

Manual M-2, Clinical Programs. Part IV, Medical Service

Chapter 6, Infectious Diseases (Paragraphs 6.01 through 6.07)

Rescinds Chapter 6 dated October 23, 1990

This document includes:

- Title page and title page verso M-2, Part IV, dated **April 29, 1994**
- Contents page for M-2, Part IV, dated **April 29, 1994**
- Rescissions page iv for M-2, Part IV, dated **April 29, 1994**
- Rescissions page v for M-2, Part IV, dated **September 11, 1991** (Change 1)
- Contents page Chapter 6, dated **April 29, 1994**
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- Text for Chapter 6, dated **April 29, 1994**

Transmittal sheet located at the end of the document:

Sheet dated **April 29, 1994**

Change prior to 1994 located at the end of the document:

Sheet dated **October 23, 1990**



Department of
Veterans Affairs

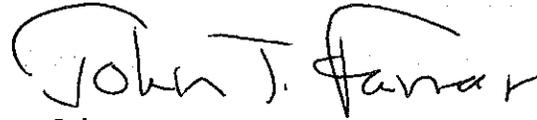
Clinical Programs

Medical Service

April 29, 1994

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Department of Veterans Affairs, Veterans Health Administration manual M-2, "Clinical Programs," Part IV, "Medical Service," is published for the compliance of all concerned.



John T. Farrar, M.D.
Acting Under Secretary for Health

Distribution: RPC: 1027
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a. Manuals

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Letter and DateSubject

November 20, 1950

Cortisone and ACTH

December 4, 1950

Reporting of Cases of Syphilis to Health Authorities

March 15, 1951

Cortisone and ACTH

June 15, 1951

Physical Examination for Residuals of Filariasis

December 28, 1951

Letter refers to availability and use of cortisone and ACTH

August 26, 1953

Use of Antihypertensive Drugs Subsequent to Hospitalization

August 28, 1953

Purchase of Antigens for Treatment of Disease Due to Allergy

December 4, 1953

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February 5, 1954

Physical Examination for Residuals of Hepatitis (Viral)

August 5, 1954

Procurement of Allergenic Material From the VA Central Laboratory at Aspinwall

August 9, 1954

Special Boards for the Control of Therapeutic Management of Cases

August 9, 1954

ACTH and Cortisone Therapy

August 13, 1954

Prerequisite for Medical Therapy (Malaria)

August 13, 1954

Self-Administration of Hyposensitization Therapy

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RESCISSIONS

1. Manuals

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CHAPTER 6. INFECTIOUS DISEASES**6.01 POLICY**

It is the Department of Veterans Affairs (VA) policy that treatment, control, and prevention of infectious diseases in all VA health care facilities be similar.

6.02 THE ADVISORY COMMITTEE ON INFECTIOUS DISEASES

a. A VA Central Office Advisory Committee on Infectious Diseases exists to advise the Associate Deputy Chief Medical Director (ADCMD) for Clinical Programs on policy.

(1) The Director, Medical Service, acts as liaison through the Program Director in Infectious Diseases.

(2) The committee ordinarily consists of the Infectious Disease Field Advisory Group (Medical Service) under the direction of the Program Director in Infectious Diseases, who is specially trained in this medical subspecialty.

b. Some of the areas in which the committee might make recommendations include:

(1) Work force;

(2) Design of health care and extended care facilities, including the Microbiology Laboratory;

(3) Policies on prevention and control of communicable diseases;

(4) Policies on the use of antimicrobials and anti-infectious biologics;

(5) Training recommendations;

(6) Policies on methods of infection surveillance and data analysis;

(7) Infection Control Program;

(8) Advice on the development and adoption of new laboratory procedures;

(9) Development of specialized resources within selected laboratory Services;

(10) Acquired Immunodeficiency Syndrome (AIDS) (in conjunction with the AIDS Service); and,

(11) Tuberculosis (TB).

6.03 HOSPITAL INFECTION CONTROL COMMITTEE

Each health care facility should establish an Infection Control Committee (see M-1, Pt. I, Ch. 26, par. 26.07 and App. 26A; and MP-3, Pt. III, Ch. 32, par. 32.29). A physician, specially trained in Infectious Diseases, should be chairperson of this committee. The Hospital Infection Control Committee may serve as a consultant to the Safety, Occupational Health and Fire Protection Committee on matters relevant to infection control.

6.04 INFECTIOUS DISEASES SECTIONS

a. Infectious Diseases Sections should be formed as a subspecialty under Medical Service at all health care facilities where feasible. The functions of such a section are to:

(1) Provide optimal patient care with relation to infectious diseases by consultation throughout the facility. This would include the consideration of inpatient and outpatient problems.

(2) Conduct the business of the Infection Control Committee, including policy recommendations in such areas as:

- (a) Procedures for isolation and prevention of infection,
- (b) Environmental sanitation,
- (c) Infection surveillance,
- (d) Epidemiologic studies,
- (e) Employee health (where communicable diseases and/or infection is involved), and,
- (f) Immunization programs.

(3) Advise appropriate local facility committees regarding:

- (a) Selection and control (restriction) of antimicrobials, and,
- (b) Audit of antimicrobial usage.

(4) Provide guidance for activities under the Infection Control Program.

b. The Chief, Infectious Diseases Section, or designee, should have close liaison with Pathology and Laboratory Medicine Service, and work actively with the Chief, Pathology and Laboratory Medicine Service, on the development and implementation of programs and policies in the Microbiology Section, Pathology and Laboratory Medicine Service, particularly with regard to staffing, space, and equipment. The Chief, Infectious Diseases Section, should consult with appropriate members of Pathology and Laboratory Medicine Service regarding:

(1) The collection of specimens, the establishment of priorities for collection of specimens,

(2) The establishment of priorities for cultures, susceptibility tests, new diagnostic procedures, and

(3) The compilation of laboratory data for epidemiologic evaluation.

c. The Section Chief should work with the Associate Chief of Staff for Education, or appropriate staff of other services, to maintain a program of inservice education. This program will provide improved knowledge of infectious diseases to appropriate medical center personnel.

NOTE: The Section Chief should maintain a liaison function with other local hospitals and public health authorities in the community regarding infectious disease problems.

6.05 INFECTION CONTROL PROGRAM

The prevention and control of infections in all VA health care facilities will be addressed through Infection Control Programs that are similar in design. The regional offices may review each medical center's Infection Control Program in conjunction with a planned systematic review process, utilizing criteria developed in concert with the Infectious Diseases Program Office. The Infection Control Programs must meet current requirements from external regulatory agencies and comply with written VA requirements and guidelines.

a. Each VA health care facility will institute an Infection Control Program. The Infection Control Program is under the auspices of Medical Service, specifically under the Infectious Diseases section, if feasible, with oversight function provided by a multidisciplinary hospital Infection Control Committee.

b. Control activities directed toward the prevention of nosocomial infections and the control of infections are integral components of the Infection Control Program. Control functions are performed by the Infection Control staff and other facility personnel through a cooperative effort to prevent and/or control infections in patients, personnel, families, and visitors. Considering that an Infection Control Program cannot be effective without control activities, each facility must have in place control activities to include, but not limited to:

- (1) Written policies and/or procedures that:
 - (a) Define the indications for specific precautions to prevent transmission of infection;
 - (b) Give authority to person(s) in infectious diseases control and registered nurses to implement isolation procedures in an emergency without a physician's order;
 - (c) Describe the role and scope of each service in infection prevention and control activities;
 - (d) Describe the handling and disposal of refuse considered by regulation(s), laws, or statutes to be regulated medical waste and/or infectious waste;
 - (e) Identify the role and scope of employee health (see MP-5, Pt. I, Ch. 792; MP-3, Pt. III, Ch. 32; and M-1, Pt. III, Ch. 4) for reporting infections, evaluation and intervention as appropriate for exposure of employees to a potentially communicable agent;
 - (f) Address cleaning, disinfection, decontamination and sterilization issues;
 - (g) Address separation of soiled and contaminated supplies from clean and sterile supplies; and
 - (h) Handle the purchase of chemical supplies and equipment related to infection control in the facility.
- (2) Monitoring staff compliance with specific patient care practices and/or procedures and/or policies as they relate to infection control issues.

(3) Mechanisms for obtaining consultation from person(s) in infectious diseases control regarding equipment, supplies, renovation and construction with infection control implications.

(4) Educational efforts directed toward infection control topics for orientation classes for new employees and in-service training for relevant employees.

c. Control activities will be reviewed to determine effectiveness, revised, modified, and changed, as necessary, since the appropriateness of control activities depends heavily on the surveillance findings and the circumstances within the individual facilities.

d. Written infection control documents will be updated at the facility level when clinically indicated, or based, on most current written rules and regulations generated by the VA and/or valid oversight regulatory bodies.

e. Surveillance activities. The major goal of an Infection Control Program is to lower the risk of a hospital acquired or associated infection. Surveillance activities have a significant influence on the control activities employed to achieve the goal of a lower risk for a hospital acquired or associated infection. NOTE: *Surveillance, when applied to disease, may be defined as "the continuing scrutiny of all those aspects of the occurrence and spread of disease that are pertinent to effective control."*

(1) Such a surveillance system, designed to establish and maintain baseline infection rates, gives a facility an indication of its endemic infection rates. These rates represent the frequency with which a specific type of infection occurs within the total or targeted population in a particular facility based on past surveillance. Knowledge of the endemic rate(s) enhances recognition of a situation to be reviewed when the infection rate(s) rise above the endemic rate(s). Equally true, the drop of infection rate(s) below the endemic rate(s) may signify the effectiveness of in place infection control activities.

(2) An ongoing system of surveillance is an integral component of an Infection Control Program. Inherent in the system should be detection of and control of outbreaks of infections. Being mindful of the major infection sites (bloodstream, lungs, surgical wound, and urinary tract), the surveillance system should be so planned to provide baseline data on each over a designated period of time.

(3) Each facility will establish a written system of surveillance to include, but not be limited to, the following elements:

(a) Definition of the events to be surveyed;

(b) Definitions of nosocomial infections with criteria for determining presence or absence of infection;

(c) Systematic collection of relevant data;

(d) Tabulation of the data;

(e) Qualitative and quantitative (if appropriate) analysis and interpretation of the data;
and

(f) Preparation and dissemination of findings to individuals, groups, and/or committees, as appropriate.

NOTE: A critical element of the program is feedback of accumulated data to those individuals, groups, and committees who can most benefit from this information.

f. The determination of rates is a key factor in the analysis portion of the surveillance system. Consistency in the use of the term and calculation of rates is a crucial issue.

(1) Rate is a numerical statement of the frequency of an event per unit of time obtained by dividing the number of events or the number of individuals experiencing the event (numerator) by the total number capable of experiencing the event (denominator or population at risk during the specific time interval) and multiplying by a constant such as 100, 1,000 or 10,000.

(2) A rate measures the probability of occurrence in a population of some particular event, such as cases of disease. The following is the basic formula for rates:

$$\text{Rate} = \frac{\text{Numerator}}{\text{Denominator}} \times \text{Constant}$$

(a) Numerator = the number of times the event (e.g., infections) has occurred during a specified time interval.

(b) Denominator = a population (e.g., number of patients at risk) from which those experiencing the event were derived during the same time interval.

(c) Constant = a whole number (100, 1,000, 10,000 usually used). Selection of the whole number is usually made so that the smallest rate calculated has at least one digit to the left of the decimal point.

(d) Incidence density is determined by making the denominator the number of patient-days at risk during the period of surveillance.

g. Data can be expressed using analytical statistical methodologies or other descriptive statistical methods such as:

(1) Ratio is the expression of the relationship between a numerator and denominator which may involve either an interval in time or may be instantaneous in time;

(2) Proportion is an expression in which the numerator is always included in the denominator, and the base is equal to 100. Therefore, a proportion is expressed as a percent; and

(3) Index is the best available approximation to a true rate. This occurs when one is unable to count directly the number at risk (denominator) and something else is used which one can count to give an impression of the number at risk.

h. Through the utilization and implementation of standing requests (see M-1, Pt. I, Ch. 9) VA facilities will report diseases (disclosure of information related to infection with the Human Immunodeficiency Virus (HIV) to public health authorities will be discussed

as a separate issue, (see M-1, Pt. I, Ch. 9) as required by State law for State, county, and city health departments in accordance with the provisions of the Privacy Act of 1974 (5 United States Code (U.S.C.) 522a), and the VA confidentiality statutes, 38 U.S.C. 5701 and 7332.

(1) A purpose of this disclosure is to cooperate with a state reporting requirement.

(2) The required data will be furnished without the written consent of the patient.

(3) Disclosure of information related to infection with HIV will be made to public health authorities, providing the disclosure is in accordance with M-1, Part I, Chapter 9, and M-2, Part I, Chapter 23. Disclosure of the information will be so documented in the patients' medical record as required by the Privacy Act and 38 Code of Federal Regulations (CFR) 1.576(c).

(4) Each facility will develop in writing a system for reporting diseases to include but not limited to:

(a) Administrative management of the standing request and facility responses (see M-1, Pt. I, Ch. 9);

(b) Designated responsibility for report submission;

(c) Notification within the facility to the facility designated reporting official of a disease to be reported; and

(d) Documentation expectations at the facility level.

6.06 STAFFING GUIDELINES

a. Recommendations for staffing of Infectious Diseases Sections should include the following:

(1) A physician section chief (specifically trained in Infectious Diseases and who has taken at the minimum one training course in hospital infection control).

(2) In addition, one staff physician for each 200 to 250 general medical and surgical (GM&S) beds. In areas of high incidence of persons who are HIV positive or with Acquired Immune Deficiency Syndrome (AIDS), additional staffing in accordance with facility need will be necessary.

(3) At least one full-time practitioner of infectious diseases control with the same distribution as staff physicians in subparagraph (2). In areas of high incidence of persons who are HIV positive or with AIDS, additional staffing in accordance with facility need will be necessary.

(4) Subspecialty resident positions in Infectious Diseases where appropriate and specific infectious diseases training positions in AIDS may be of value.

(5) One unit secretary and at least one clerical support person whose duties include, but are not limited to typing for the Infection Control Program. **NOTE:** *This is critical to the functioning of the section and the Infection Control Program.*

b. If no Infectious Diseases Section exists in the facility, then availability should be ensured by a physician specifically trained in infectious diseases, who has taken at the minimum one training course in hospital infection control.

NOTE: The Laboratory Service should have skilled (Ph.D. level or equivalent) leadership in the Microbiology Section and be staffed adequately to ensure provision of necessary services.

6.07 EQUIPMENT AND SUPPORT

The healthcare facility should furnish whatever space, equipment, office supplies and other clerical services necessary for the effective operation of the section and the Infection Control Program. This includes:

- a. Appropriate data processing equipment (or access to such items);
- b. Supplies to fulfill the mission of the section and the Infection Control Program; and
- c. Adequate funds for the training and continuing education of the infectious diseases staff and infection control personnel.

1. Transmitted is a revision to the Department of Veterans Affairs, Veterans Health Administration manual M-2, "Clinical Programs," Part IV, "Medical Service," Chapters 1 through 8.

2. Principal changes are:

a. Chapter 1: Delegates general supervision of the Medical Officer of the Day to the Chief of Staff.

b. Chapter 2: Revises and updates policies regarding cardiology.

c. Chapter 3: Defines policy for Intensive Care Units.

d. Chapter 4: Revises and updates policies on the Dialysis Program including new 38 United States Code (U.S.C.) citations.

e. Chapter 5: Establishes policy for providing outpatient oxygen therapy.

f. Chapter 6: Amended to include the Infection Control Program.

g. Chapter 7: Defines ethnic origin of applicant and includes new 38 U.S.C citations.

h. Chapter 8: Defines policy for providing Allergen Therapy.

3. Filing Instructions

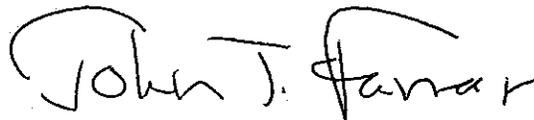
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8-i through 8-1 ✓

4. RESCISSIONS: M-2, Part IV, dated October 23, 1990, chapters 1 through 8.



John T. Farrar, M.D.
Acting Under Secretary for Health

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Printing Date: 5/94

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1. Transmitted is a revision to Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," Part IV, "Medical Service," chapters 1 through 8. Brackets have not been used to indicate changes.

2. Principal change:

This is a major revision of Part IV, "Medical Service," providing updated and expanded guidance.

3. Filing Instructions

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4. **RESCISSION:** M-2, part IV, dated April 15, 1955; and changes 3, 5, 7, 13, 15, and 17. Interim Issue II 10-72-13, dated May 17, 1972.


JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

Distribution: RPC: 1027
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October 23, 1990

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," Part IV, "Medical Service," is published for the compliance of all concerned.


JAMES W. HOLSINGER, JR., M.D.
Chief Medical Director

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REMARKS

DO NOT REPRINT. Change 1, M-2, Part IV, will be revised some time in 1961. *(Same for Chg. 3)*

H. F. WRIGHT
PCO, IM&S (10E)
Jan. 3, 1961

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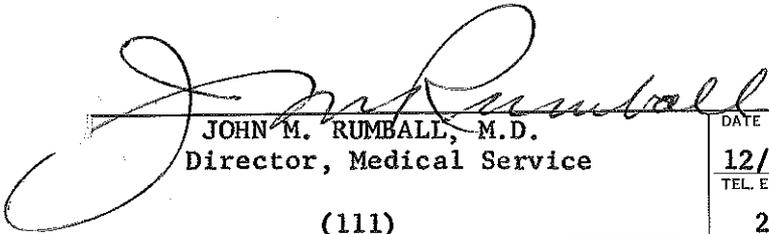
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REMARKS

The specific items requested in your note of 12/1/60 have been reviewed.

I do believe a change should be considered, however, before doing so the Area Consultants in Tropical Medicine must be consulted. This will be done in 1961.


JOHN M. RUMBALL, M.D.
 Director, Medical Service

	DATE
	12/30/60
	TEL. EXT.
	2549

(111)

**VETERANS ADMINISTRATION
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REMARKS

Changes 1 and 3 of M-2, Part IV, have come up for reprinting, 100 copies each.

Would you look over these changes and let us know whether any revisions ^{are indicated} in the manual (re these pages) at your earliest convenience, since we must make reply to the Depot as soon as possible.

If you find that revisions are indicated, please return these changes, so stating, and the revisions *should* be submitted as a new change and one or both of these changes *will be* disapproved for reprint.

This should be discussed with Dr. Rumball

FROM <i>R. Strachan</i> for H. F. WRIGHT PCO, DM&S (10E)	DATE 12/1/60 TEL. EXT. 2507
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