August 22, 2012

Office of Disease Prevention and Health Promotion
1101 Wootton Parkway
Suite LL100
Rockville, MD 20852

Attention: Draft Phase 3 Long-Term Care Facilities Module

Dear Sir or Madam:

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to review and provide comments on the Draft Phase 3 Long-Term Care Facilities Module of the HHS National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination. SHEA believes that prevention of healthcare-associated infections (HAIs) in long-term care facilities (LTCFs) is a critical topic that warrants focused attention.

SHEA is generally very supportive of the goals and recommendations contained within the draft long-term care (LTC) chapter and we look forward to continued collaboration with HHS and other stakeholders to implement the recommendations. SHEA offers the following specific comments and recommendations related to the draft LTC chapter.
Current Status of HAIs and Infection Control in LTC

Recommendation:

Clostridium difficile infection (CDI): Clostridium difficile infection (CDI) is a continuing concern in older adults residing in LTCFs. It is widely recognized that inadequate diagnostic tests lead to underdiagnosis and underreporting of CDI in LTCFs. This has been noted to contribute to transmission of disease and increased morbidity and mortality in this highly susceptible population. We recommend the exploration of more sensitive tests as a step toward improved surveillance and treatment. There needs to be a standard, sensitive, specific, and cost-effective diagnostic test available to all facilities.

Challenges for HAI Prevention in Long-Term Care Settings

Recommendations:

Infection Preventionist: SHEA strongly recommends that LTCF administrations provide financial, administrative, and educational support for facility infection preventionists to ensure that their infection prevention programs are run at the highest level.

Hand Hygiene: SHEA recommends that hand hygiene be addressed in this setting. Contamination of the hands of healthcare personnel (HCP) plays a major role in transmission of organisms in healthcare settings. In one study, healthcare workers were shown to be colonized frequently with gram-negative bacilli (GNB) (66%), Candida (41%), S. aureus (20%), and vancomycin-resistant enterococci (VRE) (9%). Hand hygiene remains the most cost-effective measure to prevent transmission of pathogenic organisms. However, HCP compliance with hand hygiene recommendations averages 30%-50% and improves only modestly following educational interventions. Reasons frequently reported for poor compliance with hand hygiene measures by HCP include skin irritation from frequent washing, too little time due to a high workload, and simply forgetting. In a study by Thompson et al, hands were washed when needed before an interaction in 27% of interactions, 0% during interactions, and 63% after an interaction. SHEA recommends that hand hygiene must be addressed, a program for education and monitoring be put in place, and shared at the administrative level.
Environmental Services: The important role of environmental services in long-term care needs to be clearly emphasized. Residents, often with limited ability to optimize their own hygienic practices, particularly hand hygiene, participate in group activities, use common dining areas for meals, move around the facility, and attend occupational and physical therapy where shared equipment is used. These activities increase the risk of person-to-person transmission and exposure to contaminated environmental surfaces. Furthermore, the LTC module should note the negative impact of contaminated surfaces on the effectiveness of hand hygiene. SHEA recommends that environmental services personnel receive training on infection transmission, their critical role in prevention, safe and effective use of disinfectants, and prevention of occupational exposures. Documentation of receipt of training and monitoring of environmental cleaning should be required.

Isolation and the Use of Personal Protective Equipment (PPE): Special needs related to isolation (and non-isolation) should be addressed. The very important role of standard precautions needs and gown and glove use should be emphasized as well as the impact of isolation precautions on the resident. While glove use is common, change of gloves between residents is poor. In the Thompson et al study, gloves were worn in 139 (82%) of 170 interactions when indicated, but changed appropriately in only 1 (16%) of 132 interactions. SHEA recommends that a focus on standard precautions and appropriate isolation use be considered.

HHS Data Sources and Projects on Reducing and Preventing HAIs in LTCFs

Recommendation:

SHEA strongly recommends use of clear and consistent definitions of HAIs for all LTCFs. HHS recognizes the lack of information on the incidence and trends of HAIs in LTCFs. This is due in part to a lack of standardized definitions, surveillance methods and reporting. The majority of LTCFs use the McGeer definitions of infection but do not apply them consistently.

The lack of agreement about the burden of HAIs in long-term care stems from the lack of consistent definitions of what constitutes an infection and how data is collected and utilized.
The revised 2012 McGeer/Centers for Disease Control and Prevention’s (CDC) National Healthcare Safety Network (NHSN) infection definitions for long-term care provide an excellent starting point for consistency. SHEA recommends consistent application of these definitions through all agencies of HHS, including the Centers for Medicare & Medicaid Services (CMS). The definitions need to be adopted and applied to all interpretive guidance for federal regulations such as F-441 as well as MDS 3.0 coding tips.

Nursing home (NH) and skilled nursing facility (SNF) LTCFs look to the CMS/State Operation Manual as the primary source of practice guidance. The revised 2012 McGeer/NHSN definitions need to be fully integrated into all regulatory and practice guidance to avoid creating unnecessary complexity and confusion, hindering voluntary NHSN enrollment by LTCFs, and creating a barrier to development of cost-effective, evidence-based infection prevention strategies in those settings.

**Metrics and Evaluation**

**Recommendations:**

SHEA proposes a change in the Priority 1 Metric, “1. # certified nursing homes enrolled into the NHSN LTC Component # certified nursing homes in the US Goal: 5% of certified nursing homes enroll in NHSN over the 5 years following launch of the component.” SHEA does not believe the goal of 5% over 5 years is a meaningful target. HHS is committed to the adoption of a meaningful, useful infection surveillance system that can be used to monitor and reduce infection-related morbidity and mortality. We believe all reporting facilities should be enrolled and entering data into the NHSN in five years. With increasing enrollment in NHSN, LTCFs should be encouraged to utilize the healthcare personnel influenza component to monitor vaccination rates. The NQF-endorsed NHSN measure provides influenza vaccination rates at the facility level by type of employee (direct pay, independent practitioners, and student/trainees/volunteers) and differentiates between declination and deferral for medical or religious reasons. Use of NHSN will provide facility-specific information that can be analyzed and used by local, state, and federal partners for surveillance, monitoring, prevention, and public reporting. The use of NHSN eliminates or minimizes many of the limitations associated with national surveys (i.e. as a single snapshot national estimates do not provide
sufficient data for assessment of state, local, or facility trends and are not sufficient for facility-specific public reporting).

SHEA recommends the goal for the proposed Metric “Proportion of Healthcare Personnel who work in long-term care who received the seasonal influenza vaccine as measured by the National Health Interview Survey” under Priority 4 be changed from 70% of HCPs in LTC receiving the seasonal influenza vaccination to 90% by 2015. The suboptimal response of the elderly residents to influenza vaccination due to immunosenescence makes vaccination of HCP critical.

SHEA recommends the addition of a Priority #6: Every LTCF should have an antibiotic stewardship program (ASP). We support the implementation of ASPs as soon as possible, beginning with assessment of a facility’s antibiotic use and pilot programs that promote appropriate prescribing. Given the data on inappropriate antibiotic use and the higher prevalence of colonization with multidrug resistant organisms (MDROs), such as methicillin-resistant \textit{S. aureus} and MDR GNB in NH/SNF residents compared to acute care hospitals, SHEA feels that antibiotic stewardship and antimicrobial resistance should be included in the priorities. Some studies have found that more than 40% of LTCF residents are colonized with MRSA and that 25% are colonized with MDR GNB.

Moreover, one of the important goals of ASPs is to reduce adverse drug events, including CDI, which we note above is a growing priority in long-term care settings. Studies show that approximately 85% of patients who develop CDI have had antibiotics in the previous 28 days and confirm that any antibiotic exposure and particularly duration of therapy, are a major risk factor for CDI incidence. More recent studies have demonstrated that antimicrobial stewardship has reduced the incidence of CDI.

It is therefore important to control the overuse of antibiotics and prevent antibiotic resistance. Such initiatives should focus on appropriate use and involve the prescribing physician, the facility pharmacist, and the infection prevention team. ASPs may be uncomplicated programs such as antibiotic usage assessment and antibiotic resistance monitoring. SHEA suggests a
metric that determines whether LTCFs have some form of antibiotic stewardship program with a target of 50% within five years.

Next Steps and Future Directions

Recommendation:

SHEA recommends a section D: Isolation Precautions. There should be an assessment of isolation precaution practices in LTCFs. The rising incidence of MDROs in LTCFs, variable isolation practices, diverse resident activities of daily living, and the exchange of residents between LTCFs and hospitals indicate the complexity and need for applicable, standard precautions, and isolation procedures for residents with MDROs.

SHEA applauds HHS for its commitment to addressing HAIs in LTCFs. We greatly appreciate the opportunity to provide recommendations on the goals and recommendations in the draft long-term care chapter of the National Action Plan to Prevent Healthcare–Associated Infections.

Sincerely,

Jan E. Patterson, MD, MS
President, SHEA


4. Smith, P., Watkins, K., Miller, H., VanSchooneveld, T. Antibiotic Stewardship Programs in Long-Term Care