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Comment for the Sept. 13, 2022, Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria (PACCARB) meeting.

To whom it may concern:

The United States has seen a surge in Antibiotic Resistant Bacteria. According to a recent 2022 CDC special report on the impact of COVID-19 on antibiotic resistance there was a significant increase in infections during the pandemic. For example, according to the CDC "carbapenem resistant Acinetobacter cases increased overall by 35% in 2020 compared with 2019, driven by hospital-onset cases"; "*C. auris* clinical cases increased about 60% in 2020 compared to 2019"(1) and the rate of hospital-onset MRSA increased 17% during the pandemic, well above the 2015 baseline.(2)

Instead of focusing on the implementation of adding resources to address this problem, the United States response appears to be adjusting and not collecting data which may inhibit the development and implementation of effective strategies.

A finalized rule by CMS published in the Federal Register on Aug. 10, 2022,(2) multiple changes were made to adjust and even suppress the reporting of Healthcare Associated Infections (HAI), many of which are antibiotic resistant bacteria, during the COVID-19 pandemic. Some of the changes include:

Relating to the Value Based Purchasing (VBP) program, "... we are finalizing our proposals to suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and the five Healthcare—Associated Infection (HAI) measures for the FY 2023 program year."

Relating to the Hospital Acquired Condition Reduction Program, "... we are suppressing the five NHSN measures from the FY 2023 HAC Reduction Program. We are also suppressing CY 2021 CDC NHSN HAI data from the FY 2024 program year."

"...We note that for the FY 2023 program year, we will be applying an exclusion to CMS PSI 90 for patients with a diagnosis of COVID-19 ..."

"updates to the measure (PSI-90) specifications being made for the FY 2024 to risk-adjust for COVID-19 diagnoses (in any position) present on admission.."

COVID-19 risk adjustment and suppression is also applied to hospital-onset MRSA. Unlike the United States' private healthcare system, the Veterans Health Administration saw an 84% decrease in MRSA infections since 2010, a decrease which has been maintained throughout the pandemic up to the second quarter of fiscal year 2022, the most recent statistics available.(4) The VHA maintained a strategy of active surveillance and contact precautions for those colonized with MRSA. During the United States' healthcare staffing crisis, the VHA was able to lend over 3500 staff members to non-VHA facilities including, community nursing homes, private hospitals, Indian Health services and state veteran's homes.(5)

Risk adjustment should only be performed when mitigation strategies cannot be implemented. It should not be used to normalize deviance or to mask or make poor performance acceptable. If risk adjustment is done, the raw data should be readily available to researchers and the public.

The United States has a healthcare system which is designed to optimize economic efficiency and eliminate any excess or reserve capacity. It was not able to respond to the stresses of the pandemic and in many regions virtually collapsed with the suspension of elective and semi-elective services. For one had non-elective surgery postponed during this time period. Instead of transforming our system we have chosen instead to risk adjusting our shortcomings and, in many cases, not generate the needed data for control of multi-drug resistant organisms during the COVID-19 pandemic.

Thank you for this consideration,



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