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

To the Editor:

In their letter, Halpin et al describe the many institutions that have implemented initiatives toward the prevention of catheter-associated urinary tract infections (CAUTIs), but paradoxically Centers for Disease Control and Prevention–National Healthcare Safety Network (CDC–NHSN) data indicate the rates of CAUTI are not decreasing. Clearly, either there are problems with the metric and/or data, or gains have not taken place. The 2014 CAUTI data are currently available and the Agency for Healthcare Research and Quality metric indicates there are 7.6 CAUTI infections per 1,000 discharges,[1] 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 = 2,268 for acquisition dates January 1, 2014-December 31, 2014) compared with a 2009 baseline.[2] This is a large discrepancy in findings.

The data presented by Halpin et al, which we assume are from the full NHSN dataset and not data from the Partnership for Patients, found no decrease in urinary catheter use in nonintensive care unit (ICU) settings and only an 11% decrease in ICUs. US health care facilities not achieving a substantial drop in catheter use is simply unacceptable, because it is known that catheter use is a major risk factor for urinary tract infection. The Center for Medicare and Medicaid Services 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 overuse.

We also believe there are concerns regarding unaudited reporting of data. Among patient advocates, these concerns were heightened by an advisory letter sent October 8, 2015 from Beth P. Bell, MD, MPH, director of the National Center for Emerging and Zoonotic Infectious Diseases of the CDC, and Patrick Conway, MD, deputy administrator for Innovation and Quality and chief medical officer of the Center for Medicare and Medicaid Services[3]:

> 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 Center for Medicare and Medicaid Services believed this practice was not widespread, but the letter did include a comprehensive section on legal sanctions. Other reports have found significant underreporting in unaudited data. The most recent example is the underreporting of infections to government agencies of carbapenem-resistant Enterobacteriaceae infections associated with retrograde endoscopes.[4,5]

One could argue that efforts to improve reporting quality and encourage better and more complete reporting may bias year-to-year comparisons. Thus, we believe concerns persist regarding unaudited or unverified data. We encourage the CDC to expand their validation efforts. We are not suggesting 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, a metric should reflect both techniques for insertion and maintenance, along with the numbers of catheters used and intermittent catheterization. Unlike the new metric proposed by Halpin et al, 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 patients, which is whether or not they developed a CAUTI during their hospitalization.

We call on the CDC to continue its leadership role in the prevention of CAUTI by supporting value-based purchasing initiatives and we applaud the change in directions to develop metrics to discourage unnecessary catheter use while rewarding hospitals who expend resources to implement catheter stewardship programs.

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