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

October 15, 2010

BY ELECTRONIC SUBMISSION:
NATIONAL_QUALITY_STRATEGY@HHS.GOV

Carolyn Clancy, MD
Director
Agency for Healthcare Research and Quality
Department of Health and Human Services
Attention: Nancy Wilson - Room 3216
540 Gaither Road
Rockville, MD 20850

Re: Comments on National Health Care Quality Strategy and Plan

Dear Dr. Clancy:

The Infectious Diseases Society of America appreciates the opportunity to provide comments on the National Health Care Quality Strategy and Plan, which was developed by the Agency for Healthcare Research and Quality (AHRQ) as statutorily required by Section 3011 of the Patient Protection and Affordable Care Act.

IDSAs represents more than 9,000 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States 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 and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

The following comments respond to Feedback Question 1: *Are the proposed Principles for the National Strategy appropriate? What is missing or how could the principles be better guides for the Framework, Priorities and Goals?*

IDSAs believes that priority should be given to the development of performance measures for hospital-based physicians. To date, virtually all of the physician-level measure development efforts have been focused on the outpatient setting. Little thought and few resources have been given to developing accountability measures for predominantly hospital-based physicians, many of whom play pivotal roles not only in the treatment of highly complex inpatients but also in implementing system-wide practices that reduce costs and avoid prolonged hospitalizations or unnecessary readmissions.

For example, ID specialists' value to the hospital extends beyond patient care activities. Their expertise in the areas of infection control and antimicrobial stewardship often means that they are at the forefront of implementing procedures that retard the development of antimicrobial resistance, reduce the incidence of hospital-acquired infections and prevent new disease outbreaks. Widely recognized measures that assess the quality of ID specialists' services in these areas do not currently exist and, in general, systems level measures that focus on the role of individual providers have been ignored by Medicare, the National Quality Forum, and measure developers.

The clinical measure gaps described above threaten Medicare's and other payers' efforts to confidentially report cost and quality data to hospital-based physicians for both performance improvement and value-based payment purposes. Moreover, the success of Accountable Care Organizations and other innovative payment models that focus on incentivizing physicians and other providers across multiple settings of care are contingent on the availability of both clinical and system-level measures of individual physicians' performance. For these reasons, **IDSA urges the Agency to include the development of performance measures for hospital-based physicians as a priority area in the National Health Care Quality Strategy and Plan.**

The following comments respond to Feedback Question 3: Using the legislative criteria for establishing national priorities, what national priorities do you think should be addressed in the initial National Health Care Quality Strategy and Plan in each of the following areas: Better Care, Affordable Care, Healthy People/Healthy Communities.

IDSA believes that there is a critical need for data in the area of home infusion therapies to demonstrate the value of transitioning Medicare beneficiaries with serious infections to the home setting for antimicrobial infusion therapies. The emergence of home infusion therapy over the past 25 years as a safe and cost effective alternative to the provision of intravenous therapies in the inpatient setting has resulted in its coverage by virtually all commercial payers. Traditional Medicare denies this benefit due in large part to a lack of available retrospective data that demonstrates the value of these services and evidence-based measures that would prospectively ensure the provision of high quality and cost effective infusion therapy treatments in the home setting.

Outcomes measures related to home infusion therapies could focus on the duration of infusion therapy treatments, the rates of avoidable emergency department visits and hospital readmissions, and the rate of avoidable healthcare-associated complications across all settings of care. Efficiency measures could compare the costs associated with infusion therapies (e.g., the cost of drugs, supplies and equipment, nursing services, etc.) in various settings of care. **AHRQ should prioritize the development of home infusion therapy measures so that Medicare beneficiaries can benefit from these high quality and cost effective care transitions.**

The following comments respond to Feedback Question 4: What aspirational goals should be set for the next 5 years, and to what extent should achievable goals be identified for a shorter timeframe?

The Centers for Disease Control and Prevention ("CDC") estimates that healthcare-associated infections cost each hospital \$15,275 in excess direct costs, with collateral costs totaling an

estimated \$38,600¹. In addition, a 2007 study found that, in 2002, 1.7 million hospital-acquired infections were associated with 99,000 deaths.² While Medicare's Hospital-Acquired Conditions (HAC) payment policy attempts to encourage infection prevention procedures by not paying extra for several healthcare-associated infections acquired in the inpatient setting, institutions can easily avoid this negative incentive by miscoding the secondary diagnosis.

Medicare and other payers will need to use all the tools at their disposal in order to eliminate healthcare-associated infections. While the HAC's payment policy is one of these tools, greater emphasis should be placed on engaging key stakeholders, such as ID physicians, who are integral to the development of infection prevention and antimicrobial stewardship strategies. As a first step towards fostering engagement opportunities that could include positive incentives for key stakeholders, **IDSA believes that the elimination of healthcare-associated infections should be cited as an aspirational goal.**

If you have any questions or comments, please feel free to contact Jason A. Scull, IDSA's Program Officer for Clinical Affairs, at (703) 299-0200 or jscull@idsociety.org. We look forward to working with AHRQ as it finalizes the National Health Care Quality Strategy and Plan.

Sincerely,



Richard Whitley, MD, FIDSA
President, IDSA

cc:

Janet Corrigan
National Quality Forum

Nalini Pande
National Quality Forum

Mark Miller
MedPAC

¹ Daniel P. McQuillen et al., The Value of Infectious Disease Specialists: Non-Patient Care Activities, 47 Clin. Infect. Dis. 1052, 1052 (Oct. 15, 2008) (citing Rebecca R. Roberts et al., The Use of Economic Modeling to Determine the Hospital Costs Associated with Nosocomial Infections and Zhan, 36 Clin. Infect. Dis. 1424-32 (June 1, 2003) and Chunliu Zhan et al., Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization, 290 J. of Amer. Med. Assoc. 1868-74 (Oct. 8, 2003)).

² 73 Fed. Reg. at 48471 n.4 (citing Klevens et al., Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. Public Health Reports. March–April 2007. Volume 122).