H. R. 2285

To amend the Public Health Service Act to enhance efforts to address antimicrobial resistance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 6, 2013

Mr. Matheson introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to enhance efforts to address antimicrobial resistance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Strategies to Address Antimicrobial Resistance Act”.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The advent of the antibiotic era has saved millions of lives and allowed for incredible medical progress; however, the increased use and overuse of
antimicrobial drugs have correlated with increased rates of antimicrobial resistance.

(2) Through mutation as well as other mechanisms, bacteria and other infectious disease-causing organisms—viruses, fungi, and parasites—develop resistance to antimicrobial drugs over time. The more antimicrobial drugs are used, whether appropriately or inappropriately, the more this contributes to the development of antimicrobial resistance.

(3) Scientific evidence suggests that the development of antimicrobial resistance in humans is not due only to use of antimicrobial drugs in humans, but also may be caused by the use of antimicrobial drugs in food-producing animals.

(4) A study estimates that in 2005 more than 94,000 invasive methicillin-resistant Staphylococcus aureus (MRSA) bacterial infections occurred in the United States and more than 18,500 of these infections resulted in death—7 times more than a decade earlier.

(5) The 2009 Influenza A: H1N1 virus outbreak, and the yearly seasonal influenza outbreaks, exacerbate concerns about antiviral resistance given that so few antivirals are available to treat influenza as well as secondary bacterial infections due to
MRSA, antibiotic-resistant Streptococcus pneumonia, and other bacteria that cause respiratory diseases. Given that, during the 1918 influenza pandemic, many thousands of deaths were caused by complications due to secondary bacterial infections and not by the influenza virus itself.

(6) Each year, nearly 2,000,000 people contract bacterial infections in hospitals and approximately 90,000 of these people die from these infections. Many of these infections are resistant to one or more commonly used antibiotics.

(7) A 2012 study conducted at Columbia University ("Clinical Infectious Disease", September 2012) found that each antibiotic-resistant infection cost, on average, over $15,000 more to treat than susceptible infections.

(8) The costs of antimicrobial-resistant infections in terms of lives lost and the economy will only rise as antimicrobial resistance continues to spread.

SEC. 3. ANTIMICROBIAL RESISTANCE TASK FORCE.

Section 319E of the Public Health Service Act (42 U.S.C. 247d–5) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking “TASK FORCE” and inserting the following:
“ANTIMICROBIAL RESISTANCE OFFICE, TASK FORCE, AND ADVISORY BOARD”;

(B) in paragraph (1)—

(i) by striking “as of the date of the enactment of this section” and inserting “as of September 30, 2006”; and

(ii) by adding at the end the following: “The Secretary shall, not later than 1 year after the date of enactment of the Strategies to Address Antimicrobial Resistance Act, direct the Assistant Secretary of Health to establish an Antimicrobial Resistance Office and appoint a director to that Office. The Secretary shall, not later than 1 year after the date of enactment of such Act, establish the Public Health Antimicrobial Advisory Board as an advisory board to the Director of the Antimicrobial Resistance Office. The Director of the Antimicrobial Resistance Office shall serve as the Director of the Antimicrobial Resistance Task Force. To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Director shall work in conjunction with the Fed-
eral agencies represented on the Task Force to coordinate all antimicrobial resistance activities undertaken and supported by the Federal Government, including the activities and budgetary allocations of the Office, Task Force, and Public Health Antimicrobial Advisory Board.”;

(C) by amending paragraph (2) to read as follows:

“(2) Members.—

“(A) Members of the Antimicrobial Resistance Task Force.—The task force described in paragraph (1) shall be composed of representatives of such Federal agencies as the Secretary determines necessary, including representation of the following:

“(i) The Antimicrobial Resistance Office.

“(ii) The Assistant Secretary for Preparedness and Response.

“(iii) The Biomedical Advanced Research and Development Authority.

“(iv) The Centers for Disease Control and Prevention.
“(v) The Food and Drug Administration.

“(vi) The National Institutes of Health.


“(ix) The Health Resources and Services Administration.

“(x) The Department of Agriculture.

“(xi) The Department of Education.

“(xii) The Department of Defense.

“(xiii) The Department of Veterans Affairs.

“(xiv) The Environmental Protection Agency.


“(xvi) The United States Agency for International Development.

“(B) Members of the Public Health Antimicrobial Advisory Board.—

“(i) In general.—The Public Health Antimicrobial Advisory Board shall be
composed of 19 voting members, appointed
by the Secretary. Such members shall in-
clude experts from the medical professions
(including hospital and community-based
physicians), pharmacy, public health, vet-
erinary, research, and international health
communities, as well as one representative
from a public interest group.

“(ii) TERMS.—Each member ap-
pointed under clause (i) shall be appointed
for a term of 3 years, except that of the
19 members first appointed—

“(I) 6 shall be appointed for a
term of 12 months; and

“(II) 6 shall be appointed for a
term of 2 years.

“(iii) CHAIR.—The Secretary shall ap-
point a Chair of the Public Health Anti-
microbial Advisory Board from among its
members to lead and supervise the activi-
ties of the Advisory Board.

“(iv) DISCLOSURE OF FINANCIAL IN-
TERESTS.—Prior to a meeting of the Pub-
lic Health Antimicrobial Advisory Board,
each member of the Advisory Board shall
disclose to the Secretary any potential, relevant financial interests as defined under section 208(a) of title 18, United States Code.”;

(D) in paragraph (3)(B), by striking “in consultation with the task force described in paragraph (1) and” and inserting “acting through the Director of the Antimicrobial Resistance Office and the Director of the Centers for Disease Control and Prevention, and in consultation with”; and

(E) by amending paragraph (4) to read as follows:

“(4) MEETINGS AND DUTIES.—

“(A) ANTIMICROBIAL RESISTANCE OFFICE DUTIES.—The Director of the Antimicrobial Resistance Office, working in conjunction with the Federal agencies that are represented on the task force described in paragraph (1), shall issue an update to the Public Health Action Plan to Combat Antimicrobial Resistance within 1 year of the establishment of the Office and annually thereafter. The updates shall include enhanced plans for addressing antimicrobial resistance in the United States and internation-
ally. The Director of the Office shall post on a website these updates as well as summaries of all non-proprietary data the Task Force makes available. The Director of the Antimicrobial Resistance Office shall work in conjunction with the Federal agencies that are represented on the task force described in paragraph (1), and in consultation with the Public Health Antimicrobial Advisory Board, to—

“(i) establish benchmarks for achieving the goals set forth in the action plan;

“(ii) assess the ongoing, observed patterns of emergence of antimicrobial resistance, and their impact on clinical outcomes in terms of how patients feel, function, or survive;

“(iii) assess how antimicrobial products are being used in humans, animals, plants, and the environment and the risks and benefits of those uses in furthering the development of resistance and the implications thereof for patient safety and public health;

“(iv) establish a priority list of human infectious diseases with the greatest need
for development of new point-of-care and
other diagnostics, antimicrobial drugs, and
vaccines, and in particular serious and life-
threatening resistant infections, for which
there are few or no diagnostic, treatment,
or prevention options;

“(v) recommend basic, clinical, epidemiological, prevention, and translational research where additional federally sup-
ported studies may be beneficial;

“(vi) recommend how to support anti-
microbial development through Food and
Drug Administration activities, including
through the agency’s Critical Path Initiative and the Reagan-Udall Foundation;

“(vii) recommend how best to
strengthen and link antimicrobial resist-
ance-related surveillance and prevention
and control activities; and

“(viii) collaborate with the Assistant
Secretary for Preparedness and Response
to ensure that strategies to address anti-
microbial-resistance are coordinated with
initiatives aimed at pandemic influenza, se-
vere acute respiratory syndrome, and bio-
terrorism.

“(B) ANTIMICROBIAL RESISTANCE TASK
FORCE MEETINGS AND DUTIES.—

“(i) MEETINGS.—The Antimicrobial
Resistance Task Force shall convene peri-
odically as the Director of the Anti-
microbial Resistance Task Force deter-
mines to be appropriate, but not fewer
than twice a year, to consider issues relati-
ning to antimicrobial resistance.

“(ii) PUBLIC HEALTH ACTION
PLAN.—At least twice a year, the task
force described in paragraph (1) shall have
a meeting to review, discuss, and further
develop the Public Health Action Plan to
Combat Antimicrobial Resistance first
issued by the interagency task force on
antimicrobial resistance in 2001. Among
other issues, the task force may discuss
and review, based on current need or con-
cern—

“(I) antimicrobial clinical suscep-
tibility concentrations proposed, estab-
lished, or updated by the Food and Drug Administration;

“(II) data obtained by government agencies and, as possible, by private sources on emerging antimicrobial resistance related to clinical outcomes as well as data related to how antimicrobial drugs may have been used inappropriately;

“(III) surveillance data and prevention and control activities regarding emerging antimicrobial resistance from reliable sources including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Department of Defense, the Department of Veterans Affairs, the Department of Agriculture, the Environmental Protection Agency, and as feasible from private sources and international bodies;

“(IV) data on the amount of antimicrobial products used in humans, animals, plants, and the environment from reliable sources, includ-
ing data from the Centers for Disease Control and Prevention, the Food and Drug Administration, the Environmental Protection Agency, the Department of Veterans Affairs, the Centers for Medicare & Medicaid Services, the Department of Homeland Security, and the Department of Agriculture, and as feasible from private sources and international bodies;

“(V) the impact of antimicrobial resistance on human health resulting from the approval of antimicrobial drugs for use in humans, animals, or plants (including consideration of and recommendations on potential management plans to limit and reduce the negative impacts of such resistance on human health and consideration of the benefits to animal health and food safety);

“(VI) reports of federally supported antimicrobial resistance research and antimicrobial drug, related diagnostics, and vaccine development
for antimicrobial resistant infections
(such as methicillin-resistant Staphy-
lococcus aureus (MRSA)) and other
research activities (including clinical,
epidemiological, prevention, and trans-
lational research) obtained from Fed-
eral agencies, as well as reports of re-
search sponsored by other countries,
industry, and non-governmental orga-
nizations;

“(VII) reports on efforts by the
Food and Drug Administration to de-
velop policies and guidance which en-
courage antimicrobial drug, related
diagnostics, and vaccine development
and appropriate use while maintaining
high standards for safety and effec-
tiveness;

“(VIII) quality measures, which
may include health plan employer
data and information set (HEDIS)
measures, pertaining to appropriate
use of antimicrobial drugs; and

“(IX) other data and issues the
task force described in paragraph (1)
identifies as relevant to the issue of antimicrobial resistance.

“(iii) Pending applications.—The Food and Drug Administration may consult with the Director of the Antimicrobial Resistance Office concerning the pending application of any antimicrobial drug application submitted to the Secretary under section 505 or 512 of the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

“(C) Public health antimicrobial advisory board meetings and duties.—

“(i) Meetings.—The Public Health Antimicrobial Advisory Board shall meet as the Chair of the Public Health Antimicrobial Advisory Board determines to be appropriate, preferably in conjunction with meetings of the Antimicrobial Resistance Task Force, but not fewer than 2 times each year.

“(ii) Recommendations.—The Public Health Antimicrobial Advisory Board shall make recommendations to the Sec-
retary, and the Antimicrobial Resistance Office, regarding—

“(I) ways to encourage the availability of an adequate supply of safe and effective antimicrobial products, related diagnostics, and vaccines;

“(II) research priorities and other measures (such as antimicrobial drug resistance management plans) to enhance the safety and efficacy of antimicrobial products;

“(III) how best to implement and update the goals of the Public Health Action Plan to Combat Antimicrobial Resistance;

“(IV) incentives necessary to establish uniform mechanisms (which could include electronic surveillance systems) and data sets for State and local reporting of resistance;

“(V) the adequacy of existing United States antimicrobial resistance and use surveillance;

“(VI) the development of a national plan for the collection and anal-
ysis of isolates of resistant pathogens, including establishing priorities as to which isolates should be collected; and

“(VII) areas for government, nongovernment, and international cooperation to strengthen implementation of the Public Health Action Plan to Combat Antimicrobial Resistance.

“(D) AVAILABILITY OF INFORMATION.—
The Antimicrobial Resistance Office shall ensure that all information shall be made available to the public on the website described in subparagraph (A) consistent with section 9 of the Strategies to Address Antimicrobial Resistance Act.”;

(2) by amending subsection (b) to read as follows:

“(b) ANTIMICROBIAL RESISTANCE STRATEGIC RESEARCH PLAN.—The Secretary, acting through the Director of the National Institutes of Health, working in consultation with the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Preparedness and Response, the Director of the Biomedical Advanced Research and Development Authority, the Director of the Antimicrobial Resistance Office, the Public Health
Antimicrobial Advisory Board, and other non-government experts, including representatives from professional societies and the pharmaceutical, vaccine, and medical device industries, and other Federal agencies shall develop a blue-ribbon antimicrobial resistance strategic research plan that strengthens existing epidemiological, interventional, clinical, behavioral, translational, and basic research efforts to advance the understanding of—

“(1) the development, implementation, and efficacy of interventions to prevent and control the emergence and transmission of antimicrobial resistance;

“(2) how best to optimize antimicrobial effectiveness while limiting the emergence of resistance, including addressing issues related to duration of therapy, effectiveness of therapy in self-resolving diseases, and determining populations most likely to benefit from antimicrobial drugs;

“(3) the extent to which specific uses of antimicrobial products in humans, animals, plants, and other uses accelerates development and transmission of antimicrobial resistance;

“(4) the natural histories of infectious diseases (including defining the disease, diagnosis, severity, and the time course of illness);
“(5) the development of new therapeutics, including antimicrobial drugs, biologics, and devices against resistant pathogens, and in particular diseases for which few or no therapeutics are in development;

“(6) the development and testing of medical diagnostics to identify patients with infectious disease and identify the exact cause of infectious diseases syndromes, particularly with respect to the detection of pathogens resistant to antimicrobial drugs;

“(7) the epidemiology, pathogenesis, mechanisms, and genetics of antimicrobial resistance; and

“(8) the sequencing of the genomes, or other DNA analysis, or other comparative analysis of priority pathogens (as determined by the Public Health Antimicrobial Advisory Board), in collaboration with the Department of Defense and the Joint Genome Institute of the Department of Energy.”;

(3) in subsection (c)—

(A) by inserting “acting through the Director of the Antimicrobial Resistance Office,” after “The Secretary,”; and

(B) by striking “members of the task force described in subsection (a),”;
(4) in subsection (d)(1), by inserting “, through
the Antimicrobial Resistance Office,” after “The
Secretary”;

(5) in subsection (c)—

(A) by amending the subsection heading to
read as follows: “IMPROVING UPTAKE AND
MEASUREMENT OF ANTIMICROBIAL STEWARD-
SHIP”;

(B) in paragraph (1)—

(i) by inserting “, acting through the
Director of the Antimicrobial Resistance
Office,” after “The Secretary”; and

(ii) by striking “judicious use of anti-
microbial drugs or control the spread of
antimicrobial-resistant pathogens” and in-
serting “the uptake and measurement of
antimicrobial stewardship programs in the
Nation’s health care facilities”;

(C) in paragraph (2), by striking “labora-
tory”;

(D) in paragraph (3), by inserting “, act-
ing through the Antimicrobial Resistance Of-

cine,” after “The Secretary”; and

(E) by adding at the end the following new
paragraphs:
“(4) Definition of Antimicrobial Stewardship.—For purposes of this subsection and Act, ‘antimicrobial stewardship’ means coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents, including promoting the use of antimicrobials only when clinically indicated, and, when antimicrobials are indicated, promoting the selection of the optimal antimicrobial drug regimen including dosing, duration of therapy, and route of administration.

“(5) Preference in Making Awards.—In making awards under paragraph (1), the Secretary shall give preference to eligible entities that will use grant funds to establish demonstration projects that lead to the development of quality measures for health care providers prescribing antimicrobial drugs.”;

(6) by redesignating subsections (f) and (g) as subsections (i) and (j), respectively; and

(7) by inserting after subsection (e) the following new subsections:

“(f) Appropriate Antimicrobial Use.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall take such additional actions as follows:
“(1) To pilot and test health care quality measures to help providers, facilities, and health systems measure and benchmark appropriate antimicrobial use. As appropriate, the Director shall work with standard setting organizations (such as the National Quality Forum, the Joint Commission, and the National Committee for Quality Assurance) to determine if any such measure is suitable for national quality reporting efforts.

“(2) To develop methods to help providers, facilities, and health systems measure and improve appropriate antimicrobial use, including methods and tools to assess the change in antimicrobial use, the impact on antibiotic resistance and adverse effects (such as Clostridium difficile infections), and the economic impact and cost savings of antimicrobial stewardship programs.

“(g) Collection of Human Antimicrobial Consumption and Resistance Trend Data.—

“(1) Antimicrobial use data.—The Director of the Centers for Disease Control and Prevention shall work with private vendors, health care organizations, pharmacy benefit managers, and other entities to obtain reliable and comparable human antimicrobial drug consumption data (including volume
antimicrobial distribution data and antimicrobial use, including prescription data) by State or metropolitan area.

“(2) Antimicrobial resistance trend data.—The Director of the Centers for Disease Control and Prevention shall intensify and expand their efforts to collect antimicrobial resistance data including through the establishment of an Antimicrobial Resistance Surveillance and Laboratory Network, established in section 4 of the Strategies to Address Antimicrobial Resistance Act, and development of a fully automated antimicrobial resistance and use module within the National Healthcare Safety Network. The Director shall seek to collect data from electronic medication administration reports (eMAR) and laboratory systems to produce regular reports on antimicrobial resistance patterns and antimicrobial use.

“(3) Meaningful use reporting.—The Office of the National Coordinator for Health Information Technology shall work with the Director of the Centers for Disease Control and Prevention to determine how best antimicrobial use, susceptibility, and resistance data can be incorporated into meaningful use reporting.
“(4) REPORT.—Not later than 2 years after the date of the enactment of the Strategies to Address Antimicrobial Resistance Act, and every two years thereafter, the Director of the Centers for Disease Control and Prevention shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor and Pensions of the Senate and make available on the agency’s website a report summarizing key trends and major issues related to antimicrobial resistance and use in the United States. Each such report shall include the most relevant and up-to-date data available from the infectious diseases and surveillance programs of the Centers for Disease Control and Prevention. Each such report shall—

“(A) outline major issues and threats in antimicrobial resistance facing the United States;

“(B) provide data on the incidence, prevalence, morbidity, mortality, and general societal burden, including economic, of antimicrobial resistant pathogens;

“(C) provide updates on resistance patterns and antimicrobials use data and potential impacts on human health and patient safety;
“(D) articulate activities of the Centers for Disease Control and Prevention targeted toward measuring and preventing the spread of drug-resistant pathogens;

“(E) describe any international developments that may impact antimicrobial resistance in the United States; and

“(F) identify the major gaps that the Nation faces in the areas of antimicrobial resistance surveillance, prevention, use, and antimicrobial stewardship.

“(h) Ensure Access to Antimicrobial Resistance Data and Research.—The Director of the Antimicrobial Resistance Office shall work with the Federal agencies represented on the Antimicrobial Resistance Task Force to identify relevant data and formats, and mechanisms for communicating such data to the Antimicrobial Resistance Office and Antimicrobial Resistance Task Force and, in a manner consistent with section 9 of the Strategies to Address Antimicrobial Resistance Act, with the Public Health Antimicrobial Advisory Board and the public, including relevant data obtained by the agencies through contracts with other organizations, including—
“(1) use and clinical outcomes data on patients receiving antimicrobial drugs for the treatment, prevention, or diagnosis of infection or infectious diseases;

“(2) surveillance data regarding emerging antimicrobial drug resistance and existing resistance patterns;

“(3) susceptibility data related to antimicrobial drug use;

“(4) data related to the amount of antimicrobial products used in humans, animals, plants, and the environment;

“(5) data from federally funded research intended to support antimicrobial drug, vaccine, and related diagnostics development;

“(6) data demonstrating the impact of research, surveillance, and prevention and control initiatives in understanding and controlling antimicrobial resistance; and

“(7) data regarding implementation and evaluation of interventions to improve antimicrobial drug prescribing practices.”.
SEC. 4. ANTIMICROBIAL RESISTANCE SURVEILLANCE AND LABORATORY NETWORK.

(a) In general.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control, shall establish at least 10 Antimicrobial Resistance Surveillance and Laboratory Network sites, building upon the intramural and extramural programs and laboratories of the Centers for Disease Control and Prevention, to intensify, strengthen, and expand the national capacity to—

(1) monitor the emergence and changes in the patterns of antimicrobial resistant pathogens;

(2) describe, confirm, and as necessary facilitate a response to local or regional outbreaks of resistant pathogens;

(3) assess and describe antimicrobial resistance patterns to inform public health and improve prevention practices;

(4) obtain isolates of pathogens, and in particular, pathogens that show new or atypical patterns of resistance adversely affecting public health;

(5) study the epidemiology of infections from such pathogens;

(6) evaluate commonly used antimicrobial susceptibility testing methods to improve the accuracy of resistance testing and reporting; and
(7) as necessary, develop novel diagnostic tests capable of detecting new or emerging resistance in pathogens.

(b) Geographic Distribution.—The sites established under subsection (a) shall be geographically distributed across the United States.

(c) Nonduplication of Current National Capacity.—The sites established under subsection (a) may be based in academic centers, health departments, and existing surveillance and laboratory sites.

SEC. 5. CLINICAL TRIALS NETWORK ON ANTIBACTERIAL RESISTANCE.

(a) In General.—The Secretary, acting through the Director of the National Institute of Allergy and Infectious Diseases, shall establish a Clinical Trials Network on Antibacterial Resistance to enhance, strengthen, and expand research on clinical science, antibacterial and diagnostic development, and optimal usage strategies, and shall, at a minimum—

(1) facilitate research to better understand resistance mechanisms and how to prevent, control, and treat resistant organisms;

(2) advance clinical trial efforts to develop antimicrobial therapies, vaccines and diagnostics, and evaluate and optimize their usage;
(3) conduct clinical research to develop natural histories of resistant infectious diseases;

(4) examine patient outcomes with currently available antimicrobial therapy and validate and improve upon biomarkers and other surrogate endpoints; and

(5) study shorter treatment duration and early cessation of antimicrobial therapy for treatment efficacy and effect on development of resistance.

(b) LEADERSHIP GROUP FOR A CLINICAL RESEARCH NETWORK ON ANTIBACTERIAL RESISTANCE.—The Secretary, acting through the Director of the National Institute of Allergy and Infectious Diseases, shall establish a Leadership Group for the Clinical Research Network on Antibacterial Resistance described in subsection (a) to develop and implement a comprehensive clinical research agenda to address antibacterial resistance that takes into consideration the recommendations contained in the Strategic Research Plan on Antimicrobial Resistance developed in accordance with section 319E of the Public Health Service Act. The Leadership Group shall provide support for the following components—

(1) scientific leadership and operations;

(2) network laboratories; and

(3) statistical and data management.
(c) APPROPRIATIONS.—There are authorized to be appropriated from the existing budget of the National Institute of Allergy and Infectious Diseases, $100,000,000 annually for each of fiscal years 2014 through 2020 to carry out this section.

SEC. 6. REGIONAL PREVENTION COLLABORATIVES.

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall work with State health departments to support regional prevention collaboratives designed to interrupt and prevent the transmission of significant antibiotic resistant pathogens being transmitted across health care settings in a geographic region. Such regional prevention collaboratives shall work to—

(1) identify significant drug resistant pathogens being transmitted across health care settings locally;

(2) implement evidence-based interventions to interrupt and prevent the transmission of such pathogens; and

(3) evaluate the impact of such measures on hospital readmissions, transitions of care, rates of health care associated infections, or any other relevant measures that characterize the health or economic impact of the collaboratives.
SEC. 7. PREVENTION EPICENTERS.

To provide the regional prevention collaboratives established under section 6 with tools, strategies, and evidence-based interventions, the Director of the Centers for Disease Control and Prevention may intensify and expand academic public health partnerships through the work of the Prevention Epicenters Program of the Centers of Disease Control and Prevention. The Centers for Disease Control and Prevention and the epicenters participating in such program shall work with the regional prevention collaboratives to—

1. evaluate new and existing interventions to prevent or limit the emergence of antimicrobial resistance throughout the geographic region of the collaboratives;
2. facilitate public health research on the prevention and control of resistant organisms; and
3. assess the feasibility, cost-effectiveness, and appropriateness of surveillance and prevention programs in differing health care and institutional settings.

SEC. 8. CONTINUATION OF CURRENT PROGRAMS.

Subsection (j) of section 319E of the Public Health Service Act (42 U.S.C. 247d–5), as redesignated by section 3(6), is amended by inserting “and for each of the fiscal years 2014 through 2018” after “2006.”
SEC. 9. PROTECTION OF CONFIDENTIAL AND NATIONAL SECURITY INFORMATION.

Except as otherwise required by law, this Act (and the amendments made by this Act) shall not permit public disclosure of trade secrets, confidential commercial information, or material inconsistent with national security that is obtained by any person under this Act (or amendments made by this Act).