Author's Response to Letter Regarding "Questionable validity of the catheter-associated urinary tract infection metric used for value-based purchasing"

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(Letter’s Authors)’s describes the many institutions that have implemented initiatives in the prevention of Catheter Associated Urinary Tract Infections (CAUTIs) but paradoxically the CDC NHSN data indicates the rates of CAUTIs are not decreasing.\(^1\) Clearly, either there are problems with the metric and/or data; or gains have not taken place. The 2014 CAUTI data is currently available and the AHRQ metric indicates there are 7.6 CAUTI infection per 1000 discharges,\(^2\) a 38% decrease over the 2010 baseline. The CDC/NHSN metric indicates there is a 5% increase in CAUTIs based on the average hospital performance (N=2268, acquisition dates 1/1/2014 to 12/31/2014) compared to a 2009 baseline.\(^3\) This is a large discrepancy in findings.

(Letter’s Authors)’s data, which we assume is the full NHSN data set and not the Partnership for Patients, found no decrease in urinary catheter utilization in non-ICU settings and only an 11% decrease in the ICU. U.S. healthcare facilities not achieving a substantial drop in catheter utilization is simply unacceptable, since it is known that catheter utilization is a major risk factor for urinary tract infections. CMS’ value-based purchasing initiative is designed to drive catheter infections to the lowest possible level. Thus, it would seem logical to adopt a metric that discourages catheter overutilization.

We also feel there are concerns regarding un-audited reporting of data. Among patient advocates these concerns were heightened by an advisory letter set on Oct 8, 2015 from Beth P. Bell, MD, MPH, Director, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention (CDC) and Patrick Conway, M.D. Deputy Administrator for Innovation & Quality, CMS Chief Medical Officer Centers for Medicare & Medicaid Services (CMS) which stated:\(^4\)
"CDC has received reports from NHSN users indicating that in some healthcare facilities, some of the decisions about what infections should be reported to NHSN are made by individuals who may choose to disregard CDC’s protocol, definitions, and criteria or who are not thoroughly familiar with the NHSN specifications."

CDC and CMS felt this practice was not widespread, but the letter did include a comprehensive section on legal sanctions. Other reports have found significant under reporting with unaudited data. The most recent example is the underreporting of infections to governmental agencies which was found to have occurred with carbapenem resistant enterobacteriaceae infections associated with retrograde endoscopes.5, 6

One could argue that efforts to improve the reporting quality and encourage better and more complete reporting may bias year to year comparisons. Thus, we feel concerns persist regarding unaudited or unverified data. We encourage the CDC to expand their validation efforts. We are not advocating that unaudited data should be discounted but that auditing would improve its reliability and future year to year comparisons. The more reliable the data the better.

Outcomes measures that cover the broadest number of processes should be used. Thus, in the case of CAUTI’s, a metric should reflect both techniques for insertion and maintenance, along with the numbers of catheters used and intermittent catheterization. Unlike the proposed new metric discussed by (letter’s authors),1 a metric whose denominator was based on hospital discharges would not only encompass these variables, but also simplify the reporting for facilities. In addition, it would more clearly reflect what is most important to the patient, which is whether or not they developed a CAUTI during their hospitalization.
We would like to call on the CDC to continue its leadership role in the prevention of catheter infections by supporting value-based purchasing initiatives and we applaud its change in directions to develop metrics to discourage unnecessary catheter utilization, while rewarding hospitals who expend resources to implement catheter stewardship programs.

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1 (Submitted letter to AJIC)