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Infectious Diseases Society of America

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February 13, 2018

The Honorable Alex Azar

Secretary

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

Dear Secretary Azar,

The Infectious Diseases Society of America (IDSAs) congratulates you on your confirmation as the Secretary for Health and Human Services. The IDSAs looks forward to working with you and we are pleased to offer our society as a resource to you. We also write to highlight key issues facing patients and public health that we hope you will prioritize. We look forward to developing a strong relationship with you and your staff enabling us to assist you and your team on important issues, including antimicrobial resistance, the infectious diseases implications of the opioid epidemic, public health infrastructure, global health security, investment in biomedical research, and the infectious diseases (ID) workforce. We request the opportunity to meet with you at your earliest convenience.

### Antimicrobial Resistance

As you are aware, antimicrobial resistance (AMR) poses a significant risk to patient safety, public health and national security. The Centers for Disease Control and Prevention (CDC) estimate that at least 2 million individuals in the U.S. are sickened by antibiotic resistant infections annually, resulting in at least 23,000 deaths. Since 2016, new federal investments have strengthened our response to AMR. Some specifics include CDC collaboration with state and local health departments to improve our prevention, detection and tracking of AMR threats; NIH and DoD supported research to further our understanding of AMR and to drive the discovery of urgently needed new tools to combat AMR; and BARDA partnerships with industry to support the development of new antibiotics. The U.S. is a leader in global efforts to address AMR, and we are encouraged by recent commitments to fight AMR from the G20. We strongly encourage you to maintain and to build upon these efforts. We would welcome the opportunity to work with you on this important issue. We encourage you to consider two specific recommendations to advance current U.S. AMR efforts:

1. Give priority to the development of new economic incentives to support the research and the development of new antibiotics that address unmet medical needs. Antibiotics are typically used for a short duration and held in reserve to protect their utility, making them a financially unattractive investment for companies—most have abandoned antibiotic discovery.
2. Work with the Centers for Medicare and Medicaid Services (CMS) to establish a Condition of Participation requiring hospitals to establish ID physician-led antimicrobial stewardship programs (ASP) aligned with CDC guidelines. ASPs have been proven to improve patient outcomes, reduce inappropriate antibiotic

use and save money. Unfortunately, only 48% of hospitals currently have robust stewardship programs in place.

### **Infectious Diseases Implications of the Opioid Epidemic**

New outbreaks of infectious diseases attributed to injection drug use have materialized in recent years, such as the 2015 HIV and viral hepatitis outbreak in Scott County, Indiana. CDC has identified 220 counties in 26 states that are vulnerable to ID outbreaks among injection drug users. In addition to HIV and hepatitis C (HCV), additional comorbidities associated with injection drug use, such as infective endocarditis, osteoarticular infections, and skin, joint, and bone infections, can have severe public health consequences at the regional and community levels. We greatly appreciate the administration's focus on addressing the opioid epidemic. We urge you to adopt comprehensive approaches that also combat the concurrent rise of devastating infectious diseases. Specifically, we recommend improved surveillance of infections related to injection drug use, increased research including on vulnerable and underrepresented groups, increased access to comprehensive ID and addiction treatment services, expanded public health and prevention activities, and increased support for research to inform service delivery and prevention and treatment interventions.

### **Global Health Security**

Infectious diseases threats are domestic and global in nature and know no borders. Recent outbreaks of Ebola and Zika viruses stand as clear evidence. The CDC estimates it takes only 36 hours for a pathogen to spread from an isolated village in the developing world to any major city on the planet. Investing in global health security and global responses to infectious diseases is essential to prevent such threats from reaching our shores. Through emergency supplemental funding to respond to the Ebola outbreak in 2014, the U.S. government allocated \$1 billion over five years for global health security initiatives, conducted in partnership with other countries and international organizations. Specific activities have included boosting biosecurity; increasing immunization; developing surveillance systems, laboratory capacity and disease reporting mechanisms; strengthening the workforce; and focusing on antimicrobial resistance and zoonotic infections (i.e., infections that can spread from animals to humans, like Ebola). While important progress has been made, significant work remains to operationalize a basic global infrastructure to prevent, detect and respond to these infectious disease threats that rapidly emerge.

Unfortunately, U.S. funding for global health security is set to expire in 2019. Without continued funding, CDC will be forced to halt the majority of its global health security activities. Starting in October 2019, CDC will end programs in 39 countries, including China, Pakistan, Haiti, Rwanda, Congo and other epidemic hotspots. Instead, it will focus on 10 "priority countries," including India, Thailand, Vietnam, Kenya, Uganda, and Guatemala. The interruption to critical response networks and operational capabilities across so many areas will allow many public health capacities to collapse and leave us unprepared for the next major outbreak. We urge you to champion continuation of essential U.S. leadership in global health security to protect the health of our citizens.

### **Public Health Infrastructure and Immunizations**

As our nation's leaders consider new investments in U.S. infrastructure, we encourage you to think beyond roads and bridges. Infrastructure must also include a robust public health system, with state-of-the-art technology to prevent, detect and track infectious diseases threats; a highly skilled workforce; and coordinated and well-resourced programs to meet public health needs. Diverse threats range from HIV and hepatitis C to vector-borne diseases; from pandemic influenza to multidrug resistant tuberculosis; and from rising rates of syphilis to outbreaks of foodborne illnesses.

We must work to maximize the potential of one of the greatest public health tools at our disposal—vaccines. Every year, more than 50,000 adults die from vaccine preventable diseases. Adult vaccination rates fall far below recommended targets. For example, only 27% of adults over age 60 receive the shingles vaccination and only 20% of high risk adults under age 64 receive the pneumococcal

vaccination. Barriers such as fragmented Medicare coverage of vaccines and uneven public health infrastructure to support vaccination must be addressed. Among children, some parents' vaccine hesitancy is the source of dangerous outbreaks of measles and other vaccine-preventable diseases, threatening to undo decades of progress toward eradicating certain infectious diseases. Awareness campaigns and tools to help providers promote vaccination are essential to combat misinformation about vaccines. We must also continue to support vaccine innovation, both to improve existing vaccines and to develop new vaccines for existing and emerging threats. A universal influenza vaccine and a pertussis vaccine with longer-lasting immunity would both be incredibly important advances over existing vaccines. Vaccines that could prevent multidrug resistant and nosocomial pathogens could also be groundbreaking tools for protecting patients from life-threatening disease.

### **Investment in Research**

America's biomedical research enterprise is the envy of the world, and continued investment to maintain our position as a global leader in innovation is essential. Robust funding for the National Institutes of Health (NIH) is critical to support the discovery and development of new vaccines, diagnostics and therapeutics for a host of infectious diseases threats, including HIV, antibiotic resistant infections, and influenza. NIH is also the engine that fosters the next generation of biomedical researchers. NIH has recently undertaken numerous initiatives to support young investigators, including the Next Generation Researchers Initiative, programs to increase research opportunities for medical residents and clinical fellows, structured mentoring opportunities and other educational activities, and efforts to provide additional grants to young researchers and at-risk investigators. We urge you to prioritize federal efforts to strengthen and optimize the United States scientific workforce.

### **ID Physician Workforce**

Protecting the public from infectious diseases requires a skilled workforce that must include infectious diseases physicians. ID physicians care for complex patients with or at risk of serious infections, including patients with HIV, hepatitis C or tuberculosis; patients undergoing solid organ or bone marrow transplants; patients receiving cancer chemotherapy; patients with infections related to opioid use; and patients with infections caused by multidrug resistant pathogens. We conduct basic, translational and clinical research to drive innovation in diagnostics, therapeutics and vaccines. We lead population health programs in our health care facilities and communities, including antimicrobial stewardship programs, infection prevention and control programs, bioemergency preparedness programs and other quality improvement activities. We also help lead public health responses to threats including Ebola, Zika, pandemic influenza, MERS-CoV and bioterror attacks.

Unfortunately, fewer young physicians are pursuing infectious diseases specialty training. According to the National Residency Match Program (NRMP), only 80% (or 312 out of 390) of available ID fellowship positions filled for 2017-2018. In many specialty areas, all or nearly all available fellowship positions are typically filled. These data indicate an undervaluation of ID. In 2014, IDSA surveyed nearly 600 Internal Medicine residents about their career choices. We identified that very few residents self-identified as planning to seek specialty training in ID. A far higher number reported that they were interested in ID but chose another field instead. Among that group, salary was the most often cited reason for not choosing ID. Over 90% of the care provided by ID physicians is considered evaluation and management (E&M) services. These face-to-face, cognitive encounters are undervalued by the current payment systems compared to procedural practices (e.g., surgery, cardiology, and gastroenterology). *This has resulted in a significant compensation disparity between ID physicians and those physicians who provide procedure-based care.* Young physicians' significant debt burden (\$200,000 average for the class of 2014) is understandably driving many individuals toward more lucrative specialties, often with faster paths to practice.

Additionally, the Merit-Based Incentive Payment System and Alternative Payment Models authorized by MACRA rely on these very same outdated E/M codes on the current Medicare Physician Fee Schedule (MPFS), potentially limiting the ability of individual cognitive physicians to fully benefit from the opportunities presented by delivery system reform. This additional limitation potentially further discourages young physicians from entering ID.

Securing a strong pipeline of ID physicians for future generations is critical to our public health preparedness, patient care and national security. We encourage you to work closely with CMS to strive for more appropriate physician compensation and to explore other opportunities, such as loan repayment, to help secure the future of the ID workforce.

We congratulate you again on your new role, and thank you for your service to our country. We look forward to the opportunity to work with you and your team.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul G. Auwaerter". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Paul G. Auwaerter, MD, MBA, FIDSA  
President, IDSA

### **About IDSA**

IDSA represents over 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients with or at risk of serious infections such as HIV, hepatitis C virus (HCV), infections caused by antimicrobial resistant pathogens and opportunistic infections afflicting transplant patients and other immunocompromised individuals. ID physicians are on the front lines of responses to public health emergencies including outbreaks of Ebola, Zika, MERS-CoV, and influenza viruses. They lead antimicrobial stewardship and infection prevention programs. With a view toward improving patient safety and leading cutting-edge research, IDSA advocates for developing urgently needed new antimicrobial drugs, diagnostics, and vaccines.