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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3295–P
P.O. Box 8010
Baltimore, MD 21244
By electronic submission at: http://www.regulations.gov

RE: 42 CFR Parts 482 and 485 Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased offer comments in response to questions posed by CMS in the Proposed Rule regarding Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule. Our comments are limited to the rural-specific issues in the proposed rule for Critical Access Hospitals (CAHs).

Provision of Services: nutritional services (p. 39461)
We recognize of the importance of appropriate dietary and nutritional services to CAH patients, which is especially important given the disproportionate number of frail elderly served in rural hospitals. We support inclusion of Registered Dieticians as key members of the CAH interdisciplinary care team, and the proposed data-driven change which would allow appropriate ordering privileges.

Infection Prevention and Control and Antibiotic Stewardship Programs (p. 39462)
We applaud the emphasis in the proposed rule on facility-wide infection prevention and antibiotic stewardship for CAHs, both of which are core to quality improvement activities for CAHs and essential to ensuring patient safety. While we agree with the updated requirements of an Infection

Preventionist responsible for the infection prevention and control program at a CAH, the reality of most CAHs is that this role will be fulfilled by a nurse who also has other related responsibilities (e.g., quality improvement, risk management) and may not have the specialized training necessary for the infection preventionist role. In implementing the rule, we encourage attention to ensuring that low cost, remotely accessible education and training are available for CAH infection preventionists, and that ongoing technical assistance support be provided (e.g., through QIN-QIOs or HIINs). We further encourage flexibility in allowing infection preventionist expertise be available through shared services agreements across CAH networks or similar arrangements which would cost-effectively allow the needed expertise be available to CAHs. As a result of the anticipated additional training and technical assistance needed by CAHs, we believe that the estimated costs are under-represented in the narrative and table provided in the proposed rule (p. 39473-39475).

In Antibiotic Stewardship, we support the intent of the rule requiring leadership of the Antibiotic Stewardship program in CAHs. As we have commented above, however, we are concerned that fulfilling this role effectively will be difficult in many CAHs with limited nursing and pharmacy staff and expertise. In implementing the rule, therefore, we encourage attention to ensuring that low cost, remotely accessible education and training are available for CAH antibiotic stewardship leaders, and that ongoing technical assistance support be provided (e.g., through QIN-QIOs or HIINs). We further encourage flexibility in allowing antibiotic stewardship expertise be available through shared services agreements across CAH networks or similar arrangements which would cost-effectively allow the needed expertise be available to CAHs.

Infection planning and control, and antibiotic stewardship need to extend beyond the hospital walls and into the community to be effective. We encourage CMS to align the Conditions of Participation for skilled nursing facilities and other settings of care, and to work to actively engage both primary care providers and EMS in such efforts.

Lastly, we recognize the importance of data collection and reporting as part of a broader infection surveillance program, but also understand the the CDC's NHSN database and repository is complex. CAHs may need additional training and technical assistance to be able to regularly participate and benefit from the NHSN data.

Quality Assessment and Performance Improvement (QAPI) Program (p. 39464)

We appreciate the affirmation noted in the proposed rule that "the general concept of health care quality does not change from urban to rural settings," as articulated by the NAC (The National Advisory Committee on Rural Health and Human Services), while recognizing the unique scope and scale of care and services in rural hospitals. We support the more specific and purposeful proposed requirement for CAHs "…to develop, implement, and maintain an effective, ongoing, facility-wide, and data-driven QAPI program. The QAPI program would have to be appropriate for the complexity of the CAH's organization and services provided."

CAHs across the country have been increasingly implementing the MBQIP (Medicare Beneficiary Quality Improvement Program) and we support the ability of CAHs to use MBQIP data to fulfill new QAPI data collection requirements. We further encourage the continuous evolution of MBQIP areas of focus as new rural-relevant measures emerge and as more comprehensive and community health care delivery and payment strategies are developed.

Sincerely,

The Rural Policy Research Institute Health Panel

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