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October 14, 2015

Via <http://www.regulations.gov>

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3260-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

RE: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, Proposed Rule

Dear Mr. Slavitt,

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to comment on the proposed rule for the Reform of Requirements for Long-Term Care Facilities in the Medicare and Medicaid program.

SHEA represents more than 2,000 physicians and other healthcare professionals globally with expertise in healthcare epidemiology, antibiotic stewardship, and infection prevention. SHEA is dedicated to advancing the science and practice of healthcare epidemiology and preventing and controlling morbidity, mortality, and the cost of care linked to healthcare-associated infections (HAIs).

SHEA respectfully submits comments on the following sections of the proposed rule:

- F. Transitions of Care (§ 483.15)
- M. Pharmacy Services (§ 483.45)
- U. Infection Control (§ 483.80)
- X. Training Requirements (§ 483.95)

In the development of these comments, SHEA relied heavily on the following documents to support its recommendations:

Philip W. Smith, Gail Bennett, Suzanne Bradley, Paul Drinka, Ebbing Lautenbach, James Marx, Lona Mody, Lindsay Nicolle and Kurt Stevenson (2008). Shea/Apic Guideline: Infection Prevention and Control In The Long-Term Care Facility. Infection Control & Hospital Epidemiology, 29, pp 785-814 doi:10.1086/593114

Sara E. Cosgrove, Elizabeth D. Hermsen, Michael J. Rybak, Thomas M. File, Sarah K. Parker and Tamar F. Barlam (2014). Guidance for the Knowledge and Skills Required for Antimicrobial Stewardship Leaders. Infection Control & Hospital Epidemiology, 35, pp 1444-1451 doi:10.1086/678592

Neil Fishman (2012). Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and the Pediatric Infectious Diseases Society (PIDS). Infection Control & Hospital Epidemiology, 33, pp 322-327 doi:10.1086/665010

The Core Elements of Antibiotic Stewardship for Nursing Homes. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 22 Sept. 2015. Web. 14 Oct. 2015.

While SHEA's policy recommendations will be clearly outlined in this document, we urge CMS to examine these guidelines and policy statements independently for a detailed clinical and scientific basis of these recommendations.

SHEA thanks CMS for soliciting public comment on the Medicare and Medicaid Program Reform of Requirements for Long-Term Care Facilities proposed rule. For future inquiries on this submission, please contact Lynne Batshon at 703-684-0761 or [lbatschon@shea-online.org](mailto:lbatschon@shea-online.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthony D. Harris', written in a cursive style.

Anthony D. Harris, MD, MPH, FSHEA, FIDSA, President, SHEA

## **F. Transitions of Care (§ 483.15)**

CMS is proposing to designate a new section, Section 483.15 “Transitions of Care” in order to reflect current terminology that applies to all instances where care of a resident is transitioned between care settings. This section includes revisions to the current regulations that would require new policies regarding admissions, transfer, discharges, communication among providers, and requirements for providing the necessary information to the resident’s receiving provider. Additionally CMS proposes to require specific data elements or a set of information that must be communicated during the transfer process that includes but is not limited to

*“...name, sex, date of birth, race, ethnicity, and preferred language, resident representative information including contact information, advanced directive information, history of present illness/reason for transfer, including primary care team contact information, past medical/surgical history, including procedures, active diagnoses/current problem list, laboratory tests and the results of pertinent laboratory and other diagnostic testing, functional status, psychosocial assessment including cognitive status, social supports, behavioral health issues, medications, allergies including medication allergies, immunizations, smoking status, vital signs, unique identifier(s) for a resident’s implantable device(s), if any, comprehensive care plan including health concerns, assessment and plan, goals, resident preferences, other interventions, efforts to meet resident needs, and resident status.”*

Because residents of long-term care facilities (LTCFs) are hospitalized frequently, they can transfer pathogens between LTCFs and referring or receiving hospitals; transfer of residents colonized with multi-drug resistant organisms (MDROs) between hospitals and LTCFs has been well documented. SHEA notes that CMS does not explicitly include isolation precautions or potential exposures to communicable diseases among the list of recommended data elements for communication between and among providers during transitions of care. SHEA recommends CMS require the following information be transmitted when a resident is admitted, transferred or discharged:

- Colonization or infection with multidrug resistant organisms or *Clostridium difficile*.
- Potential exposure to a communicable disease (e.g., scabies, influenza-like illness, norovirus, etc.).
- Whether the resident was on transmission-based precautions, the type of precautions, reason for additional precautions, and anticipated duration should be specified.
- Whether the resident has devices such as central line, urinary catheter, feeding tube, etc. and validation of continued need after transition for the receiving or referring providers.

## **M. Pharmacy Services (§ 483.45)**

CMS proposes that,

*“...a pharmacist be required to review the resident’s medical record coincident with the drug regimen review when—(1) the resident is new to the facility; (2) a prior resident returns or is transferred from a hospital or other facility; and (3) during each monthly drug regimen review when the resident has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug the QAA Committee has requested be included in the pharmacist’s monthly drug review. We are proposing the last criteria to give each facility’s QAA Committee the ability to request that certain drugs receive more scrutiny during the monthly drug regimen review.”*

SHEA agrees that the consultant pharmacist has a critical role in evaluating individual residents’ drug regimens concurrent with information about residents’ medical conditions documented in the medical record. In support of compliance with and improvement of infection prevention practices and antibiotic stewardship programs, SHEA supports CMS’s recommendation that the consultant pharmacist be familiar with facilities’ antibiotic use protocols and develop a system for antibiotic use reporting. Further, SHEA recommends CMS support, but not require in regulation, training in antibiotic stewardship for all consultant pharmacists to help ensure facilities’ compliance with new (proposed) antibiotic stewardship regulations.

### **Infection Prevention and Control Programs**

SHEA supports CMS’s proposal to update the regulatory description and scope of infection prevention programs for LTCFs and to include antibiotic stewardship programs as a requirement for participation in the Medicare and Medicaid program. The acuity of illness among skilled nursing facility residents has increased substantially over time and as such residents have an increased risk of developing HAIs similar to acute care in-patient populations.

To ensure the success of these proposed requirements, SHEA recommends CMS coordinate a national multi-stakeholder partnership initiative to improve infection prevention programs and to incentivize implementation of effective antibiotic stewardship programs in LTCFs. Such an initiative would be similar to the successful National Partnership to Improve Dementia Care in Nursing Homes, which achieved its original stated goals over a three-year period and continues to strive for further reduction in antipsychotic utilization in nursing homes.

The proposed changes in Section 483.80 include development of new clinical standards and guidelines, investments in workforce expansion, development of new training and education programs, and improving and expanding EHR systems. Existing guidelines, standards and resources intended for acute care in-patient settings can serve as a blueprint for implementing antibiotic stewardship and new infection prevention practices for LTCFs. However SHEA believes that LTCFs should be afforded the opportunity to introduce these new concepts using a stepwise approach while identifying and

implementing strategies that are most appropriate for individual facilities. An appropriate timeframe is needed for LTCFs to develop new partnerships with experts across the healthcare continuum and to develop these strategies carefully.

SHEA believes that a national partnership initiative based on the Centers for Disease Control and Prevention's (CDC's) recently published, *The Core Elements of Antibiotic Stewardship for Nursing Homes*, and similar to the dementia care National Partnership would assist LTCFs with gradual implementation of new strategies over a reasonable period of time. With assistance from infectious diseases and public health experts, such an approach would accommodate the highly variable 15,000 nursing homes across the country. This program should integrate the goals of the National Action Plan for Combatting Antibiotic Resistant Bacteria (CARB) with a goal of reducing inappropriate antibiotic prescribing by 20% by 2020.

Further, SHEA is concerned that CMS has underestimated the cost to develop, implement, and sustain many of the new programs and policies proposed in this draft regulation. There are limited existing resources available to expand the scope of infection prevention responsibilities beyond what already exists and to initiate antibiotic stewardship programs. Without adequate access to the resources needed to manage infection prevention and antibiotic stewardship programs as envisioned by CMS, LTCFs run the risk of failing to implement these programs and in a manner that meets the objectives of the proposed regulations.

The following are SHEA's recommendations for revisions to the regulatory language proposed by CMS in this *Federal Register* notice. SHEA believes the LTCF community has not been provided reasonable resources or a framework to abide by prescriptive regulations in the near term. SHEA believes that LTCFs should be subject to regulations based on proven strategies and consensus-based national standards that are developed in partnership with all relevant stakeholders.

#### **U. Infection Control (§ 483.80)**

CMS is proposing to

*"...revise the regulatory description of the infection control program..."*

and to

*...revise paragraph (a) to read "Infection prevention and control program" and add new § 483.80(a)(1), (2) and (3) to specify the elements of the IPCP. We propose to require that the program must follow accepted national standards, be based upon the facility assessment conducted according to proposed § 483.70(e) and include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement."*

SHEA notes that CMS uses the term “infection control” throughout the regulatory language and text of the proposal to describe policies intended to prevent, identify, and monitor the prevalence of infections within patient populations in LTCFs. The term “infection control” is no longer the preferred terminology used to describe these policies or the delivery of these healthcare services. SHEA recommends CMS update the regulatory language to “infection prevention” throughout the regulatory text and preamble of the final rule. The following terms and phrases should be updated as follows:

- “Infection control and prevention” should become “Infection prevention”
- “Infection control and prevention program” should become “Infection prevention program”
- “Infection control and prevention officer” should become “Infection prevention officer”

Among other factors, LTCFs and acute care facilities differ in that LTCFs serve as the primary residences for their patient populations. As residences, LTCFs provide a more social environment by incorporating group activities to promote good physical and mental health. However these practices may also increase communicable infectious disease exposure and transmission. Additionally, the high prevalence of risk factors for infection among LTCF residents, including the high colonization rate of MDROs in skilled care units, and frequent reports of LTCF infectious disease outbreaks support the need for improved infection prevention practices in this setting.

The elements of an infection prevention program should include the following:

- Surveillance—Systematic data collection to identify infections in residents
- Outbreak control—A system for detection, investigation, and control of epidemic infectious diseases in the LTCF
- Isolation—An isolation and precautions system to reduce the risk of transmission of infectious agents
- Policies and procedures—Relevant to infection prevention
- Education—Continuing education in infection prevention and control
- Resident health program
- Employee health program
- Disease reporting to public health authorities
- Facility management, including environmental control, waste management, product evaluation and disinfection, sterilization and asepsis
- Performance improvement/resident safety
- Preparedness planning

SHEA is concerned that clinically-based national standards that could be cited in order to develop, implement and sustain infection prevention programs (IPPs) in LTCFs are not sufficiently current and robust at this time. SHEA believes these standards can be developed provided the LTCF community is allowed a reasonable timeframe and as part of a nation multi-stakeholder partnership initiative as stated above. CMS should consider this timeframe when setting a date for requiring LTCFs to be in compliance with establishing the elements of an IPP within their facilities.

CMS is proposing to

*“...require the facility to have written standards, policies, and procedures for the IPCP...”*

SHEA supports requiring each facility to have written standards policies and procedures for the IPP, and that facility staff should be trained on the elements of the IPP. An important aspect of IPPs is the development and routine updating of infection prevention policies and procedures. Because practices change, they should be reviewed on a scheduled basis. In the event that a LTCF must respond to an epidemic with appropriate measures, obtaining consent from the resident or the resident’s physician or legal representative may be difficult to obtain on short notice. One way to circumvent this problem is to develop preexisting policies and procedures approved by the medical staff and to obtain consent for vaccination and outbreak control measures at the time of admission from the resident or their power of attorney/ medical decision maker.

CMS is proposing that

*“...the facility’s IPCP must also include an antibiotic stewardship program that includes antibiotic use protocols and systems for monitoring antibiotic use and recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.”*

SHEA is a strong supporter of requiring LTCFs to establish antibiotic stewardship programs. These programs are needed to ensure the appropriate use of antibiotics, to ensure the continued use of needed antibiotics, to prevent the prescribing of unnecessary antibiotics, to improve residents’ quality of life, and to prevent antibiotic resistance.

However SHEA believes the resources, skills, and leadership needed to develop, implement, and sustain an effective antibiotic stewardship program are distinct from those needed for an effective infection prevention program. Therefore, antibiotic stewardship programs should be considered stand-alone programs separate from infection prevention programs but complementary to both.

SHEA respectfully offers the following recommended revisions to the proposed regulatory language at Section 483.80:

“§483.80 Infection ~~control~~ **prevention and antibiotic stewardship.**

The facility must establish and maintain an infection prevention ~~and control~~ program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

(a) *Infection prevention ~~and control~~ program.* The facility must establish an infection prevention ~~and control~~ program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.75(e) and following accepted national standards;

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When isolation should be used for a resident;

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact,

~~(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.~~

~~(4)~~ **(3)** A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

(b) *Infection prevention ~~and control~~ officer.* The facility must designate one individual as the infection prevention ~~and control~~ officer (IPCO) for whom the IPCP at that facility is a major responsibility. The IPCO must:

- (1) Be a clinician who works at least part-time at the facility, and
- (2) Have specialized training in infection prevention ~~and control~~ beyond their initial professional degree.

(c) *IPCO participation on quality assessment and assurance committee.* The person designated as the IPCO must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

**d) *Antibiotic stewardship program.* The facility must implement an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Minimum requirements for the program should include:**

**(i) creation of a multidisciplinary antibiotic stewardship team responsible for promoting and overseeing antibiotic stewardship activities in the facility. The number of team members may vary on the basis of the size and complexity of the facility. Team members should include but are not limited to a physician, a pharmacist, a clinical nurse leader and an IPO.**

**(ii) institutional treatment protocols for the management of common infections and clinical syndromes;**

**(iii) interventions to improve the use of antibiotic;**

**(iv) processes to measure and monitor antibiotic use at the institutional level;**

**(v) a system to periodically assess the extent of resistance to antimicrobial agents commonly employed in the facility.**

(e) *Antibiotic stewardship program leader.* The facility must designate a qualified individual or individuals as the antibiotic stewardship program leader (ASPL) for whom the antibiotic stewardship program at that facility is a major responsibility.

(f) *ASPL participation on quality assessment and assurance committee.* The individual or individuals designated as the ASPL must be members of the facility's quality assessment and assurance committee and report to the committee on the antibiotic stewardship program on a regular basis.

~~(d)~~ (g) *Influenza and pneumococcal immunizations* — (1) *Influenza*. The facility must develop policies and procedures to ensure that—

(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) *Pneumococcal disease*. The facility must develop policies and procedures to ensure that—

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

(2) *Pneumococcal disease*. The facility must develop policies and procedures to ensure that—

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

(e) *Linens*. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

f) *Annual review*. The facility will conduct an annual review of its IPCP and update their program, as necessary.”

Although SHEA agrees that the day-to-day oversight of an infection prevention program and antibiotic stewardship program should be the primary responsibility of the individual or individuals providing the oversight, SHEA is concerned that CMS’s proposed policy is too narrowly written and presumes the oversight will be provided by a single person. Further, CMS’s proposal presumes that same clinician would be employed by the facility on a part-time or full-time basis and responsible for the day-to-day oversight of the antibiotic stewardship program in addition to all other aspects of the infection prevention program.

LTCFs currently lack resources, in-house training, and educational support to sustain a full-time IPO that oversees both infection prevention and antibiotic stewardship programs at a level that would meet national standards and compliance expectations as outlined in the proposal. Although antibiotic stewardship programs are one tool for the prevention of infections, SHEA believes the components of an antibiotic stewardship program and the necessary training and expertise required to develop, implement, and oversee a program are outside the scope of IPOs as proposed by CMS. Many IPOs represent the nursing, social work, or other professions and as such, prescribing antibiotics or diagnosing

infections are not part of their training. This lack of training would prohibit them from making recommendations about appropriate selection or use of antibiotics and the development of treatment algorithms.

Therefore, SHEA recommends CMS emphasize the need for antibiotic stewardship activities to be promoted and overseen by multidisciplinary teams, with distinct leads for infection prevention and antibiotic stewardship. Members of the antibiotic stewardship team should include but not be limited to a physician, a pharmacist, a clinical nurse leader, and an IPO. Further, CMS recommends looking to the CDC's *The Core Elements of Antibiotic Stewardship for Nursing Homes* document to guide LTCFs on best practices for implementing antibiotic stewardship principles.

SHEA recommends CMS encourage facilities to designate an antibiotic stewardship program leader (ASPL) to lead antibiotic stewardship teams. ASPLs should also participate on the quality assessment and assurance committee and report to the committee on the antibiotic stewardship program on a regular basis. Physicians with specialized training in infectious diseases such as healthcare epidemiologists are the ideal provider for the development, implementation, and responsibility for oversight of team-based antibiotic stewardship programs in LTCFs. Healthcare epidemiologists specialize in understanding disease exposure and transmission, and have expertise in measures of disease incidence and prevalence. They also specialize in the diagnosis and management of infections, particularly those endemic to healthcare settings, and selection of appropriate antibiotic choices. They are best positioned to develop therapeutic recommendations based on clinical microbiology laboratory data and help drive appropriate decision-making for prescribers, consultant pharmacists and LTCF leaders. Where changes in prescriber behavior through culture change are needed, healthcare epidemiologists present a peer-to-peer opportunity for prescriber education, audit, and feedback. A qualified ASPL has training in infectious diseases through a subspecialty fellowship program or in-person or online course work. They also receive comprehensive training in antibiotic stewardship through in-person or online course work.

SHEA recognizes that the components of a healthcare epidemiologist-led antibiotic stewardship team may not be readily available or identifiable to LTCFs in most operational models today. And as such, the LTPAC community should be afforded the opportunity to develop strategies that would allow for implementation of a healthcare epidemiologist-led antibiotic stewardship team. They should have the opportunity to develop and invest in manpower needed to meet the expectations stated in the proposed rule. SHEA believes CMS should encourage LTCFs striving for optimal or exemplary performance in antibiotic stewardship to procure the services of a healthcare epidemiologist or other ID-trained physician to assemble and lead an antibiotic stewardship team in order to implement antibiotic stewardship programs. LTCFs who seek to procure the services of a healthcare epidemiologist-led antibiotic stewardship team would not need a full-time or part-time equivalent physician that is in the facility on a daily basis. LTCFs often contract out the services of clinical specialists in a variety of specialty areas on an as-needed basis, and receive high-quality care for their residents in

return. SHEA believes that a national multi-stakeholder partnership initiative as described above would afford the healthcare epidemiology profession an opportunity to recruit and train a workforce in preparation for meeting the needs of LTCFs across the country.

### **Infection and Prevention Control Officer**

CMS proposes to

*“...add a new paragraph (b) to require that the facility designate an IPCO who is responsible for the IPCP and who has received specialized training in infection prevention and control.”*

And to

*“...to require that the IPCP be a major responsibility for the individual assigned as the facility's IPCO,” and, “...require that the IPCO be a healthcare professional with specialized training in infection prevention and control beyond their initial professional degree.”*

An IPO is an essential component of an effective infection prevention program. SHEA agrees an IPO should be designated by the facility with primary responsibility for overseeing infection prevention. The number of LTCF beds justifying a full-time IPO is unknown and usually depends on the acuity level of residents and the level of care provided. A LTCF with more than 250 beds should consider but not be required to designate a full-time IPO.

Data from a collection of surveys summarized in the SHEA/APIC 2008 guideline establishes a composite profile of a LTCF infection prevention professional as they likely operate today. A typical LTCF IPO is a nurse who still has not necessarily received formal training in infection control and works part-time on infection prevention activities regardless of the number of beds or patient acuity. Most IPOs have other duties such as general duty nursing, nursing supervision, in-service education, employee health, and quality assurance.

As documented in the SHEA/APIC 2008 guideline, SHEA recommends the following criteria for IPOs:

- One person, the IPO, should be assigned the responsibility of directing infection control activities in the LTCF. The IPO should be someone familiar with LTCF resident care problems.
- They should have a written job description of infection prevention duties.
- The IPO is responsible for implementing, monitoring, and evaluating the infection prevention program for the LTCF.
- The IPO should be guaranteed sufficient time and the support of the administration to effectively direct the infection prevention program.

- The IPO (or another appropriate individual, such as the medical director) should have written authority to institute infection prevention measures in emergency situations.
- The IPO should have a sufficient infection prevention knowledge base to carry out responsibilities appropriately.

Comment: A background in infection surveillance, microbiology, geriatrics, and educational methods is advisable. Management and teaching skills also are helpful. Continuing education is essential for the IPO (e.g., meetings, courses, journals).

- The IPO should know the federal, state, and local regulations dealing with infection prevention in the LTCF.
- The IPO should communicate with relevant facility committees and personnel within the facility, IPOs from transferring facilities, and public health authorities to ensure appropriate isolation and collection of surveillance information.
- No recommendation on number of IPOs per 100 LTCF beds.

SHEA agrees with CMS in that training and education above and beyond the IPO's initial degree should be required to oversee an IPP. The LTCF administrative staff should support the IPO with appropriate educational opportunities and resources, including access to expert consultation in infectious diseases and infection prevention as needed. The importance of IPO education is accentuated by the great turnover in LTCF personnel. Access to a healthcare epidemiologist, an infectious diseases physician, or other healthcare professional with training or expertise in infection prevention should be available on at least a consultative basis.

CMS proposes to

*"...require that the IPCO be a member of the facility's Quality Assessment and Assurance (QAA) committee."*

SHEA supports requiring the IPO to be a member of the facility's QAA committee to ensure proper communication among each clinical area of the facility, and to identify and address any deficiencies identified by the IPO. We further recommend that healthcare epidemiologists or other ID-trained leaders of antibiotic stewardship programs be members of the QAA committee, should CMS choose to adopt SHEA's recommendations for implementing antibiotic stewardship programs.

CMS proposes to

*"...add a new § 483.80(f) to require that the facility review its IPCP annually and update the program as necessary."*

In order to ensure continuous improvement and in keeping with the needs of each LTCF's patient population, SHEA recommends that the IPP be reviewed at a minimum annually and that the IPP be updated on an ongoing basis, as necessary.

### **Infection Control Training**

CMS proposes to

*"...at § 483.95(e) we propose to require LTC facilities to include staff training as part of their efforts to prevent and control infection."*

One of the most important roles of the IPO and the ASPL should be education of LTCF personnel on basic infection prevention and antibiotic stewardship principles. It is recommended that the IPO and ASPL work together to routinely assess the educational needs of staff, residents, and families and develop educational objectives and strategies to meet those needs; collaborate in the development, delivery, and evaluation of educational programs or tools that relate to infection prevention, control, and epidemiology; and continuously evaluate the effectiveness of educational programs and learner outcomes.

Education for staff other than the IPO and ASPL should focus on new personnel and certified nursing assistants. Priority for training should be directed toward orientation, OSHA-mandated programs, problem-oriented teaching, and other programs required by regulations. Surveillance data are an excellent starting point for infection prevention and antibiotic stewardship training, and compliance rounds provide an opportunity for the IPO and ASPL to provide timely, informal education to personnel. Infection prevention and antibiotic stewardship content should include information on disease transmission, hand hygiene, barrier precautions, and basic hygiene. In addition, all individuals with direct resident care responsibility need education in early problem and symptom recognition. The teaching methods used need to be sensitive to language, cultural background, and educational level.

A variety of courses and training programs in infection control and antibiotic stewardship are available for physicians, pharmacists, infection preventionists and other healthcare professionals practicing in acute care in-patient settings. SHEA as well as other organizations offer courses for clinicians and practitioners with different levels of experience. However, SHEA believes CMS should allow more time for the LTPAC community, infectious diseases community, and government agency partners to develop a more robust offering of training programs for LTCFs and assure that the resources specifically required for LTCFs are readily available. The existing programs designed for acute care settings can be adapted for LTCFs, but more time is needed to develop them to ensure success in implementation and to meet the regulatory objectives outlined by CMS in this proposal. As stated previously, SHEA recommends CMS roll out a national partnership initiative to reduce antibiotic use in nursing homes. Such a program would present an opportunity to develop appropriate education programs for infection prevention programs, antibiotic stewardship leaders, and other team members.

## **Conclusion**

SHEA applauds CMS's proposal to require significant changes to existing infection prevention regulations for LTCFs. We especially commend CMS's efforts to require antibiotic stewardship programs for LTCFs as a requirement for participating in Medicare and Medicaid programs. These recommendations represent some of the more important updates to LTCF regulations that have been a long time in coming.

SHEA is concerned that these proposals, taken with the many other proposed regulatory changes included in this *Federal Register* notice, may be difficult for LTCFs to achieve at one time. The LTCF community must be afforded more time to develop strategies for implementing successful infection prevention and antibiotic stewardship programs that can be supported by realistic and available resources. Additionally, more time is needed to develop education and training programs, recruit infection prevention and antibiotic stewardship leaders, team members, and other support staff specifically designed for the LTCF setting. The best way to successfully execute these programs is to allow the LTPAC, infectious diseases, and public health communities to work collaboratively to develop these strategies within a reasonable timeframe.