



IDSAs

Infectious Diseases Society of America

2013-2014 BOARD OF DIRECTORS

President

Barbara E. Murray, MD, FIDSA
THE UNIVERSITY OF TEXAS HEALTH
SCIENCE CENTER
HOUSTON, TX

President-Elect

Stephen B. Calderwood, MD, FIDSA
MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MA

Vice President

Johan S. Bakken, MD, PhD, FIDSA
ST. LUKE'S ID ASSOCIATES
DULUTH, MN

Secretary

Penelope H. Dennehy, MD, FIDSA
HASBRO CHILDREN'S HOSPITAL
PROVIDENCE, RI

Treasurer

Cynthia L. Sears, MD, FIDSA
JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
BALTIMORE, MD

Immediate Past President

David A. Relman, MD, FIDSA
STANFORD UNIVERSITY SCHOOL OF MEDICINE
PALO ALTO, CA

Judith A. Aberg, MD, FIDSA

ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI
NEW YORK, NY

**Barbara D. Alexander, MD, MHS,
FIDSA**

DUKE UNIVERSITY MEDICAL CENTER
DURHAM, NC

Upton D. Allen, MD, FIDSA

HOSPITAL FOR SICK CHILDREN
TORONTO, ONTARIO, CANADA

Helen W. Boucher, MD, FIDSA

TUFTS MEDICAL CENTER
BOSTON, MA

R. Michael Buckley, MD, FIDSA

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
PHILADELPHIA, PA

Deborah Cotton, MD, MPH, FIDSA

BOSTON UNIVERSITY SCHOOL OF MEDICINE
BOSTON, MA

Stanley C. Deresinski, MD, FIDSA

STANFORD UNIVERSITY SCHOOL OF MEDICINE
PALO ALTO, CA

Louis B. Rice, MD

WARREN ALPERT MEDICAL SCHOOL
OF BROWN UNIVERSITY
PROVIDENCE, RI

Steven K. Schmitt, MD, FIDSA

CLEVELAND CLINIC
CLEVELAND, OH

Chief Executive Officer

Mark A. Leasure

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

May 20, 2014

Nicole Lurie, M.D., M.S.P.H.

Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
200 Independence Ave., S.W., Room 638-G
Washington, DC 20201

SUBJ: IDSA Comments on 2015-2018 Draft National Health Security Strategy

Dear Dr. Lurie:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to comment on the 2015-2018 National Health Security Strategy (NHSS). IDSA represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, antibiotic-resistant bacterial infections such as those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE) and Gram-negative bacterial infections such as *Acinetobacter baumannii*, *Klebsiella pneumoniae*, and *Pseudomonas aeruginosa*, and, finally, emerging infections such as West Nile Virus, the 2009 H1N1 influenza virus, SARS and MERS coronaviruses, and bacteria containing the New Delhi metallo-beta-lactamase (NDM) enzyme that makes them resistant to a broad range of antibacterial drugs.

As the organization representing the majority of U.S. infectious disease physicians, IDSA recognizes—as is stated in the strategy document—the crucial role that national health security plays in the broader role of national security and the impact that infectious disease has in this realm. The recent reporting of the first domestic cases of MERS and the emergence of chikungunya for the first time in the Western Hemisphere illustrate the fundamental need for such a strategy, as does the continuing threat of pandemic influenza.

Taken as a whole, the NHSS offers a comprehensive approach to this issue, employing the needed multi-faceted strategy necessary to achieve the vision articulated. Indeed, many of the areas addressed by the NHSS are completely consonant with [IDSA's Pandemic and Seasonal Influenza Principles for United States Action](#).¹ Specifically, the inclusion of both the unique needs of children and

¹ Infectious Diseases Society of America. Pandemic and Seasonal Influenza Principles for United States Action. September 2012. Available at, http://www.idsociety.org/uploadedFiles/IDSA/Policy_and_Advocacy/Current_Topics_and_Issues/Influenza_and_Bio-Threats/Seasonal_and_Pandemic_Influenza/IDSA%20Seasonal%20and%20Pandemic%20Influenza%20Principles%20for%20US%20Action%202012.pdf.

the discussion of the need for research on non-pharmaceutical interventions are particularly praiseworthy (both are included in IDSA’s influenza principles as well). We also applaud the emphasis on the “One Health” approach to infectious disease surveillance, prevention, and control.

There are several areas that IDSA would like to highlight for further consideration and refinement:

1. Situational awareness [*Ref. p. 15–16; ln. 340–68*]: The emphasis placed on situational awareness in the NHSS is well founded. However, situational awareness can sometimes be too narrowly construed. For example, during the 2009 H1N1 pandemic, it was not enough to know where cases of the novel virus were appearing. What was missing from early reports was an understanding of the severity of illness (e.g., proportion of hospitalizations, intensive care unit admission, outpatient treatment)—an essential element of preparing the general public, public health agencies and healthcare facilities. Situational awareness requires scientific depth as well as breadth. Developing the capacity to rapidly characterize severity of illness and transmission dynamics for unfamiliar pathogens, including those that are vector-borne, should be prioritized. Activities should strive to provide as comprehensive a picture as possible, providing the most actionable data.
2. Public health preparedness capacity [*Ref. p. 18–19; ln. 442–71*]: In the thirteen years since the anthrax attacks on American soil, the capacity for state and local public health agencies to conduct robust emergency preparedness functions has deteriorated substantially, due in large part to reductions in the federal funding upon which state and local governments depend—as has been documented extensively.² As the events of 2001 fade from public memory, funding for positions needed to support the myriad requirements to achieve preparedness and full national health security has also ebbed. According to a 2013 report from the National Association of County and City Health Officials (NACCHO), local public health departments eliminated 44,000 jobs since 2008.³ A knowledgeable public health workforce and sufficient deployable clinical resources must be maintained over time in order to be ready to respond to a public health emergency. An emphasis on the crucial nature of supporting the national health security functions of state and local public health agencies would draw more attention to this deficiency.

² See, e.g., Trust For America’s Health. Investing in America’s health: A state-by-state look at public health funding & key health facts. May 2014. Available at, <http://healthyamericans.org/assets/files/TFAH2014-InvestInAmericaRpt08.pdf>.

³ National Association of City and County Health Officials. Local health department job losses and program cuts: Findings from the 2013 profile study. 2013. Available at, <http://www.naccho.org/topics/infrastructure/lhdbudget/upload/Survey-Findings-Brief-8-13-13-3.pdf>.

3. Healthcare coalitions [*Ref. pp. 18–19; ln. 442–71*]: The growth of healthcare coalitions has been one of the most important results of the emphasis on emergency preparedness since 2001. As these coalitions mature, they will need to not only include traditional components of the healthcare system, but all components. For example, urgent care centers, dialysis centers, methadone clinics, pharmacy-based healthcare delivery, and related entities are often disconnected from hospital-based systems and are frequently not included in regional preparedness activities. Recognition of this fact and devising means to remedy it would further enhance the operation of coalitions.
4. Medical countermeasures [*Ref. pp. 11–12; ln. 252–76*]: Medical countermeasures (MCMs) provide the backbone of bioemergency response and will be the most pressing focus for the general public. As such, the ability to distribute these assets will be paramount. While the NHSS discusses MCMs in detail, there is relatively little attention devoted to ascertaining the local distribution and administrative capacity. As the last link in the chain, local efforts will be critically important and must be optimized in order for successful implementation. A mechanism for monitoring the efficacy of MCMs would further enhance response efforts. Specific needs could also be discussed (e.g., influenza point of care diagnostics, better influenza vaccines, additional antivirals, MCMs that would be active against naturally occurring multi-drug resistant organisms (MDRO) as well as engineered bacterial biothreats). Additionally, a discussion of how to prioritize MCM needs and mechanisms to fill known MCM gaps would further strengthen the strategy.
5. Antimicrobial resistance [*Ref. pp. 11–12; ln. 252–76*]: While the NHSS does not focus on specific threats in detail, antimicrobial resistance is a threat that demands as much recognition as possible since antimicrobial resistance may not be adequately addressed with traditional measures outlined in the document. As this continual threat increases in severity and scope, it has the capability to render MCMs obsolete and return the world to a pre-antibiotic age. As such, a better understanding of all aspects of antimicrobial resistance and devising new approaches to the treatment of infectious diseases (including new rapid diagnostics, new traditional and non-traditional treatments, and improving antimicrobial stewardship) will increasingly become part of a comprehensive NHSS.

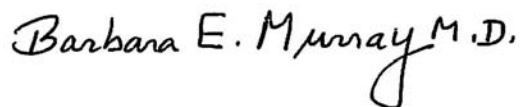
IDSA advocates for a [coordinated, multifaceted plan](#), involving all levels of government and relevant stakeholders, to address antimicrobial resistance. Solutions must include incentives to develop new antimicrobial drugs and diagnostics, effective stewardship programs in all healthcare facilities, research to determine the best ways to limit the development of resistance and the spread of resistant infections, and improved surveillance and data collection regarding antimicrobial drug use and resistance patterns.⁴

⁴ Infectious Diseases Society of America. Combatting antimicrobial resistance: Policy recommendations to save lives. *Clin Infect Dis.* (2011) 52 (suppl 5): S397-S428. Available at, http://cid.oxfordjournals.org/content/52/suppl_5/S397.full.

6. Electronic health records [Ref. pp. 18–19; ln. 442–71]: IDSA shares the belief in the promise of electronic health records (EHRs) to augment preparedness and response activities; however, the discussion in the NHSS could be clarified and made more accessible to the public. A discussion less burdened with jargon would facilitate a clearer grasp of this resource. EHRs should also have a higher profile in clinical settings—most health systems look at preparedness and response functions as a secondary objective or afterthought.
7. Dual Use Research of Concern [Ref. pp. 20–21; ln. 517–42]: Noticeably absent from the NHSS is a discussion of the national security risks posed by Dual Use Research of Concern (DURC) gain-of-function experiments. IDSA advocates balancing the public health risk of impeding the conduct of DURC against the public health risk of an accidental or intentional release from a laboratory or an act of bioterrorism. The NHSS should explicitly acknowledge this potential threat and tie it into a broader federal DURC framework.

Thank you again for this opportunity to comment. The IDSA applauds the efforts undertaken to produce this strategy and looks forward to further engagement and collaboration on this vital issue. Should you have any questions or require clarifications to this letter, please contact John Billington, IDSA Sr. Program Officer for Health Policy at 703.299.0015 or jbillington@idsociety.org.

Sincerely,

Handwritten signature of Barbara E. Murray M.D. in black ink.

Barbara E. Murray, MD, FIDSA
President

cc: Lisa Kaplowitz, MD, MSHA