August 27, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3260-P
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-3260-P: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

To Whom It May Concern:

Trust for America's Health (TFAH) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule concerning requirements for Medicare and Medicaid Long-Term Care (LTC) Facilities. As a non-profit, non-partisan organization dedicated to saving lives and working to make disease prevention a national priority, TFAH is particularly interested in the infection control and antibiotic stewardship requirements outlined in the proposed rule.

Infection control and antibiotic stewardship are two critically important components of public health promotion and disease prevention. Antibiotic usage and routine vaccination are two of the most important tools in combatting infectious diseases and have saved countless lives. However, antibiotic over-usage and vaccine under-utilization have respectively led to the emergence of antibiotic resistant bacteria and reemergence of other infectious diseases. TFAH is pleased that CMS has acknowledged these dual public health threats, especially for residents in LTC settings, in its reform of requirements for LTC facilities.

Our views are outlined in detail below:

TFAH supports the designation of an infection prevention and control officer at each facility.

We strongly support the proposed rule's requirement for each facility to designate an infection prevention and control officer (IPCO) (§483.80(b)). Requiring each facility to appoint a clinician who works at least part time in the facility and who has specialized training in infection prevention and control helps ensure that IPCOs will have sufficient institutional and medical

knowledge to oversee an effective infection prevention and control program at their facilities. The Center for Disease Control's (CDC) Study on the Efficacy of Nosocomial Infection Control found that hospital infection prevention and control programs with "better infection control professional staffing and those programs headed by physicians dedicated to hospital epidemiology ha[ve] more intense infection prevention and control activities and lower health care–associated infection (HAI) rates" than programs with different structures and leadership.[1] It is reasonable to apply these lessons as a basis for similar organizational structure in LTC settings. Like hospitals, LTC facilities provide a wide range of services through various healthcare providers. Unified direction under one IPCO will enable these various healthcare providers to work in concert toward the goal of infection control and prevention.

Because the proposed rule permits part-time clinicians the opportunity to become IPCOs, a facility's IPCO may have multiple priorities beyond the facility's infection control and prevention program. We believe that it would be useful for CMS to offer recommendations regarding sufficient staff time for IPCOs and other staff in infection prevention and control programs, for example by specifying the number of full-time equivalent (FTE) infection control staff a facility should employ in relation to the number of beds in the facility. The CDC's National Nosocomial Infections Surveillance (NNIS) system requires hospitals to have 1 FTE infection control staff member per 100 beds.[2] An analogous requirement for LTC facilities could help ensure appropriate infection control staffing, even for facilities with part-time IPCOs.

TFAH encourages CMS to include healthcare personnel in the scope of the influenza and pneumococcal immunization requirements.

We recommend extending the influenza and pneumococcal immunization education and access requirements for residents in LTC facilities to include healthcare personnel at LTC facilities. The current proposed rule requires that each resident receive information about influenza and pneumococcal immunizations as well as access to the immunizations themselves between October 1 and March 31. This requirement does not, however, include healthcare personnel working closely with residents. Multiple studies have demonstrated an association between increased vaccination of healthcare workers and decreased morbidity and mortality among patients in hospitals and long-term care facilities.[3] Consistent with this analysis, the CDC's

[1] Stone, P. W., Dick, A., Pogorzelska, M., Horan, T. C., Furuya, E. Y., & Larson, E. (2009). Staffing and structure of infection prevention and control programs. *American Journal of Infection Control*, *37*(5), 351–357.
[2] Richards et al. (2000), "Characteristics of hospitals and infection control professionals participating in the National Nosocomial Infections Surveillance System 1999" *American Journal of Infection Control*, 29 (6), 400-403 December 2001, Pages 400–403 (online at http://www.sciencedirect.com/science/article/pii/S0196655301467034).
[3] Ahmed, F., Lindley, M. C., Allred, N., Weinbaum, C. M., & Grohskopf, L. (2014). Effect of influenza vaccination of healthcare personnel on morbidity and mortality among patients: systematic review and grading of evidence. *Clinical infectious diseases*, *58*(1), 50-57.

Advisory Committee on Immunization Practices (ACIP) recommends influenza vaccination of all healthcare workers, including those in LTC facilities.[4]

Encouragingly, the rate of immunization of healthcare workers for influenza has grown from only 40% in 2003[5] to 75% in 2013-14.[6] Nonetheless, immunization rates were lowest among healthcare personnel in LTC facilities, at only 63% in 2013-14.[7] There is state precedent for including LTC healthcare personnel within the scope of immunization requirements, including in Alabama[8], New York[9], Kentucky[10], Texas[11], and Oregon.[12] Extending federal immunization requirements on education and access to LTC personnel may encourage more healthcare workers in LTC facilities to access immunization, which will improve resident safety and support facility infection prevention and control programs.

TFAH supports the establishment of antibiotic stewardship programs within LTC facilities and looks forward to further guidance from CDC and CMS.

We are supportive of the proposed rule's requirements for LTC facilities to establish an "antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use" (§483.80(3)). Antibiotics are some of the most effective and, in turn, commonly prescribed medications in healthcare.[13] Their misuse or misapplication due to incorrect dosage or duration chips away at this effectiveness by creating antibiotic resistance. Consequently, it is imperative that healthcare providers closely monitor their prescription practices so that they only prescribe antibiotics in the appropriate circumstances.

The current proposed rule contains sparse information about antibiotic stewardship programs beyond that they must exist with protocols for antibiotic prescribing and monitoring systems. We understand the CDC is currently in the process of developing a "core elements" document for antibiotic stewardship programs in LTC facilities that may elaborate on best practices for these programs. We look forward to the release of this document, and hope that CMS will be amenable to updating the proposed rule with information from the CDC about best practices.

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[4] Shefer et al. (2011). Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). (online at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm).
[5] CDC, "Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP) (Jul. 29, 2005) (online at www.cdc.gov/mmwr/pdf/rr/rr5408.pdf).
[6] CDC, "Influenza Vaccination Coverage Among Health Care Personnel — United States, 2013–14 Influenza Season" (Sep. 19, 2014) (online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a1.htm).
[7] *Id.*
[8] Alabama Code § 22-21-10 (online at http://codes.lp.findlaw.com/alcode/22/1/21/1/22-21-10).
[9] New York Code Article 21-A Long-Term Care Resident and Employee Immunization Act (online at http://codes.lp.findlaw.com/nycode/PBH/21-A).
[10] Kentucky Administrative Regulations Title 902, § 2.065 (online at http://www.lrc.ky.gov/kar/902/002/065.htm).
[11] Texas Code § 161.0051 (online at http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.161.htm).
[12] Oregon Code § 433.416 (online at https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors433.html).
[13] CDC, "About Antimicrobial Resistance" (September 16, 2013) (online at http://www.cdc.gov/drugresistance/about.html).

TFAH supports pharmacist review of medical charts when a resident has been prescribed antibiotics.

We support the proposed rule's requirement that pharmacists conduct a monthly drug regimen review for any resident who has been prescribed antibiotics (§483.45(2)(iii)). Such a review would, as CMS notes, be in service of the proposed rule's new antibiotic stewardship program requirement and work toward ensuring healthcare providers prescribe antibiotics only when medically necessary.

TFAH supports the development of Quality Assurance and Performance Improvement (QAPI) programs.

We strongly support the proposed rule's requirement to require facilities to "develop, implement, and maintain effective, comprehensive, data-driven QAPI program, reflect in its QAPI plan, that focuses on systems of care, outcomes and services for residents and staff" (§483.75(a)). Effective data collection and monitoring at the facility level is integral in providing LTC residents with safe and effective care.

QAPI programs are useful in a number of ways within LTC facilities. At TFAH, we are primarily interested in QAPI programs for their impact on facilities' infection control and antibiotic stewardship programs. Requiring LTC facilities to develop QAPI programs will enable them to codify methodologies for monitoring and measuring the effectiveness of their efforts to control and prevent infection and administer antibiotics responsibly. Furthermore, requiring the newly designated IPCO to be a member of a his/her facility's quality assessment and assurance committee (§483.80(c)) will assist the committee in designing and maintaining a QAPI program that collects the data necessary to adequately monitor the infection control and prevention program.

We strongly support robust collection, measurement and disclosure of data related to LTC antibiotic stewardship and infection control initiatives, including in the context of the new QAPI programs. We encourage CMS to consider ways to make LTCs' activities in these areas more transparent to the public, including considering the addition of new measures to the Nursing Home Compare website. With a more complete picture of the LTC landscape, individuals and their families could make more informed decisions about selecting facilities to provide long term care. Enhanced collection and disclosure of infection control and prevention measures may also encourage a race to the top for LTC facilities whose quality data will be directly comparable to their competition.

Conclusion

Thank you for your consideration of these comments. We look forward to the release of the final rule which we think will have a positive impact on public health and disease prevention. If you have any questions, please feel free to contact Dara Lieberman, TFAH's Senior Government Relations Manager, at (202) 223- 9870 x 20 or dlieberman@tfah.org.

Sincerely,

Jeffrey Levi, PhD
Executive Director