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Via:OHQ@hhs.gov

Don Wright, M.D., M.P.H.
Acting Assistant Secretary for Health
Director of the Office of Disease Prevention and Health Promotion (ODPHP)
HHS Office of the Secretary
Department of Health and Human Services
1101 Wootton Parkway, Suite
LL100, Rockville, MD 20852

RE: Phase Four of the National Action Plan To Prevent Health Care-Associated Infections: Road Map to Elimination; Coordination Among Federal Partners To Leverage HAI Prevention and Antibiotic Stewardship

Dear Dr. Wright,

The Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA) appreciate the opportunity to provide comments on Phase Four of the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination.

SHEA represents more than 2,000 physicians and other healthcare professionals globally with expertise in healthcare epidemiology, infection prevention, and antibiotic stewardship. 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.

IDSA represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. IDSA members possess clinical expertise in recognition, diagnosis, treatment, and prevention of infectious diseases.

The societies reaffirm our commitment to supporting the call to action in the National Action Plan to Prevent Health Care-Associated Infections Road Map to Elimination. We applaud the addition of Phase Four, which focuses on the role of antibiotic stewardship as a means for reducing health care-associated infections (HAIs), antibiotic resistance, and adverse events associated with antibiotic misuse. Many HAIs are tied to inappropriate use of antibiotics, stressing the need for both antibiotic stewardship and infection prevention to achieve and sustain improved patient outcomes. Antibiotic stewardship programs optimize antibiotic use to achieve the best clinical outcomes while minimizing adverse events from unnecessary antibiotics, limiting selective pressures that drive the emergence of resistance, and reducing costs attributable to suboptimal antibiotic use. Antibiotic stewardship must be a fiduciary responsibility for all healthcare institutions across the continuum of care and as such, institutions must have access to adequate resources to ensure their programs are successful.

It is important to state the core aspects of our position on antibiotic stewardship programs in acute care settings, which has evolved through our long history of raising awareness of the threat of antibiotic resistance and our involvement in establishing clinical guidelines and resources for implementing antibiotic stewardship programs. These core aspects are as follows:

- Antibiotic stewardship is a patient safety program, separate and distinct from infection prevention, yet complementary. Antibiotic stewardship requires clinical intervention and guidance, often accomplished by direct physician-to-physician dialogue.
- We believe that antibiotic stewardship programs are best led by physicians trained and experienced in the subspecialty of infectious diseases who, as part of their routine training, are skilled in antibiotic stewardship, who hold accountability for effective performance, and who are able to provide clinical knowledge and judgment in peer-to-peer consultations involving the diagnosis of infection and the prescription of antibiotic treatments. Infectious diseases physicians have the requisite clinical training necessary to recognize and correctly diagnose serious infections, to assess the correct antibiotic agent, including dose and duration, to evaluate data from the clinical microbiology laboratory in the patient context to decide on de-escalation of therapy when warranted, and to review the facility-specific antibiogram in order to provide the leadership and decision-making to achieve success in patient populations specific to individual facilities. We suggest that infectious diseases physician leadership in these programs is desirable to drive appropriate clinical use of antibiotic agents and change inappropriate use, where necessary. In particular, we posit that physicians accept suggestions for change of therapy best from colleague physicians, than from non-physician providers. Effective stewardship programs also require drug expertise from an infectious disease-trained pharmacist.
- Antibiotic stewardship involves a multi-disciplinary team-based approach, involving infectious disease-trained pharmacists, clinical microbiologists, front-line providers, and information technology specialists adept at leveraging IT systems for surveillance, action, and reporting.
- Effective antibiotic stewardship programs cover not only the judicious use of antibiotic treatments but also ongoing education and training efforts to other stakeholders involved in care delivery.
- Effective antibiotic stewardship programs should reduce inappropriate antibiotic use at the facility level and contribute to the goal of a 20% reduction in inappropriate antibiotic use in the inpatient setting by 2023, as stated in the Combating Antibiotic Resistant Bacteria National Action Plan.

We also strongly support he need for antibiotic stewardship in the long-term care and outpatient settings. We concur with the approaches for implementation and staffing as outlined in CDC's *Core Elements of Antibiotic Stewardship in Nursing Homes*[1], and *Core Elements of Antibiotic Stewardship*[2]

[1] Sanchez, G.V., Fleming-Dutra, K.E., Roberts, R.M., Hicks, L.A. *Core Elements of Outpatient Antibiotic Stewardship.* MMWR Recomm Rep 2016;65(No. RR-6):1–12.

[2] CDC. The Core Elements of Antibiotic Stewardship for Nursing Homes. Atlanta, GA: US Department of Health and Human Services, CDC; 2015. Available at: **http://www.cdc.gov/longtermcare/index.html**

documents. Access to infections disease trained physicians to guide stewardship efforts we believe is strongly preferred.

We would like to see recommendations in the following areas included in Phase Four of the National Action Plan:

1) Finalize the proposed Condition of Participation to require antibiotic stewardship in acute care settings

We would like to see progress toward finalizing revisions to the infection prevention and control regulations for hospitals and critical access hospitals included in the draft Medicare and Medicaid condition of participation published in the June 16, 2016 *Federal Register*[3]. Requiring hospitals to implement antibiotic stewardship programs as a condition of participation will significantly enhance the uptake of robust and funded antibiotic stewardship programs across the country.

2) Resources to support robust antibiotic stewardship programs at the institutional level

Phase Four of the National Action Plan captures all federal programs that address antibiotic resistance through antibiotic stewardship efforts, recognizing that these agencies must work collaboratively toward a collective goal. It is critical to note that in order for these efforts to achieve the stated goals, which includes universal implementation of antibiotic stewardship programs across all health care settings, institutions must have access to adequate resources.

Although greater awareness of antibiotic resistance and antibiotic stewardship practices continues to grow, the availability of resources to support these practices is inconsistent among health care facilities. Often physicians and pharmacists responsible for developing and implementing stewardship programs do not have protected time, adequate reimbursement, or staffing levels to ensure success. This is observed in all health care settings but is particularly concerning in ambulatory and long-term care where it is not at all clear whether current staffing models have the resources, expertise, or training required to carry out the responsibilities of an antibiotic stewardship program. Antibiotic stewardship programs in each of these distinct settings need access to appropriate expertise to ensure success. In order to provide the stewardship expertise to the number of acute care and long-term care facilities that need it, more infectious diseases physicians are needed. In order for that to occur, incentives are needed to convince young physicians to consider the field.

3) Timeline and information technology support for required reporting of antibiotic use data

To help drive improvements in appropriate antibiotic use, hospitals and providers need better data on their prescribing in relation to peers. In the inpatient setting, we encourage the Department of Health and Human Services to specify a timeline for when U.S. acute care hospitals will need to publicly report their antibiotic use and resistance data to the Centers for Disease Control and Prevention's Antibiotic Use and Resistance (AUR) Module. This will allow hospitals to obtain their Standardized Antimicrobial Administration Ratio (SAAR), indicating a hospital's observed use relative to expected use, based on

[3] Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care. 81 Fed. Reg. 39448 June 16, 2016.

national data. The SAAR is similar to the Standardized Infection Ratio (SIR) that hospitals currently use to analyze relative performance on other metrics (e.g., central line-associated bloodstream infection and catheter-associated urinary tract infection). When the majority of U.S. acute care hospitals report antibiotic use data to the CDC, it will be possible to establish some benchmarks for antibiotic use and carry out critical work on risk adjustment to ensure that hospitals are fairly compared. It will be important for the CDC and others to evaluate patient case mix and unit type when evaluating "appropriate use," with the understanding that there are many opportunities for improving antibiotic use to improve patient outcomes.

Beyond the inpatient setting, collection of data on prescribing in the long-term care and outpatient settings is also critical. We support work that the Centers for Medicare and Medicaid Services is doing to help benchmark prescribing in the non-acute care settings.

We would also like to note that collection of antibiotic use data is complex and relies heavily on information technology infrastructure. Therefore, dedicated antibiotic stewardship resources for information technology are imperative to collect the data necessary to drive improvements in antibiotic prescribing and to facilitate national benchmarking described above.

4) Federal support for state-based antibiotic stewardship effort

Federal agencies such as CDC and the Agency for Healthcare Research and Quality (AHRQ) have received substantial federal funding to support the efforts to meet the goals outlined in Phases 1-3 of National Action Plan. This support has enabled researchers and educators to make progress toward finding solutions to antibiotic resistance, of which antibiotic stewardship is a critical component. As a result, there is evidence of a decline in rates of antibiotic-resistant infections in hospitals. A portion of the funding received by CDC is disbursed to state HAI programs to support their antibiotic stewardship programs. For many states and localities, these programs are still in their formative stages and will require continuation of robust and sustained federal funding for their continued growth and development.

5) Promotion of vaccination programs as a means to reducing antibiotic use

In addition, given that increased vaccination rates are associated with decreases in antibiotic resistance due to fewer infections and less antibiotic use, we believe that promotion of vaccinations and adherence to national vaccination recommendations should also be a part of this report and the Phase Four plan. We suggest incorporating plans for increasing vaccination rates (e.g. influenza, pneumococcus) among the general public. This can be facilitated through a few potential mechanisms including adequate resourcing of public health departments, public service announcements regarding the importance of vaccines, and partnering with private organizations that can facilitate vaccinations among the public (e.g. national pharmacy chains).

In summary, we are strongly supportive of this phase of the National Plan. We urge that this call to action include recommendations for ensuring access to capital, human, and information technology resources critical for the success of these programs.

Thank you for the opportunity to provide comments. For future inquiries on this submission, please contact Lynne Batshon at 703-684-0761 or lbatshon@shea-online.org.

Sincerely,

Sara Cosgrove, MD, MS, FSHEA
President, SHEA

Paul G. Auwaerter, MD, FIDSA
President, IDSA

Paul W. Spearman, MD, FPIDS
President, PIDS