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Infectious Diseases Society of America

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**IDSAs Headquarters**  
1300 Wilson Boulevard  
Suite 300  
Arlington, VA 22209  
**TEL:** (703) 299-0200  
**FAX:** (703) 299-0204  
**EMAIL ADDRESS:**  
info@idsociety.org  
**WEBSITE:**  
www.idsociety.org

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Marilyn Tavenner, RN, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3276-NC  
P.O. Box 8013

Baltimore, MD 21244-8013

Submitted electronically through [www.regulations.gov](http://www.regulations.gov); CMS-3276-NC

### **Re: Request for Information on the Use of Clinical Quality Measures Reported under the PQRS, the EHR Incentive Program, and Other Reporting Programs**

Dear Acting Administrator Tavenner:

The Infectious Diseases Society of America (IDSAs) thanks CMS for the opportunity to provide input on ways in which an eligible professional might use clinical quality measure data reported to non-federal entities to satisfy federal quality reporting requirements, such as those of the Physician Quality Reporting System (PQRS) and the Electronic Healthcare Record (EHR) Incentive Program. The IDSAs represents almost 10,000 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research in the area of infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the U.S. and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms, people living with HIV and AIDS, and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza. Infectious disease physicians practice in a wide range of settings, each of which requires a unique approach to quality improvement.

ID specialists who are considered Eligible Professionals (EPs) currently participate in PQRS at a lower rate than that of the national EP average. This is largely due to the fact that many of our members work in inpatient settings where PQRS reporting options are limited. As well, there are very few ID-specific quality measures on which to report. IDSAs seeks to promote the participation of our members in quality initiatives as well as support the development of quality measures specific to the practice of ID specialists, across all sites-of-service. We very much appreciate the recognition from CMS of the need to minimize the reporting burden for practicing healthcare professionals, to accelerate alignment between federal and other non-federal quality initiatives, and to move beyond a one-size-fits-all approach to quality measurement.

### **Accelerate Quality Improvement**

IDSA understands that CMS must set minimum standards to ensure basic data integrity across all quality initiatives. In setting these standards, we request that CMS keep in mind the current challenges related to measure development, testing, and implementation. Currently, these processes are resource intensive, often too time-consuming, and rely on strict evidence standards that often fail to account for clinical issues of great societal importance. One area of particular concern to IDSA, and of societal import, is related to the promotion of antimicrobial stewardship – the coordinated interventions often led by ID specialists and designed to measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial drug regimen. Despite ample evidence regarding the impact of inappropriate antibiotic use on both health outcomes and healthcare expenditures, there is less concrete evidence on the effectiveness of interventions aimed at promoting better antimicrobial stewardship. Furthermore, even where well-documented interventions exist, their adoption has been limited.

IDSA, in collaboration with the Society of Healthcare Epidemiology of America (SHEA), has developed measure concepts that will promote antimicrobial stewardship; however, the evidence base so far is limited and may not currently meet the standards of the National Quality Forum's current Consensus Development Process. As CMS looks to set minimal standards for quality data integrity, we highlight this as an example where attempts to address a critical and proven problem in healthcare may be hindered by strict evidence requirements. We call attention to this in particular, as we believe the principles of antimicrobial stewardship support safer, more effective and more efficient care, and are in alignment with the HHS Action Plan to Prevent Healthcare-Associated Infections. We encourage CMS to recognize "outside-of-the-box" approaches to reporting quality that balance accelerated quality improvement with *specific* elements to ensure integrity, such as the following: transparency related to both measure development and analytics; measure development driven by relevant clinical experts; reliance on minimum sample sizes; basic auditing requirements (e.g., comparable to those currently used under the PQRS); and requirements that measure-developers continually evaluate feasibility of measures, impact on outcomes, and alignment with newly available evidence. While it is critical that quality measures aim to align with the current state of the evidence, we request that CMS employ a more flexible approach that accommodates the testing of measures for which societal importance outweighs the current clinical evidence base. Testing of these types of measures may actually produce the data needed to strengthen the evidence base and to draw conclusions about their links to outcomes.

It also is important to note that the sophistication of quality measures will not be able to advance in ways that support more meaningful delivery and payment reforms unless there are simultaneous advancements in health information technology (HIT). Programs such as the EHR Incentive Program should not mandate that professionals meaningfully use certain technological functionalities to improve patient care when those functionalities are not widely available or do not yet exist. Federal certification criteria and, more importantly, mechanisms to ensure that vendors adhere to those criteria, must be in place before professionals can be held accountable for using HIT to satisfy specific clinical objectives and measures.

### **Reduce Reporting Burden for Eligible Providers**

IDSA fully supports federal recognition of alternative quality improvement activities that account for the diversity of medical practice and that facilitate reporting, learning, and improvement in an environment that encourages voluntary participation. We believe the easiest ways to reduce reporting burden is to accept other evidence of quality care from sources that are comparable to existing federal quality reporting requirements.

IDSA would like to use this opportunity to highlight the value of board-sponsored quality improvement initiatives, which we believe can serve as an excellent proxy for federal quality reporting requirements. The primary goal of the American Board of Internal Medicine (ABIM), for example, is to promote continuous learning and improvement of a professional's clinical judgment in an effort to improve patient care. As part of maintaining continuous certification, professionals must engage in systematic practice performance measurement and demonstrate improvements in patient care. This includes continuous monitoring of performance feedback, comparing individual performance to clinical guidelines and comparable peers in the field, identifying improvement goals, and demonstrating actions to improve upon practice and to assess the impact of such improvements. These last two actions, in particular, go beyond current federal quality reporting requirements and are an extremely valuable element for ensuring meaningful use of performance data to improve patient care. Furthermore, professionals often can select from a range of educational interventions and practice improvements designed for sustained improvement in patient care, and personal practice performance is measured against professionals treating similar patient populations in comparable care settings.

Clinical data registries and other data collection methods used by many specialty boards are able to capture more robust clinical data and provide a more accurate and complete picture of both the patient and the care provided. As well, board-maintained data collection instruments have the advantage of being able to capture data from a broader mix of patients.

### **ABIM Maintenance of Certification**

The self-evaluation component of the ABIM's Maintenance of Certification program provides an opportunity for infectious disease physicians to maintain a commitment to lifelong learning. The self-evaluation requirement includes two components: 1) Self-Evaluation of Medical Knowledge, which includes open-book modules testing clinical and practical knowledge in a particular field; and 2) Self-Evaluation of Practice Performance, which includes the completion of one of the ABIM's Practice Improvement Modules (PIMs) or one of the ABIM Approved Quality Improvement (AQI) pathway programs of other organizations.

The ABIM PIMs and AQIs are web-based tools that guide physicians through a review of patient data and support the implementation of practice-based quality improvement plans. The ABIM currently offers or recognizes the following infectious-disease related PIMs and AQIs for MOC reporting:

- ***Hepatitis C (HCV)***: This module requires a minimum of 25 chart reviews (a larger sample than what is currently required for PQRS measure groups) and includes 41 measures covering the topics of diagnostic testing, treatment and monitoring, appropriate HCV RNA testing done during treatment according to genotype, other tests and assessments, antiviral treatment received in another practice, preventive care, immunizations, medications, screening, and counseling. These measures encompass data

elements related to eight of nine HCV measures currently approved for reporting under the PQRS. A detailed list of the measures offered through the HCV PIM is available at <http://www.abim.org/sep2/77A0903p/html/measures.pdf>

- **Human Immunodeficiency Virus (HIV):** This module requires a minimum of 25 chart reviews (a larger sample than what is currently required for PQRS measure groups) and includes 36 outcomes and processes measures covering the topics of CD4 count and viral load, common coexisting infections, treatment and monitoring, general and preventive healthcare, and patient engagement. A detailed list of these measures is available at <http://www.abim.org/sep2/78A0902p/html/measures.pdf>
- **Management of MRSA Hospitalized Patients:** Designed for physicians who treat and manage patients with post-surgical skin/soft tissue infections, catheter-related bloodstream infections, and/or ventilator associated pneumonia in a hospital setting, and who want to be engaged in an activity to identify and reduce CA-MRSA occurrences.
- **Adult Vaccination and Education:** Aimed at improving vaccination screening and administration practices and rates in adults 19 years and older with regard to the following vaccines: hepatitis A and B, HPV, Influenza, Meningococcal, PPSV, Td/Tdap, Varicella, and Zoster. Specifically, this includes the identification of all adult patients whom the ACIP recommends for vaccination; offering those adults the appropriate vaccinations; appropriately counseling those adults regarding the risks and benefits of their recommended vaccinations; and finally, ensuring that those who are eligible are indeed vaccinated.
- **Self-Directed and Completed Project PIMs:** Directed at hospitalists and other physicians working in an inpatient setting. Includes measures related to specific conditions, as well as ones related to patient safety, utilization of services and other inpatient concerns.

### Conclusion

IDSA strongly believes that reform must foster clinically meaningful improvements in patient care. It must recognize various interventions that are relevant to a range of specialties, practice types, patient populations, and geographic regions. It also must ensure that physicians – the true clinical experts trained in specific diseases and conditions – are empowered to determine the most clinically meaningful measures and to set achievable, realistic benchmarks.

IDSA appreciates consideration by CMS of our comments and looks forward to working with the agency to overcome current quality measurement challenges in ways that allow for more meaningful approaches to quality improvement with broader adoption. If you have any questions or comments, please feel free to contact Andres Rodriguez, IDSA's Senior Program Officer for Practice & Payment Policy, at (703) 299-5146 or [arodriguez@idsociety.org](mailto:arodriguez@idsociety.org).

Sincerely,



David Relman, M.D. FIDSA  
President, IDSA