NATIONAL QUALITY FORUM

Moderator: Suzanne Theberge
March 11, 2014
2:00 p.m. ET

Suzanne Theberge: Our members joined or committee members joined the line.

(Off-Mike)

Suzanne Theberge: Folks have their computer speakers on. That's what causing the feedback.

Ed Septimus: I got it. I took care of it.

Suzanne Theberge: Great, thank you. So, who was that?

Ed Septimus: Ed Septimus.

Suzanne Theberge: Hi. And this is Suzanne from NQF. I'm here with the rest of the NQF team. Anybody else on yet?

Laura Ardizzone: Laura Ardizzone.

Suzanne Theberge: Great.

Ed Septimus: Are the developers going to be on this call?

Suzanne Theberge: They should be, yes.

Ed Septimus: Good, OK, because there may be some questions that come up, so.

Suzanne Theberge: Yes. Yes, we have invited the developers to be on the call and we'll do a roll call.

Ed Septimus: In fact I see Dan Pollock is already online form the CDC, so that's helpful.

Suzanne Theberge: Great, yes.

Ed Septimus: It says here you're the leader.

Suzanne Theberge: I'm sorry?

Ed Septimus: It says you're the leader.

Suzanne Theberge: Is that Ed?

Ed Septimus: Yes.

Suzanne Theberge: You're being told that you're the leader?

Ed Septimus: No, you are.

Suzanne Theberge: Oh, Suzanne.

Ed Septimus: Suzanne it says.

Suzanne Theberge: Yes, that's probably just how the webinar is set up. That just means the slide – the person who advances the slides.

Ed Septimus: I'm only kidding you.

Suzanne Theberge: OK.

Ed Septimus: Relax.

Suzanne Theberge: We had some technical issues today with our SharePoint site and that's why I was getting a little worried there that we are having some other technical issues.

Have any other committee members joined and not introduced themselves yet?

And just a reminder, if you have your computer speaker on, please turn that off so the echo – that's what's causing the echo.

I think we're still expecting another three or four committee members, so we'll wait another couple of minutes to get started.

Are you able to see the PowerPoint.

(Crosstalk)

Male: OK, great.

Ed Septimus: I can see it.

Male: Great.

Suzanne Theberge: This is Suzanne from NQF. Has anyone else joined yet?

(Marcie Deed): (Marcie Deed).

Suzanne Theberge: OK, great. Any other committee members who have not introduced themselves?

OK, we're still waiting for a couple of folks. I know that several developers were planning to join us. Can any of you – or any of you on the line yet?

All right. You may be muted. If there's a – if there are developers on the line, we'll want you to have a chance to speak if the committee has a question for you. So, please press star 0 to speak with the operator and ask to be put in the main line. That way, you can answer any questions that might come up.

Dan Pollock: Hello? Hi.

Suzanne Theberge: Hi.

Dan Pollock: Hi. This is Dan Pollock at CDC. A colleague, Kathy Bridson, is calling in on a separate line.

Suzanne Theberge: OK.

Dan Pollock: Can you inform the operator to open her line for the appropriate time period when we're responding to the committee's questions?

Suzanne Theberge: Sure. Operator, did you catch that? Kathy Bridson, she'd get put in the main line.

Operator: Yes, her line is open.

Suzanne Theberge: OK, great.

Dan Pollock: Thank you.

Kathy Bridson: Hi, I'm on.

Dan Pollock: Thanks, Kathy.

Richard Dutton: Kathy, this is Dr. Richard Dutton and I'm representing the American Society of Anesthesiologists. And on a separate line this morning (Amis) and we'll want the same thing to have both our lines unmuted when it's our turn.

Suzanne Theberge: Great. That's – operator, if you can assist them.

Operator: Yes.

Richard Dutton: Thank you.

Suzanne Theberge: It sounds like someone may have their computer speaker on or just not be on mute. We're getting some feedback on the line.

(Karen Reilly): Hi, Suzanne, this is (Karen Reilly) at (RPI).

Suzanne Theberge: Hi there.

Albert Wu: Albert Wu's on the line.

Suzanne Theberge: Great. Well, I think we've got most of our committee members and all of our developers. So, we should probably get started. It's about five past two by my clock. So, we should probably get started.

Andrew, do you want to take it away?

Andrew Lyzenga: Sure, sure. So, just I'd like to first say welcome to all of our committee members that have joined us today and our workgroup members. I'll also note that this call is open to the public. We'll be doing a bit of time at the end of the call to see if there are any public comments. And we would also like to welcome a number of our developers on this call.

So, if you have questions about the measures that you would like to address to the developers, we should have at least some of them on the line. I believe we may have all of them or representatives of each of those developers. So, we should be able to get some questions answered as well.

Just to sort of remind you about the point of this call, we won't be doing our official evaluation on this call or doing any rating at this time, but this is really just a venue for us to hold some discussion on the measures given your preliminary review of them to walk through the criteria a little bit and how the measures sort of stack up against the criteria in your first read of them.

And again, to ask any questions of the developers if you have any or to give them sort of some guidance if there are things that you would like to know by the in-person meeting or anything like that.

So, I think what we're going to do is just sort of walk through the measures as we have them here on our agenda. We assigned some lead discussants to each of the measures here.

Hopefully, we've got the folks on the line who are the lead discussants and I think what we'll do is just sort of walk through each of the measures if we could have one of the lead discussants give a brief introduction of the measure to sort of some general information around it. And then walk through each of the criteria and just give your thoughts on the measure, any sort of issues you may have noticed, questions you have about it. And we'll open it up for discussion with the rest of the workgroup after that.

So, any questions about the process today and what we'll be doing?

Jesse Pines: No. (inaudible). This is Jesse. Just as a point of reference as our folks to have the measure evaluation guidance documented in front of you, it probably makes sense to – as we go through each measure, to actually have in front of you the NQF algorithm or the guidance for evaluating clinical evidence and also for reliability and validity.

And I think we had communicated this to the group that you know one thing that's changed is the – our staffs need to do to really adhere to these guidelines has increased dramatically (inaudible). So, we really have to you know we're taking a look at issues of criteria you know particularly for evidence, reliability, validity just to have that in front of you as a reference and also (staff around the line) to be able to answer any questions about this algorithm.

Andrew Lyzenga: Thanks, Jesse. You know that's a good point. That'll probably be a very useful exercise to walk through the algorithms as we're walking through these measures so we can get a sort of sense and feel of how to use them.

OK, with that, we might as well just jump into it. We are – I guess I should mention, we're talking about healthcare associated infection measures today. And the first measure on our list is measuring number 0138, the National Healthcare Safety Network Catheter Associated Urinary Tract Infection Outcome Measure. This is a CDC measure. And I know we've got a couple of folks from the CDC on the line. And they can answer your questions if you have any.

I don't know if I heard (Charlotte Alexander) …

(Charlotte Alexander): I'm here.

Andrew Lyzenga: You're here?

(Charlotte Alexander): Yes.

Andrew Lyzenga: Perfect. So, I know we have you, (Charlotte), Ed Septimus, and Albert Wu as the lead discussant. If you guys can fight it out amongst yourselves if you

want to for who's going to sort of introduce the measure or I can just call on (Charlotte) and you're the first person up there.

(Charlotte Alexander): I'm happy to introduce it and then I've got a question for Ed especially since we had a lot of input from – via the people online and I'd be interested in his comments on that as well.

So, this is an outcome measure. It is put forward by the CDC. The numerator is the observed healthcare associated CAUTIs or cancer associated urinary tract infections among patients embedded in patient care locations. So, that excludes level two or three neonatal ICUs.

And the denominator is the total number of in-dwelling urinary catheter days. There are some exclusions. Suprapubic catheters, common catheters, in and out catheterization, and (frosting) tubes are excluded.

And it is – how do you want me to go through? You want to go through the different things like the importance of evidence next or do you want to talk …

Andrew Lyzenga: If that – I mean, that's I think good for now, and yes, we could just walk – if any of the other lead discussants have any initial thoughts, we can hear those. But otherwise, yes, maybe we could just kind of walk through the criteria one by one.

(Charlotte Alexander): OK.

Ed Septimus: This is Ed. If I can ask a question with the developer. Dan, if I read this correctly, this is all CAUTIs both symptomatic and asymptomatic and it's house-wide, is that correct?

Kathy Bridson: Hi, this is Kathy. Dan, did you want me to …

Dan Pollock: Go ahead, Kathy.

Kathy Bridson: OK. This is Kathy Bridson. I'm one of the co-developers on the criteria. It does include all inpatient at its locations other than (NQF) has identified. And

it also includes not only the symptomatic urinary tract infections but also asymptomatic urinary tract that have a matching bacteremia.

Ed Septimus: OK. So, it's asymptomatic with a matching bacteremia. That was my clarification.

Kathy Bridson: Correct.

Ed Septimus: So, if you're asymptomatic without bacteremia, they're not in this measure.

Kathy Bridson: That's correct.

Ed Septimus: And is there any qualification in this measure about whether or not the only source is the urine?

Kathy Bridson: There is no clarification spelled out in here. In general, what – if there is another source of – I mean, for instance, if there's urine selected from a (frosting) tube or a different …

Ed Septimus: Let's say I have an E-coli. The patient is asymptomatic but they have a different organism in the blood or they have an organism in the blood that might be coming from a GI source that's also in urine.

Kathy Bridson: OK. So, physically if they have at least one matching organism, they could have some organisms that are not matching. So, if they have at least one matching organism in the blood and urine and they meet criteria for a UTI, the (abuti), then it would be considered (an abuti).

Ed Septimus: OK …

Kathy Bridson: It doesn't …

Ed Septimus: I wanted that clarification. I know currently for public reporting, it's only been in the intensive care unit, but this measure for public reporting would what be 2015?

Kathy Bridson: This is actually already publicly reported in 2014 outside of ICU.

Ed Septimus: OK, 2014, I'm sorry.

Kathy Bridson: Yes.

Ed Septimus: And this is a re-endorsement, correct?

Dan Pollock: It's a measure-maintenance proposal, Ed.

Ed Septimus: That's what I mean. OK. I appreciate you clarifying it because the asymptomatic thing with bacteremias cause some difficulty in terms of the infection preventionist. So, I just wanted to get some clarification on that.

Kathy Bridson: Yes, and I can provide you the rationale for that if it's helpful.

Ed Septimus: No you know I sort of – no, I understand that, but I'm just saying …

Kathy Bridson: OK.

Ed Septimus: … it's been from this – from the infection preventionist perspective who usually does this, it's been a little less clear for them.

And I guess the other point that this has been a problem for them is the overall patients who have a positive urine culture where they don't think the fever is coming from the urine.

Kathy Bridson: Yes. At this point, we are not able to identify or distinguish what the fever is coming from in all instances. In order to be consistent and make sure that the facilities are reporting things the same, we simply do not have facilities try to prioritize where they believe a fever may be coming from. And it's just black or white if they have a fever and they need the criteria then it's all reported.

Ed Septimus: I understand. At this point, I have two things that they've had some difficulty. I really appreciate the information.

Andrew Lyzenga: Thanks, Ed. Any other thoughts from the lead discussants or questions or comments on the sort of overall measure?

(Charlotte Alexander): Do you want to talk now about the exclusions and the comment that was made when it was open to the public about of how we request for another exclusion or do you want to go through the rest of it first?

Andrew Lyzenga: Let's walk through the rest of it. I think the exclusion piece will come in probably under the scientific acceptability portion. That's sort of an issue of reliability and validity that we can discuss when we come to that section. Does that sound good?

(Charlotte Alexander): That sounds fine.

Andrew Lyzenga: OK. And then we can look at importance first.

(Charlotte Alexander): Let me go to importance. Hang on one second. Let me get over to that area.

Andrew Lyzenga: And just for the committee's information, I just – I had neglected to do this before but I just posted up the algorithm on the SharePoint site on the main page as separate document, so you can just pull those up as an easy reference at this point.

Male: I'm limited in the number of screens that I can have open on my desk at this moment.

Andrew Lyzenga: Fair enough. We can also screen sharing when we're walking through it.

(Charlotte Alexander): I'm sorry, I'm still turning pages.

Andrew Lyzenga: Not a problem, not a problem.

As you're looking, I've got the algorithm up here and I'll just kind of walk through at least the first step or two. We can say at this point the question – the first question is, does the measure assess performance on a health outcome? And the answer to that is clearly yes.

(Charlotte Alexander): Yes.

Andrew Lyzenga: It's an outcome measure. So, the algorithm then leads us to the question of whether the steering committee agrees that the relationship between the measured health outcomes and at least one healthcare action, structure, process, intervention, or service, is identified and supported by the stated rationale in the measure. So maybe that's the next question which I will discuss here.

Is there a strong relationship between the outcome and some sort of healthcare actions that's supported by the rationale of the measure?

Ed Septimus: Yes, this is Ed. I'll just jump in and say the answer is yes.

Andrew Lyzenga: Yes.

Ed Septimus: And it is a priority and I'm sure that the CDC folks can chirp in, but we've not really brought CAUTI rates down to any substantial degree in the last three or four years and one of the more problematic measures that is tracking NHSN. Am I correct in that?

Dan Pollock: Ed, this is Dan Pollock. It's easy, absolutely. Thank you for that.

Ed Septimus: So, I think it's an important measure and it's one that we all struggle with. As I mentioned, there's still – so issues about clearing the definition, but in spite of that, this has been a stubborn measure for outcome indicator in terms of bringing down actual rates. So I think it does lot of importance on our evidence based interventions that had been associated with improved outcomes.

Andrew Lyzenga: Great. Thanks, Ed. Is there a general agreement among the other workgroup members?

Female: Yes.

Female: Yes.

Andrew Lyzenga: OK. And just as a reminder, for outcome measures, we do not have to evaluate the quality, consistency, and quantity of the evidence, the QQC, as we would for process measures. So, again, that's – well, this is really the core

question we're answering here is whether it's an important outcome and whether there are healthcare actions that can influence it and it sounds like the answer to both for those questions was yes from what I'm hearing.

So that I think actually sort of take us through importance and we can move on to scientific acceptability at this point and we have got another algorithm for that evaluation. And we're just pulling that up now as well.

And so the first question we want to ask here are about the specifications and whether those specs are precise and ambiguous and complete so that they can be consistently implemented. And do we have any thoughts on that from the workgroup? The precision and ambiguity of the specifications?

Male: Well, I guess the – there could be disagreement about the number of catheter days?

Male: And also, I think a good thing that's (inaudible) while we're discussing the acceptability with the algorithm too. So we start a few guidance for evaluating the liability and also the guidance for evaluating validity.

Male: Yes.

Male: Can you explain what you mean by – the side and the problem with catheter days other than the fact that it takes labor?

Male: Well, I think that it also takes precise recording of when for example a catheter went in or out. I think you can wind up with fractions of days or you could wind up a day off potentially.

Female: Is there any discussion and it's there, I missed it. Is any day where a catheter is there for any portion of the day counted as a whole day? And …

Kathy Bridson: Yes, of course.

Female: Yes. Sorry.

Female: Go ahead and finish.

Kathy Bridson: OK. Sorry, this is Kathy. The guidance that is provided is that the facility is to count the – or the location is to count the number of catheters that are present in patient at the same time each day and so (inaudible) the catheter was only in for a part of the day is not included is simply account at that point in time.

So, and then we do also allow for electronic capture of the data as long as the facility has done a manual account and then at the same time concurrently is collecting electronic day – catheter days and some comparing those two and making sure there's not a difference on more than plus or minus 5 percent. So if the measure doesn't identify partial days, it simply is a counting of the number at this time of the count.

Female: Thank you.

Male: So some facilities will go by at midnight to count the catheters? As an example.

Female: That's correct. They are allowed to identify the time of day that is most convenient and most accurate for them to select their patient risk.

Male: Any other thoughts on the specifications or questions?

Male: Yes, quite. I mean, when you're done with your validity studies, how does that work out?

(Crosstalk)

Male: (inaudible) done validity studies.

Female: At validity studies of catheter days?

Male: No. Just on the measure in general. They call CAUTI to CAUTI.

Female: Well, you recognize that there you know most of the validity size have been done by state health departments.

Male: Correct.

Female: As opposed to CDC and there has been a variety – variation in the findings related to that.

Ed Septimus: Have you done any (Capa) values or inter-operator variability?

Dan Pollock: So, Ed, this is Dan. We have not. I know that inter-rater reliability is an issue that has been attended to in a number of the state studies gets a concern for these observational measures. But I think the results by and large that we have seen from the state studies give us a measure of confidence that the measure impact is one that can be just characterized as reliable.

Male: I'm not speaking against it but again as I mentioned in my previous comments. I know unlike this particular measure does have inter-operator variability is still a very important measure and there's lots of opportunities for improvement. But I think this is probably one of the soft spots of this measure but I don't think in and of itself means it should not be re-endorsed.

(Jim): But – and this is (Jim). Just to point you to where that is in the (form) so under the validity testing that there were a validity in the number of the states, just a (redeploy) numbers here so that that (sensitivity) with 64 percent, specificity 92 percent, positive predictive value is 70 percent and negative predictive value with 90 percent.

Male: I mean, I guess the thing that I'd be most interested in since the sensitivity is pretty low but the specificity is high. I'm wondering if the sensitivity varies much by you know across organizations.

Male: I don't know that we necessarily have that type of information. Good question.

Male: I mean, if this is certainly you need at positive culture and certainly their place is the culture more, culture less.

Male: Sure. So it's you know you're in concept to what you're describing is probably a realistic expectation because there is – the evolutional element is to get cultured. But you know if the culture result is not you know in and of itself

always required but clearly there's going to be variation and diagnostic practice in place to place and that does have the implications for what's reported.

Male: So take a look at the algorithm here that the second question after the – one of our specifications does get into this question about whether empirical reliability testing was conducted using statistical tests with the measure I had specified.

Jesse, I think you just cited some results from some testing that was done. Have we discussed them, just taking a look at the testing data and do you have any thoughts on it?

Jesse Pines: No. I think they speak for themselves. I think – I'm comfortable of where we are but we always need better deposition that are out there, flatly more objective but they're reasonable.

Dan Pollock: So this is Dan of CDC. I think it's important of course to keep in mind that there is no gold standard definition of what is a urinary tract infection. And so that poses a certain amount of difficulty with respect to having consistency in methods that would be used in sensitivity analysis. So it would be great to have a standard clinical definition, great to use it for surveillance purposes but we're not there.

Male: All right. Any additional thoughts on (liability or validity) for the developers or just comments or thoughts of things we want to discuss at the in person meeting?

All right. Hearing none …

Male: Well, I think we need to re-discuss this issue just for the whole committee.

Male: Sure.

Male: But other than that, I can't think of anything specific.

Male: OK. In that case, we can move on to the question of feasibility.

Any thoughts from the lead discussions or any other workgroup members on the feasibility of implementing this measure?

Female: Well, much of the data is electronic, some of it maybe by hands. What is being done now and being reported and has been for a while. So I think feasibility is good.

Male: Well, some people are doing it electronically. We've been – but I think right now – of course the data is being transmitted to CDC electronically through the NHSN portal. But I suspect a lot of the collection of data is still mostly – is mostly manual.

Ed Septimus: And as I understand, this is not an electronic measure, it's not an e-measure, correct?

Dan Pollock: No. This is Dan. That's correct, Ed.

Male: OK. Any other thoughts on that issue?

Male: Well, the usability of the measure, use and usability and so sort of getting to the end user to some degree a question of whether the results of this measure are meaningful and usable for to make healthcare decisions or to use for payment purposes for example or other accountability purposes, any sort of questions about the application or usability of the measure.

Female: Well, to show the 16.1 percent reduction in quality rates when they did one study of for over 14 months. Intervention data collection so it seems to work though we haven't fixed it for everyone. And it is being reported so I think usability is there.

Male: Yes what's that initiative in the keystone project and some of the other cost projects certainly show that if you really roll up your sleeves that you can make a difference.

Laura Ardizzone: This is Laura Ardizzone I think it's a great measure for quality and I think it's important to keep measuring it. I do think though because of the problems that we've all said with there's not a standardized kind of measurement where

unsure some people maybe reporting it differently that I don't think it's the point yet for reimbursement. Or people being unfairly penalized because they're reporting it differently or you know what I'm saying.

Albert Wu: Yes it's Albert so I mean I think I agree with that there is certainly you know the more you test the more you know more likely you are to find (CAUTIs) and that the issues is probably in the wrong direction. So you wouldn't want to discourage people from testing so that they look better. Which would sort of make you feel less enthusiastic about using this for accountability.

Male: Again to remind everybody on the call we do at this point the NQF policy is that we when we endorse the measure it is for the purposes of both quality improvement and accountability including public reporting or payment purposes. And we are sort of exploring questions about endorsing what we're calling fit for purpose. And looking at the questions of how it's going to be used and maybe endorsing for the purposes of the quality improvement or endorsement for public reporting or payment.

But at this point if measure using NQF endorsed that means we are recommending that it is suitable for both quality improvement and accountability purposes. So this is one thing to keep in mind here.

Male: So in sort of a general question which you know I'm novice to this. How much this sort of inter organization reliability is required before you know a measure is judged to be adequate to compare those two different organizations?

Male: Well it's sort of a question for the committee to some degree let's say sort of subjective decision to some degree on and using of the developers submission as a guide in the testing results that they've done around reliability and whether the – we don't give any sort of threshold that measure needs to meet in terms of any you know reliability statistics, or any particular inter-organizational reliability.

It's sort of a question that you kind of have to answer as committee members whether you think that the measure does meet a standard of reliability.

Male: All right. So for each of the measures that you know go to the algorithm, we – you know the committee will you know should look at the algorithm and sort of see based on those criteria where broadly, the reliability and validity fits within you know within those criteria.

And essentially, it can get us a rating of high, moderate, low, or insufficient. You know for this measure, this is actually one of the measures that did go through staff review and their thinking from the staff was that the validity testing was – should be rated here as either moderate or low depending upon how the you know the interpretation of some of the (inaudible).

But ultimately you know if something is rated as low, the committee can still both you know based upon their overall impression of the measure.

Female: And this is (Leslie Schultz). Kind of the shipment sales in terms of payment and policy, is this is one of the triple (threat) ones, isn't it?

I mean, this (inaudible) in the HAC reduction as well as other things.

Andrew Lyzenga: I believe so. The developers may have a better sense of that, of what program is being used at the moment. We actually will talk about that at the in person meeting a little bit as well. Take a – we'll kind of review the safety portfolio and take a little bit of a look at the – which measures are in which programs and that sort of thing until then.

Dan Pollock: Andrew, this is Dan. Presently, the quality measure just figures into the inpatient quality reporting program which was the paid-for reporting program, not the paid-for performance programs.

Male: Thanks Dan. Just so we move things forward, I think we've also (inaudible) discuss the comment that came in on this measure. So Andrew, you can describe that.

Andrew Lyzenga: Yes. So (inaudible). We got a number of comments on this measure and just try to pull one up here. Related to patients with spinal cord injuries, and I don't know if our workgroup members have had a chance to look at those comments, they claim that the measure may not be appropriate for patients

with these spinal cord injuries that's leading to a number of problems and again, trying to pull those comments up here.

Female: They were fairly consistent though there were a number of them and from different places. They were all saying about the same thing.

Male: Yes. It appeared to be a sort of coordinated campaign of some kind.

Female: Yes. Still the same introductory paragraph.

(Crosstalk)

Male: And that has never happened with NQF before. Just sitting around with a spinal cord injury, you might have a little extra time on your hands.

Female: (Inaudible) 684, the long-term care percent of residents with urinary tract infection.

Female: No, this is about the CAUTI. And – I mean, their points were good. It is a very different patient population than how we're usually thinking about hospital acquired CAUTI by you know not doing catheterizations and good things like that.

When you've got a spinal injury or you've got a documented neurogenic bladder, that's kind of a different kettle of fish.

Male: And also, just (inaudible) if you take a look at the numerator and the denominators and exclusions, that might be a good place to look at. I'm not sure that's you know one of the questions that I had is I'm not sure the answer to this would be with spinal cord injury patients gets medically excluded because they would fall into one of the other denominator exclusion such as having a suprapubic catheter, (inaudible) catheter or you know some other – one of these other exclusions.

Female: This is Kathy from (inaudible). Several – the majority of those spinal cord injury patients are not excluded – I don't believe from the input that we have from our users.

Male: OK.

Female: We did review the public comments from the rehab facility. And you know we understand that they're concerned about the use of fever, sort of that's the only symptoms in combination with the positive urine cultures that's (inaudible) there. And their concerns about being potentially compared to other facility types or population type.

When we look at our data in reality about 80 percent of all of the parties that are reported in NHSN really only had (inaudible) the only symptom. So – and that's for all patients whether it is a spinal cord injury or not.

We have put on our new – on our annual survey form that is the quarter participation for rehab facility and new questions that will collect information and the proportion of patients that are admitted that are at the specific place in one of those places is spinal cord injury.

And you know we planned – we're looking at that data as we get (inaudible) 2014. We planned to be looking at that as a first step to evaluating (inaudible) station population uniquely with regard to the CAUTI reporting.

And also, I know that there were some concerns about being – these patients being compared to other facility types or whatnot. But historically you know CAUTIs have been risk-stratified by locations site and so that the CAUTI rates from rehabilitations as compared to other CAUTI – from other reallocations and that to other locations like (inaudible) was standardized and infection ratios are determined.

So again, (inaudible) interest reports notes, spinal cord injury (inaudible) and then we have facilities there is associated with the CAUTI then we'll be using that information for future decisions about risk stratification. But as it (inaudible) right now, we just don't have that information.

Male: Let me ask you this, the people who made that comment know that there is at least – that this is reported by units so you're being compared to other units that are far similar?

Female: I guess I can't really answer what they know and what they don't know. We do teach this in our training and you know are reported by location sites with the (FIR) as listed. So they should be able to understand and I can't say (inaudible) you know they're all doing that.

Ed Septimus: Well, I think the key response is that if they feel comfortable enough that at least they're not being wanting the other non-rehab facilities, that at least there is some comparison between (likes).

Female: Well Ed, there are a lot of different rehab facilities. There is a rehab facility that's total (inaudible) to normal bladder whereas the ones that are spinal cord injury or neurogenic and then entirely different animal.

And so I guess my question is, is it stratified enough or is the question detailed enough that you're going to be able to tell that you're comparing spinal cord injury (inaudible) facilities against each other or are they going to be lumped in with all rehab facilities?

Female: So (inaudible) is that we're using the categories that the facility utilize themselves when they describe themselves. And I know it includes like, total brain injury, spinal cord injury. I think there are five categories. I thought I have them right here and I don't find them. So you know that's what we're utilizing is the categories that they utilize themselves when identifying themselves.

Male: I guess my suggestion is that we lead in and maybe do a little bit of research to see how that's being reported so we can answer that question at the face to face meeting. That would be my recommendation, if that's OK with everybody else.

Male: Yes.

Male: We're talking about making an inclusion, correct?

Male: And that I think is the question or request from the commenters whether or not it should be – whether spinal cord injury, patients should be excluded from the measure.

Female: (inaudible) again, the only thing I would want offer in this discussion is the fact that we would have to have a way of excluding those patients not only from the numerators but from the denominators. And that could cause some problems for infection prevention to be able to identify not only when catheter days or patient days (inaudible) patients that have CAUTIs but when they're also from patients that don't develop CAUTI. So to be able to pull those out may create some burden for (inaudible).

Dan Pollock: So this is Dan at CDC. The CAUTI measure is already in use in inpatient rehabilitation facilities. We have been in discussions with (inaudible) over many months. As Kathy mentioned, we've incorporated into the annual survey, questions that we'll provide, strata that we may well use in our risk adjustment. We have to analyze the data first.

As Kathy also mentioned and I'll just reiterate, remove spinal cord injured patients from the numerator means also removing them from calculations with catheter days. It is a burden to actually do that. So that has to be reckoned with.

There are other patient populations for which risk of catheter-associated urinary tract infection may be high. We would be opening up a likely scenario where there would be additional input calling for those patients to be excluded.

Our strategy is to do our level best to incorporate those increased risks in a risk adjustment methodology rather than an exclusion methodology. After all, these are patients who are at risk for catheter-associated urinary tract infection.

And so we think not sort of including them in the measure to begin with are far way the types of issues that are being brought up which we readily acknowledge needed to be addressed but we need an opportunity to address them deliberately and not jump to the conclusion that spinal cord injury patients should be removed altogether.

Ed Septimus: This is Ed. Can I make a recommendation because we're probably going to run short on time?

Male: Yes. Yes, go ahead Ed.

Ed Septimus: Yes. I guess I'll sure been here as (inaudible) but I wonder if we could finish this measure and then we can all obviously have those questions for the face to face meeting but try to quickly move on to (inaudible) which I think will go a look faster.

Male: Yes. I think that sounds good and we'll reach out to maybe some of the commenters and see if we can get somebody to join us with the in person meeting so we can have a bit of discussion around this issue there.

So yes, let's go ahead and move on to the CLABSI measure. At this point I think we've got the same lead discussant. We should have probably pretty similar issues around this measure. I would imagine as around the county measure but either (Charlotte) or Ed, if you want to take a quick – give us a quick summary of the measure and any preliminary thoughts?

Ed Septimus: This is Ed. Since (Charlotte) did such a great job at the last one, thank you (Charlotte). This is again, a (inaudible) to the endorsement, a re-endorsement, and again, I'll have to ask our CDC folks, you've got NBIs in here as well. Social barrier, isn't that new?

Male: Well, a good question Ed. It's actually been voluntarily reported throughout 2013. It's new but it's been in the works for quite some time. It's in response to concerns that patients with mucosal barrier injury who have bacteremia are at this higher risk for having that bacteremia due to the mucosal barrier injury rather than to a central line. So, we are reckoning with that and we're capturing data. Now (inaudible) began, we may well be using as part of the way that we summarize and report up these data in the future.

Male: Right. And so this measure and the way you're currently doing it now, you're lumping NBIs with the total CLABSI rate, correct?

Male: Well, we are but we're then having the opportunity to differentiate the bloodstream infections that are due or attributable to mucosal barrier entries in the bloodstream infection that are due – or attributed to central lines.

Reporting is actually at the levels of bloodstream infection. And we capture on the bloodstream infection, data collection form, a presence or absence with central line, presence or absence of a mucosal barrier injury. So in a sense you know we're in the position now to have another metric that would be exposed into the mucosal barrier injury patient.

Male: Right. I understand that but for this measure, it's being lumped in together, correct?

Male: Correct.

Male: It (inaudible) may separate that. I just want to make sure that I had gotten that.

Male: Correct.

Male: And this is also (inaudible). I can go through this pretty quickly. I think the evidence here is obviously very strong. There is clear evidence of what evidence (inaudible) intervention and reduction of CLABSI rates. We've done actually better with CLABSI rates than we've done with CAUTIs, but there are still some opportunity and of course, this is going to be (inaudible). And I think the long-term acute care is also under this measure Dan, is that correct?

Dan Pollack: Yes Jesse.

Jesse Pines: OK. I just want to make sure that everyone understood that and the NBI issue. But as far as the evidence, the acceptability for the measure, the feasibility, reliability and validation, again, most of the validation has gone on at the state level. But in this case, isn't CMS doing some validation as well? Is that correct for CLABSI?

Dan Pollock: Yes they are.

Male: Yes. So that's been ongoing. So I think this has got a little bit – little stronger validation. Obviously, there is some burden in reporting. This is not an (inaudible) measure so it's very similar to CAUTI but still very doable.

And in terms of a measure that can be used for accountability and improvement purposes, I think it can. And I don't see any other competing measures right now. So this one, I think is a little bit more straightforward as occasionally, some subjectivity on what people call CLABSI but I think this is a little bit tighter than CAUTIs. And I just wanted to bring the attention of people who are maybe not in this field that are on the committee. And Dan has explained it very well about the (inaudible) and how the CDC has began try to separate those that might be translocation, bacteremia in patients who have lines and potentially separate that out from the CLABSI rate.

So, I think I've covered all the key elements I think. So I do think it's more of a reliability, validation is moderate in my opinion and certainly feasible. And I think it's definitely usable. And it's a high scientific acceptability.

Male: Thanks Ed. Any other thoughts from other workgroup members or comments?

Laura Ardizzone: This Laura Ardizzone. And I would agree. I just had to question for the developers. I was reading, it said they had specific locations that were not valid for this type of surveillance like (Ors), cardiac cath lab, C-section rooms, (IR).

And you know coming sort of from that world, I know there are a lot of temporary and permanent lines placed in that kind of environment. And I was just wondering what the thought process was for excluding those locations.

Female: This is Kathy. Most locations are excluded because they're not (inaudible) locations. So we can't speculate a rate for the locations because we don't collect central lines days or inpatient days for that location.

So it's not to say that those you know in-persons that are done in those locations are not important, they certainly are. But we simply can't attribute

and we can't calculate a rate for them. So we attribute them to another location. We have you know ruled and identify those.

Female: So then they are captured in the (inaudible) days as they become inpatient or something?

Female: Absolutely, yes.

Female: Had been missed.

Female: They're not being missed. They're …

Female: (Inaudible), OK.

Female: … not attributed to those types of locations that are not (inaudible).

Male: Thank you. Any additional thoughts, or questions, or comments? All right, I think we're good with that measure then for the time being. Nothing to bring up on the workgroup call. So we can go ahead and move to the process measure. We've got a workgroup that is (inaudible) for prevention of catheter-related bloodstream infections (inaudible).

As the (ASA) measure and I believe we also have representatives from the (ASA) on the line, (inaudible).

Richard Dutton: Yes. This is Dr. Richard Dutton.

Male: Hi. Great. So if you have any questions for the developers, you can ask them. (Laura), I think we have you as the lead discussion on this one. Do you want to give a quick intro to the measure?

Laura Ardizzone: Yes, a quick intro. This is (inaudible) presented by the (ASA). This would be the (inaudible) process measure, not an outcome measure. And it's the percentage of patients regardless of age who undergo a CDC insertion and have all the elements of maximal sterile barriers techniques, hand hygiene, skin prep. And as an ultrasound (inaudible) that sterile ultrasound techniques are followed.

From kind of capping off all the people, all our committee members who look at this, I think we sort of feel based on the logic that there isn't a ton of evidence. However, possibly, this is an exception.

It's OK to hold the providers accountable without sort of evidence because this is an important measure that doesn't measure an outcome but measure as a process and it's important.

I do think there were some confusion from the committee members about the gap in care. Yes, a lot of the people aren't reporting on this but then again, their data set only captures about a quarter of the workforce. So we – and we thought, possibly, there could be some bias that you know the people who are in this workforce are either reporting even – could be higher than what the rest of the people are reporting which would be kind of scary since not everybody is reporting this.

I don't think we felt that any of it is – there should be no stratification for disparities. It isn't kind of an important priority as we know healthcare infection and central line-associated infections cause a lot of burden on the healthcare system and on patients. It is a high prevalence, high severity, high cost.

Reliability, I guess testing. If we were going to go by the algorithm here, it's sort of insufficient. Let's see, the validity, I think we gave it moderate. Let me see if there's anything else (inaudible).

I think people felt also that it was feasible to do although there is a bit of a burden on it because not everybody is doing electronic health recordkeeping. And it sounds as though not everybody is reporting this and that there's a large variation in what people are reporting.

My personal thought is I think it's important (inaudible) captured many places but I do think it would be better served as an outcome measure that we're measuring CLABSI infection rate versus whether somebody is following maximal barrier precautions or not.

Female: Hi. This is (inaudible), actually (inaudible) topic.

Laura Ardizzone: Oh great.

Female: And I completely agree. I think we should be following outcome measures. I think the process measure, I also happened to do information technology for my group. I think it's going to be really hard to collect the data on this as a process. So I think obviously an outcomes measure would be a better solution for this.

Male: Thanks both of you. Any other comments from the other committee members?

Albert Wu: Well – it's Albert. The only sort of an added feasibility problem is it is difficult (inaudible) put it all over the place in the hospital and not just sort of in the OR. It's basically more challenging to be ready to collect the data at any time in any place.

Female: So I have a question. If we're already collecting central line infection with another measure, is there a place to make the use of a maximal barrier in protection as a subset of that or a stratification of that?

Male: Well, the other CLABSI measure that we just took a look at is an outcome measure. So I don't know if we could – you know we'd stratify that to identify adherence to processes.

(Leslie): And this is (Leslie). I think if we have a very robust outcome measure and folks look at their performance on the outcome measure and find they have a problem, then you'd back up to a process measure and whether or not we need to endorse this one or NSHN clip, we've got some really good process measures. We can use them locally for performance improvement. But if we endorse a process measure and we have a much more robust outcome measure, it kind of seems – I don't find the value in the process measure in that instance.

But for performance improvement, I mean, this is a nice handy one to have because you can use this as a diagnostic with these things reliably. If the answer is no, then we're going to – we're cut out for.

Richard Dutton: Hi. This is (Rick Dutton), a developer. I agree totally with what you just said. We obviously need both the outcome and the process measures here. But the purpose of the process measure specifically for anesthesiologists (inaudible) anesthesia (inaudible) perspective is for performance improvement at the local level.

And there is no question in the literature, in our literature that's essential to these measures has produced changes in the long-term (inaudible). That was the (inaudible) few years back.

(Crosstalk)

Laura Ardizzone.: I'm sorry, I think we lost you.

Richard Dutton: Sorry. Can you hear me?

Laura Ardizzone.: Yes. Now, you're there.

Richard Dutton: OK. Sorry. I'll be louder. No trouble with that.

Laura Ardizzone: All right, thanks.

Richard Dutton: We agreed that an outcome measure is totally appropriate as well. We see this process measure as partnering with that in exactly the way (inaudible) described as a way of getting to individual performance and in improving that inside a practice, inside a facility.

From the anesthesiologist perspective, we see what we do when we put the central line in. We don't see the result which might happen days or weeks later of the line infection. So in terms of doing performance improvement for anesthesiologists focusing on the process has worked well for us. And as I was saying, the studies from Peter Pronovost in the State of Michigan that was reported, I think it was in the (inaudible) journal but it's in our evidence base showing that attention to this kind of process will lower your outcome rate, is very important. And so one of the purposes for us to perform this improvement here is to push everybody to do this.

I can speak briefly about how the measure is collected to hit those questions. When the line is placed, there is documentation in the medical record that appropriate precautions were followed. And that can be by the provider who placed the line or by a nurse watching the procedure.

If it's an electronic record, obviously that documentation is in the form of checkboxes in the electronic record that go straight into the registry or wherever you're capturing it. If it's paper records, it would have to be abstract coder in order to submit for this measure.

As we pointed out, there's a very big gap in the number of people who are reporting the measure. Those who do report it tend to do very well when it is reported. And I agree completely with the previous comment that there's a bias in who's reporting it. Obviously, it's the organizations that are better able to do it and are getting good results. But our goal obviously is to get everybody who report it and for everybody to have good results. We're a long way from that right now.

Male: Thank you.

Ed Septimus: This is Ed. Do you have any evidence of other things other than insertion? For instance, how the lines are maintained after surgeons in the operating room based on some of the studies that were done at Dartmouth?

Male: I don't know if the CDC folks are still on the line but sure, there's a rich literature around how you take care of the line after it goes in. How create sterile reports and injection into the line. How you dress the wound site, and even you know what you put in it, big difference between crystalloid and TPN in terms of your line infection risk, and then obviously all the other risk that's going on with the patient including the previously mentioned open wounds, other sources of bacteremia et cetera.

Those things start to run out of the control of the anesthesiologists who's the person I'm trying to measure performance for. So, we focused just to in the act of putting it in, which we know is part of this, but by no means (inaudible).

Male: Thank you. Any other general comment from the measure? Probably we move through the last one pretty quickly. So, if we want to we could walk through the algorithm on this one as sort of up to the committee if we want to get into you on this call.

I know it sounded like there were some concerns about the evidence (inaudible).

Male: Well, I'll speak just from the developer point of view. The evidence to this is mostly empiric. And we know that if we do all this things and are diligent about it that the line infection rate goes down.

But this is a bundle of care and it's impossible to find studies or do studies that look at single pieces of it outside of all the other pieces, you see what I mean. And, given the numbers involved and the power you need, I don't there would be any way to randomize to do a prospective study of these elements. I certainly wouldn't volunteer.

Male: You could do a good observational study if you really collected the presence of absence of all of the data elements and see if (inaudible) example if there and some risk adjustment you can see whether or not you know missing one or another of the factors was more less (inaudible).

Male: True. So that can be appoint of discussion again at the in-person meeting whether really feel that the evidence and studies done has been sufficient in whether you would like to recommended the developer any particular approaches or anything like that.

Jesse Pines: I just (inaudible) where the – this is a form of (inaudible) review and is addressed to the page on the evidence algorithm. If you think of (inaudible) as sort of the pathway of (inaudible) or towards the bottom of the box 789, that was really the thinking there, because there was really no formal rate of the evidence or any systematic assessment of (inaudible) in this area. So one of the question for those (inaudible) maybe sort of lies on this (inaudible).

So, I'll read just it for (inaudible) do you agree that (inaudible) beneficial (inaudible) accountable at the performance in the absence of interest of

evidence of (inaudible). And again you know I think the developer did mention the (inaudible) this area, the recording to our (inaudible) that there's a lack of (total) grading and any systematic assessments pertaining to (inaudible) there's other division (inaudible) or sort of (inaudible) exception to that, so ultimately (inaudible).

Male: Thanks, Jesse. So, that again is something we'll need to have longer discussion about I think at the committee meeting whether we would like to grab that exception and we'll probably walk through the algorithm in more detail and sort of see how it applies to this measure in particular as well as others, so more to come on that.

But any issues anybody would like to bring up at this time on the measure or any questions or comments. All right, I'm hearing none, I guess we could move on to the next one.

Leslie Schultz: OK, this is Leslie Schultz. And my partner in crime was Martha. And I will just lead off here.

We are now looking at 0684. This is the percent of residents and these are long stay residents with the urinary tract infection. The measure steward is CMS. The measure is one item within the minimum data set 3.0, now 2 version 8. Measure estimates the percentage of long stay residents who have a urinary tract infection on target MDS assessment. And there are specified times when this MDS assessment is done on a resident. In order to address seasonal variation, this measure usually the six month average for the facility. And again, long stay residents are those more than a hundred accumulative days at the facility.

(Of note) is that this UTI quality measure is the only infection measure currently in use in a long-term care setting. And so it is an important quality measure, particular (inaudible) level of looking at the continuum of care. The numerator and denominator are well specified who is in and who is out. The important thing is the exclusions on the denominator are well described and sound in terms of the exclude folks who are being assessed at the time of

admission because they may actually have had a facility as an hospital-acquired UTI that now presents itself in a long term care setting.

And so you really probably don't want to be holding the nursing home accountable for that. If you were a readmission or return assessment, again you're getting this person, this resident back from another care setting.

It is an outcome measure, the data source are electronic, clinical data, it is not an emeasure, the levels of analysis is the facility. And this is a proposed re-endorsement. So the MDS, the minimum data set is well described in terms of the reliability and validity. Note the measure has – the MDS itself has gotten more stable, more precise, more relevant in going from version 2.0 to version 3.0.

And this particular item, we continue to see nationally steady, it'll be at somewhat modest, improvement nationally with the most current data which would be quarter two 2013, a mean nationally at 6.2 percent of long-term stay residents which is down from 9 percent a couple of years earlier. We're talking a rather large and some over 13,000 organizations or facilities over 1.1million residents. There is variation across the nation between facilities, there are organizations who are reporting zero, and that's about 3.5 percent of the facilities.

In the 90th percentile, like we're looking at worse performers is about double the means, so it's 12.9 percent. So there are a lot of patients or residents with UTI.

There is no risk adjustment and that does not – a missing data. It doesn't seem to be a meaningful concern. It does not seem to be a meaningful concern with disparities. The MDS itself has continuing and demonstrated reliability and validity.

As I said 3.0 is a tighter version than the MDF where this measure originally stem from. This item is posted to the Nursing Home Compare and it is publicly reported and out there for folks who are looking at you know "where should we place mom or where should I place myself". I think the concerns that we saw are there is probably an opportunity for more robustness. If I

could, if it were more aligned in some regards with the efforts underway on the inpatient side using NSHN CAUTI because right now, this captures UTI.

And those are UTIs that were documented by a physician, a PA, a nurse practitioner or in some cases, a clinical nurse specialist. For someone at the facility, these are the evidence in checks off the box, yes this person I'm looking back with over the past 30 days backing up with exclusion, this person have documentation of the UTI. It does not differentiate whether catheter – associated or not. So this is all UTI.

Question for the developer might be I mean if there's an opportunity at some point to look more closely with NHSN and look at NSHN CAUTI SUTI, the Symptomatic UTI criteria, and would that add value to the robustness of this individual item.

I don't know if we need to reflect or incorporate that earlier concern about our spinal cord injury patients or long-term stay patients with neurogenic bladders. Are they somehow different or not, this is all long-term care setting and so I don't believe there's any differentiation or profiling. Or maybe there is an – the measures to the developer could kind of map if there's any sort of the stratification by long-term care facility criteria or profile questions.

So, I mean in the bigger picture where does that step? Will better overall quality of care, making care of more patient-centered you know if it's a CAUTI, there are things we know about how to prevent CAUTI, "Don't catheterize me. How to take care of me." If it's UTI not catheter-associated, well then the processes of care maybe related to hygiene, hydration, mobility, et cetera.

The cost of a UTI is across it society bears or the patient (bears or you know. So this is our part of reducing the overall cost of healthcare because if I do develop a UTI in a nursing home setting, I'm probably going to require more resources and I could eventually have a you know unpleasant outcome if we – if we don't take care of me good enough.

I think the alignment – if we could somehow align this on the single infection measure in a long-term care setting, with NHSN criteria somehow on the

inpatient (inaudible) so we could have greater continuity from acute care CAUTI to long-term care CAUTI. I'm not sure what we can do about that but the consistency would help.

So, all in all, a good measure, a useful measure, it is important. The reliability and validity and the measure properties of the MDS (inaudible) pretty descent, moderate to good, feasible is this the long standing assessment care process measurement approach that's been used for many, many years. The MDS 3.0 is – is more frankly relevant, it's more precise, it's more stable than the original version. It's already out there for (inaudible) and hospital compare or nursing home compare, pardon me.

And so it's – it is – it is already in the accountability measure. It is an improvement measure. It's not a bad measure.

Male: Great. Thanks, Leslie. Any other comments from the committee members?

Martha Deed: Well, the only other thing I would say, other than thank you, Leslie because that was a wonderful presentation – this is Martha Deed. I have a patient (inaudible) and this particular measure, I think is one of the ones that people I know have been really relying on pretty heavily. It's kind of immediately understandable to a lay audience I think.

Laura Ardizzone: This is Laura. If I could just – it really – it does bother me a little bit if there's absolutely no risk adjustment at all. So, it's hard to tell you know because facility A has a 6 percent rate of UTI and facility B has a 3 percent, that doesn't necessarily mean that A is doing a better – B is doing a better job than A. I mean they could have you know there's a lot of reason of higher risk of UTI and it was – the steward in the data.

Gender differences, comorbidities, traumatic brain injury, steroid use, diabetes, I mean there's so many – and I'm not saying that each one of those should be – they should be considered when you're reporting such a straight rate especially if consumers are looking at it, and that there's no differentiation for that kind of (sticks) a little (long) with me.

Leslie Schultz: Well, I think one the thing that happens in practice is you see afigure and you talk with the people at the facilities that you're considering and you get that information.

So, I'm not sure if it's need to be presented in general but as it's being used by the people that I know, that how it gets used. So you go to facility A and find out you know they have a whole bunch of ventilator patients who are subject to complication that obviously you don't want them to have complication either, but you understand the difference between what's going on with that group and what's going on you know with your elderly mother who you know basically is having dizziness. And that's one reason why she you know needs to be in this kind of a facility. So, is that lower risk?

And so then you have the conversation about what's happening with people like your mother and that institution. That's my thinking anyway.

Male: I know we've got the developers on the line here. Have you considered doing risk adjustment on this measure? Is there a rationale for not doing risk adjustment?

Laura Smith: This is Laura Smith from RTI. I'm going to start and then (Karen Riley) (inaudible) if anything that I'm leaving out. So, during the initial development of the MBS 3.0 of version of this measure, risk adjustment did get got discussed. There were a couple of factors that were in play at that time. It was decided not to – risk adjustment measure, one was that the prior work that has been done on the 2.0 version of the measure had been inconclusive in terms of identifying effective risk adjustors that gave – there were sufficiently predictive and had a good discrimination in the model.

The other factor though that came into play in the discussion was a couple of issues related to, I think there's – weighing out concerns about the interpretability of measures for consumers when you apply risk adjustment. And then the other sort of I think bigger argument that got put forward was this notion of the fact that there are facilities that are able to identify high risk residents and do well providing them care. And to – risk adjustment doesn't recognize the potential for being able to handle high risk residents at a high

quality facility. I want to just pause for just moment to make sure that (Karen Riley) doesn't have anything that she wants to add to that.

(Karen Riley): No, I think that's right. In – as for your second point, it penalizes facilities who are taking on with higher risk residents – doing well. Yes, (inaudible).

I did start only – ongoing concern on something that we monitor during the maintenance work, but those were the main sort of reason for the measure as it currently design that it's not adjusted.

Male: Great. Thank you. Any thoughts from the workgroup members on that rationale for elective risk adjustment?

Leslie Schultz: This is Leslie Schultz again. The only think I would ask do Laura and (Karen) is at some point might you consider segmenting catheter-associated UTIs from UTIs or non-catheter (inaudible). Laura, do you want to speak to that?

Laura Smith: Sure. So, certainly this is a decision that also – CMS is the steward that's involve with, but and I don't know whether or not (Teren Mullin) has her line open, but we were just conversing by e-mail that certainly that something that CMS would consider in the future.

One of the issues with the NHSN system is just simply at the moment it doesn't have very much penetration into nursing home setting. So – these are things to learn certainly from how the measure is specified for the NHSN measures, but that system I believe is only about 7 percent of the (nursing) facility have in that system in place …

Female: Yes. I think it would be you know probably a pretty sound move at some point in time to at least do a pilot of maybe looking at the SUTI criteria, the Symptomatic UTI criteria, to see if maybe those could be put in place. It just adds to the robustness of here are the criteria of what one would have to find evidence for to definitely say this was a UTI – a symptomatic UTI.

(Karen Riley): This is (Karen Riley). When we explored this initially, we were trying to use MDS data that was available to us, the items in the assessment. And when we looked at this and try to align the loop back periods for the UTI, and that loop

back periods was 30 days, with another item on the assessment which was looking at intermediate catheterization. And that loop back period for that item was seven days. So, they're in a manner that the data is being collected for focusing on the MDS data, there's challenge in there. Not (inaudible) insurmountable but it is something that we would consider in the future.

Male: All right. Thank you. Additional thoughts or comments on this measure or are there any aspect to this measure? It doesn't sound like it.

In that case, at this point we might as well check to see if there is any public or member comment. Operator, could you see if there is anybody on the line who'd like to make a comment.

Operator: At this time if you'd like to ask a question or have a comment. Please press star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

We have a question from Matthew Davis.

Matthew Davis: Yes. This is Matt Davis. I am the (inaudible) that coordinated that effort along the spinal cord injury regarding the catheter-associated UTI measure. And I have patients here going into acute renal failure because they're pulling out these catheters on my patient in the acute care hospital. In the acute care hospitals are really equipped to handle intermittent catheterization. They don't recognize the importance of that in this population. I think that's something – it was kind of missed in your earlier discussion. And I think there are lots of nuances in this particular population that are kind of being missed in the discussions I've been hearing so far.

So you know I think someone had mentioned that you would might want to reach out to somebody who's been involved in this. I would love to spend lots of time talking to somebody on the phone about this, kind of explaining the just the unique characteristics of the spinal cord population.

Andrew Lyzenga: Yes. This is Andrew from the NQF staff. If you'd be available to join us at our in-person meeting or on the phone for our in-person meeting to sort of engage in some discussion about this issue there, that would be great. We'd

be happy to have a phone call with you as well to you know get some additional input, that would be great. So we can reach out to you separately about that.

Matthew Davis: OK. That would be wonderful. The in-person meeting is going to be, where is it? On like Washington DC or something.

Andrew Lyzenga: It is in Washington DC. I believe it's April 17th and 18th is when we have it scheduled.

Female: Yes, that's correct.

Andrew Lyzenga: OK.

(Crosstalk)

Andrew Lyzenga: You can call in you know and be on the phone for it as well if that works.

Matthew Davis: OK. Yes. I definitely do either one of those two options, and you know I have to see if I can take off that time. We'll see – we'll see what happens. OK. Great.

And so, that would be a time where I'd give a little bit more time for a little bit open discussion about this. I think we got kind of a short 10 minute time right now.

Andrew Lyzenga: Right. Yes. I believe so. Do any of the committee members or maybe the developers have any response to Matthew's comment?

Dan Pollock: This is Dan Pollock at CDC. We would welcome an opportunity to solve this was with Matthew. We have reached out to the (Earth) facility, the professional groups, we welcome additional input. We know this is a high priority and we want to do everything we can to factor the special populations into our further evolution of the measures.

Matthew Davis: OK. It sounds good. I know that you know I didn't send out a whole lot of e-mails and got a pretty robust respond. So, I mean I'm not the only one in the spinal cord injury committee who'd kind of passionate about this. Because we

are seeing – I got, I was surprised at kind of, that number of responses. You know people sent me responses back as well saying, "Hey, I'm seeing this too and it's a problem that we like to see addressed."

So, yes, I mean, I can you know in fact if you read – if you pull up the comments, I think –I don't know if you can pull up my phone number. But I'm happy to you know even talk to people outside of the you know round of this meeting just to kind of explain the nuances because this really affects you know not only their acute help in the healthcare setting as far as you know risk for acute renal failure. They would also affect their quality of life when at leave the rehab facility will have – I can get into this at another time, but it really – I had some patients who's had their quality of life really dramatically affected by kind of the (inaudible) it's perpetuated that you know you shouldn't have indwelling catheters in.

And that's – you know if you look at the data, the data really doesn't show a reductions in UTI rate between in and out catheter and indwelling catheters. At least not a consistent and (inaudible) significant effect. I mean, if there is an effect, it's probably a pretty small one and yet it's really dramatic effect on quality of life.

So, like I said, I'd be happy to talk some more – and if I could probably talk for awhile but I know, probably you guys that are (sit) here and have me go through a line item list for half an hour. But you know I guess we'll talk to you guys in the 17th and 18th.

Suzanne Theberge: Matthew, this is Suzanne Theberge, the project manager for the project. If you want to send us an e-mail at patientsafety@qualityforum.org with your contact information you know we can – as Andrew suggested, we can set up a time to chat with you about the NQF process, and then we can also – with the developer's permission, pass on or just pass your information unto them and you know you folks can discuss as well.

Dan Pollock: This is Dan. You have our permission to do that. Thank you.

Suzanne Theberge: All right. Yes. So, I can put you folks in touch with each other.

Matthew Davis: Great. So, patientsafety@qualityforum.org

Suzanne Theberge: Yes.

Matthew Davis: OK. Wonderful. OK. I will do that.

Suzanne Theberge: Great.

Matthew Davis: All right …

(Crosstalk)

Male: You're welcome.

Male: Thank you.

Operator: Again, for questions and comments, please press star 1 on your telephone keypad.

There are no further public questions or comments at this time.

Andrew Lyzenga: OK.

Suzanne Theberge: Well …

(Crosstalk)

Suzanne Theberge: … if there's anything, we have a couple of next steps to go over, but I think we can probably wrap up a little bit early.

Andrew Lyzenga: Yes.

Suzanne Theberge: Before – I'll just go to the next steps, then we can see if anybody has any questions. So, as the committee members and the developers now, we've got two more of workgroup calls. One of them on Thursday and one next Tuesday. You are welcome to listen in to those calls if you're interested.

And in the meantime, the next – your next steps as you're done with your workgroup call are to review the remaining 11 measures and the projects and

be ready to discuss those at the in-person meeting in April. We'll be sending you information after the workgroup calls. We'll post the transcript and recording from these calls on the public site on SharePoint in case you'd like to review anything.

And we'll send more information after they are over, but next steps will be getting ready for the meeting, sending in more information about that. You should have received earlier this week a message from our meetings team about making your hotel and travel arrangements. If you did not get that, let me know, but it did went out I think yesterday. So, you should have that.

Ed Septimus: What does it – well, I changed my e-mail address or password.

Suzanne Theberge: I'm sorry to hear that. That is – that has technical issue that our meeting will have to fix. We sometimes have some login issues with it. Who – I'm sorry, who just …

Ed Septimus: That was Ed.

Suzanne Theberge: Ed, OK. I'll …

Ed Septimus: I'm always a troublemaker you know. Who did that – what was the from address for that? I didn't see it yesterday.

Suzanne Theberge: I think it was probably from NQF meetings. I think that's the e-mail address that it comes from.

Female: It came from meetings@qualityforum.org.

Ed Septimus: Yes, but I – even that little trip about putting the number behind your name, it doesn't work.

Suzanne Theberge: OK. So, I'll have our meetings team look into your login and get in touch with you. If anyone else has similar problems or just didn't get the message, let me know and we'll follow up. I think (in case) sometimes get filtered as spam.

Ed Septimus: I found it right here but it won't let me – I mean, the earlier we make reservations, the less expensive it is to get to D.C. So, which is …

Suzanne Theberge: Yes, I'll follow up with you this afternoon. We should be able to get that fixed pretty soon.

Ed Septimus: I certainly appreciate that so we can get it done.

Albert Wu: Yes, thanks. I did not get anything yesterday that I should tell.

Suzanne Theberge: OK, that was …

Albert Wu: It's Albert Wu.

Suzanne Theberge: Albert Wu, OK, great. I will let them know.

(Ann O'Brian): And hi, Suzanne. This is (Ann O'Brian). I also did not get the e-mail regarding the reservations.

Suzanne Theberge: Maybe I should rephrase it. Did anyone get the e-mail?

(Charlotte Alexander): I did. This is (Charlotte) and I did.

Suzanne Theberge: OK.

(Crosstalk)

Female: I did.

Suzanne Theberge: OK. So, it did go out. Yes, I thought if it gone out, I got a CC so I thought it had gone out. But I will follow up with the meetings team when I get off this phone with you folks to let them know that the three of you didn't get that message and you should hear from somebody soon.

I'm sorry, who didn't get it and one of you can't get in.

Male: I can't get in. I guess that maybe you're trying to tell me something.

Suzanne Theberge: We – we'll hopefully get that straightened out in the next couple of days. You'll be getting an agenda for the meeting from us with you know the order that we'll be discussing the measures then probably around the end of the month. We like to wait until the workgroup calls are over to put the agenda together so we have a sense of what the issues are that will need to be discussed.

So, that's everything from my end. I don't know if Andrew has anything to add or (Jessie) or if anyone has any questions.

Andrew Lyzenga: Nothing from my end. Anything from you, (Jessie)?

(Jessie): Nothing from my end.

Andrew Lyzenga: Any questions from the committee or final comments or thoughts?

Ed Septimus: No, I think we – I mean, this is Ed. I think we have to think about those last two measures a little bit.

Andrew Lyzenga: Yes, yes, I agree.

Ed Septimus: I think even though it's as soft as my own opinion about the CAUTI measures, I think it's probably OK. But I think the last two need some serious thoughts and I got to say at least from me, I got to really think about that before the face-to-face meeting.

Andrew Lyzenga: OK, great. And we will, again, I think walk through those algorithms and specific criteria and subcriteria in a little bit more rigor at the in-person meeting and we'll actually do our ratings there, so we'll have a chance to sort of work through these issues a little bit more there.

Ed Septimus: And you'll also send a summary out of all the calls and what this …

Andrew Lyzenga: Yes, we will.

Ed Septimus: Just like you did before?

Andrew Lyzenga: Yes.

Ed Septimus: Good. Because that kind of sort of help us remind ourselves what we've discussed.

Andrew Lyzenga: We're still figuring out how exactly we're going to do the summary. We actually may have something attached to each measure summarizing some of the workgroup comments and discussion or something like that. So, that have to be determined, but we'll get you a summary of the discussion in some way or another.

Any other thoughts or questions?

All right. Then we'll let you go a little bit early. Thanks again everybody for joining us. We appreciate you taking the time both to our committee members and developers …

Male: … everyone.

Andrew Lyzenga: … members of the public. Thank you.

END