All contracted staff should be offered the influenza vaccination just like any other staff. And we would encourage you to and recommend that you track influenza vaccinations for contracted workers like you would all the other workers, even though they’re not part of that NQF measure at this time.

**Caller:** And you’re saying that you should track it separately or with your staff? Correct?

**Kelly Podgorny:** Yes.

**Caller:** Is there any information for us that will help answer the other reasons for not accepting the vaccination? For example, I’ll get Alzheimer’s; my children will all be autistic. The list goes
on, and it gets more and more ridiculous. Do you have any resources for us for something that we could answer these kinds of responses?

**Bob Wise:** We’re well aware that organizations are in fact going to face some of the kinds of issues that you’re taking about, which is what Kelly talked about in the myths. One of the things that you’re seeing here is that it is slowly going to get ramped up through 2020, so you have eight years, before you have to get to 90 percent. We would not expect that the number of staff who are so misinformed would be such a large percentage, so one of the ways to do it would be to make sure you concentrate on the staff who are understanding, who can be easily educated. We’re assuming that the group that you’re talking about is going to be a reasonably small group and obviously in the first tier so that may not be the first group that you go after. The other thing is that as this program continues, we will start to hear more stories like that, and I think that we will also be able to then inform you about different approaches, but one of the resources that could help you right away, if you’re interested, is the one that was talked about, which is the monograph. That’s one of the last slides, slide 43. I would start with that, which states those kinds of issues and talks in detail about how to handle it.

**Kelly Podgorny:** And that monograph, by the way, can be downloaded for free.

**Caller:** I was interested in understanding how this applies to imaging providers.
Kelly Podgorny: If you’re accredited under one of the programs that we talked about today, then the standard applies those who are in imaging. You’re accredited under the ambulatory program?

Caller: Right. But we have off-site LIPs.

Cathy Barry-Ipema: But you’re still caring for patients?

Caller: Not our LIPs, but our staff may be.

Bob Wise: So the image is taken at the center and then sent through a telemedicine link to be read?

Caller: Or a physician, sitting in a radiology reading room, who has no contact with patients.

Bob Wise: If they’re sitting in the room, they actually are on-site, and they’re staff.

Caller: OK, but if they’re off-site, reading remotely?

Bob Wise: Right, that is one of the exceptions that we talked about, that if they’re being sent through a telemedicine link, that’s the only exception of staff that does not have to be included.
Caller: And how do you offer flu vaccines to LIPs if your own staff has coverage or access through their insurance provider? We don’t offer flu clinics or on-site flu shots. Can we tell people to do it through their health plan or health insurance?

Kelly Podgorny: From the perspective of this standard, that is not having an influenza vaccination program. What will be very important for your organization is to put together a program; we’re not saying that you have to pay for it, but to make the influenza vaccination easily accessible to staff and licensed independent practitioners. But just telling them that they can go to Walgreens or to a pharmacy or to their health plan, we would not consider that meeting the intent of this standard.

Caller: Well, when you have a national organization with over 2,000 sites, then should I email SIG to find out the recommendations? It would be infeasible to do that.

Bob Wise: I would say that if you’re seeing that there’s a special situation, where you do not see how you can implement these standards, especially if you’re a larger organization, we should probably take that discussion offline.

Caller: Do you know if and when CMS may begin to require organizations such as home care to report using the CDC/NQF formula?

Kelly Podgorny: I can answer that to a degree. You know that CMS is going to be making, I think, that ambulatory surgery and hospitals are going to be at the very beginning, collecting
data, I think hospitals in 2013, ambulatory surgery 2014, and then the data has to be sent by 2016. So, again, you do have some time here. I'm not familiar yet about home care, so I would really recommend that you keep in touch with the CMS site and the rules as they come out.

**Caller:** You said that telling people to go to Walgreens or to their doctor and stuff like that is basically not acceptable. But yet, you're saying that we don't have to pay for it? Then what would be an acceptable way to do that if we cannot pay for the vaccine, or we're not able to?

**Kelly Podgorny:** That's a really good question, and we know of some organizations that have actually contracted with a pharmacy, and that the pharmacy has been available to provide the vaccination at a particular time, and then the employee is charged; it's taken out of their paycheck. So that's one very successful story that we know about. The organization was actually able to work with the pharmacy to get a reduced rate.

**Caller:** Ok, now let's say, for instance, we're a home health care agency, and we offer insurance to our employees. So is there any way that we can deal with our insurance company? For instance, that all of our staff that are insured through our company, because they have the flu clinics and everything else, that would be acceptable to put in the policy, as well?

**Kelly Podgorny:** Yes, absolutely. That really is. We're not going to be prescriptive in telling you how to do this. You all know your own situation the best. But what we can recommend is that you really collaborate, not only with pharmacies, if possible, but also with your local public
health department, that they should be able to help you, particularly if you cannot afford to pay for this.

**Bob Wise:** Let me see if I understand your question, take a little bit of a different twist on it. Are you saying that because you’re home health, there’s no centralized place where all your staff come to meet?

**Caller:** Exactly.

**Bob Wise:** And therefore, they’re all over the place, and how do you offer the staff the vaccine if it’s such a decentralized approach? I think that’s what your question is?

**Caller:** Yes. We have three different offices. We have employees serving nine counties, and so, it’s just one of things; we send the home health aides out to the field, and I was just trying to figure out the best way to implement this policy and make it work. And obviously, the tracking situation, I understand everything. The presentation was wonderful, and I get all that. I am just trying to figure how do I write in my policy to make it work best with my situation. The majority of our staff do have direct contact with the employees, and I understand all that. I’m just trying to think; I’m trying to brainstorm, where would be the best places; for instance, our health insurance company that we offer to our employees; should I contract through each office through a pharmacy to close to each office. This is a little confusing. That’s all.
Bob Wise: Actually, I think it’s a very interesting question. One of the reasons that we’re having this call now, but it’s not going into effect until 2012, because there are questions like this that are quite interesting, that we can talk about and maybe get some thoughts out throughout Frequently Asked Questions. You actually just listed about five or six things that seem quite reasonable. I’m wondering if you can write to Kelly and just list those, and we’ll have our own internal conversations, and when there are unusual situation, we will eventually put some thoughts out there.

Caller: We’re a very small, ambulatory surgery center, and what I want to know is do we have to supply the vaccine, or can we give the people a list of places that they can go get the vaccine with their health insurance, or with payment?

Kelly Podgorny: No, we’ve had a lot of discussions about this, and our position at this point is that handing a piece of paper is not really having an established program. And so, what we would encourage you to do is maybe work more collaboratively with those organizations that you just mentioned, and see if they can come on site, or if there are times that you actually let staff go during work hours to get the vaccinations, if that would be reasonable, but just providing the list is not really offering it, as sites and times available to the licensed independent practitioners and staff.

Caller: Ok, so you’re saying that we need to provide the vaccine, basically is that what you’re saying?
**Bob Wise:** Yes, you need to offer the vaccine.

**Caller:** We need to offer the vaccine. Nobody has to take it, but we need to offer it?

**Bob Wise:** The answer to your question is yes, you have to be able to physically offer the vaccine to all staff, but no, if they choose to decline it, that would be information that you would want to track on the back end.

**Caller:** Hi, I also am a home health care agency, and I just want to get some clarity on slide 20. It says that for all other programs, the organization provides influenza vaccinations at sites and times accessible to licensed independent practitioners and staff. We have nurses that operate completely off-site, so for home care, does that mean we have to have in our hub, if you will, our main office, we have to provide that vaccination at that location?

**Kelly Podgorny:** I think that what we are going to have to do is figure out the best way to do that. You want to offer the vaccination physically in some capacity, and if that means that you have it available at particular days during the influenza season, and then have staff come in to get it, that would be one option.

**Caller:** So that also would entail that we would have store the vaccine on site, as well? And go into all those types of requirements that involve that?
Kelly Podgorny: Let me just clarify that. You can offer the vaccination off-site. But you have to determine where that will be, and it has to be within an established program. So, I want to be clear about that; maybe haven’t been that clear since it keeps coming up.

Bob Wise: If I can add one thing, I think there is a confusion here between giving a person a piece of paper and saying, “You can go to any Walgreens,” which we would not consider a legitimate program. What Kelly just said is if there is someplace off-site where it’s part of your program, and they understand that they are connected to your program, that is different, and that would be acceptable.

Caller: I just wanted to get some clarification, because I know on slide 20, there was verbiage saying, “with the exception of home care,” and I just wanted to capture what that was.

Kelly Podgorny: Yes, and actually, I can tell you exactly what the difference was, is that for home care, we don’t use the word “and times” in the EP, because home care is mostly provided on the day shift, and so that’s at least the thinking we had at the time.

Caller: Our infectious disease physician, who sits on our infection control committee, strongly feels that any employee who declines the influenza vaccine should wear a mask during their shift. I’m wondering if that’s something that you’re hearing or seeing in other facilities?

Kelly Podgorny: The answer to that is yes, we are hearing about that happening, that masks need to be worn by individuals who have declined the influenza vaccination. It really does
make sense from a scientific perspective. You want to try and minimize any kind of
transmissions, but we are not requiring that in this standard.

**Caller:** Hi. We’re an ASC, and we’re Joint Commission-accredited, but our employees are
leased employees from the hospital, and flu vaccine program is offered through our hospital,
but since we’re separately accredited, do we have to have our separate program then?

**Kelly Podgorny:** Well, I think you have your program. The requirements are the same across
programs, so you do have a program because all those Elements of Performance would be
met by the program in the hospital.

**Linda Kusek:** Wait, they are accredited separately?

**Caller:** Yes, we are accredited separately.

**Linda Kusek:** So are you included in the influenza program fostered by the hospital?

**Caller:** Yes, because the associates are leased associates.

**Linda Kusek:** Ok. So, staff at that ambulatory site are all involved or included in the hospital
program, all staff?

**Caller:** Right.
Bob Wise: Let me just also ask, is that including non-clinical staff, too, that everybody from admissions to whomever else is there?

Caller: Yes.

Bob Wise: Ok. So, I guess the point would be that if you’re included already in another program, then I think it sounds like that would be fine.

Kelly Podgorny: I would just say that you want to have the documentation, though, that is required, and you want to be able to talk about what the hospital does and what the process is during your systems tracer on infection prevention.

Bob Wise: I would also agree. You have to know which one of your staff declined, which ones are vaccinated, etc.

Caller: Right, we’re getting those numbers all together now.

Bob Wise: It sounds like you’re doing fine, then. I think there was a similar question that about some of the problems with DME and home care. I’m not sure we can, each company has a different configuration. I’m not sure how we can answer that specific to your company. I think you will have to sort of struggle with what the requirement is, understand that you are
going to have offer a program, but we’ve heard in the last half an hour that there’s lots of
different ways to potentially do that, so I’m not sure we can answer directly for your company.

Your organization, which is accredited, does have to deal with this standard, so you have to
set up a program, but what we’ve heard is that there are so many configurations, specifically
for the different types of home care, that each home care, in this case, DME, has to work it out
separately, what works for your configuration, where your staff is, etc.

**Cathy Barry-Ipema:** We’re going to explain. We are hearing this question over and over
again. We want to make this very clear to everyone exactly what we’re talking about.

**Kelly Podgorny:** All right, so the standard, there is one standard, and there are nine
Elements of Performance. Each organization that is accredited will need to have a program
that is required by the standard and meet all those Elements of Performance. So, you will
need to do that, but how you do it will be something that you will have to determine, as Bob
Wise was saying, based on the specifics of your circumstances. So you do have to do this,
even if you are a very small company. You will have to figure out the best way to do it for your
organization. And it’s not just offering the vaccination; it’s also providing the education, doing
the tracking, providing the information to your key stakeholders.

**Bob Wise:** This specific question has come up several times. What we might be able to do is
after this is over, sort of talk about what we think is not coming across clearly, and then write a
Frequently Asked Question and address it, because I think we now sort of understand what
may not be clear in the standard, and we can clarify that.
**Cathy Barry-Ipema:** Right, I think what we’re really talking about is how to operationalize it. The standard is clear; everybody understands that there needs to be a program. It’s how to operationalize, and each organization is very different. Some are national in scope, and they have employees all over. Some are very localized, so we need to help them explain how to operationalize it in your organization and give suggestions and recommendations. These have been very helpful questions. Since this standard is not going into effect until July of 2012, we do have a period of time to work on this, so thank you

**Caller:** We’re accredited in four programs, but the hospital is the main one that provides this program. Do I have to track each separate program, like home care, behavioral health and the long term care; do I have to track those separately, or can I track them all together?

**Bob Wise:** Let me understand, you are going to have a single program that you’re going to make available to the staff in all four programs?

**Caller:** Correct.

**Bob Wise:** Well then, essentially, you’re making a single program. Each program will have its own vaccination program, so you could have a single one, as long as it includes all the staffs, that would be fine. You would have to be clear, though, that when behavioral health was dealt with or home care, or whatever, that it is all being put together in a single place.
Caller: Ok, but I don’t have to have the single numbers from each area, then; like home care, I don’t have to have their single tracking numbers, like they have three that do not and nine that do, or do I have to keep that separate from the hospital, percentage?

Kelly Podgorny: I would recommend that you keep it separate if you’re accredited separately, and that the hospital should be able to pull that information out for you, so that you have the required documentation that’s required in this standard.

Caller: Ok, I know I already have it for the whole hospital in the percentages and all, but I have not pulled them separately, yet.

Bob Wise: So for instance, if you had 90 percent of all of them together, that it turns out that that 10 percent was the entire behavioral program, that’s a problem. You wouldn’t know that unless you break it out by program.

Caller: Ok, I’ve got it. Perfect. Thank you.

Caller: I have a question about the numerator and denominator. We are a day surgery center in an urban area; we’re in Dallas. Due to the nature of the business, we may have 150 anesthesia providers credentialed and on staff. We may see some of them only two or three times a year. I can make that vaccine available to them, but in terms of including them in my overall rates, I may never even see them to offer it to them. And they’ve also are credentialed at other hospitals, other day surgery centers in the area.
**Kelly Podgorny:** This is actually an issue that came up nationally, and that my understanding is that you really should be tracking all of these individuals in the numerator and in the denominator, because they are on your staff. They are one of your licensed independent practitioners.

**Bob Wise:** Let me also add to that, that while I’m in agreement that you can offer, they clearly are not going to be on-site, but you still should know the status of whether they, in fact, were vaccinated or not, and then that would be included in the numerator and denominator. If you want to break it out, you may want to stratify it, according to licensed independent practitioners or staff, or in some other way, but you have to know. If they’re on your staff, you’re responsible for knowing their status.

**Caller:** Offering vaccine to people and purchasing vaccine for people that we may never see would certainly seem like a waste.

**Bob Wise:** This gets into another issue about why you have people on your staff that you never see. That gets into another situation, but if they’re on your staff, you have made a statement that you have a responsibility towards them.

**Cathy Barry-Ipema:** Thank you, everyone for joining us. In addition, please feel free to contact our SIG office with questions. That number is 630.792.5900, and also, there is a form on The Joint Commission website, so you can certainly fill that out, and send in any questions
that you have. I would like to thank everyone who took the time to participate into today’s call. We hope it was of value to you. We know this is a very important issue, and we want to make sure that people understand exactly what our expectations are, and we want to give you plenty of time to begin working on these standards. Good day.

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