



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 3690

Corresponding Measures:

Measure Title: Inappropriate diagnosis of urinary tract infection (UTI) in hospitalized medical patients; Abbreviated form: Inappropriate diagnosis of UTI

Measure Steward: University of Michigan

sp.02. Brief Description of Measure: The inappropriate diagnosis of UTI in hospitalized medical patients (or "Inappropriate Diagnosis of UTI") measure is a process measure that evaluates the annual proportion of hospitalized adult medical patients treated for UTI who do not meet diagnostic criteria for UTI (thus are inappropriately diagnosed and overtreated).

1b.01. Developer Rationale: The goal of this measure is to improve the process for diagnosis and treatment of urinary tract infection (UTI). Literature has demonstrated that while UTI is one of the most common infectious etiologies for which patients are hospitalized, it is often inappropriately diagnosed, resulting in inappropriate antibiotic administration and delay in diagnosis of a true underlying condition. The implications of inappropriate antibiotics are well described and include risks of antibiotic-associated adverse events such as *Clostridioides difficile* infection, prolonged length of hospital stay, and antimicrobial resistance, all of which can increase patient morbidity and mortality. Missed or delayed diagnosis of a true underlying condition is equally troubling, as data suggest that diagnostic error results in the highest morbidity, mortality, and malpractice cost of any medical error. Through adoption of this measure, we anticipate a decrease in inappropriate diagnosis of UTI, a decrease in unnecessary antibiotic use, and improved patient outcomes.

sp.12. Numerator Statement: The measure quantifies adult, hospitalized medical patients inappropriately diagnosed with UTI. Here, inappropriate diagnosis is defined as patients treated with antibiotics for UTI who do not meet diagnostic criteria for UTI. Patients were considered inappropriately diagnosed if they received antibiotic therapy for a UTI but did not have at least one sign or symptom of a UTI.

sp.14. Denominator Statement: The denominator includes all adult, general care, immunocompetent, medical patients hospitalized and treated for UTI who do not have a concomitant infection.

sp.16. Denominator Exclusions:

Exclusion Criteria:

- Left against medical advice or refused medical care
- Admitted on hospice

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- Pregnant or breastfeeding
- Spinal cord injury
- UTI-related complication (e.g., perinephric abscess)
 - Operationalized as >14 days of antibiotics at discharge

Measure Type: Process

sp.28. Data Source:

Electronic Health Records

Electronic Health Data

Other (specify)

Chart Review

sp.07. Level of Analysis:

Facility

IF Endorsement Maintenance – Original Endorsement Date: 2022-12-12 05:00 AM

Most Recent Endorsement Date: 12/12/2022 5:00:00 AM

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

sp.03. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?:

1. Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria

Please separate added or updated information from the most recent measure evaluation within each question response in the Importance to Measure and Report: Evidence section. For example:

2021 Submission:

Updated evidence information here.

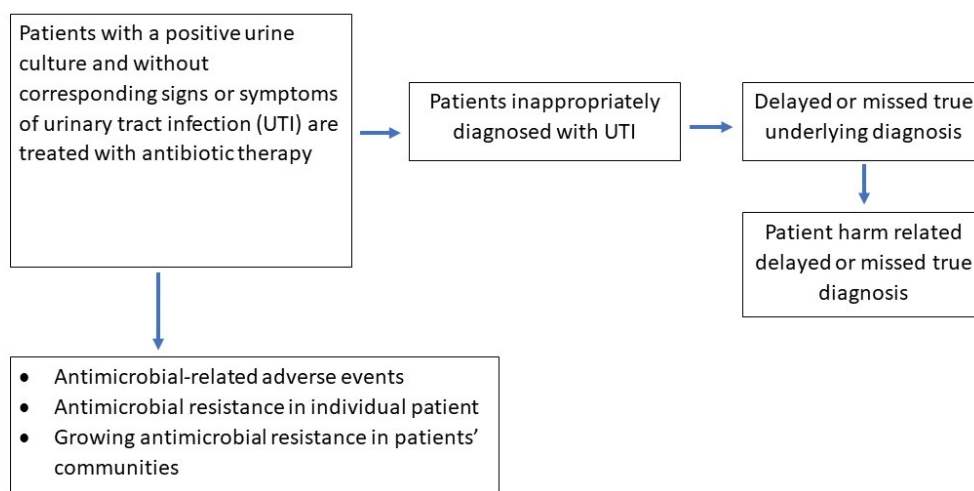
2018 Submission:

Evidence from the previous submission here.

1a.01. Provide a logic model.

Briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

[Response Begins]



Patients with a positive urine culture and without corresponding signs or symptoms of urinary tract infection (UTI) may be inappropriately diagnosed with UTI which in turn may result in delayed or missed true diagnosis which in turn leads to patient harm. Antibiotic treatment of patients with a positive urine culture and without corresponding signs or symptoms of urinary tract infection (UTI)

can lead to antimicrobial-related adverse events and antimicrobial resistance in individuals and communities.

[Response Ends]

1a.02. Select the type of source for the systematic review of the body of evidence that supports the performance measure.

A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data.

[Response Begins]

Clinical Practice Guideline recommendation (with evidence review)

[Response Ends]

If the evidence is not based on a systematic review, skip to the end of the section and do not complete the repeatable question group below. If you wish to include more than one systematic review, add additional tables by clicking "Add" after the final question in the group.

Evidence - Systematic Reviews Table (Repeatable)

Group 1 - Evidence - Systematic Reviews Table

1a.03. Provide the title, author, date, citation (including page number) and URL for the systematic review.

[Response Begins]

Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. Infectious Disease Society of America. 15 May 2019.

Nicolle LE, Gupta K, Bradley SF, Colgan R, DeMuri GP, Drekonja D, Eckert LO, Geerlings SE, Köves B, Hooton TM, Juthani-Mehta M, Knight SL, Saint S, Schaeffer AJ, Trautner B, Wullt B, Siemieniuk R. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. Clin Infect Dis. 2019 May 2;68(10):e83-e110. doi: 10.1093/cid/ciy1121. PMID: 30895288.

<https://www.idsociety.org/practice-guideline/asymptomatic-bacteriuria/>

[Response Ends]

1a.04. Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the systematic review.

[Response Begins]

II. Should ASB (asymptomatic bacteriuria) be screened for or treated in healthy nonpregnant women?

1. In healthy premenopausal, nonpregnant women or healthy postmenopausal women, we recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*).

IV. Should ASB Be Screened for and Treated in Functionally Impaired Older Women or Men Residing in the Community, or in Older Residents of Longterm Care Facilities? Recommendations

1. In older, community-dwelling persons who are functionally impaired, we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).

2. In older persons resident in long-term care facilities, we recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*)

V. In an older, functionally or cognitively impaired patient, which nonlocalizing symptoms distinguish ASB from symptomatic UTI?

1. In older patients with functional and/or cognitive impairment with bacteriuria and delirium (acute mental status change, confusion) and without local genitourinary symptoms or other systemic signs of infection (e.g., fever or hemodynamic instability), we recommend assessment for other causes and careful observation rather than antimicrobial treatment (*strong recommendation, very low-quality evidence*).

VI. Should patients with diabetes be screened or treated for ASB?

1. In patients with diabetes, we recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*).

XI. Should patients with an indwelling urethral catheter be screened or treated for ASB?

1. In patients with a short-term indwelling urethral catheter (<30 days), we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*). **Remarks:** Considerations are likely to be similar for patients with indwelling suprapubic catheters, and it is reasonable to manage these patients similar to patients with indwelling urethral catheters, for both short-term and long-term suprapubic catheterization.
2. In patients with long-term indwelling catheters, we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).

[Response Ends]

1a.05. Provide the grade assigned to the evidence associated with the recommendation, and include the definition of the grade.

[Response Begins]

Grading of Recommendations Assessment, Development and Education (GRADE) approach for rating the confidence and the evidence.

Table 1. Five factors that influence confidence in evidence:

| Factor | Description |
|--------------------------|---|
| Study limitations | Severity of threats to studies' internal validity (e.g., randomized vs observational design, potential for confounding, bias in measurement) |
| Inconsistency of results | Do different studies provide similar or different estimates of effect size |
| Indirectness of evidence | How relevant are the studies to the clinical question at hand (e.g., nature of study population, comparison group, type of outcomes measured) |
| Imprecision | Precision of estimates of effect |
| Reporting bias | Risk of bias due to selective publication of results |

Table 1 describes 5 factors that influence confidence in evidence including: study limitations, inconsistency of results, indirectness of evidence, imprecision, and reporting bias.

Table 2. GRADE quality of evidence definitions (can be modified by confidence factors, above)

| Quality of Evidence | Definition |
|---------------------|--|
| High Quality | Further research is very unlikely to change our confidence in the estimate of effect |
| Moderate Quality | Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate |

| Quality of Evidence | Definition |
|---------------------|--|
| Low Quality | Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate |
| Very Low Quality | Any estimate of effect is very uncertain |

GRADE quality of evidence definitions for high, moderate, low, and very low quality are presented.

1. Guyatt GH, Oxman AD, Vist GE, et al. ; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008; 336:924–6.
2. Jaeschke R, Guyatt GH, Dellinger P, et al. ; GRADE Working Group. Use of GRADE grid to reach decisions on clinical practice guidelines when consensus is elusive. BMJ 2008; 337:a744.
3. Schünemann HJ, Oxman AD, Brozek J, et al. GRADE: assessing the quality of evidence for diagnostic recommendations. Evid Based Med 2008; 13:162–3.

The grades assigned by Infectious Disease Society of America clinical practice guidelines to the quality of evidence varied by recommendation and are summarized in Table 3, below.

Table 3. Quality of evidence grades assigned by Infectious Disease Society of America (IDSA) clinical practice guidelines.

| Recommendation | Evidence Grade |
|---|---|
| II.1. In healthy premenopausal, nonpregnant women or healthy postmenopausal women, we recommend against screening for or treating ASB | Moderate-quality evidence, defined as “Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate” |
| IV.1. In older, community-dwelling persons who are functionally impaired, we recommend against screening for or treating ASB | Low-quality evidence, defined as “Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate” |
| IV.2. In older persons resident in long-term care facilities, we recommend against screening for or treating ASB | Moderate-quality evidence, defined as “Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate” |
| V.1. In older patients with functional and/or cognitive impairment with bacteriuria and delirium (acute mental status change, confusion) and without local genitourinary symptoms or other systemic signs of infection (e.g., fever or hemodynamic instability), we recommend assessment for other causes and careful observation rather than antimicrobial treatment | Very low-quality evidence, defined as “Any estimate of effect is very uncertain” |
| VI.1. In patients with diabetes, we recommend against screening for or treating ASB | Moderate-quality evidence, defined as “Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate” |

| Recommendation | Evidence Grade |
|---|---|
| XI.1. In patients with a short-term indwelling urethral catheter (<30 days), we recommend against screening for or treating ASB Remarks: Considerations are likely to be similar for patients with indwelling suprapubic catheters, and it is reasonable to manage these patients similar to patients with indwelling urethral catheters, for both short-term and long-term suprapubic catheterization | Low-quality evidence, defined as “Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate” |
| XI.3. In patients with long-term indwelling catheters, we recommend against screening for or treating ASB | Low-quality evidence, defined as “Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate” |

Quality of evidence grades assigned by Infectious Disease Society of America (IDSA) clinical practice guidelines. Rating for the 7 recommendations were as follows: 3 moderate, 3 low, 1 very low

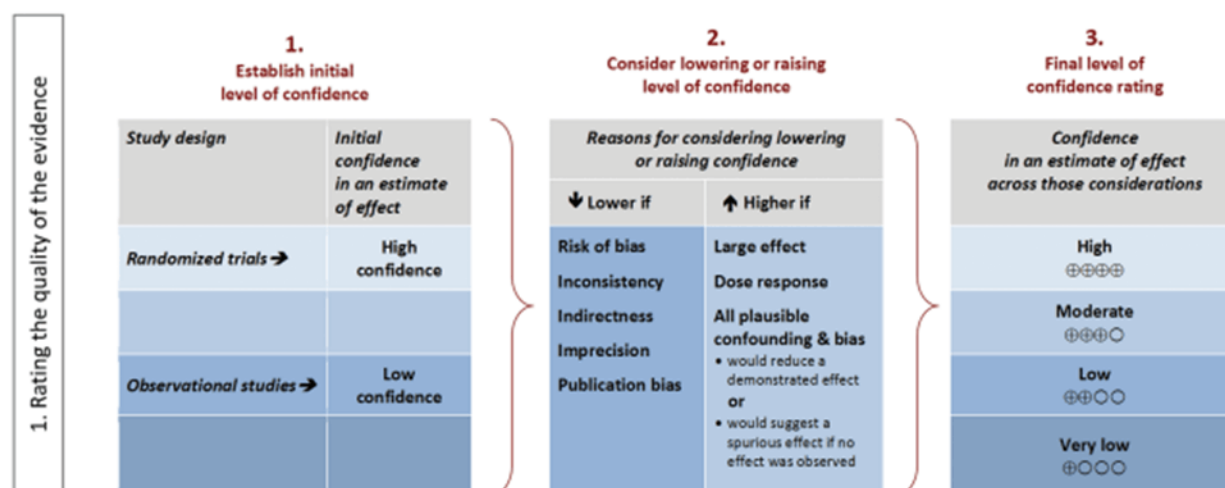
[Response Ends]

1a.06. Provide all other grades and definitions from the evidence grading system.

[Response Begins]

High Quality Evidence - Further research is very unlikely to change our confidence in the estimate of effect

Figure 1. Quality of evidence was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE).



Summary of the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) for rating quality of evidence. In general, high quality evidence is derived from randomized trials, and low quality evidence is derived from observational studies. Confidence in ratings is decreased by risk of bias, inconsistency, indirectness, imprecision, and publication bias. Reasons for increased confidence include large effect, dose response, and all plausible confounding and bias.

Figure from the US GRADE Network

[Response Ends]

1a.07. Provide the grade assigned to the recommendation, with definition of the grade.

[Response Begins]

Table 4. Grade assigned to recommendations by Infectious Disease Society of America (IDSA) clinical practice guidelines.

| Recommendation | Recommendation Grade |
|---|---|
| II.1. In healthy premenopausal, nonpregnant women or healthy postmenopausal women, we recommend against screening for or treating ASB | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. “There is high-quality evidence that antibiotics have an increased risk of adverse effects, that screening and treating ASB is extremely costly, and that the use of antibiotics promotes emergence of antimicrobial resistance.” |
| IV.1. In older, community-dwelling persons who are functionally impaired, we recommend against screening for or treating ASB | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. “We make strong recommendations because there is low- or moderate-quality evidence that there is no benefit and high-quality evidence of harm.” |
| IV.2. In older persons residing in long-term care facilities, we recommend against screening for or treating ASB | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. “We make strong recommendations because there is low- or moderate-quality evidence that there is no benefit and high-quality evidence of harm.” |
| V.1. In older patients with functional and/or cognitive impairment with bacteriuria and delirium (acute mental status change, confusion) and without local genitourinary symptoms or other systemic signs of infection (e.g., fever or hemodynamic instability), we recommend assessment for other causes and careful observation rather than antimicrobial treatment | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. “We make a strong recommendation because there is high certainty for harm and low certainty of any benefit from treatment of ASB in older adults.” |
| VI.1. In patients with diabetes, we recommend against screening for or treating ASB | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. “Based on the lack of demonstrated benefit and the possible harms that occur with additional antimicrobial use, we recommend against screening for or treating ASB in persons with diabetes.” |

| Recommendation | Recommendation Grade |
|---|--|
| XI.1. In patients with a short-term indwelling urethral catheter (<30 days), we recommend against screening for or treating ASB Remarks: Considerations are likely to be similar for patients with indwelling suprapubic catheters, and it is reasonable to manage these patients similar to patients with indwelling urethral catheters, for both short-term and long-term suprapubic catheterization | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. Whether or not antimicrobials for ASB are effective in preventing symptomatic UTI, sepsis, or death is uncertain. In the acute care hospital setting, the risk of <i>Clostridioides difficile</i> infection is high; thus, avoiding antimicrobials is particularly important in hospitalized patients. |
| XI.3. In patients with long-term indwelling catheters, we recommend against screening for or treating ASB | Strong recommendation - Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action. Whether there is a benefit of antimicrobial therapy for ASB while a catheter remains in situ is uncertain (low-quality evidence), and there is high-quality evidence of harm with increased antimicrobial resistance. |

All 7 recommendations received a grade of “strong recommendation” by Infectious Disease Society of America (IDSA) clinical practice guidelines.

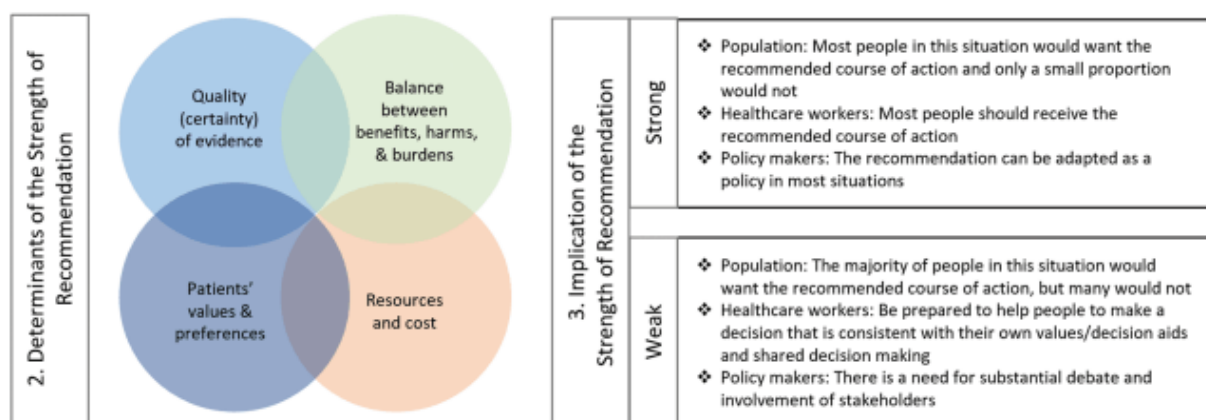
[Response Ends]

1a.08. Provide all other grades and definitions from the recommendation grading system.

[Response Begins]

All recommendations followed GRADE and are either “strong” or “weak”. Figure 2 outlines how strength of recommendations was determined and implications of the strength of recommendations.

Figure 2. GRADE determinants of the strength of recommendations and implications.



GRADE determinants of strength of recommendations include: a) quality of evidence, b) balance between benefits, harms, and burdens, c) patients’ values and preferences, and d) resources and cost. Strength of recommendation influences decisions by the population, healthcare workers, and policy makers.

A recommendation was graded as “Strong” when:

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- Moderate- or high-quality evidence that the desirable consequences outweigh the undesirable consequences for a course of action, OR
- High-quality evidence of harm and benefits are uncertain (i.e., low or very low quality)

A recommendation was graded as “Weak” when conditions for strong recommendation were not met.

Table 5. Interpretation of Strong and Weak (Conditional) Recommendations

| Stakeholder | Strong Recommendation | Weak (Conditional) Recommendation |
|---------------|--|--|
| Patients | All or almost all individuals in this situation would want the recommended course of action, and only a small proportion would not. | Most individuals in this situation would probably want the suggested course of action, but many would not. |
| Clinicians | All or almost all individuals should receive the intervention. | Recognize that fully informed individuals might reasonably choose different courses of action. A shared decision-making process is typically useful in helping individuals to make decisions consistent with their values and preferences. |
| Policy makers | The recommendation can be adopted as policy in most situations. Adherence to this recommendation according to the guideline can be used as a quality criterion or performance indicator. | Policymaking will require substantial debate and involvement of various stakeholders. |

For patients, clinicians, and policy makers, a strong recommendation would be the recommended course of action for all or almost all patients and could be used as a quality criterion or performance indicator. A weak (conditional) recommendation would be followed much less and is associated with greater uncertainty and room for debate.

[Response Ends]

1a.09. Detail the quantity (how many studies) and quality (the type of studies) of the evidence.

[Response Begins]

Table 6. Quantity and type of studies in support of each recommendation.

| Recommendation | Number of Studies | Study Type (N) |
|---|-------------------|--|
| II.1. In healthy premenopausal, nonpregnant women or healthy postmenopausal women, we recommend against screening for or treating ASB | 7 | Randomized clinical trial (2) Retrospective cohort (2) Conference report (1) Clinical Practice Guideline (1) Systematic Review (1) |
| IV.1. In older, community-dwelling persons who are functionally impaired, we recommend against screening for or treating ASB | 5 | Randomized clinical trial (4) Cohort study and clinical trial (1) |

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| Recommendation | Number of Studies | Study Type (N) |
|--|-------------------|---|
| IV.2. In older persons resident in long-term care facilities, we recommend against screening for or treating ASB | 14 | Prospective cohort study (5) Comparative study (3) Clinical practice guideline (2) Clinical trial (1) Consensus conference report (1) Cross-sectional study (1) Retrospective cohort (1) |
| V.1. In older patients with functional and/or cognitive impairment with bacteriuria and delirium (acute mental status change, confusion) and without local genitourinary symptoms or other systemic signs of infection (e.g., fever or hemodynamic instability), we recommend assessment for other causes and careful observation rather than antimicrobial treatment | 14 | Prospective cohort study (4) Clinical practice guideline (2) Cross-sectional study (2) Retrospective cohort (2) Systematic review (2) Consensus conference report (1) Randomized clinical trial (1) |
| VI.1. In patients with diabetes, we recommend against screening for or treating ASB | 5 | Prospective cohort study (3) Clinical practice guideline (1) Randomized clinical trial (1) |
| XI.1. In patients with a short-term indwelling urethral catheter (<30 days), we recommend against screening for or treating ASB Remarks: Considerations are likely to be similar for patients with indwelling suprapubic catheters, and it is reasonable to manage these patients similar to patients with indwelling urethral catheters, for both short-term and long-term suprapubic catheterization | 10 | Prospective cohort study (3) Randomized clinical trial (2) Case-control study (1) Cochrane review (1) Clinical practice guideline (1) Retrospective cohort study (1) Systematic review (1) |
| X1.3. In patients with long-term indwelling catheters, we recommend against screening for or treating ASB | 9 | Prospective cohort study (5) Retrospective cohort study (2) Randomized clinical trial (1) Randomized intervention trial, QI (1) |

The quantity and type of studies in support of each recommendation. A range of 5 to 14 studies support each recommendation. At least one randomized trial supports 6/7 recommendations.

[Response Ends]

1a.10. Provide the estimates of benefit, and consistency across studies.

[Response Begins]

This publication did not provide an estimate of benefit or consistency across the cited studies.

[Response Ends]

1a.11. Indicate what, if any, harms were identified in the study.

[Response Begins]

Within the clinical practice guideline, authors considered values and preferences from the viewpoint of the patient and the societal perspective. While most patients may wish to receive antimicrobial therapy for ASB where benefits outweigh harms, they highlight the significant potential harms related to antimicrobial therapy, including adverse drug effects, *Clostridioides difficile* infection, and the potential for antimicrobial resistance. They state that while the evidence quality is generally low and there is no suggestion of potential harm, the general recommendation for not treating ASB stems from high-quality evidence that antimicrobial therapy contributes to antimicrobial resistance.

[Response Ends]

1a.12. Identify any new studies conducted since the systematic review, and indicate whether the new studies change the conclusions from the systematic review.

[Response Begins]

Since publication of the guidelines, there have been additional studies evaluating trends in inpatient use¹ and multi-drug resistant bacterial infections in US hospitalized patients.² For example, one study suggests that between 2012 and 2017, overall antibiotic days of therapy in US hospitals were unchanged.¹ While the prevalence of some multi-drug resistant bacteria decreased over that time period (e.g., methicillin-resistant staphylococcus aureus (MRSA)), other highly concerning multi-drug resistant organisms flourished. For example, the incidence of infections resulting from extended-spectrum beta-lactamase (ESBL) producing organisms increased by 53.3% (from 37.55 to 57.12 cases per 10,000 hospitalizations).² Another recent study found that recent antibiotic exposure was positively associated with baseline multi-drug resistant colonization (odds ratio 1.70; 95% confidence interval 1.22-2.38).³ These studies add further support to the IDSA guidelines referenced above.

¹ James Baggs, PhD, Sophia Kazakova, MD, MPH, PhD, Kelly M Hatfield, MSPH, Sujun Reddy, MD, MSc, Arjun Srinivasan, MD, Lauri Hicks, DO, Melinda M Neuhauser, PharmD, MPH, John A Jernigan, MD, MS, 2891. Trends in Inpatient Antibiotic Use in US Hospitals, 2012–2017, *Open Forum Infectious Diseases*, Volume 6, Issue Supplement_2, October 2019, Page S79,

²Jernigan JA, Hatfield KM, Wolford H, Nelson RE, Olubajo B, Reddy SC, McCarthy N, Paul P, McDonald LC, Kallen A, Fiore A, Craig M, Baggs J. Multidrug-Resistant Bacterial Infections in U.S. Hospitalized Patients, 2012-2017. *N Engl J Med*. 2020 Apr 2;382(14):1309-1319.

³ Gontjes KJ, Gibson KE, Lansing BJ, Mantey J, Jones KM, Cassone M, Wang J, Mills JP, Mody L, Patel PK. Association of Exposure to High-risk Antibiotics in Acute Care Hospitals With Multidrug-Resistant Organism Burden in Nursing Homes. *JAMA Netw Open*. 2022 Feb 1;5(2):e2144959.

[Response Ends]

1a.13. If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, describe the evidence on which you are basing the performance measure.

[Response Begins]

Our definition of inappropriate diagnosis of UTI is based on treatment for urinary tract infection in the absence of meeting criteria for UTI. The criteria for urinary tract infection within our measure is consistent with the National Healthcare Safety Network (NHSN) classification of UTI.¹

Table 7. Comparison of NHSN classification of UTI to the inappropriate diagnosis of UTI measure

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| Condition | NHSN Definition | Changes associated with submitted measure |
|--|---|---|
| Non-catheter-associated UTI in any age patient | <p>Patient must meet 1, 2, and 3 below:</p> <p>1. One of the following is true:</p> <ul style="list-style-type: none"> • Patient has/had an indwelling urinary catheter, but it has/had not been in place for more than two consecutive days in inpatient location on the date of the event, OR • Patient did not have an indwelling urinary catheter in place on the date of the event nor the day before the date of the event <p>2. Patient has at least one of the following signs or symptoms:</p> <ul style="list-style-type: none"> • Fever (>38 degrees Celsius) • Suprapubic tenderness with no other recognized cause • Costovertebral angle pain or tenderness with no other recognized cause • Urinary frequency • Urinary urgency • Dysuria <p>3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml.</p> | No differences |

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| Condition | NHSN Definition | Changes associated with submitted measure |
|--|---|--|
| Catheter-associated Urinary Tract Infection (CAUTI) in any age patient | <p>Patient 1, 2, and 3 below:</p> <ol style="list-style-type: none"> Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of the event AND was either: <ul style="list-style-type: none"> Present for any proportion of the calendar day on the date of the event, OR Removed the day before the date of the event Patient has at least one of the following signs or symptoms: <ul style="list-style-type: none"> Fever (>38 degrees Celsius) Suprapubic tenderness with no other recognized cause Costovertebral angle pain or tenderness with no other recognized cause Urinary frequency Urinary urgency Dysuria Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU/ml. | <p>While the NHSN guidelines are designed to facilitate identifying hospital-acquired infections, our measure targets patients either at the time of admission or during their hospitalization. As a result, we do not require that a urinary catheter be in place for 2 consecutive days in an inpatient location, rather our measure allows for catheter presence in either the inpatient or outpatient location.</p> <p>We also have a shorter “window period” in which to evaluate for symptoms. We discussed with our Technical Expert Panel whether to be consistent with the NHSN (-3 to +3 days) or to narrow the window to -1 to +2 days (with day 0 being the day of urine culture collection). The data using both window periods were quite similar but the time needed for data collection (and thus feasibility) would be reduced if we moved to a -1 to +2 range. All experts agreed with reducing to -1 to +2, noting that NHSN was focused on healthcare-associated infections whereas these inappropriate diagnoses are often community-associated and therefore a longer range for symptoms collection is not typically needed.</p> |

The NHSN classification of UTI is compared to the inappropriate diagnosis of UTI measure. The majority of NHSN criteria apply to the inappropriate diagnosis of UTI measure, with 2 differences: 1) length of time a catheter has been in place, and 2) the symptom window for the inappropriate diagnosis of UTI is -1 to +2 days with respect to urine culture collection (NHSN window is -3 to +3 day).

Similarly, the Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America defines asymptomatic bacteriuria as “the presence of 1 or more species of bacteria growing in the urine at specified quantitative counts ($\geq 10^5$ colony-forming units [CFU]/mL or $\geq 10^8$ CFU/L), irrespective of the presence of pyuria, in the absence of signs or symptoms attributable to urinary tract infection (UTI). This definition of ASB, or absence of UTI, is consistent with the submitted measure.² These clinical practice guidelines, discussed in more detail in 1a.03-1a.12, highlight the lack of benefit of treatment of ASB in several populations, described further in 1a.14. We also use their criteria of when to treat altered mental status as a UTI: 1) when altered mental status occurs with other symptoms or 2) when patient has “other systemic signs of infection (e.g., fever or hemodynamic instability).”² We also evaluated symptom criteria from the Society for Healthcare Epidemiology of America’s evaluation of the use of non-specific symptoms in elderly populations.³

[Response Ends]

1a.14. Briefly synthesize the evidence that supports the measure.

[Response Begins]

Antibiotics and ASB

Lack of benefit for treatment of ASB has been demonstrated in several populations. In a study of 673 consecutively enrolled, asymptomatic women, aged 18-40, from January 2005 to December 2009, ASB recurrence (based on microbiological and clinical information) was significantly higher in the group treated for ASB at 6 months (relative risk [RR] 1.31; 95% CI, 1.21-1.42, $P < 0.0001$), and at 12 months (RR 3.17; 95% CI, 2.55-3.90; $p < 0.0001$).⁴ In a study of women (> 16 years of age) with diabetes, bacteriuria, and no symptoms, patients treated for ASB had lower rates of bacteriuria at four weeks, but no difference in frequency of symptomatic urinary tract infection, time to first urinary tract infection, pyelonephritis, or hospitalization for urinary tract infection during a mean follow-up period of 27 months. Patients in the antimicrobial-therapy group had nearly five times as many days of antibiotic use as those in the placebo group.⁵ In another study of patients aged ≥ 18 years who had an indwelling urinary catheter in place for at least one week, patients with cephalexin-sensitive bacteriuria receiving cephalexin had similar rates of fever but higher rates of growth of cephalexin-resistant urinary bacteria than those not receiving antibiotics.⁶ An additional study of elderly institutionalized women (mean age 83.4 years \pm 8.8 years) with asymptomatic bacteriuria showed that those assigned to receive antibiotic therapy for all episodes of bacteriuria has higher rates incidence of reinfection (1.67 versus 0.87 per patient year) and adverse antimicrobial drug effects (0.51 versus 0.046 per patient year) compared to those only receiving therapy with development of symptoms.⁷ Another study evaluating hospitalized adult patients treated for ASB noted no differences in 30-day post-discharge mortality, readmissions, or ED visits, though did note a longer duration of hospitalization for patients treated for ASB than those not treated (median 4 vs 3 days, adjusted relative risk 1.37 [1.28-1.47], $p < 0.001$).⁸ Finally, while not directly related to treatment of ASB, the United States Preventative Services Taskforce recommends that men and nonpregnant women not be screened for ASB, providing a D grade, indicating that “the USPSTF recommends against this service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.”⁹

Delayed Time to True Diagnosis

Diagnostic errors are associated with poor outcomes including longer length of stay, higher inpatient mortality, increased ICU admission, and higher 30-day readmission. Diagnostic errors are also the most common cause of malpractice claims, are financially costly, and—compared to other claims—result in the most harm. Specifically, diagnostic error related to infections account for 13.5% of high-severity diagnostic error cases (i.e., resulting in serious, permanent disability or death).¹⁰⁻¹⁵ Specifically, we found that inappropriate diagnosis of UTI is associated with a 1 day longer length of stay after urine testing.⁸ This delay is likely the result of waiting for urine culture sensitivities to return. Each additional day of hospitalization costs approximately \$2,607 making this harm very costly to hospitals and health systems. If you estimate 400,000 hospitalizations for UTI every year¹⁶ of which 1/3 inappropriately diagnosed³ and result in a 1 day increase in LOS⁸ the annual excess cost in the US alone of inappropriate diagnosis of UTI is approximately \$326 million (estimated cost \$2,607/hospital day). Another prospective study actually found a trend toward higher 30-day readmission (9.6% vs. 6.3%) and mortality (7.0% vs. 4.8%) in patients inappropriately diagnosed with UTI when compared to patients with ASB who were not treated with antibiotics.¹⁷

Antibiotic Associated Adverse Events

In our HMS cohort, we found that up to 3% of patients reported antibiotic-associated adverse events after being inappropriately diagnosed with UTI. Deep chart review by trained clinicians suggests that number is far higher and that up to 20% of hospitalized patients treated unnecessarily with antibiotics develop an antibiotic-associated adverse-event.¹⁸ Most common are gastrointestinal, renal, and hematologic abnormalities, accounting for 42%, 24%, and 15% of 30-day ADEs respectively. In addition, 1-3% of patients treated with antibiotics in the hospital setting will develop *Clostridioides difficile* infections. One prospective study found that patients inappropriately diagnosed with UTI had a 30-day *Clostridioides difficile* infection rate of 1.3% vs. those with AS not treated with antibiotics.¹⁹ Fortunately, many of these harms could be reduced with better antibiotic use. Improving appropriate antibiotic use for UTI can reduce patient-reported antibiotic-associated adverse events and ecological or

retrospective studies have suggested that up to 60% of *Clostridioides difficile* infections (and related mortality) could be eliminated by improving antibiotic prescribing.²⁰

Antibiotic Use and Antimicrobial Resistance

Antibiotic use in patients inappropriately diagnosed with infections continues to be a large driver of antibiotic use and antibiotic resistance. Between 2012 and 2017, overall antibiotic days of therapy in US hospitals were unchanged.²¹ While the prevalence of some multi-drug resistant bacteria decreased over that time period (e.g., methicillin-resistant staphylococcus aureus (MRSA)), other highly concerning multi-drug resistant organisms flourished. For example, the incidence of infections resulting from extended-spectrum beta-lactamase (ESBL) producing organisms increased by 53.3% (from 37.55 to 57.12 cases per 10,000 hospitalizations).²² A systematic review and meta-analysis of the literature found a significant positive relationship between antibiotic consumption and development of antimicrobial resistance, with a pooled odds ratio of 2.3 (95% confidence interval 2.2-2.5).²³ Similarly, a recent study found that recent antibiotic exposure was positively associated with baseline multi-drug resistant colonization (odds ratio 1.70; 95% confidence interval 1.22-2.38).²⁴ The implications of these antimicrobial resistant organisms are significant. Globally, predictive statistical models estimate 4.95 million (3.62-6.57 million) deaths associated with bacterial antimicrobial resistance in 2019, of which 1.27 million (95% uncertainly interval 0.911-1.71) deaths were attributable to bacterial antimicrobial resistance.²⁵ In a study of inpatient admissions in the US Department of Veterans Affairs between October 2007 and November 2010, healthcare-associated infections (HAI) with multi-drug resistant gram negative bacteria were associated with a significantly elevated risk of mortality as was HAI or colonization with MRSA.²⁶

[Response Ends]

1a.15. Detail the process used to identify the evidence.

[Response Begins]

Evidence was identified through appropriate clinical practice guidelines^{2,9} and through comprehensive Pubmed search of studies as they pertain to diagnosis of ASB, UTI, or treatment of ASB.

[Response Ends]

1a.16. Provide the citation(s) for the evidence.

[Response Begins]

¹Urinary Tract (Catheter-Associated Urinary Tract Infection [CAUTI] and Non-Catheter-Associated Urinary Tract Infections [UTI]) Events. National Healthcare Safety Network. Centers for Disease Control. January 2022. <<https://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf>>

²Rowe, T., Jump, R., Andersen, B., et al. (2020). Reliability of nonlocalizing signs and symptoms as indicators of the presence of infection in nursing-home residents. *Infection Control & Hospital Epidemiology*, 1-10. doi:10.1017/ice.2020.1282

³ Nicolle LE, Gupta K, Bradley SF, Colgan R, DeMuri GP, Drekonja D, Eckert LO, Geerlings SE, Köves B, Hooton TM, Juthani-Mehta M, Knight SL, Saint S, Schaeffer AJ, Trautner B, Wullt B, Siemieniuk R. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2019 May 2;68(10):e83-e110. doi: 10.1093/cid/ciy1121. PMID: 30895288.

⁴ Cai T, Mazzoli S, Mondaini N, Meacci F, Nesi G, D'Elia C, Malossini G, Boddi V, Bartoletti R. The role of asymptomatic bacteriuria in young women with recurrent urinary tract infections: to treat or not to treat? *Clin Infect Dis*. 2012 Sep;55(6):771-7.

⁵ Harding GK, Zhanel GG, Nicolle LE, Cheang M; Manitoba Diabetes Urinary Tract Infection Study Group. Antimicrobial treatment in diabetic women with asymptomatic bacteriuria. *N Engl J Med*. 2002 Nov 14;347(20):1576-83.

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- ⁶ Warren JW, Anthony WC, Hoopes JM, Muncie HL. Cephalexin for Susceptible Bacteriuria in Afebrile, Long-term Catheterized Patients. *JAMA*. 1982;248(4):454–458
- ⁷ Nicolle LE, Mayhew WJ, Bryan L. Prospective randomized comparison of therapy and no therapy for asymptomatic bacteriuria in institutionalized elderly women. *Am J Med*. 1987 Jul;83(1):27-33.
- ⁸ Petty LA, Vaughn VM, Flanders SA, et al. Risk Factors and Outcomes Associated With Treatment of Asymptomatic Bacteriuria in Hospitalized Patients. *JAMA Intern Med*. 2019;179(11):1519-1527.
- ⁹ Screening for Asymptomatic Bacteriuria in Adults: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, Rockville, Maryland. 1 July 2008.
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- ¹¹ Gupta A, Snyder A, Kachalia A, Flanders S, Saint S, Chopra V. Malpractice claims related to diagnostic errors in the hospital. *BMJ Qual Saf*. 2017;27(1). doi:10.1136/bmjqs-2017-006774.
- ¹² Johnson T, McNutt R, Odwazny R, Patel D, Baker S. Discrepancy between admission and discharge diagnoses as a predictor of hospital length of stay. *Journal of Hospital Medicine*. 2009;4(4):234-239. doi:10.1002/jhm.453.
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- ¹⁸ Tamma PD, Avdic E, Li DX, Dzintars K, Cosgrove SE. Association of Adverse Events With Antibiotic Use in Hospitalized Patients. *JAMA Intern Med*. 2017.
- ¹⁹ CDC. Nearly half a million Americans suffered from *Clostridium difficile* infections in a single year. U.S. Department of Health & Human Services; 02/25 2015.
- ²⁰ Thorpe KE, Joski P, Johnston KJ. Antibiotic-Resistant Infection Treatment Costs Have Doubled Since 2002, Now Exceeding \$2 Billion Annually. *Health Aff (Millwood)*. 2018;37(4):662-669. doi:10.1377/hlthaff.2017.1153.
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[Response Ends]

1b.01. Briefly explain the rationale for this measure.

Explain how the measure will improve the quality of care, and list the benefits or improvements in quality envisioned by use of this measure.

[Response Begins]

The goal of this measure is to improve the process for diagnosis and treatment of urinary tract infection (UTI). Literature has demonstrated that while UTI is one of the most common infectious etiologies for which patients are hospitalized, it is often inappropriately diagnosed, resulting in inappropriate antibiotic administration and delay in diagnosis of a true underlying condition. The implications of inappropriate antibiotics are well described and include risks of antibiotic-associated adverse events such as *Clostridioides difficile* infection, prolonged length of hospital stay, and antimicrobial resistance, all of which can increase patient morbidity and mortality. Missed or delayed diagnosis of a true underlying condition is equally troubling, as data suggest that diagnostic error results in the highest morbidity, mortality, and malpractice cost of any medical error. Through adoption of this measure, we anticipate a decrease in inappropriate diagnosis of UTI, a decrease in unnecessary antibiotic use, and improved patient outcomes.

[Response Ends]

1b.02. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.

Include mean, std dev, min, max, interquartile range, and scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

[Response Begins]

Data below are from 7/1/2017-3/31/2020 across 49 acute care hospitals in the state of Michigan. This includes 13,805 patients treated for UTI, of whom 23.2% (3,197) were inappropriately diagnosed with UTI. For data of scores over time, we do not report 2020 data as it only includes a single quarter (ending 3/31/2020).

Here, we divided all 49 hospitals each year into performance deciles with decile 1 representing the top performing hospitals. Scores or the percentage of patients treated for pneumonia who were considered inappropriately diagnosed with UTI are then reported by decile, first giving mean (standard deviation [SD]) then providing median (inter-quartile range [IQR]) data.

Table 1. Mean (SD) percent of cases inappropriately diagnosed with UTI (i.e., “score”) by Year; N=49 hospitals

| Decile | 2017; mean (SD) | 2018; mean (SD) | 2019; mean (SD) |
|---------------------|-----------------|-----------------|-----------------|
| 1 (best performing) | 10.6 (3.2) | 11.5 (2.3) | 5.3 (4.1) |
| 2 | 19.0 (1.4) | 15 (0.6) | 10.7 (0.5) |
| 3 | 22.3 (0.2) | 18.2 (0.8) | 13.3 (1.1) |

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| Decile | 2017; mean (SD) | 2018; mean (SD) | 2019; mean (SD) |
|-----------------------|-----------------|-----------------|-----------------|
| 4 | 23.5 (0.4) | 21.4 (0.6) | 16.8 (0.7) |
| 5 | 24.9 (0.5) | 23.6 (0.9) | 18.8 (0.3) |
| 6 | 27.6 (0.9) | 26.8 (0.6) | 20.0 (0.5) |
| 7 | 30.5 (0.8) | 28.7 (0.9) | 23.4 (1.2) |
| 8 | 34.0 (1.8) | 32.1 (0.5) | 26.5 (0.7) |
| 9 | 40.2 (2.5) | 35.5 (0.4) | 28.5 (1.2) |
| 10 (worst performing) | 60.7 (22.9) | 41.7 (7.2) | 32.4 (2.2) |

Mean (SD) percent of cases inappropriately diagnosed with UTI trended downward from 2017 to 2019 in all deciles.

*2020 includes only 1 quarter of data and thus is not reported in the time trend above.

Table 2. Median (IQR) percent of cases inappropriately diagnosed with UTI (i.e., “score”) by Year; N=49 hospitals

| Decile | 2017; median (IQR) | 2018; median (IQR) | 2019; median (IQR) |
|-----------------------|--------------------|--------------------|--------------------|
| 1 (best performing) | 11.2 (8.1, 1.3) | 11.5 (9.8, 13.1) | 6.0 (2.1, 8.5) |
| 2 | 18.4 (18.3, 19.7) | 14.9 (14.6, 15.5) | 10.8 (10.3, 11.0) |
| 3 | 22.3 (22.1, 22.5) | 18.3 (17.6, 18.9) | 13.4 (12.5, 14.1) |
| 4 | 23.4 (23.3, 23.7) | 21.7 (20.9, 21.9) | 16.8 (16.3, 17.4) |
| 5 | 25.0 (24.6, 25.2) | 23.5 (22.9, 24.4) | 18.8 (18.6, 19.0) |
| 6 | 27.6 (27.0, 28.1) | 27.0 (26.4, 27.1) | 20.0 (19.6, 20.5) |
| 7 | 30.0 (30.0, 30.7) | 28.4 (28.3, 28.6) | 23.2 (22.6, 24.2) |
| 8 | 33.3 (33.3, 33.9) | 32.0 (31.7, 32.5) | 26.3 (26.0, 26.9) |
| 9 | 40.4 (38.3, 42.2) | 35.5 (35.2, 35.8) | 28.2 (27.8, 29.2) |
| 10 (worst performing) | 53.8 (46.7, 60.0) | 40.0 (38.0, 40.3) | 31.7 (30.9, 33.8) |

Median (IQR) percent of cases inappropriately diagnosed with UTI trended downward from 2017 to 2019 in all deciles.

*2020 includes only 1 quarter of data and thus is not reported in the time trend above.

[Response Ends]

1b.03. If no or limited performance data on the measure as specified is reported above, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement. Include citations.

[Response Begins]

N/A

[Response Ends]

1b.04. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.

Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included. Include mean, std dev, min, max, interquartile range, and scores by decile. For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an

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opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.

[Response Begins]

Data below are from 7/1/2017-3/31/2020 across 49 acute care hospitals in the state of Michigan. This includes 13,805 patients treated for UTI, of whom 23.2% (3,197) were inappropriately diagnosed with UTI.

Here, we report the demographics for patients with UTI as compared to the demographics of patients inappropriately diagnosed with UTI. We also compare demographics of those inappropriately diagnosed in 2017 to those inappropriately diagnosed in 2020. All comparisons were conducted using chi-squared tests.

Table 3. Demographics of UTI cohort and inappropriately diagnosed patients, Year 2017

| Variable | UTI, N=1929; % (N) | Inappropriate Diagnosis of UTI, N=752; % (N) | P-value |
|-------------------------|--------------------|--|---------|
| Medicaid | 9.9% (191) | 6.0% (45) | <.001 |
| Medicare | 75.4% (1455) | 83.1% (625) | * |
| Private Insurance | 14.7% (284) | 10.9% (82) | * |
| Female | 69.3% (1402) | 79.2% (614) | <.001 |
| Male | 30.7% (622) | 20.8% (161) | * |
| Race Black | 19.7% (399) | 18.2% (141) | 0.505 |
| Race Other ^b | 3.9% (78) | 3.4% (26) | * |
| Race White | 76.4% (1548) | 78.5% (609) | * |
| Age 65 years or older | 71.3% (1443) | 80.7% (626) | <.001 |
| Age < 65 years | 28.7% (582) | 19.3% (150) | * |

Demographic comparisons of the UTI cohort to those inappropriately diagnosed with UTI in 2017 indicate significant differences by payer, gender, and age. Patients inappropriately diagnosed with UTI were more likely to have medicare insurance (vs. private or Medicaid) compared to patients with UTI. Compared to patients with UTI, patients inappropriately diagnosed with UTI were more likely to be women and more likely to be older than 65 years. There were no differences by race.

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^a P-value compares demographics of patients with UTI to those inappropriately diagnosed with UTI using chi-squared tests. P<0.05 considered significant.

^a“other” race includes American Indian or Alaskan Native, Arab and Chaldean Ancestries, Asian, Native Hawaiian or Pacific Islander, Other (i.e., if patient demographic information indicates the patient is a race other than what is listed above), and Unknown (i.e., if patient’s race is not indicated in the medical record).

Table 4. Demographics of entire UTI cohort and inappropriately diagnosed patients, Q1 2020

| Variable | UTI, N=561; % (N) | Inappropriate Diagnosis of UTI, N=140; % (N) | P-value |
|-------------------|-------------------|--|---------|
| Medicaid | 10.1% (60) | 8.6% (12) | 0.020 |
| Medicare | 78.9% (470) | 87.9% (123) | * |
| Private Insurance | 11.1% (66) | 3.6 % (5) | * |
| Female | 69.3% (446) | 75.8% (113) | 0.112 |
| Male | 30.8% (198) | 24.2% (36) | * |
| Race Black | 22.3% (144) | 22.2% (33) | 0.933 |

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| Variable | UTI, N=561; % (N) | Inappropriate Diagnosis of UTI, N=140; % (N) | P-value |
|-------------------------|-------------------|--|---------|
| Race Other ^b | 5.4% (35) | 4.7% (7) | * |
| Race White | 72.3% (466) | 73.2% (109) | * |
| Age 65 years or older | 73.8% (476) | 77.9% (116) | 0.306 |
| Age < 65 years | 26.2% (169) | 22.2% (33) | * |

Demographic comparisons of the UTI cohort to those inappropriately diagnosed with UTI in quarter 1 of 2020 indicate significant differences by payer. Patients inappropriately diagnosed with UTI were more likely to have Medicare insurance (vs. private or Medicaid) compared to patients with UTI.

There were no differences between patients with UTI and those inappropriately diagnosed with UTI by gender, race, or age.

*cell intentionally left empty

Abbreviations: Q1: quarter 1

^a P-value compares demographics of patients with UTI to those inappropriately diagnosed with UTI using chi-squared tests. P<0.05 considered significant.

^a“other” race includes American Indian or Alaskan Native, Arab and Chaldean Ancestries, Asian, Native Hawaiian or Pacific Islander, Other (i.e., if patient demographic information indicates the patient is a race other than what is listed above), and Unknown (i.e., if patient’s race is not indicated in the medical record).

Table 5. Trends in demographics of patients inappropriately diagnosed with UTI; 2017 vs. Q1 2020

| Variable | 2017 Inappropriately Diagnosed with UTI, N=752; % (N) | Q1, 2020 Inappropriately Diagnosed with UTI, N=140; % (N) | P-value |
|-------------------------|---|---|---------|
| Medicaid | 6.0% (45) | 8.6% (12) | 0.020 |
| Medicare | 83.1% (625) | 87.9% (123) | * |
| Private Insurance | 10.9% (82) | 3.6 % (5) | * |
| Female | 79.2% (614) | 75.8% (113) | 0.355 |
| Male | 20.8% (161) | 24.2% (36) | * |
| Race Black | 18.2% (141) | 22.2% (33) | 0.342 |
| Race Other ^b | 3.4% (26) | 4.7% (7) | * |
| Race White | 78.5% (609) | 73.2% (109) | * |
| Age 65 years or older | 80.7% (626) | 77.9% (116) | 0.429 |
| Age < 65 years | 19.3% (150) | 22.2% (33) | * |

A higher percentage of inappropriately diagnosed cases were seen for patients with Medicare and Medicaid compared to private insurance (P=0.02). Other demographics (gender, race, and age) of patients inappropriately diagnosed with UTI were not different between all of 2017 to quarter 1 of 2020 (P=0.34-0.43).

*cell intentionally left empty

Abbreviations: Q1: quarter 1

^aP-value compares demographics of patients inappropriately diagnosed with UTI in 2017 to those inappropriately diagnosed with UTI in Q1 of 2020 using chi-squared tests. P<0.05 considered significant.

^a“other” race includes American Indian or Alaskan Native, Arab and Chaldean Ancestries, Asian, Native Hawaiian or Pacific Islander, Other (i.e., if patient demographic information indicates the patient is a race other than what is listed above), and Unknown (i.e., if patient’s race is not indicated in the medical record).

[Response Ends]

1b.05. If no or limited data on disparities from the measure as specified is reported above, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in above.

[Response Begins]

N/A

[Response Ends]

2. Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.

sp.01. Provide the measure title.

Measure titles should be concise yet convey who and what is being measured (see [What Good Looks Like](#)).

[Response Begins]

Inappropriate diagnosis of urinary tract infection (UTI) in hospitalized medical patients; Abbreviated form:
Inappropriate diagnosis of UTI

[Response Ends]

sp.02. Provide a brief description of the measure.

Including type of score, measure focus, target population, timeframe, (e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year).

[Response Begins]

The inappropriate diagnosis of UTI in hospitalized medical patients (or “Inappropriate Diagnosis of UTI”) measure is a process measure that evaluates the annual proportion of hospitalized adult medical patients treated for UTI who do not meet diagnostic criteria for UTI (thus are inappropriately diagnosed and overtreated).

[Response Ends]

sp.04. Check all the clinical condition/topic areas that apply to your measure, below.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- Surgery: General

[Response Begins]

Genitourinary (GU): Urinary Tract Infection (UTI)

Infectious Diseases (ID)

[Response Ends]

sp.05. Check all the non-condition specific measure domain areas that apply to your measure, below.

[Response Begins]

Safety

Safety: Healthcare Associated Infections

Safety: Overuse

[Response Ends]

sp.06. Select one or more target population categories.

Select only those target populations which can be stratified in the reporting of the measure's result.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Populations at Risk: Populations at Risk*

[Response Begins]

Adults (Age >= 18)

Elderly (Age >= 65)

[Response Ends]

sp.07. Select the levels of analysis that apply to your measure.

Check ONLY the levels of analysis for which the measure is SPECIFIED and TESTED.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- *Clinician: Clinician*
- *Population: Population*

[Response Begins]

Facility

[Response Ends]

sp.08. Indicate the care settings that apply to your measure.

Check ONLY the settings for which the measure is SPECIFIED and TESTED.

[Response Begins]

Inpatient/Hospital

[Response Ends]

sp.09. Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials.

Do not enter a URL linking to a home page or to general information. If no URL is available, indicate "none available".

[Response Begins]

<https://mi-hms.org/inappropriate-diagnosis-urinary-tract-infection-uti-hospitalized-medical-patients>

[Response Ends]

sp.11. Attach the data dictionary, code table, or value sets (and risk model codes and coefficients when applicable). Excel formats (.xlsx or .csv) are preferred.

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Attach an excel or csv file; if this poses an issue, [contact staff](#). Provide descriptors for any codes. Use one file with multiple worksheets, if needed.

[Response Begins]

Available in attached Excel or csv file

[Response Ends]

Attachment: 3690_Data_Dictionary_UTI_Measure_3.22.22.xlsx

sp.12. State the numerator.

Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome).

DO NOT include the rationale for the measure.

[Response Begins]

The measure quantifies adult, hospitalized medical patients inappropriately diagnosed with UTI. Here, inappropriate diagnosis is defined as patients treated with antibiotics for UTI who do not meet diagnostic criteria for UTI. Patients were considered inappropriately diagnosed if they received antibiotic therapy for a UTI but did not have at least one sign or symptom of a UTI.

[Response Ends]

sp.13. Provide details needed to calculate the numerator.

All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets.

Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.

[Response Begins]

Patients in the numerator include those that received antibiotics for a UTI but did not have ≥ 1 sign or symptom of a UTI.

- Minor numerator exclusions:
 - Those with a blood culture positive for a pathogenic bacteria (1.8% [91/4961])

Signs (e.g., fever) and symptoms (e.g., dysuria) of UTI are found in the attached excel file. Abstractors are asked to review the medical record for documentation of any signs or symptoms the day prior to obtaining a urine culture (referred to as day -1), the day of the urine culture (day 0), or the two days following the urine culture (days 1, 2). Any combination of 1 or more symptoms at any point in this time frame is required to be considered appropriately diagnosed. The exception is patients with new onset mental status changes. Consistent with recent IDSA guidelines, patients with new onset mental status changes must also have signs of a systemic infection (i.e., leukocytosis, hypotension, or ≥ 2 systemic inflammatory response syndrome [SIRS] criteria) to be considered a UTI. Any patients without signs and symptoms of a UTI are considered inappropriately diagnosed and placed in the numerator.

[Response Ends]

sp.14. State the denominator.

Brief, narrative description of the target population being measured.

[Response Begins]

The denominator includes all adult, general care, immunocompetent, medical patients hospitalized and treated for UTI who do not have a concomitant infection.

[Response Ends]

sp.15. Provide details needed to calculate the denominator.

All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets.

Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.

[Response Begins]

The denominator includes all sampled patients eligible for abstraction during the measure period (typically annual measurement). To be considered “treated for a UTI,” a patient had to: a) have a positive urine culture, b) receive antibiotic therapy, and c) not have a concomitant infection. Please see excel file (inclusion criteria tab) for detailed operationalized definitions.

Inclusion criteria:

- Adult patient admitted and discharged from the participating hospital
- With a positive urine culture (except for excluded organisms listed in data dictionary) during hospitalization.
- Admitted to a general care medicine service
- Received any eligible antibiotic during the symptom collection window (day -1, 0, 1, 2, where day 0 = day of first positive urine culture)
- Immunocompetent (allowing for mild immune suppression)
- Do not have a concomitant infection (e.g., COVID-19, antibiotic treatment for unrelated infection or prophylaxis)
- Have normal urinary anatomy

[Response Ends]

sp.16. Describe the denominator exclusions.

Brief narrative description of exclusions from the target population.

[Response Begins]

Exclusion Criteria:

- Left against medical advice or refused medical care
- Admitted on hospice
- Pregnant or breastfeeding

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- Spinal cord injury
- UTI-related complication (e.g., perinephric abscess)
 - Operationalized as >14 days of antibiotics at discharge

[Response Ends]

sp.17. Provide details needed to calculate the denominator exclusions.

All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.

[Response Begins]

Inclusion and exclusion codes and criteria are provided in the attached excel file.

[Response Ends]

sp.18. Provide all information required to stratify the measure results, if necessary.

Include the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate. Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format in the Data Dictionary field.

[Response Begins]

N/A

[Response Ends]

sp.19. Select the risk adjustment type.

Select type. Provide specifications for risk stratification and/or risk models in the Scientific Acceptability section.

[Response Begins]

No risk adjustment or risk stratification

[Response Ends]

sp.20. Select the most relevant type of score.

Attachment: If available, please provide a sample report.

[Response Begins]

Rate/proportion

[Response Ends]

sp.21. Select the appropriate interpretation of the measure score.

Classifies interpretation of score according to whether better quality or resource use is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score

[Response Begins]

Better quality = Lower score

[Response Ends]

sp.22. Diagram or describe the calculation of the measure score as an ordered sequence of steps.

Identify the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period of data, aggregating data; risk adjustment; etc.

[Response Begins]

The measure estimates hospital-level inappropriate diagnosis of UTI. If the hospital has elected to sample patients, they will generate a sample by first identifying all hospitalized patients with a positive urine culture (using institutional definition of positive) during that month or quarter (based on whether they elect to sample monthly or quarterly). Next, they will apply electronic inclusion criteria (medicine admission, antibiotic receipt during window period [day -1 to day +2]) to either their quarterly or monthly patient sample. The resulting list will be randomized, and patients screened in order of randomization. First, patients are screened for inclusion in the denominator. All adult, general care, medical patients hospitalized and treated for UTI are potentially eligible. If the patient meets eligibility criteria and does not have any exclusions, they are placed in the denominator. Patients automatically excluded from the numerator are those with blood cultures positive for a pathogenic organism. Patients are then assessed for whether they meet diagnostic criteria for UTI (i.e., do they have at least one sign or symptom of a UTI). If a patient does NOT meet diagnostic criteria they are placed in the numerator. A lower score is considered better diagnostic quality for UTI.

[Response Ends]

sp.25. If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.

[Response Begins]

Sampling: Hospitals have the option to sample from their population or submit their entire population. Hospitals also have the option to sample quarterly or monthly. Over the entire year, 59 cases are recommended for the denominator. Thus, hospitals whose Initial Patient Population size is less than or equal to the minimum number of cases per quarter (N=15) or month (N~5) for the measure should not sample and rather, should include all cases. A hospital may choose to use a larger sample size than is required.

Sampling Procedures:

Potentially eligible patient lists should be reviewed monthly or quarterly (as desired). Lists will be determined by the ability of the facility; however, we suggest electronically including the following criteria:

- Initial sample based on positive urine culture
- Exclude patients who did not receive antibiotics during hospitalization (if able, can refine to day -1 to day +2 with day 0 being date of urine culture collection)
- Exclude patients admitted to a non-medicine service
- Exclude patients admitted to intensive care

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Due to exclusions, hospitals selecting to sample cases MUST submit AT LEAST the minimum required sample size.

Eligible lists should then be randomized and reviewed in order until the desired number of cases is included (~5/month or ~15 per quarter).

Minimum Sample Size:

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Using the Spearman Brown prophecy, we evaluated the number of cases needed to reach each reliability threshold:

Table 1. Number of annual cases needed to achieve each reliability threshold.

| Reliability | Number of annual cases needed |
|----------------|-------------------------------|
| 0.6 | 22 |
| 0.7 | 35 |
| 0.8 (standard) | 59 |
| 0.9 | 132 |

In order to achieve a desired reliability of 0.8, each hospital would need to abstract 59 cases annually.

Based on these data, for a desired reliability of 0.8, each hospital would need to abstract 59 cases annually or ~5 cases per month.

[Response Ends]

sp.28. Select only the data sources for which the measure is specified.

[Response Begins]

Electronic Health Data

Electronic Health Records

Other (specify)

[Other (specify) Please Explain]

Chart Review

[Response Ends]

sp.29. Identify the specific data source or data collection instrument.

For example, provide the name of the database, clinical registry, collection instrument, etc., and describe how data are collected.

[Response Begins]

Electronic medical record data. The data collection instrument is provided. Those interested in using our online REDCap tool may also contact us directly to coordinate.

[Response Ends]

sp.30. Provide the data collection instrument.

[Response Begins]

Available in attached appendix in Question 1 of the Additional Section

[Response Ends]

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Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate fields in the Scientific Acceptability sections of the Measure Submission Form.

- Measures must be tested for all the data sources and levels of analyses that are specified. If there is more than one set of data specifications or more than one level of analysis, contact NQF staff about how to present all the testing information in one form.
- All required sections must be completed.
- For composites with outcome and resource use measures, Questions 2b.23-2b.37 (Risk Adjustment) also must be completed.
- If specified for multiple data sources/sets of specifications (e.g., claims and EHRs), Questions 2b.11-2b.13 also must be completed.
- An appendix for supplemental materials may be submitted (see Question 1 in the Additional section), but there is no guarantee it will be reviewed.
- Contact NQF staff with any questions. Check for resources at the [Submitting Standards webpage](#).
- For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for the [2021 Measure Evaluation Criteria and Guidance](#).

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF's evaluation criteria for testing.

2a. Reliability testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For instrument-based measures (including PRO-PMs) and composite performance measures, reliability should be demonstrated for the computed performance score.

2b1. Validity testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For instrument based measures (including PRO-PMs) and composite performance measures, validity should be demonstrated for the computed performance score.

2b2. Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure;

AND

If patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2b3. For outcome measures and other measures when indicated (e.g., resource use):

- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; 14,15 and has demonstrated adequate discrimination and calibration
- rationale/data support no risk adjustment/ stratification.

2b4. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful 16 differences in performance;

OR

there is evidence of overall less-than-optimal performance.

2b5. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2b6. Analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders) and how the specified handling of missing data minimizes bias.

2c. For composite performance measures, empirical analyses support the composite construction approach and demonstrate that:

2c1. the component measures fit the quality construct and add value to the overall composite while achieving the related objective of parsimony to the extent possible; and

2c2. the aggregation and weighting rules are consistent with the quality construct and rationale while achieving the related objective of simplicity to the extent possible.

(if not conducted or results not adequate, justification must be submitted and accepted)

Definitions

Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).

Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measure scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.

Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

Risk factors that influence outcomes should not be specified as exclusions.

With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of \$25 in cost for an episode of care (e.g., \$5,000 v. \$5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

Please separate added or updated information from the most recent measure evaluation within each question response in the Importance to Scientific Acceptability sections. For example:

2021 Submission:

Updated testing information here.

2018 Submission:

Testing from the previous submission here.

2a.01. Select only the data sources for which the measure is tested.

[Response Begins]

Electronic Health Data

Electronic Health Records

Other (specify)

[Other (specify) Please Explain]

Chart Review

[Response Ends]

2a.02. If an existing dataset was used, identify the specific dataset.

The dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry).

[Response Begins]

For reliability testing, we used data from the Michigan Hospital Medicine Safety Consortium (HMS). HMS is a collaborative quality initiative sponsored by Blue Cross Blue Shield of Michigan (<https://mi-hms.org/>). HMS includes 62 non-governmental hospitals throughout the state of Michigan. In July 2017, HMS hospitals joined in the “Antimicrobial Use Initiative” to collect patient-level data related to hospitalized, medical patients treated for urinary tract infection (UTI) (<https://mi-hms.org/quality-initiatives/antimicrobial-use-initiative>).^{1,2}

For all analyses included in this measure submission, data from HMS are censored as of March 31, 2020, at which time 49 hospitals had contributed data to the dataset.

The dataset includes chart abstracted data, such as:

- Patient demographics (e.g., age, admission, and discharge dates)
- Positive urine culture information (e.g., organisms)
- Presence of signs or symptoms of a UTI within the period of the day prior to the urine culture being collected through two days after urine culture being collected (day -1 to +2 where the urine culture collection date is day 0)
 - Physical exam findings (e.g., costovertebral angle tenderness)
 - Vital signs (e.g., fever)
 - Documented symptoms (e.g., dysuria)
 - Laboratory findings (e.g., leukocytosis)
- Antibiotic use during admission and on discharge
- Urinary catheter use
- Comorbidities – including diabetes, end stage renal disease (ESRD), dementia, admission from a skilled nursing facility/long term care facility
- 30-day adverse events (emergency department visit, mortality, *Clostridioides difficile* infection, antibiotic associated side effects) documented in the medical record
- 30-day adverse events collected via telephone interview (conducted 30-days post discharge)

References:

#3690 Inappropriate diagnosis of urinary tract infection (UTI) in hospitalized medical patients;
Abbreviated form: Inappropriate diagnosis of UTI, Submission Last Updated: Dec 19, 2022

¹ Petty LA, Vaughn VM, Flanders SA, et al. Risk Factors and Outcomes Associated With Treatment of Asymptomatic Bacteriuria in Hospitalized Patients. *JAMA Intern Med.* 2019;179(11):1519–1527.

² Petty LA, Vaughn VM, Flanders SA, et al. Assessment of Testing and Treatment of Asymptomatic Bacteriuria Initiated in the Emergency Department. *Open Forum Infect Dis.* 2020 Nov 3;7(12):ofaa537.

[Response Ends]

2a.03. Provide the dates of the data used in testing.

Use the following format: “MM-DD-YYYY - MM-DD-YYYY”

[Response Begins]

07-01-2017 - 03-31-2020

[Response Ends]

2a.04. Select the levels of analysis for which the measure is tested.

Testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan.

Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.

Please do not select:

- Clinician: Clinician
- Population: Population

[Response Begins]

Facility

[Response Ends]

2a.05. List the measured entities included in the testing and analysis (by level of analysis and data source).

Identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample.

[Response Begins]

Table 1. Characteristics of Participating Hospitals

| Hospital Characteristic | HMS Hospitals n=49; n (%) | All Michigan Hospitals ¹ n=127; n (%) |
|--------------------------------|------------------------------|---|
| Academic Hospital ¹ | 40 (82%) | 74 (58%) |
| Location ^{2,3} | * | * |
| Metropolitan | 40 (82%) | 71 (56%) |
| Micropolitan | 8 (16%) | 24 (19%) |
| Rural | 1 (2%) | 32 (25%) |

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| Hospital Characteristic | HMS Hospitals n=49; n (%) | All Michigan Hospitals ¹ n=127; n (%) |
|--------------------------------------|------------------------------|---|
| Profit Type ² | * | * |
| Non-Profit | 45 (92%) | 116 (59%) |
| For profit | 4 (8%) | 9 (33%) |
| Government | 0 (0%) | 2 (2%) |
| Bed Size (Staffed beds) ⁴ | * | * |
| ≤50 | 2 (4%) | 46 (36%) |
| 51-100 | 4 (8%) | 21 (17%) |
| 101-200 | 9 (18%) | 16 (13%) |
| >200 | 34 (69%) | 44 (35%) |

Participating HMS hospitals (N=49) are compared to all Michigan hospitals (N=127) for proportion classified as academic; location; profit type; and bed size (staffed beds). Relative to all Michigan hospitals, more HMS hospitals were academic (82% vs 58%), located in metropolitan areas (82% vs 56%), were non-profit (92% vs 59%), and had >200 beds (69% vs 35%).

*Cells intentionally left empty

Data compiled from the following sources:

¹ List of Michigan Hospitals compiled from the Michigan Health & Hospital Association⁵ mha.org/about/our-hospitals Accessed January 3, 2022

² U.S. Census Bureau, Michigan: 2020 Core Based Statistical Areas and Counties
https://www2.census.gov/programs-surveys/metro-micro/reference-maps/2020/state-maps/26_Michigan_2020.pdf

³ U.S. Census Bureau, Core based statistical areas (CBSAs), metropolitan divisions, and combined statistical areas (CSAs) <https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html>

⁴ American Hospital Directory, Individual Hospital Statistics for Michigan
https://www.ahd.com/states/hospital_MI.html

⁵The following types of hospitals were excluded:

- Children's hospitals
- Long-term acute care hospitals
- Psychiatric/mental health/substance abuse hospitals
- Rehabilitation hospitals
- Surgical hospitals
- Those providing only specialty services (i.e., cardiac hospital)

[Response Ends]

2a.06. Identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis), separated by level of analysis and data source; if a sample was used, describe how patients were selected for inclusion in the sample.

If there is a minimum case count used for testing, that minimum must be reflected in the specifications.

[Response Begins]

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Between 7/1/2017 and 3/31/2020 there were 13,805 hospitalized patients treated for UTI across 49 HMS hospitals. All 13,805 patients were used to test validity and reliability of the inappropriate diagnosis of UTI measure. Of the 13,805 patients treated for UTI, 23.2% (3,197) were assessed to be inappropriately diagnosed with UTI. Reliability and validity were assessed at the hospital level and validity was assessed at the encounter (i.e., patient) level. Descriptive characteristics of the entire UTI cohort are as follows:

Table 2. Descriptive characteristics of the entire UTI cohort, patients with appropriate diagnosis of UTI, and patients with inappropriate diagnosis of UTI

| Characteristic | Entire UTI Cohort, n (%) | Appropriate Diagnosis, n (%) | Inappropriate Diagnosis, n (%) |
|------------------------------|--------------------------|------------------------------|--------------------------------|
| <i>Gender</i> | * | * | * |
| Male | 4097 (29.7%) | 3311 (31.2%) | 786 (24.6%) |
| Female | 9702 (70.3%) | 7292 (68.7%) | 2410 (75.4%) |
| <i>Race</i> | * | * | * |
| White | 10257 (74.3%) | 7885 (74.3%) | 2372 (74.2%) |
| Black | 2945 (21.3%) | 2251 (21.2%) | 694 (21.7%) |
| Asian | 74 (0.5%) | 64 (0.6%) | 10 (0.3%) |
| American Indian | 37 (0.3%) | 26 (0.2%) | 11 (0.3%) |
| Native Islander | 22 (0.2%) | 18 (0.2%) | 4 (0.1%) |
| Other | 227 (1.6%) | 186 (1.8%) | 41 (1.3%) |
| Unknown | 190 (1.4%) | 143 (1.3%) | 47 (1.5%) |
| <i>Age (years)</i> | * | * | * |
| 18-30 | 494 (3.6%) | 445 (4.2%) | 49 (1.5%) |
| 31-40 | 453 (3.3%) | 399 (3.8%) | 54 (1.7%) |
| 41-50 | 624 (4.5%) | 515 (4.9%) | 109 (3.4%) |
| 51-60 | 1235 (8.9%) | 999 (9.4%) | 236 (7.4%) |
| 61-70 | 2435 (17.6%) | 1895 (17.9%) | 540 (16.9%) |
| 71-80 | 3463 (25.1%) | 2665 (25.1%) | 798 (25.0%) |
| 80-90 | 3709 (26.9%) | 2706 (25.5%) | 1003 (31.4%) |
| 91-100 | 1316 (9.5%) | 929 (8.8%) | 387 (12.1%) |
| 100+ | 76 (0.6%) | 55 (0.5%) | 21 (0.7%) |
| <i>Insurance Status</i> | * | * | * |
| Private | 1316 (9.5%) | 1077 (10.2%) | 239 (7.5%) |
| Medicare | 10165 (73.6%) | 7600 (71.6%) | 2565 (80.2%) |
| Medicaid | 1209 (8.8%) | 1012 (9.5%) | 197 (6.2%) |
| Uninsured | 114 (0.8%) | 105 (1.0%) | 9 (0.3%) |
| <i>Comorbidities</i> | * | * | * |
| Presence of urinary catheter | 1876 (13.6%) | 1426 (13.4%) | 450 (14.1%) |
| Renal disease | 5643 (40.9%) | 4303 (40.6%) | 1340 (41.9%) |
| Liver disease | 811 (5.9%) | 636 (6.0%) | 175 (5.5%) |
| Congestive heart failure | 3241 (23.5%) | 2403 (22.7%) | 838 (26.2%) |

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| Characteristic | Entire UTI Cohort, n (%) | Appropriate Diagnosis, n (%) | Inappropriate Diagnosis, n (%) |
|---------------------------------------|--------------------------|------------------------------|--------------------------------|
| Chronic obstructive pulmonary disease | 2507 (18.2%) | 1889 (17.8%) | 618 (19.3%) |
| Home oxygen | 619 (4.5%) | 457 (4.3%) | 162 (5.1%) |
| Structural lung disease | 0 (0%) | 0 (0%) | 0 (0%) |
| Current/Former smoker | 6489 (47%) | 5111 (48.2%) | 1378 (43.1%) |
| Cancer | 2778 (20.1%) | 2143 (20.2%) | 635 (19.9%) |
| Immune compromise | 95 (0.7%) | 74 (0.7%) | 21 (0.7%) |
| Diabetes mellitus | 5331 (38.6%) | 4111 (38.8%) | 1220 (38.2%) |
| Sepsis | 3774 (27.3%) | 3551 (33.5%) | 223 (7%) |
| Severe Sepsis | 339 (2.5%) | 339 (3.2%) | 0 (0%) |

Descriptive characteristics of the entire UTI cohort, patients with appropriate diagnosis of UTI, and patients with inappropriate diagnosis of UTI, including gender, race, insurance status, and co-morbidities.

*Cells intentionally left empty

Hospitals within HMS use the following case identification strategy to determine patients to abstract for HMS:

- Data collection involves abstraction of eligible cases every two weeks.
- To minimize sampling bias, abstractors are expected to select cases from every day during a two-week period, including weekends.
- The list of cases eligible for abstraction is created using the below protocol
 - For each two-week period, a list of patients admitted to all medical services is created
 - For inappropriate diagnosis of UTI, this list is generally a list of all positive urine cultures
 - If possible, hospitals apply additional electronic filters to the dataset to screen for inclusion/exclusion criteria. For example, they may exclude patients from the “inappropriate diagnosis of UTI” list if they also had a discharge diagnosis of pneumonia or were cared for on a non-medicine service.
 - All inclusion/exclusion criteria that are not electronically applied prior to list generation will require manual screening during case review
 - The list of potentially eligible patients is then organized chronologically by date and time of discharge.
 - For each discharge day, the first patient on the chronological list is reviewed for inclusion. If excluded, the next patient is reviewed.
 - This process is repeated, with patients reviewed from the chronological list ensuring that cases are distributed evenly across the two-week timeframe – meaning there are discharge dates across all days of the week – until all cases are identified and abstracted.

We do not report encounter-level reliability as we report encounter-level validity. Please see the validity documents for additional information.

[Response Ends]

2a.07. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing.

[Response Begins]

All data analysis was performed on the same dataset.

Table 3. Description of samples utilized to determine hospital-level and encounter-level reliability and empirical validity

| Type of Testing | Sample Utilized |
|--|---|
| Hospital-Level Reliability and Empirical Validity ¹ | Entire HMS UTI Dataset (based on case identification protocol outlined in 2a.06) |
| Encounter-Level Reliability ¹ | <i>Assessment of Effect of Abstraction Errors:</i> Review of a random, consecutive subset of 50 encounters within the cohort, representing cases from 29 of 46 participating hospitals. <i>Structured Implicit Case Review:</i> Seventeen cases, pseudo-randomly selected, for in-depth review by 2-4 physicians to confirm case classification (appropriate versus inappropriate diagnosis) |

The entire HMS UTI dataset was used to determine hospital-level reliability and empirical validity. Encounter-level reliability was determined by assessment of effect of abstraction errors and structured implicit case reviews.

¹Please see validity documents for further information.

[Response Ends]

2a.08. List the social risk factors that were available and analyzed.

For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

[Response Begins]

As this is a process measure, no risk adjustment was performed (including for social factors).

[Response Ends]

Note: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a.07 check patient or encounter-level data; in 2a.08 enter “see validity testing section of data elements”; and enter “N/A” for 2a.09 and 2a.10.

2a.09. Select the level of reliability testing conducted.

Choose one or both levels.

[Response Begins]

Patient or Encounter-Level (e.g., inter-abtractor reliability; data element reliability must address ALL critical data elements)

Accountable Entity Level (e.g., signal-to-noise analysis)

[Response Ends]

2a.10. For each level of reliability testing checked above, describe the method of reliability testing and what it tests.

Describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used.

[Response Begins]

Patient or Encounter Level

Please see validity testing section for encounter-level validity.

Accountable Entity Level

Signal-to-noise analysis was performed using a mixed-effect logistic model ran as an empty model such that the only effects in the model were the overall intercept and the hospital specific intercepts. This model enabled for the calculation of the hospital variance (signal), the total variance, and the within hospital variance (noise). Based on the hospital variance and the within hospital variance, an intraclass correlation was calculated. The intraclass correlation was utilized within the Spearman Brown formula in two ways: (A) to calculate the reliability for the entire hospital cohort using the median number of case abstractions for the cohort and (B) to understand minimum case abstracts necessary to achieve predetermined reliability thresholds of 0.6, 0.7, 0.8, and 0.9.

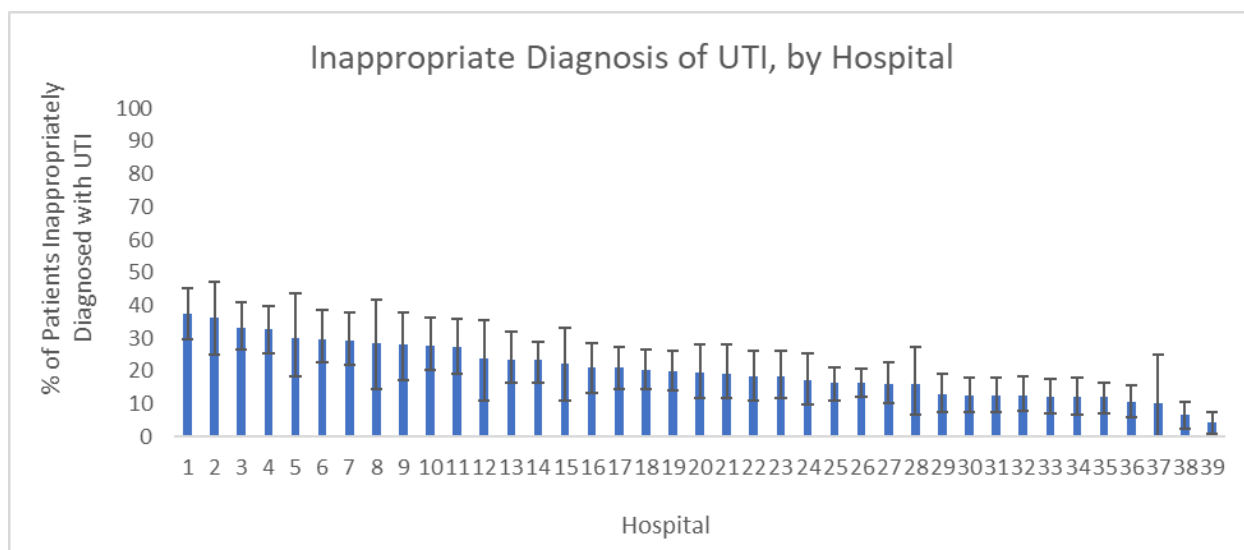
[Response Ends]

2a.11. For each level of reliability testing checked above, what were the statistical results from reliability testing?

For example, provide the percent agreement and kappa for the critical data elements, or distribution of reliability statistics from a signal-to-noise analysis. For score-level reliability testing, when using a signal-to-noise analysis, more than just one overall statistic should be reported (i.e., to demonstrate variation in reliability across providers). If a particular method yields only one statistic, this should be explained. In addition, reporting of results stratified by sample size is preferred (pg. 18, [NQF Measure Evaluation Criteria](#)).

[Response Begins]

Distribution of percentage of patients inappropriately diagnosed with UTI by hospital with 95% confidence intervals is demonstrated below. These data are based on the 4 quarters preceding March 2020 and include only hospitals that provided data during all four quarters.



Distribution of percentage of patients inappropriately diagnosed with UTI by hospital with 95% confidence intervals ranges from 4.2% to 37.3%. Data are based on the 4 quarters preceding March 2020 and include only hospitals that provided data during all four quarters (N=39 hospitals).

From these data, we were able to calculate the following:

Hospital Variance (signal): 0.225271

Total Variance: 3.5151414

Within Hospital Variance (noise): 3.28987

Based on this information, an intraclass correlation (ICC) was calculated. This ICC represents the reliability of the cohort if a single measurement (case abstraction) per hospital were included.

$ICC = 0.225271 / (0.225271 + 3.28987) = 0.225271 / 3.5151414 = 0.0641$

A. The Spearman Brown Prophecy allows to an estimation of reliability after adjusting the number of measurements. We can use this formula to estimate the reliability of the measure within the cohort after adjusting the input (in this case the number of case abstractions per site).^{1,2} The Spearman Brown Formula states the following:

$Reliability_{new} = (n \cdot r) / (1 + [n-1] \cdot r)$ where n is the number of inputs and r is the prior reliability.

Adapting to the formula to our variables suggests the following:

$Reliability_{new} = (\text{number of case reviews} \cdot ICC) / (1 + [\text{number of case reviews} - 1] \cdot ICC)$

The median case abstraction counts for the entire cohort was applied to the Spearman Brown Formula to obtain the overall reliability for the cohort.

Median case abstractions: 133 (IQR 92-154)

Reliability: $(133 \cdot 0.0640859) / (1 + (133 - 1) \cdot 0.0640859) = 0.901$

1. Spearman, C. (1910), Correlation Calculated From Faulty Data. *British Journal of Psychology*, 1904-1920, 3: 271-295.

2. Warrens MJ. Transforming intraclass correlation coefficients with the Spearman-Brown formula. *J Clin Epidemiol*. 2017 May;85:14-16

B. The ICC was then applied to the Spearman Brown Formula to calculate the minimum number of cases to achieve pre-specified reliability thresholds based on the outcome distribution of the entire cohort.

Table 1. Number of annual cases needed to achieve each reliability threshold.

| Reliability | Number of annual cases needed |
|----------------|-------------------------------|
| 0.6 | 22 |
| 0.7 | 35 |
| 0.8 (standard) | 59 |
| 0.9 | 132 |

In order to achieve a desired reliability of 0.8, each hospital would need to abstract 59 cases annually.

[Response Ends]

2a.12. Interpret the results, in terms of how they demonstrate reliability.

(In other words, what do the results mean and what are the norms for the test conducted?)

[Response Begins]

A. Based on signal-to-noise analysis, we found that reliability of the measure across the entire hospital cohort was strong (0.90), meeting the threshold for reliability for measures considered to be high stakes.

B. Using the current HMS cohort as a representative example, the minimum number of case abstracts per hospital per year to meet pre-specified reliability thresholds of 0.7 and 0.8 are highly attainable. Within a cohort of 40 HMS hospitals participating in 2019, 90% of hospitals were able to abstract the minimum of 59 cases to achieve 0.8 reliability. Of those that could not abstract the required number of cases, hospital bed sizes were 49 beds, 68 beds, 75 beds, and 133 beds. Ninety-five percent of hospitals could abstract the 35 cases/year necessary to achieve 0.7 reliability, and all but one could reach the abstraction threshold for 0.6 reliability. Of the two hospitals unable to achieve abstraction thresholds for 0.7 reliability (75 beds and 133 beds), one hospital over-sampled casers for an alternative measure, and the other had challenges with data abstractor hiring. This cohort of 40 hospitals participating in 2019 was selected as this represented the last year of complete data collection prior to the COVID-19 pandemic.

[Response Ends]

2b.01. Select the level of validity testing that was conducted.

[Response Begins]

Patient or Encounter-Level (data element validity must address ALL critical data elements)

Empirical validity testing

Systematic assessment of face validity of performance measure score as an indicator of quality or resource use (i.e., is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance)

[Response Ends]

2b.02. For each level of testing checked above, describe the method of validity testing and what it tests.

Describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used.

[Response Begins]

We performed validity testing on multiple levels and at multiple stages of measure development. A summary of validity testing is provided in the subsequent table with details provided in the following sections.

Table 1. Summary of Validity Testing

| Process | Description (stage of measure) | Results | Interpretation |
|---|--|---|--|
| During Measure Development | * | * | * |
| A. Face Validity-National Guidelines | Based on National Guidelines and literature review (Early Measure) | 2019 IDSA Asymptomatic Bacteriuria Guidelines ¹ | Initial basis for definitions |
| B. Face Validity-Expert Feedback | Data Design and Publications Committee and Michigan Hospital Medicine Safety Consortium (HMS) Hospital Experts (Early Measure AND Current Measure as Specified) | Refined inclusion/exclusion criteria and measure specifications to current form | Measure refinement to current measure specifications |
| During Early Years (2017-2019) of Measure Use | * | * | * |
| C. Encounter-level Validity: Inappropriate Diagnosis Case Reporting | All inappropriately diagnosed cases reported to participating hospital (Early Measure AND Current Measure as Specified) | Minor adjustments based on feedback from real cases | Minor measure refinement |
| During Late Years (2020-2021), Specific Measure Testing | * | * | * |
| D. Encounter-level Validity: Assessment of Effect of Abstraction Errors | Senior project manager reviewed data elements from 50 cases (representing 29 hospitals) to assess effect of any discrepancies on encounter-level validity (Current Measure as Specified) | Overall abstraction accuracy was 98.6%. Two cases changed classification due to discrepancies noted in audit. IRR: Kappa = 0.91 95% CI (0.78 – 1.00) Strong to “almost perfect” reliability | Encounter-level validity is high with a “strong” to “almost perfect” reliability. Data abstraction is typically accurate; what mistakes are made generally do not affect case classification. |

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| Process | Description (stage of measure) | Results | Interpretation |
|--|--|---|---|
| E. Encounter-level Validity: Structured Implicit Case Review | 25 cases reviewed by 2-4 physicians to confirm classification (Late Measure, only minor updates to measure after this assessment) | The κ for reviewer agreement was 0.72 | Indicates substantial agreement |
| F. Face Validity: Feedback from HMS hospitals (N=40 hospitals) | “Approximately, what percentage of cases called [inappropriate diagnosis of UTI] by HMS do you agree are [inappropriately diagnosed] (0-100%)?” (Current Measure as Specified) | Median: 90% IQR: 80% to 97% | Most participating hospitals believed the measure was highly accurate |
| G. Face Validity: National Expert Panel Feedback (N=11 experts) | Individuals representing 11 national organizations participated in 2-week online discussion of measure. (Current Measure as Specified) | Survey Question: “The inappropriate diagnosis of UTI measure as specified can be used to distinguish between better and worse quality hospitals.” Likert (1=Strongly disagree, 5=Strongly agree) 9 respondents (82%) reported that they agreed/strongly agreed with this statement. | Measure with substantial face validity by TEP Additional feedback to improve validity was provided and incorporated into the measure |
| H. Face Validity: Patient Panel Feedback (N=7 patients) | Online focus group including 7 patients who had been hospitalized and treated for an infection (Current Measure as Specified) | Patients were asked what [inappropriate] diagnosis of infections meant to them and whether the measure would be valuable. They innately understood inappropriate diagnosis and its consequences. | Patients felt the inappropriate diagnosis of UTI measure was valid and important |
| I. Empirical Validity: Evaluated association with other measures of diagnostic quality | Evaluated association at hospital level between UTI inappropriate diagnosis and inappropriate diagnosis of community acquired pneumonia (CAP). (Current Measure as Specified) | Hospitals with higher rates of inappropriate diagnosis of UTI also had higher rates of inappropriate diagnosis of CAP; $R=0.53$ (i.e., moderate positive correlation) | Hospitals performing better on this measure were also better at appropriately diagnosing CAP |

| Process | Description (stage of measure) | Results | Interpretation |
|---|---|---|--|
| J. Empirical Validity: Evaluated association of inappropriate diagnosis of UTI with outcomes | Characterized antibiotic use in patients inappropriately diagnosed with UTI and the association of antibiotic use with adverse events after hospital discharge (Current Measure as Specified) | Median (IQR) 7 (4-9) unnecessary antibiotic days Patients inappropriately diagnosed with UTI had an ~1 day longer length of stay after urine testing than those with asymptomatic bacteriuria (ASB) who were not treated with antibiotics (aRR: 1.37 [1.28-1.47]). | Inappropriate diagnosis of UTI is associated with unnecessary antibiotic use and longer hospitalizations |

Table 1 presents validity testing results and interpretation performed at various stages of measure development. Details are described in the text sections following the table.

*Cells intentionally left empty

A. Face Validity Indicated by Established UTI Guidelines

The initial definition of inappropriate diagnosis of UTI was derived from the “Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America.”¹ Additional expert feedback and review helped refine measure development and design.

The 2019 Infectious Diseases Society of America Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria (ASB) defines ASB as the following: “ASB is the presence of 1 or more species of bacteria growing in the urine at specified quantitative counts ($\geq 10^5$ colony-forming units [CFU]/mL or $\geq 10^8$ CFU/L), irrespective of the presence of pyuria, in the absence of signs or symptoms attributable to UTI.”¹ This definition is consistent with our measure which defines inappropriate diagnosis of UTI as any patient treated for UTI that does not have signs or symptoms of a UTI. We also use their criteria of when to treat altered mental status as a UTI: 1) when altered mental status occurs with other symptoms or 2) when patient has “other systemic signs of infection (e.g., fever or hemodynamic instability).”¹ We also evaluated symptom criteria from the Society for Healthcare Epidemiology of America’s evaluation of the use of non-specific symptoms in elderly populations.²

¹ Nicolle LE, Gupta K, Bradley SF, et al. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. *Clin Infect Dis*. 2019;68(10):e83-e110. doi:10.1093/cid/ciy1121.

² Rowe, T., Jump, R., Andersen, B., et al. (2020). Reliability of nonlocalizing signs and symptoms as indicators of the presence of infection in nursing-home residents. *Infection Control & Hospital Epidemiology*, 1-10. doi:10.1017/ice.2020.1282

B. Face Validity-Expert Feedback

Throughout measure development, we obtained expert and stakeholder input via these mechanisms:

1. Input from the Data, Design, and Publications (DDP) Committee of the Michigan Hospital Medicine Safety Consortium (HMS) early in measure development
2. Feedback from Experts in Quality, Antibiotic Stewardship, Diagnosis and Patient care from HMS hospitals

The **Data, Design, and Publications (DDP) Workgroup** was an ongoing meeting of champions and experts from HMS hospitals that met to address key issues related to measure methodology, including weighing the pros and cons of measure specifications, modeling, and use (e.g., defining the measure cohort and outcome) to ensure the measure was meaningful, useful, and well-designed. The group met approximately every 2 months during measure development and provided a forum for focused expert review and discussion of technical issues. They also provided final approval of the current submitted measure as specified.

List of DDP Workgroup Members:

- Suhasini Gudipati, MD Ascension Michigan St. Mary’s Hospital

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- Tina Percha, RN, MSN Beaumont Health
- Rajiv John, MD Beaumont Health
- Lama Hsaiky, PharmD Beaumont Health
- Priscila Bercea, MPH Beaumont Health Dearborn
- Scott Kaatz, DO Henry Ford Health System
- Allison Weinmann, MD Henry Ford Health System
- Emily Nerreter, MBA Henry Ford Health System
- Danielle Osterholzer, MD Hurley Medical Center
- Lisa Dumkow PharmD Mercy Health St. Mary's
- Anurag Malani, MD St. Joseph Mercy Ann Arbor Hospital
- Lakshmi Swaminathan, MD St. Joseph Mercy Ann Arbor Hospital
- Muhammad Nabeel, MD Sparrow Hospital
- Andrea White, PhD University of Utah Health
- Valerie Vaughn, MD, MSc University of Utah Health
- Vineet Chopra, MD, MSc University of Colorado Anschutz Medical Campus

Throughout measure development, we also provided opportunities from experts across the HMS collaborative to provide feedback. This included frontline clinicians, antibiotic stewards, quality improvement experts, c-suite members, and experts in quality measurement.

C. Assessment of Encounter-Level Validity: Inappropriate Diagnosis Case Reporting

Once initial measure specifications had been agreed upon, we provided all inappropriate diagnosis cases to participating hospitals for review (N=3197 cases of inappropriate diagnosis). Hospitals were encouraged to review these “fall-outs” with local experts in antibiotic stewardship, diagnosis, and quality as well as frontline clinicians to perform audit and feedback, identify trends, and assist with overall quality improvement. Occasionally, during this review the local team identified a potential issue with how the fall-out was determined based on the clinical scenario. In some instances, the case was reviewed, and we provided justification for considering the case inappropriately diagnosed. In other instances, modifications to the code and/or additional modifications to the data registry questions were required. Measure adjustments were more common during the initial launch of the measure (2017-2018). Since 2019, there have been no additional modifications to the measure based on this expert review. Since 2021, fall-out reporting has been based on the final submitted measure as currently specified.

D. Assessment of Encounter-Level Validity: Assessment of Effect of Abstraction Errors

To assess encounter-level data validity, the senior HMS project manager performed blind audits of 50 consecutive cases of patients with a diagnosis of UTI (appropriate or inappropriate). These cases included 29 hospitals. Cases were scored based on correctness of data abstraction (1 point received if data element was answered correctly, 0 points if there was disagreement). The proportion of data elements abstracted correctly (based on the submitted measure as specified) were tabulated for daily symptoms/signs, urinary catheter data, and overall abstraction accuracy. Correct data, as abstracted by the HMS project manager, were then reapplied to the measure definition to assess for changes in case classification. Using standard methods, an inter-rater reliability was obtained to assess the difference between original case classification and true case classification after identifying data errors.

E. Assessment of Encounter-Level Validity: Structured Implicit Case Review

In 2020, we conducted structured implicit review of cases of inappropriate diagnosis of UTI by 2-4 physicians to confirm accurate case categorization. Cases were randomly selected from “gray areas” that had been brought up during initial measure development (e.g., patients with altered mental status). During the review process, physician case reviewers had access to copies of medical record information such as diagnostic testing/results, emergency department note, history and physical note, progress notes, vital signs, and documented signs and symptoms. Reviewers were asked to independently assess whether they agreed with the classification of

inappropriate diagnosis of UTI and whether they would empirically initiate antibiotics. If there was disagreement in classification, a discussion would commence that included ways to improve the measure to account for any errors in classification. We calculated the inter-rater agreement (prior to discussion) using κ . The comments generated through discussion were used as part of the feedback mechanism to improve the measure to the final specifications submitted here (edits in response to this feedback were minor, see details below).

F. Face Validity: Feedback from HMS hospitals (N=40 hospitals)

In October 2021 (after measure specifications had been finalized), we systematically assessed the perceived validity of the inappropriate diagnosis of UTI measure by soliciting feedback from all HMS hospitals. Via online survey, we asked all hospitals to answer the following question: “Approximately, what percentage of cases called [inappropriate diagnosis of UTI] by HMS do you agree are [inappropriately diagnosed] (0-100%)?”

G. Face Validity: National Expert Panel Feedback (N=11 experts)

Throughout measure development, we obtained expert and stakeholder input. In October 2021, we obtained formal expert feedback by holding a series of meetings over two-weeks with a national Technical Expert Panel (TEP). This TEP included representatives from societies and organizations who would potentially be impacted by the measure to provide feedback on the measure.

In alignment with the CMS Measures Management System guidance on TEPs,³ we convened a TEP to provide input and feedback from a group of recognized experts in relevant fields. To convene the TEP, we reached out to organizations whose members could potentially be impacted by the measure and asked them to nominate individuals for participation. We selected individuals to represent a range of perspectives, including Infectious Diseases physicians, pharmacists, urologists, hospitalists, emergency medicine physicians, regulatory agencies, as well as individuals with experience in quality improvement, performance measurement, diagnostic error, antibiotic stewardship, and health care quality. We held two weeks of structured TEP zoom calls consisting of a presentation of key issues, our proposed approach, and relevant data, followed by open discussion among TEP members. We solicited additional input and comments from the TEP via survey after the meeting. A summary of the TEP can be found in the **Appendix**.

Table 2. List of TEP Panelists and their Organizations

| Organization/Institution | TEP Member |
|--|--------------------|
| American College of Emergency Medicine (ACEP) | Larissa May |
| Centers for Disease Control and Prevention (CDC) | Arjun Srinivasan |
| Infectious Disease Society of America (IDSA) | Teena Chopra |
| Pew Research Center | David Hyun |
| Society for Healthcare Epidemiology of America (SHEA) | Dan Morgan |
| Society to Improve Diagnosis in Medicine (SIDM) | David Newman-Toker |
| Association for Professionals in Infection Control and Epidemiology (APIC) | Patty Gray |
| Society of Infectious Diseases Pharmacists (SIDP) | Jason Pogue |
| The Joint Commission | David Baker |
| Emergency Medicine Physician, University of Wisconsin | Michael Pulia |
| American Urological Association (AUA) | Micheal Liss |

The eleven TEP panelists and their organizations are listed.

Following the Zoom expert panel, all participants filled out an online survey that included questions related to validity, reliability, usability, etc. Related to measure validity, we asked TEP members:

How much do you agree/disagree with the following statement?

1. “The inappropriate diagnosis of UTI measure as specified can be used to distinguish between better and worse quality hospitals.” 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree.

2. Are there any key data elements you believe are missed or not accurately captured in the inappropriate diagnosis of UTI measure?

H. Face Validity: Patient Panel Feedback (N=7 patients)

Finally, we solicited patient feedback through a Patient Engagement Panel in order to understand patient perspectives on the inappropriate diagnosis of UTI measure. This focus group was conducted on December 1, 2021 by the Community Collaboration and Engagement Team (CCET) which is part of the University of Utah Center for Clinical & Translational Science (CCTS). During this focus group, 7 patients and/or the caregivers of patients who had been hospitalized with an infection were selected to provide feedback. Topics discussed included: how patients were diagnosed, what treatment they received, their understanding of risks and benefits with antibiotics, their perceptions about their illness and recovery, and how information about how hospitals diagnose and treat infections may inform their medical decisions. The discussion was guided by a Focus Group Discussion Guide (see Engagement Session Report for questions).

I. Empirical Validity: Evaluated association with other measures of diagnostic quality

To assess empirical validity for the inappropriate diagnosis of UTI measure, we identified and assessed the measure's correlation with other measures that target similar domains of quality for similar populations. The goal was to identify if better performance on this measure was related to better performance on other relevant structural or outcome measures. After literature review and consultations with measure experts in the field, there were very few measures identified that assess the same domains of quality.

To better understand whether inappropriate diagnosis is linked across conditions—and thus may reflect the general quality of diagnosis at a hospital—we assessed the association of inappropriate diagnosis of UTI with inappropriate diagnosis of CAP at the hospital level.

J. Empirical Validity: Evaluated association of inappropriate diagnosis of UTI with outcomes

We also assessed the association of inappropriate diagnosis with antibiotic-associated adverse events. First, we characterized antibiotic use in patients inappropriately diagnosed with UTI using descriptive statistics. Because duration was skewed, we report median (IQR/inter-quartile range) duration of antibiotic therapy.

Next, we compared outcomes in patients inappropriately diagnosed with UTI vs. those who had ASB but were not unnecessarily treated with antibiotics. Outcomes assessed included: 30-day mortality, 30-day hospital readmission, 30-day emergency department visit, discharge to post-acute care settings, *Clostridioides difficile* infection at 30 days, and duration of hospitalization after urine testing. The association of inappropriate diagnosis with outcomes was assessed using logistic generalized estimating equation models, inverse probability of treatment weighted by baseline covariates identified to be significant in the bivariate and/or multivariate analysis, and other factors potentially associated with the outcome.

The results of this analysis were published in *JAMA Internal Medicine* in 2019 and are also shown below.³

³ Petty LA, Vaughn VM, Flanders SA, et al. Risk Factors and Outcomes Associated With Treatment of Asymptomatic Bacteriuria in Hospitalized Patients. *JAMA Intern Med*. 2019. doi:10.1001/jamainternmed.2019.2871. PMID: PMC6714039.

[Response Ends]

2b.03. Provide the statistical results from validity testing.

Examples may include correlations or t-test results.

[Response Begins]

D. Encounter-level Validity: Assessment of Effect of Abstraction Errors

In 2021, 50 cases were chronologically selected for detailed audit. Overall data element abstraction accuracy was 98.6%. When errors found through the data audit were corrected, there were two changes in case classification.

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Table 3. Accuracy of abstractor vs auditor classification

| Abstractor Classification (original) | Auditor Classification (updated) | Number (n=50) |
|--------------------------------------|----------------------------------|---------------|
| Inappropriate Diagnosis of UTI | Inappropriate Diagnosis of UTI | 14 |
| UTI | UTI | 34 |
| Inappropriate Diagnosis of UTI | UTI | 1 |
| UTI | Inappropriate Diagnosis of UTI | 1 |

A series of 50 cases selected for detailed audit resulted in agreement between abstractors and auditors in 48/50 cases (34/35 UTI and 14/15 Inappropriate Diagnosis of UTI cases).

Two cases changed classification due to discrepancies noted in audit. Thus, the IRR or Kappa was 0.91 (95% CI : 0.78 – 1.00) indicating strong to “almost perfect” reliability.

E. Encounter-level Validity: Structured Implicit Case Review

In 2020, 25 cases of inappropriate diagnosis of UTI underwent structured implicit case review by 2-4 physicians. **In 92% of cases (23/25) there was 100% agreement by reviewers that the cases represented inappropriate diagnosis. The κ for reviewer agreement (prior to reconciliation) was 0.72** indicating substantial agreement. Of note, our case review involved “gray areas” rather than a random selection of cases. Thus, our true κ may be even higher. As a result of feedback during this case review process, we made minor refinements to our measure specifications, including refining our inclusion definitions. Specifically, two groups of patients would no longer be included: a) those who were never treated for a UTI even if symptomatic (because they are not inappropriately diagnosed), b) those who received antibiotics only outside of our symptom collection window (symptoms may have occurred later). We also added “hypogastric” as a synonym for “suprapubic” to ensure hypogastric pain was included as a UTI symptom.

F. Face Validity: Feedback from HMS hospitals (N=40 hospitals)

We systematically assessed the perceived validity (after finalization of measure specifications) of the inappropriate diagnosis of UTI measure by soliciting feedback from all participating HMS hospitals (N=40 hospitals) via the following question: “Approximately, what percentage of cases called ASB by HMS do you agree are inappropriately diagnosed with ASB (0-100%).” All hospitals (40/40) responded. Respondents were local leaders or quality champions for the measures.

Median: 90% Inter-quartile range: 80% to 97%

G. Face Validity: National Expert Panel Feedback

Based on conversations held during our two-week online TEP, the 11 national experts who attended our TEP generally agreed with the face validity and operationalization of the overdiagnosis of UTI measure as currently specified. They believed that patients we identified as being inappropriately diagnosed were, in fact, inappropriately diagnosed. There were also some concerns about the use of the word “over-diagnosis” in the measure name. As a result, we changed the measure name to “inappropriate diagnosis” of UTI. There were no changes to measure specifications suggested by the TEP.

TEP Survey results:

Table 4. Distribution of TEP responses to **Question #1:** “The inappropriate diagnosis of UTI measure as specified can be used to distinguish between better and worse quality hospitals.”

| Rating | # of Responses (N=11) | Percent (%) | Cumulative Percent (%) |
|-----------------------|-----------------------|-------------|------------------------|
| 5 (Strongly agree) | 1 | 9.1% | 9.1% |
| 4 (Agree) | 8 | 72.7% | 81.8% |
| 3 (Neutral) | 1 | 9.1% | 90.9% |
| 2 (Disagree) | 0 | 0.0% | 90.9% |
| 1 (Strongly disagree) | 1 | 9.1% | 100.0% |

The majority (81.8%) of experts on the TEP responded “Agree” or “Strongly agree” (8/11 and 1/11, respectively). There was one response each for “Neutral” and “Strongly disagree”.

Table 5. TEP responses to **Question #2.** “What additional data would you like to see captured related to the inappropriate diagnosis of UTI? (free text)” N=11 respondents (free text question)

| % of Responses N=11 | Response | Our Action/Response to Comment |
|------------------------|----------------------------------|--|
| 72.3% (8/11) | None or N/A | None. Confirmed validity of measurement. |
| 9.1% (1/11) | Duration of Antibiotic Treatment | Added data on duration of antibiotic treatment for patients inappropriately diagnosed with UTI to measure submission. Patients inappropriately diagnosed with UTI received a median (IQR) 7 (4-9) antibiotic days, all of which were unnecessary.³ |
| 9.1% (1/11) | Balancing Measure | Added additional resources on studies of underdiagnosis to measure submission |
| 9.1% (1/11) | Length of stay data | Added data on length of stay for patients inappropriately diagnosed with UTI to measure submission. Patients inappropriately diagnosed with UTI has a median (IQR) length of stay of 5 (4-7) days. Compared to patients with ASB not treated with antibiotics, patients inappropriately diagnosed with UTI had a longer duration of hospitalization after urine testing (4 vs. 3 days, adjusted relative risk 1.37).³ |

The majority (72.3%) of experts on the TEP indicated that no additional data were needed. Suggestions from 3 TEP panelists (1 each) included: a) duration of antibiotic treatment, b) balancing measure, and c) length of stay data. We addressed each of these in our measure submission.

H. Face Validity: Patient Panel Feedback:

A summary of the findings from the Patient Engagement Panel can be found in the **Appendix**.

Generally, the patients who participated in our panel innately understood the meaning of over-diagnosis or inappropriate diagnosis:

"[over-diagnosis is] taking a somewhat minor issue and overemphasizing it and then maybe overtreating it"

"I was over-diagnosed by the doctor that I went to... I originally went because I had [a cough]... they didn't do any tests; he thought it was pneumonia and never did a test for it; he gave me 3 antibiotics within a 4-week time and so I feel like that is a perfect case of over-diagnosis. [Doctor says] hey, you're sick, I don't want to do a test, so take this." [Note. This participant was later admitted to another hospital with C. diff]

Patients also felt that measuring inappropriate diagnosis of infections was important and meaningful:

"That's [correct diagnosis] step 1... it takes me back to grad school...problem definition – you gotta make sure you're solving the right problem – that's the first step. If you don't, you're going to end up going down all these paths that are not going to lead you to the right answer."

"If you were to have a measure of more correct diagnosis and incorrect diagnosis, and I would do it on the hospital scale, ... I feel like if you were to get the correct diagnosis... I would automatically assume that you are getting the correct dose of medicine."

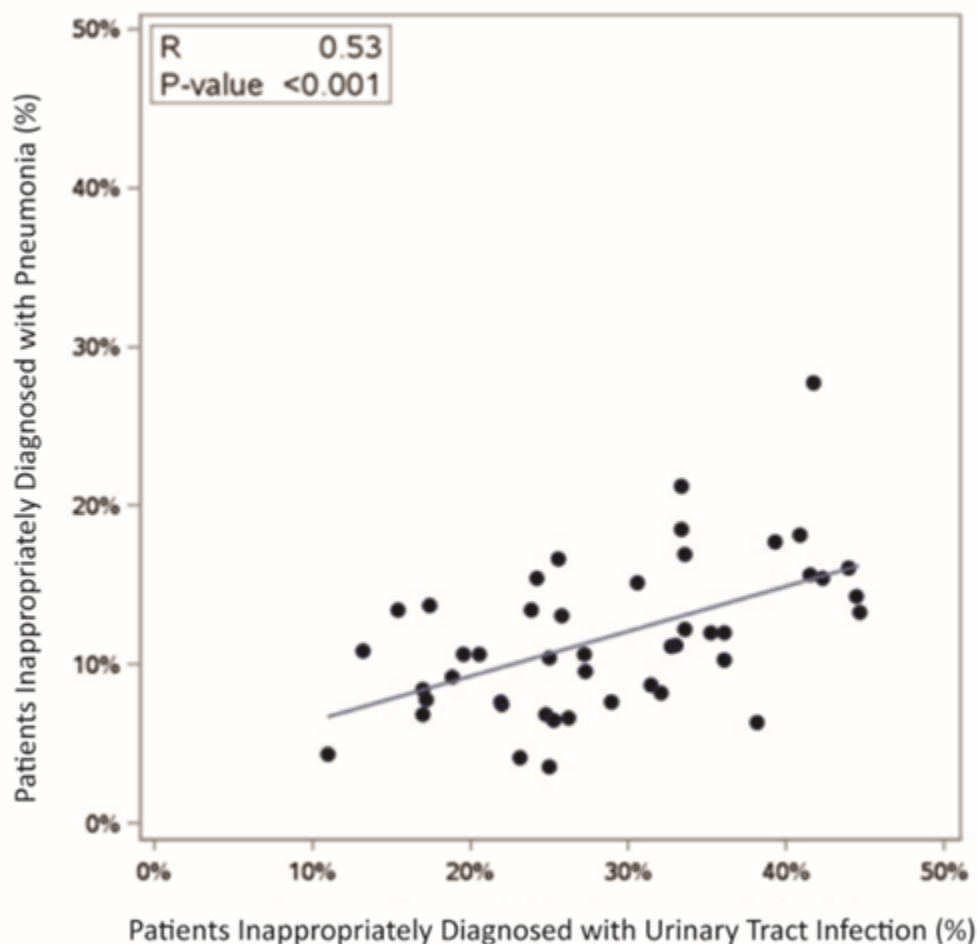
"I would like it if they had a hospital rating... I think it would be beneficial, and I would really appreciate that. I feel that it would affect my decision of where I would go... it would definitely affect where I would guide my family or loved one to go."

A participant has been looking for a care facility for his 98-year-old mother, utilizing U.S. News & Reports rankings. He said, “So yeah, I’ve been relying on that and I would definitely use something similar or look for something like that on the internet for a hospital.”

I. Empirical Validity: Association with Other Measures of Diagnostic Quality

To address whether inappropriate diagnosis of UTI was correlated with other domains of quality, we assessed whether inappropriate diagnosis of UTI (as currently specified) was related to inappropriate diagnosis of CAP. This manuscript was published in *BMJ Quality & Safety*.⁴ In it, we analyzed 10,398 patients treated for UTI and 14,085 patients treated for CAP from HMS hospitals between July 1, 2017 and March 31, 2020 and found that inappropriate diagnosis of UTI is moderately correlated with inappropriate diagnosis of CAP at the hospital level:

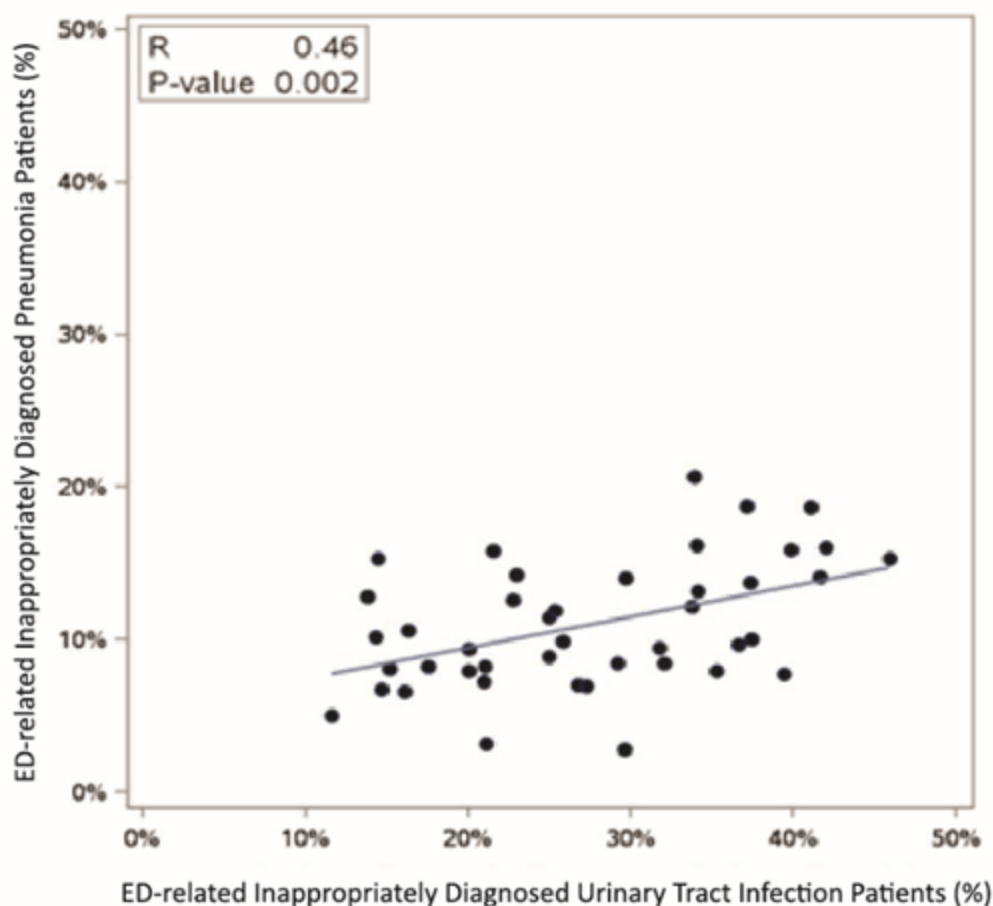
Figure 1. Relationship between inappropriate diagnosis of UTI and inappropriate diagnosis of CAP at the hospital level.



The percent of patients with inappropriate diagnosis of UTI (N=10,398) is moderately correlated with the percent of patients with inappropriate diagnosis of CAP (N=14,085) at the hospital level (R=0.53; P<0.001).

These findings were also true for 2,049 patients initially inappropriately diagnosed in the Emergency Room.

Figure 2. Relationship between inappropriate diagnosis of UTI and inappropriate diagnosis of CAP in Emergency Rooms.



In a sample of 2,049 patients from 46 hospitals and diagnosed in the Emergency Room, the percent of patients with inappropriate diagnosis of UTI is moderately correlated with the percent of patients with inappropriate diagnosis of CAP at the hospital level ($R=0.45$; $P<0.002$).

⁴ Gupta A, Petty L, Gandhi T, et al. Overdiagnosis of urinary tract infection linked to overdiagnosis of pneumonia: a multihospital cohort study. *BMJ Qual Saf*, 2022. doi:10.1136/bmjqs-2021-013565.

J. Empirical Validity: Association of Inappropriate diagnosis of UTI with Outcomes

There are three main harms associated with inappropriate diagnosis of UTI: delayed time to true diagnosis, antibiotic-associated adverse events, and antibiotic resistance.

In a paper published in *JAMA Internal Medicine*, we analyzed outcomes associated with antibiotic treatment in 2,733 hospitalized patients with ASB (i.e., inappropriate diagnosis of UTI).³ Patients inappropriately diagnosed with UTI were treated with a median (IQR) 7 (4-9) days of antibiotic therapy, all of which were unnecessary.

Outcomes of patients inappropriately diagnosed vs. those who had ASB and did not receive antibiotics are shown in the table below. Notably, patients inappropriately diagnosed with UTI who were treated with antibiotics had an approximately 1 day longer length of stay after date of urine testing than those who were not treated with antibiotics (aRR: 1.37 [1.28-1.47]).

Table 6. Outcomes for Treatment vs No Treatment for Asymptomatic Bacteriuria (N = 2733)

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| Outcome ^a | Antibiotics (n=2259) | No Antibiotics (n=474) | Unadjusted Odds Ratio (95% CI) | Unadjusted P Value | Adjusted Odds Ratio (95% CI) | Adjusted P Value |
|--|-------------------------|------------------------------|--------------------------------------|-----------------------|------------------------------------|---------------------|
| 30-d Postdischarge mortality ^b , N (%) | 63 (2.8) | 11 (2.3) | 1.22 (0.66-2.26) | 0.53 | 1.34 (0.72-2.49) | 0.35 |
| 30-d Postdischarge readmission ^b , N (%) | 362 (16.0) | 66 (13.9) | 1.16 (0.87-1.56) | 0.31 | 1.29 (0.92-1.81) | 0.14 |
| 30-d Postdischarge ED Visit ^b , N (%) | 272 (12.0) | 62 (13.1) | 0.91 (0.70-1.18) | 0.48 | 0.90 (0.66-1.24) | 0.52 |
| Discharge to post-acute care facility ^{b,c} , N (%) | 811 (35.9) | 102 (21.5) | 1.98 (1.58-2.48) | <0.001 | 1.19 (0.90-1.57) | 0.22 |
| <i>Clostridioides difficile</i> infection ^d , N (%) | 14 (0.6) | 2 (0.4) | 1.39 (0.41-4.68) | 0.59 | 0.88 (0.20-3.86) | 0.86 |
| Duration of hospitalization, median (IQR) d ^e | 4 (3-6) | 3 (2.5) | 1.37 (1.28-1.47) ^f | <0.001 | 1.37 (1.28-1.47) ^f | <0.001 |

Analysis of 2,733 patients inappropriately diagnosed with UTI and treated with antibiotics had an ~1 day longer length of stay after date of urine testing than those who were not treated with antibiotics (aRR:1.37 [1.28-1.47]).

Abbreviations: ED, emergency department; IQR, interquartile range.

^a Outcomes were adjusted for patient variables found to be significant (P<.05) and associated with treatment in the bivariate and multivariate analysis.

^b Mortality, readmissions, ED visits, and discharge to post-acute care facility were adjusted for age, Charlson Comorbidity Index score, hospitalization in 90 days preceding current admission, admission from nursing home, and insurance type.

^c Long-term acute care hospital, skilled nursing facility, inpatient rehabilitation, and subacute rehabilitation.

^d Infection occurring within 30 days of discharge was adjusted for age, history of antibiotic use and number of antibiotics in previous 90 days, admission from skilled nursing facility, prior hospitalization, proton-pump inhibitor use, immunosuppression, and Charlson Comorbidity Index score.

^e From date of urine testing (either urine culture or urinalysis, whichever was performed first). Adjusted for age, sex, Charlson Comorbidity Index score, prior hospitalization, admission from nursing home, and insurance type.

^f Relative risk given because duration of hospitalization is a continuous variable.

[Response Ends]

2b.04. Provide your interpretation of the results in terms of demonstrating validity. (i.e., what do the results mean and what are the norms for the test conducted?)

[Response Begins]

The validity of the inappropriate diagnosis of UTI measure is supported by three types of evidence: (1) strong face validity based on national guidelines and expert opinion and as gauged by feedback from TEP members, patients, and end-users (hospitals); (2) strong encounter-level validity as demonstrated by implicit review, evaluation of data abstraction errors, and hospital encounter-level feedback; (3) external empiric comparisons with other quality measures; and (4) validity of the outcome.

Face validity

The validity of the measure is supported by strong face validity results, as measured by systematic feedback from the TEP. As shown above, 82% of TEP members agreed with the statement: “The inappropriate diagnosis of UTI measure as specified can be used to distinguish between better and worse quality hospitals.”

Perhaps even more importantly, both patients and hospitals—the true end-users of the measure—found the measures to be valid. HMS hospitals who received measure scores found the measures to be highly valid, reporting they believed 90% of cases called inappropriate diagnosis of UTI were in fact inappropriately diagnosed.

Encounter-level Validity

Encounter-level validity is supported by substantial agreement between physician reviewers on case classification ($\kappa=0.72$), the low effect of abstraction errors on case classification, and by the long-standing general agreement by hospital experts with case classification during data feedback.

Empirical Validity Testing

The validity of the measure is further supported by the empiric validation results which demonstrate a correlation (in the expected strength and direction) between the inappropriate diagnosis of UTI measure and measures of inappropriate diagnosis of other infections, namely CAP. As expected, we found hospitals that performed worse on one measure also performed worse on the other. Thus, the inappropriate diagnosis of UTI measure may reflect the overall quality of diagnosis at a hospital.

Validity of the Outcome

The validity of the outcome is supported by the relationship between inappropriate diagnosis of UTI and outcomes.

[Response Ends]

2b.05. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified.

Describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided in Importance to Measure and Report: Gap in Care/Disparities.

[Response Begins]

We used the Spearman Brown prophecy to determine the minimum number of cases that hospitals participating in this measure would need to capture on an annual basis in order to allow us to distinguish performance accurately and reliably. Our analysis suggests that to meet the 0.8 standard for reliability, hospitals would need to abstract 59 cases annually.

Table 1. Number of annual cases needed to achieve each reliability threshold.

| Reliability | Number of annual cases needed |
|----------------|-------------------------------|
| 0.6 | 22 |
| 0.7 | 35 |
| 0.8 (standard) | 59 |
| 0.9 | 132 |

In order to achieve a desired reliability of 0.8, each hospital would need to abstract 59 cases annually.

Of the 40 hospitals participating in HMS in 2019 (our most recent year), 36/40 (90%) were able to meet this minimum standard of 59 annual cases (the 4 that did not were small hospitals). If we lowered the threshold for reliability to 0.7, 95% of hospitals would have been able to meet this minimum threshold of 35 cases.

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To further characterize the degree of variability in the measure score we analyzed hospitals in the HMS cohort and:

1. Report the distribution of the measure score
2. Calculate the mean; standard deviation; median; and 10th, 25th, 75th, and 90th percentile of the performance scores for each quarter.
3. Group hospitals by quartiles and assess whether the difference in mean measure score between each adjacent quartile was statistically significant.

[Response Ends]

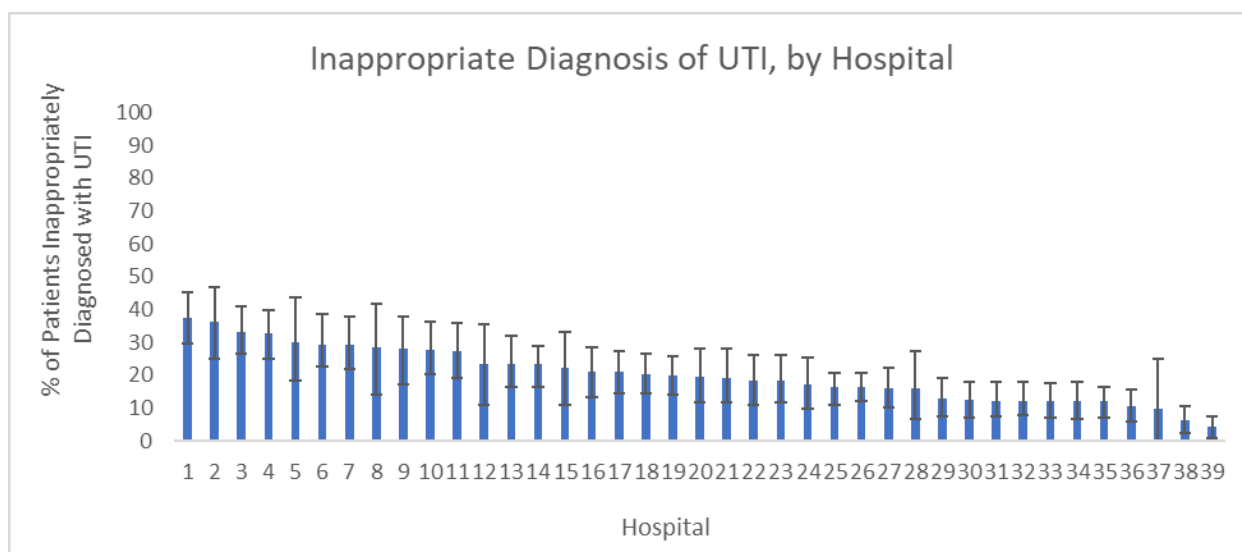
2b.06. Describe the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities.

Examples may include number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined.

[Response Begins]

The distribution of the measure for all hospitals (each hospital=1 blue bar) is shown below in **Figure 1** with error bars representing 95% confidence intervals. **Table 2** shows summary statistics for all years combined, the first 4 quarters, and the final 4 quarters.

Figure 1. Distribution of Inappropriate Diagnosis of Urinary Tract Infection by Hospital



Distribution of percentage of patients inappropriately diagnosed with UTI by hospital with 95% confidence intervals ranges from 4.2% to 37.3%. Data are based on the 4 quarters preceding March 2020 and include only hospitals that provided data during all four quarters (N=39 hospitals).

Table 2. Summary statistics for all years combined, the first 4 quarters, and the final 4 quarters.

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| Year | Number of Hospitals | Number of UTI Patients | Overall Mean Inappropriate Diagnosis | Hospital Adjusted Mean (SD) | Min-Max | 10th Percentile (better performance) | 25th Percentile | Median | 75th Percentile | 90th Percentile (worse performance) |
|------------------|---------------------|------------------------|--------------------------------------|-----------------------------|---------------|--------------------------------------|-----------------|--------|-----------------|-------------------------------------|
| All years | 45 | 12,939 | 23.9% (3088/12939) | 24.7% (0.012) | 10.9% - 47.4% | 14.7% | 18.9% | 23.2% | 30.6% | 38.0% |
| First 4 Quarters | 44 | 4,601 | 28.2% (1296/4601) | 28.3% (0.014) | 13.3% - 53.5% | 16.7% | 2.0% | 26.8% | 33.7% | 43.1% |
| Last 4 quarters | 39 | 4,791 | 19.9% (954/4791) | 20.2% (0.013) | 4.2% - 37.3% | 10.6% | 12.5% | 19.6% | 27.6% | 32.9% |

Summary statistics for all years combined, the first 4 quarters, and the final 4 quarters. Percent of patients inappropriately diagnosed with UTI decreased over time from the first 4 quarters to the last 4 quarters: 28.2% to 20.2% overall, 16.7% to 10.6% for the 10th percentile (better performance), and from 43.1% to 32.9% for the 90th percentile (worse performance).

Compared with average-performing hospitals, hospitals in the 10th percentile (better performance) have about 12 fewer patients inappropriately diagnosed with UTI per 100 patients treated for UTI than the median (~84 fewer unnecessary antibiotic use days/100 UTI discharges), and hospitals in the 90th percentile (worse performing) 15 more patients were inappropriately diagnosed with UTI per 100 patients treated for UTI than the median (~105 more unnecessary antibiotic use days/100 UTI discharges).

The grouping of hospitals by quartiles for all years, first 4 quarters, and last 4 quarters, is shown in **Table 3**. All quartiles are statistically significantly different from other quartiles.

Table 3. Differences between adjacent quartiles of performance

| Percentile comparison | Lower Quartile | Higher Quartile | Test statistic | p-value |
|---|----------------|-----------------|----------------|---------|
| All years: 1 st (best) quartile (0-25%) vs. 2 nd quartile (25-50%) | 15.23% | 20.99% | 6.34 | <.001 |
| All years: 2 nd (25%-50%) vs. 3 rd quartile (50%-75%) | 20.99% | 26.80% | 5.30 | <.001 |
| All years: 3 rd (50%-75%) vs. 4 th (worst) quartile (75%-100%) | 26.80% | 36.03% | 7.36 | <.001 |
| First 4 quarters: 1 st (best) quartile (0-25%) vs. 2 nd quartile (25-50%) | 18.42% | 23.92% | 3.26 | 0.001 |
| First 4 quarters: 2 nd (25%-50%) vs. 3 rd quartile (50%-75%) | 23.92% | 30.92% | 3.56 | <.001 |
| First 4 quarters: 3 rd (50%-75%) vs. 4 th (worst) quartile (75%-100%) | 30.92% | 40.87% | 4.62 | <.001 |
| Last 4 quarters: 1 st (best) quartile (0-25%) vs. 2 nd quartile (25-50%) | 10.76% | 16.61% | 4.21 | <.001 |

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| Percentile comparison | Lower Quartile | Higher Quartile | Test statistic | p-value |
|--|----------------|-----------------|----------------|---------|
| Last 4 quarters: 2 nd (25%-50%) vs. 3 rd quartile (50%-75%) | 16.61% | 22.47% | 3.50 | <.001 |
| Last 4 quarters: 3 rd (50%-75%) vs. 4 th (worst) quartile (75%-100%) | 22.47% | 31.75% | 4.95 | <.001 |

Differences between adjacent quartiles of performance for the inappropriate diagnosis of UTI measure were statistically significant ($P < 0.001$) for adjacent quarters overall (all years combined), for the first 4 quarters, and for the last 4 quarters.

[Response Ends]

2b.07. Provide your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities.

In other words, what do the results mean in terms of statistical and meaningful differences?

[Response Begins]

The measure was able to detect facilities with above- and below-average performance. In the first year, facility scores ranged from 13.3% to 53.5% with a mean performance of 28.3%. By the final year, facility scores had improved markedly and ranged from 4.2% to 37.3% with a mean performance of 20.2%.

Our analysis showed a statistically significant difference in performance between each quartile of hospitals, suggesting consistent performance gaps across facilities and targets for improvement.

[Response Ends]

2b.08. Describe the method of testing conducted to identify the extent and distribution of missing data (or non-response) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders). Include how the specified handling of missing data minimizes bias.

Describe the steps—do not just name a method; what statistical analysis was used.

[Response Begins]

This measure is calculated using chart-abstracted data. To limit the effects of missing data, abstractors cannot submit a value of “missing” for individual data elements because the case will be rejected by the abstraction tool. Although abstractors cannot submit missing data, for some data (e.g., white blood cell count) they may submit a value of “unknown” or “not available.” For cases submitted by hospitals from July 2017 through March 2020, we calculated the number of cases that were missing data used in case classification.

[Response Ends]

2b.09. Provide the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data.

For example, provide results of sensitivity analysis of the effect of various rules for missing data/non-response. If no empirical sensitivity analysis was conducted, identify the approaches for handling missing data that were considered and benefits and drawbacks of each).

[Response Begins]

Data that were missing or marked as “unknown/not available” are presented below. Some of these data are accurately missing (e.g., no urinalysis obtained during hospitalization), others are missing due to errors.

As expected, missing data relevant to UTI cases were extremely rare. The percentage of encounters with missing, “unknown,” or “not available” values was 5.2% (714/13,805) of all included patients.

Table 4. Percentage of encounters with missing, “unknown,” or “not available” data

| Variable | Percent missing, “unknown,” or “not available” % (n/N) |
|------------------------|---|
| Age | 0% |
| Race | 1.8% (243/13,805) |
| Sex | 0% (6/13,805) |
| Ethnicity | 14.6% (2,019/13,805) |
| Temperature | 0% (4/13,805) |
| Heart rate | 0% (4/13,805) |
| Respiratory rate | 0% (4/13,805) |
| White blood cell count | 0.5% (73/13,805) |
| Urinary catheter | 3.5% (484/13,805) |
| Urine culture organism | 0% (5/13,805) |
| Urinalysis | 1% (144/13,805) |

Percentage of encounters with missing, “unknown,” or “not available” data. For demographics (age, race, sex, and ethnicity) encounters with missing, “unknown,” or “not available” data ranged from 0% to 14.6%. For variables relevant to UTI, encounters with missing, “unknown,” or “not available” data ranged from 0% to 3.5%.

[Response Ends]

2b.10. Provide your interpretation of the results, in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and non-responders), and how the specified handling of missing data minimizes bias.

In other words, what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis was conducted, justify the selected approach for missing data.

[Response Begins]

The percentage of cases that could potentially be affected by missing data is negligible, indicating that missing data did not affect the performance results or other findings. As noted above, when data were missing it was often because they did not exist in the medical record (e.g., ethnicity), rather than due to an error in abstraction.

[Response Ends]

Note: This item is directed to measures that are risk-adjusted (with or without social risk factors) OR to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eQMs). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator). Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.

2b.11. Indicate whether there is more than one set of specifications for this measure.

[Response Begins]

No, there is only one set of specifications for this measure

[Response Ends]

2b.12. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications.

Describe the steps—do not just name a method. Indicate what statistical analysis was used.

[Response Begins]

[Response Ends]

2b.13. Provide the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications.

Examples may include correlation, and/or rank order.

[Response Begins]

[Response Ends]

2b.14. Provide your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications.

In other words, what do the results mean and what are the norms for the test conducted.

[Response Begins]

[Response Ends]

2b.15. Indicate whether the measure uses exclusions.

[Response Begins]

Yes, the measure uses exclusions.

[Response Ends]

2b.16. Describe the method of testing exclusions and what was tested.

Describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used?

[Response Begins]

All exclusions were determined by careful clinical review and discussion and feedback from our national expert panel and HMS' Data, Design, and Publications Committee.

Exclusion criteria (and reasoning) include:

- Patients who left against medical advice or refused medical care
 - This exclusion is needed for acceptability of the measure to hospitals, who do not have the opportunity to deliver full care
- Patients admitted on hospice or comfort care
 - This exclusion is needed for acceptability of the measure to hospitals, who may appropriately adjust their treatment and diagnostic procedures to comply with patient desires
- Patients who were pregnant or breastfeeding
 - This exclusion is needed for acceptability of the measure to hospitals, as pregnancy/breastfeed presents diagnostic and treatment challenges that may differ from patients who are not pregnant/breastfeeding
- Patients with a spinal cord injury
 - This exclusion was initiated by members of the TEP who believed this patient population to be substantially different from others included in the measures and to have potentially different signs and symptoms of a UTI. Thus, to increase acceptability and face validity, these patients are excluded.
- Patients with a UTI-related complication (operationalized by excluding patients discharged on more than 14 days of antibiotic therapy)
 - This exclusion is needed for acceptability of the measure to hospitals. UTI-related complications are not well documented on ICD or other coding but are important reasons to treat patients more aggressively. Generally, patients discharged on more than 14 days of antibiotics do not have typical UTIs; rather, they have an alternative reason or complication for extended therapy (e.g., nephric abscess).

To assess how common exclusion criteria were, we reviewed the literature—including national databases (Medicaid, Medicare, Premier) to estimate typical numbers of patients excluded for the above reasons. For the final exclusion criterion, we were able to estimate this directly from the HMS database.

[Response Ends]

2b.17. Provide the statistical results from testing exclusions.

Include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores.

[Response Begins]

Our exclusion results are shown below:

Table 1. Percent of individuals excluded based on exclusion criteria

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| Exclusion | Percent of Patients Excluded: Estimates from the Literature/HMS |
|--|--|
| Patients who left against medical advice | 0.37% ¹ |
| Patients who were pregnant or breastfeeding | 0.8% ² |
| Patients admitted on hospice or comfort care | 0.33% (Medicaid) to 0.62% (Medicare) 1% (Premier) ³ |
| UTI-related complication (>14 days of antibiotics at discharge) | 0.3% (9/3197)- HMS Estimates |
| Total | 1.8%-2.47% |

The total percent of patients excluded based on exclusion criteria estimated from the literature and HMS data ranges from 1.8% to 2.47%. Individual exclusion criteria would exclude 0.30% to 1.0% of patients.

In addition, we provided all exclusion criteria to participating hospitals and our technical expert panel to ensure they appeared feasible and reasonable. There was generally agreement across our groups that the exclusions led to a more accurate and fair assessment of patients inappropriately diagnosed with UTI. Spinal cord injury was one item discussed by the TEP who agreed they should be excluded. The TEP member from the American Urological Association reviewed our inclusion criteria for urinary anatomy and agreed with their operationalization. Some TEP members suggested additional populations to include in the future—such as surgical patients and those in nursing homes—but the group believed that starting with a less contentious group (i.e., hospitalized medical patients) first would be a great start and a necessary step to move into more difficult populations (e.g., nursing homes).

¹ YNHSC/CORE. Excess Days in Acute Care (EDAC) Measures Methodology. CMS.gov. Methodology Web site. <https://qualitynet.cms.gov/inpatient/measures/edac/methodology>. Published 2021. Accessed 11/20/2021.

² Dinh A, Ropers J, Duran C, et al. Discontinuing beta-lactam treatment after 3 days for patients with community-acquired pneumonia in non-critical care wards (PTC): a double-blind, randomised, placebo-controlled, non-inferiority trial. *Lancet*. 2021;397(10280):1195-1203. doi:10.1016/S0140-6736(21)00313-5.

³ Lindenauer PK, Stefan MS, Shieh MS, Pekow PS, Rothberg MB, Hill NS. Outcomes associated with invasive and noninvasive ventilation among patients hospitalized with exacerbations of chronic obstructive pulmonary disease. *JAMA Intern Med*. 2014;174(12):1982-1993. doi:10.1001/jamainternmed.2014.5430. PMID: PMC4501470.

[Response Ends]

2b.18. Provide your interpretation of the results, in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results.

In other words, the value outweighs the burden of increased data collection and analysis. Note: If patient preference is an exclusion, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion.

[Response Begins]

Exclusions were uncommon. When present they were needed to improve acceptability by the hospitals. Feedback from our TEP and from end-user hospitals was supportive of the exclusions in their current form.

[Response Ends]

2b.19. Check all methods used to address risk factors.

[Response Begins]

No risk adjustment or stratification

[Response Ends]

2b.20. If using statistical risk models, provide detailed risk model specifications, including the risk model method, risk factors, risk factor data sources, coefficients, equations, codes with descriptors, and definitions.

[Response Begins]

[Response Ends]

2b.21. If an outcome or resource use measure is not risk-adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (i.e., case mix) is not needed to achieve fair comparisons across measured entities.

[Response Begins]

N/A. Not an intermediate or health outcome, PRO-PM, or resource use measure.

In the context of healthcare performance assessment, the purpose of the risk model is to reduce bias due to case mix characteristics present at the start of care (i.e., to risk adjust), not to totally explain variation in outcomes, which would require also including variables about quality of care. Variables related to quality of care are purposely not included in risk models for performance measures used to assess quality.⁴

Specifically, CMS notes:

- “Process measures are not risk-adjusted; rather the target population of a process measure is defined to include all patients for whom the process measure is appropriate.”
- “The variation in measured entity-level (e.g., clinician or facility) performance may be due to variation in quality or variation in factors that are independent of quality (e.g., factors like the age or severity of illness of patients). Independent of quality means that the clinician treats the patients exactly the same way, but patients who have the factor (older or sicker) have worse outcomes than patients who do not (younger or less sick).”

⁴ Measures Management System Risk Adjustment. Centers for Medicare & Medicaid. Measure Management & You Web site. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Risk-Adjustment.pdf>. Published 2017. Accessed 11/30/2021.

[Response Ends]

2b.22. Select all applicable resources and methods used to develop the conceptual model of how social risk impacts this outcome.

[Response Begins]

[Response Ends]

2b.23. Describe the conceptual and statistical methods and criteria used to test and select patient-level risk factors (e.g., clinical factors, social risk factors) used in the statistical risk model or for stratification by risk.

Please be sure to address the following: potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$ or other statistical tests; correlation of x or higher. Patient factors should be present at the start of care, if applicable. Also discuss any “ordering” of risk factor inclusion; note whether social risk factors are added after all clinical factors. Discuss any considerations regarding data sources (e.g., availability, specificity).

[Response Begins]

[Response Ends]

2b.24. Detail the statistical results of the analyses used to test and select risk factors for inclusion in or exclusion from the risk model/stratification.

[Response Begins]

[Response Ends]

2b.25. Describe the analyses and interpretation resulting in the decision to select or not select social risk factors.

Examples may include prevalence of the factor across measured entities, availability of the data source, empirical association with the outcome, contribution of unique variation in the outcome, or assessment of between-unit effects and within-unit effects. Also describe the impact of adjusting for risk (or making no adjustment) on providers at high or low extremes of risk.

[Response Begins]

[Response Ends]

2b.26. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (describe the steps—do not just name a method; what statistical analysis was used). Provide the statistical results from testing the approach to control for differences in patient characteristics (i.e., case mix) below. If stratified ONLY, enter “N/A” for questions about the statistical risk model discrimination and calibration statistics.

Validation testing should be conducted in a data set that is separate from the one used to develop the model.

[Response Begins]

[Response Ends]

2b.27. Provide risk model discrimination statistics.

For example, provide c-statistics or R-squared values.

[Response Begins]

[Response Ends]

2b.28. Provide the statistical risk model calibration statistics (e.g., Hosmer-Lemeshow statistic).

[Response Begins]

N/A. Not an intermediate or health outcome, PRO-PM, or resource use measure. No risk model/stratification.

[Response Ends]

2b.29. Provide the risk decile plots or calibration curves used in calibrating the statistical risk model.

The preferred file format is .png, but most image formats are acceptable.

[Response Begins]

[Response Ends]

2b.30. Provide the results of the risk stratification analysis.

[Response Begins]

[Response Ends]

2b.31. Provide your interpretation of the results, in terms of demonstrating adequacy of controlling for differences in patient characteristics (i.e., case mix).

In other words, what do the results mean and what are the norms for the test conducted?

[Response Begins]

[Response Ends]

2b.32. Describe any additional testing conducted to justify the risk adjustment approach used in specifying the measure.

Not required but would provide additional support of adequacy of the risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed.

[Response Begins]

[Response Ends]

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3.01. Check all methods below that are used to generate the data elements needed to compute the measure score.

[Response Begins]

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

[Response Ends]

3.02. Detail to what extent the specified data elements are available electronically in defined fields.

In other words, indicate whether data elements that are needed to compute the performance measure score are in defined, computer-readable fields.

[Response Begins]

Some data elements are in defined fields in electronic sources

[Response Ends]

3.03. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using data elements not from electronic sources.

[Response Begins]

Currently, some of the inappropriate diagnosis of UTI data elements can be captured electronically in discrete fields (e.g., vital signs, laboratory values). However, not all documentation required to report the inappropriate diagnosis of UTI measure can be captured electronically in discrete fields. In particular **symptoms of UTI** are not in defined, computer-readable fields.

Rationale for Using Data Elements not from Electronic Sources

While efforts are being made to facilitate an electronic measure (see below), gaps remain in the ability to electronically capture all of the required data for measure validity. The inappropriate diagnosis of UTI measure requires data abstractors to review documentation in various formats, including narrative free text, to identify the specific information necessary to report the measure. Preliminary efforts to convert the inappropriate diagnosis of UTI measure to an eCQM within the current Health Quality Measure Format/Quality Data Model frameworks showed that the transition is not immediately feasible.

Symptoms are generally documented in free-text spaces within the medical record, and their location varies by hospital. Symptoms are critical to measure validity, as urine cultures and other diagnostic tests (e.g., urinalyses, white blood cell counts) are both insensitive and non-specific, and UTI is a clinical diagnosis.¹⁻³ Measures of diagnostic accuracy of UTI thus require clinical data—namely, symptoms.

Possible Replacement for Free-text Symptoms

Because symptoms are the primary reason the measure cannot be an eCQM, we tested a method that replaces **free text symptoms** with a discrete data element—**urine culture indications**. Some (but not all) hospitals allow or require an indication when ordering a urine culture. Indications can be free text but are often listed from discrete variables that include symptoms or signs of infection. Assuming the listed signs or symptoms in the indication are accurate (i.e., the clinician is selecting an accurate choice), then they could feasibly be used instead of free text symptoms from the medical record. We tested whether this method would be valid in the HMS cohort of hospitals.

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First, we found that over half of patients had no indication listed in the urine culture order, including 61.9% (1979/3197) of inappropriate diagnosis of UTI cases and 56.4% (5981/10,608) of UTI cases. Another quarter of patients (27.4% of inappropriate diagnosis and 24.7% of UTI cases) were the result of “reflex” cultures triggered by “positive” urinalyses and thus did not have an indication listed. This left approximately 25% of all patients with an indication listed. Of those, the most common indication listed was abnormal urinalysis; see the following table for all listed indications:

Table 1. Top 10 Indications for Urine Cultures (Indications Listed in the Urine Culture Order), N=3,981

| Discrete Urine Culture Indication | UTI by Free Text Symptoms, N=3,167 | Inappropriate Diagnosis of UTI by Free Text Symptoms, N=814 |
|--------------------------------------|------------------------------------|---|
| Abnormal Urinalysis | 53% | 68% |
| Other | 13% | 14% |
| Dysuria | 13% | 5% |
| Altered Mental Status | 11% | 10% |
| Fever | 5% | 1% |
| Frequency | 5% | 1% |
| Costovertebral Angle Pain/Tenderness | 5% | 1% |
| Hematuria | 4% | 0% |
| Suprapubic Pain | 4% | 1% |
| Urgency | 3% | 1% |
| Abdominal Pain | 3% | 2% |

The most common indication for the urine culture as indicated in the order for the urine culture was abnormal urinalysis, both for appropriate and inappropriate diagnosis of UTI cases. Specific symptoms of a UTI (e.g., dysuria, frequency) were more commonly listed indications for the urine culture in UTI cases.

*May add up to more than 100% as patients could have multiple indications.

After excluding cases with no indication in the order (n = 7,960), cases called UTI due to presence of severe sepsis or bacteremia (n = 1,430), and cases that were urine reflex cultures (n = 3,494), we compared the classification of cases as inappropriate diagnosis of UTI vs. UTI by urine culture indication to classification by chart review to determine sensitivity, specificity, negative predictive value, and positive predictive value.

We found that discrete urine culture indications have a high sensitivity but low specificity for identifying inappropriate diagnosis of UTI. This indicates there is a low positive predictive value and high negative predictive value for identifying inappropriate diagnosis of UTI. Thus, if the indication in the urine culture order indicates inappropriate diagnosis of UTI, the order is impossible to interpret. If the indication in the urine culture order indicates UTI, the order is likely to be correct – in part because UTI is more common.

Table 2. Case Classification by Chart Review vs. Urine Culture Indication, N=3150

| | UTI by Free Text Symptoms, N=2,438 | Inappropriate Diagnosis of UTI by Free Text Symptoms, N=712 |
|--|---|---|
| UTI by Discrete Urine Culture Indication, N=1,301 | True UTI 1,238 | False UTI 63 |
| Inappropriate Diagnosis of UTI by Discrete Urine Culture Indication, N=1,849 | False Inappropriate Diagnosis of UTI 1,200 | True Inappropriate Diagnosis of UTI 649 |

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The vast majority of cases called UTI based on the urine culture indication were UTIs on case review. However, the actual classification for cases called inappropriate diagnosis of UTI based on the urine culture indication was mixed. In sum, urine culture indications have a high sensitivity but poor specificity for identifying inappropriate diagnosis of UTI.

Sensitivity of discrete urine culture indication for Inappropriate Diagnosis of UTI =

True Inappropriate Diagnosis of UTI/(True Inappropriate Diagnosis of UTI + False UTI) = **91.2%**

Specificity of discrete urine culture indication for Inappropriate Diagnosis of UTI =

True UTI/(True UTI + False Inappropriate Diagnosis of UTI) = **50.8%**

Positive Predictive Value (for identifying Inappropriate Diagnosis of UTI) =

True Inappropriate Diagnosis of UTI/(True Inappropriate Diagnosis of UTI/False Inappropriate Diagnosis of UTI) = **35.1%**

Negative Predictive Value (for identifying UTI) = True UTI/(True UTI + False UTI) = **95.2%**

Based on this analysis, at this time, urine culture indications are not a valid way of capturing symptoms and classifying patients as overdiagnosis of UTI vs. UTI. This is consistent with prior studies of catheter-associated UTI which found little overlap between symptoms noted in discrete and free text fields.⁴ However, urine culture indications are a credible, near-term path to eCQM. For that to happen, hospitals would need to expand efforts to require urine culture indications (a process already underway), and indication accuracy would need to improve. Alternatively natural language processing could be developed to identify symptoms from the free-text areas of the medical record (see below).

1. Choudhuri JA, Pergamit RF, Chan JD, et al. An Electronic Catheter-Associated Urinary Tract Infection Surveillance Tool. *Infection Control & Hospital Epidemiology*. 2011;32(8):757-762.
2. Branch-Elliman W, Strymish J, Kudesia V, Rosen AK, Gupta K. Natural Language Processing for Real-Time Catheter-Associated Urinary Tract Infection Surveillance: Results of a Pilot Implementation Trial. *Infect Control Hosp Epidemiol*. 2015;36(9):1004-1010.
3. Wald HL, Bandle B, Richard AA, Min SJ, Capezuti E. Implementation of electronic surveillance of catheter use and catheter-associated urinary tract infection at Nurses Improving Care for Healthsystem Elders (NICHE) hospitals. *Am J Infect Control*. 2014;42(10 Suppl):S242-249.
4. Sanger PC, Granich M, Olsen-Scribner R, et al. Electronic Surveillance For Catheter-Associated Urinary Tract Infection Using Natural Language Processing. *AMIA Annu Symp Proc*. 2017;2017:1507-1516.

[Response Ends]

3.04. Describe any efforts to develop an eCQM.

[Response Begins]

Fortunately, as noted above, there are multiple promising pathways to eCQM development. First, there are methods under development to assess diagnostic accuracy of UTI using natural language processing to identify symptoms from the medical record. For example, one single-center study at the University of Washington was able to identify catheter-associated UTI vs. catheter-associated asymptomatic bacteriuria using natural language processing to identify symptoms.⁵ Another study tested natural language processing to identify urinary symptoms in hospitalized patients and found high sensitivity (100%) and positive predictive value (97%).¹ These methods need to be prospectively validated in different settings and for non-catheter-associated UTI; however, they show promise for eCQM development. Second, requiring urine culture indications is becoming a more standard process for hospitals which is likely to improve the sensitivity and specificity of indications for identifying overdiagnosis of UTI. Multiple research efforts (e.g., through the Centers for Disease Control and Prevention Shepherd projects and through the Gordon and Betty Moore Foundation) continue to make progress on eCQM development for UTI diagnosis.

1. Gundlapalli AV, Divita G, Redd A, et al. Detecting the presence of an indwelling urinary catheter and urinary symptoms in hospitalized patients using natural language processing. J Biomed Inform. 2017;71s:S39-s45.

[Response Ends]

3.06. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

[Response Begins]

Data Collection, Availability, Missing Data

This measure is calculated using chart-abstracted data routinely collected during the normal process of patient care and requires no additional data. Because these data are captured as standard practice, missing data were extremely rare. The percentage of encounters with any missing, “unknown,” or “not available” values was 5.2% (714/13,805) of all included patients. This missing data had little effect on the ability to classify the case as inappropriate vs. appropriate diagnosis of UTI.

Timing/Frequency of Data Collection and Patient Sampling

Hospitals have the option to sample from their population or submit their entire population. Hospitals also have the option to sample quarterly or monthly. Over the entire year, 59 cases are recommended for the denominator. Thus, hospitals whose patient population size is less than or equal to the minimum number of cases per quarter (N=15) or month (N=5) for the measure should not sample. A hospital may choose to use a larger sample size than is required.

Using the current HMS hospital cohort as a representative example, the minimum number of case abstracts per hospital per year to meet pre-specified reliability thresholds of 0.7 and 0.8 are highly attainable. Within a cohort of 40 HMS hospitals participating in 2019, 90% of hospitals were able to abstract the minimum of 59 cases to achieve 0.8 reliability. Of those that could not abstract the required number of cases, hospital bed sizes were 49 beds, 68 beds, 75 beds, and 133 beds. Ninety-five percent of hospitals could abstract the 35 cases/year necessary to achieve 0.7 reliability, and all but one could reach the abstraction threshold for 0.6 reliability. Of the two hospitals unable to achieve abstraction thresholds for 0.7 reliability (75 beds and 133 beds), one hospital over-sampled cases for an alternative measure and the other had challenges with data abstractor hiring.

Patient Confidentiality

Data are de-identified.

Time and Cost

To improve feasibility and reduce time and cost of data collection, we removed all non-essential data collection elements from the measure during measure testing. We also reviewed exclusion criteria to remove those that were uncommon and would not impact measure outcomes. This pared down data collection form was tested at 4 hospitals in Utah to estimate the time needed for case review. Those results follow:

- Review of eligibility criteria to determine whether a patient would be included vs. excluded took 1-3 minutes.
- Review time could be reduced by adding exclusion criteria (e.g., ICU admission) electronically to lists for review.
- Across the 4 hospitals, 34.7%-69.3% of patients reviewed for inclusion were eligible (see Table for details)
- Once determined to be eligible, case review took 15 to 30 minutes per case.

Table 3. Case review of hospitalized patients with positive urine culture at 4 Utah hospitals over a 6-month period.

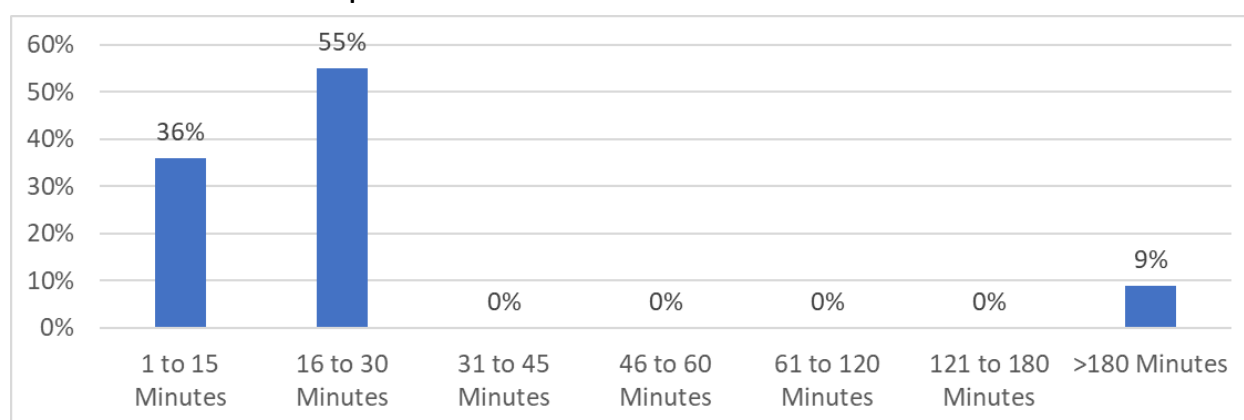
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| | # beds | # cases reviewed | # cases included | % included |
|-------------------|--------|------------------|------------------|------------|
| Hospital 1 | 1000 | 216 | 75 | 34.7% |
| Hospital 2 | 502 | 75 | 52 | 69.3% |
| Hospital 3 | 90 | 75 | 38 | 50.6% |
| Hospital 4 | 132 | 84 | 52 | 61.9% |

Across 4 Utah hospitals with bed size ranging from 132 to 1000, 34.7% to 69.3% of patients reviewed for inclusion were eligible.

When speaking to Infection Preventionists at included hospitals, the time for data collection was on par with other NHSN measures currently requiring case review (e.g., CAUTI, CLABSI, SSI, CDI, VAP). They all noted that feasibility improved for those measures over the years as electronic health record vendors built modules to reduce initial screening. The Joint Commission also provided comparative data during our Technical Expert Panel. They noted that 4 chart review measures abstracted across 11 sites had similar time requirements to our proposed measure.

Time Required for Abstraction of 4 Different Measures



The majority of abstractions (91%) took 30 minutes or less to complete (36% 1-15 minutes; 55% 16-30 minutes; 9% >180 minutes).

*Data provided by Dr. David Baker of The Joint Commission

During our technical expert panel, we surveyed our experts on measure feasibility via the following two questions:

- How appropriate is the quantity of information collected for use in determining inappropriate diagnosis of UTI? (N=11 experts)**
 - 82% (9/11) responded it was the correct amount of data
- Compared to other measures requiring chart review, how easy do you believe it would be for a hospital to collect the data needed to assess whether a case represents an inappropriate diagnosis of UTI? (N=11 experts)**
 - 46% (5/11) reported it would be "about the same as other measures"
 - 27% reported it would be easier and 27% reported it would be more difficult than other measures

We also surveyed hospitals participating in HMS (N=40) to ask about their experiences with the feasibility of the inappropriate diagnosis of UTI measure (see Table 4).

Table 4. Responses to the question: **How easy is it for your hospital to collect the data needed to assess whether a case represents asymptomatic bacteriuria? (N=40 hospitals)**

| N=40 hospitals | Response; N (%) |
|----------------|-----------------|
| Very Easy | 4 (10.0%) |
| Easy | 11 (27.5%) |

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| N=40 hospitals | Response; N (%) |
|----------------------------|-----------------|
| Neither Easy nor Difficult | 16 (40%) |
| Difficult | 7 (17.5%) |
| Very Difficult | 2 (5%) |

The majority of survey respondents representing 40 HMS hospitals (31/40, 77.5%) reported it was very easy, easy, or neither easy nor difficult to collect the data needed to assess whether a case represents asymptomatic bacteriuria.

The majority of respondents reported it was very easy, easy, or neither easy nor difficult: 31/40 (77.5%)

[Response Ends]

Consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

3.07. Detail any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm),

Attach the fee schedule here, if applicable.

[Response Begins]

All measures are free to use. Data dictionaries and data collection templates are free and accessible at our website (<https://mi-hms.org/inappropriate-diagnosis-urinary-tract-infection-uti-hospitalized-medical-patients>).

[Response Ends]

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement, in addition to demonstrating performance improvement.

4a.01. Check all current uses. For each current use checked, please provide:

- Name of program and sponsor
- URL
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

[Response Begins]

Payment Program

[Payment Program Please Explain]

Program: Michigan Hospital Medicine Safety Consortium (HMS)

Sponsor: Blue Cross and Blue Shield of Michigan

URL: <https://mi-hms.org/quality-initiatives/antimicrobial-use-initiative>

Purpose: To improve outcomes of hospitalized patients treated for urinary tract infection (UTI).

Geographic area: Acute care hospitals in the state of Michigan. Between 7/1/2017 and 3/31/2020 there were 13,805 hospitalized patients treated for UTI across 49 HMS hospitals.

Level of measurement and setting: We collect patient-level data which is evaluated for inappropriate diagnosis of UTI. Since January 1, 2018, HMS hospitals have received financial incentives based on their performance on the inappropriate diagnosis of UTI measure. Annual target goals are established by the HMS Coordinating Center and approved by the HMS Data, Design, and Publications Committee and the funder (Blue Cross and Blue Shield of Michigan). Goals are meant to be “stretch” goals that drive hospitals to improve every year.

Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

[Quality Improvement with Benchmarking (external benchmarking to multiple organizations) Please Explain]

Program: Michigan Hospital Medicine Safety Consortium (HMS)

Sponsor: Blue Cross and Blue Shield of Michigan

URL: <https://mi-hms.org/quality-initiatives/antimicrobial-use-initiative>

Purpose: To improve outcomes of hospitalized patients treated for urinary tract infection (UTI).

Geographic area: Acute care hospitals in the state of Michigan. Between 7/1/2017 and 3/31/2020 there were 13,805 hospitalized patients treated for UTI across 49 HMS hospitals.

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Level of measurement and setting: We collect patient-level data which is evaluated for inappropriate diagnosis of UTI. Hospitals receive a list of all patients considered inappropriately diagnosed. In addition, aggregated data on inappropriate diagnosis of UTI from each hospital is presented quarterly and annually to hospitals to allow them to compare: a) performance in their own hospital over time and b) performance compared to other hospitals participating in HMS.

[Response Ends]

4a.02. Check all planned uses.

[Response Begins]

Public reporting

Public Health/Disease Surveillance

Payment Program

Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Quality Improvement (internal to the specific organization)

Measure Currently in Use

[Response Ends]

4a.03. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing), explain why the measure is not in use.

For example, do policies or actions of the developer/steward or accountable entities restrict access to performance results or block implementation?

[Response Begins]

[Response Ends]

4a.04. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes: used in any accountability application within 3 years, and publicly reported within 6 years of initial endorsement.

A credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.

[Response Begins]

[Response Ends]

4a.05. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

Detail how many and which types of measured entities and/or others were included. If only a sample of measured entities were included, describe the full population and how the sample was selected.

[Response Begins]

Since 2017, the inappropriate diagnosis of UTI measure has been in use through the Michigan Hospital Medicine Safety Consortium (HMS) to measure and improve care for hospitalized patients with UTI. HMS is a collaborative quality initiative of 60+ hospitals across the state of Michigan whose purpose is to improve the care of hospitalized infections. As part of its Antimicrobial Use Initiative, data have been collected from a pseudo-random population of hospitalized patients treated for UTI. Every quarter, participating hospitals receive data on the proportion of patients treated for UTI at their hospital that are inappropriately diagnosed. In addition, each hospital receives data on how their performance compares to all other hospitals in HMS and how their performance has changed over time. Hospitals also receive a list of patients who were considered inappropriately diagnosed so that they can further evaluate inappropriate diagnosis and use those data to drive internal quality improvement efforts.

Beginning in 2018, a pay-for-performance incentives was initiated for HMS hospitals whereby a percentage of their Blue Cross and Blue Shield of Michigan reimbursements were given if they met a pre-defined performance metric. Every year since, the threshold for full payment has been made harder in order to continue to drive improvement.

[Response Ends]

4a.06. Describe the process for providing measure results, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

[Response Begins]

Tri-annual Collaborative Wide Meetings

Individuals from participating hospitals meet in person three times a year. We encourage hospitals to send their Clinical Data Abstractors, physician champions, and quality leads, as well as other individuals from their hospital that might be interested in participation. These meetings take place three times per year – in March, July, and November. Traditionally, meetings took place in-person at venues across Michigan. In 2020 and 2021, these meetings were hosted via an on-line format due to COVID-19.

The tri-annual meetings provide individuals from member hospitals with the opportunity engage with each other in a variety of formats. Each meeting includes a formal discussion of the data from each of the HMS initiatives—including data on inappropriate diagnosis of UTI—for the previous quarter, presentations from member hospitals and expert guests, breakout/work group sessions, and networking opportunities. These meetings allow individuals from member hospitals to network with individuals from other hospitals who have excelled in those areas to seek ideas on how to improve their performance. It also allows for an opportunity for feedback and to answer questions related to their measure performance.

Site-specific Reports on Measure Performance

Tri-annually, each participating hospital receives a printed and email version of a site-specific data report. These reports are also available daily within the database/registry (see below). These reports provide an in-depth look into the performance of each site. For example, we provide hospital data on the number of patients inappropriately vs. appropriately diagnosed with UTI, details on antibiotic use and outcomes (e.g., adverse events), longitudinal performance, and data on how individual hospitals compare to other hospitals in the state in terms of inappropriate diagnosis. Hospitals also receive a list of all patients who were considered “inappropriately diagnosed with UTI” to enable them to return to their hospital and conduct case reviews of those patients. Each hospital is encouraged to review these cases with their local team to perform audit and feedback, identify trends, and assist with overall quality improvement. This also provides an opportunity for measure feedback—for example, hospitals might find an error in case classification. Early during measure development this case-specific feedback was critical for improving measure validity.

Live Database Reports

Each of the HMS databases are equipped with the ability to view live reports utilizing Business Objects software. These reports provide updated data every 24 hours regarding measures (site performance and collaborative performance), fallout case information, demographics, critical/non-critical data errors, completeness of abstracted cases, and case classification information.

Individuals who participate in the collaborative either as a Clinical Data Abstractor or a quality administrator have the ability to log into the HMS databases and view these reports at their leisure. The software that HMS utilizes also allows for these reports to be exported as Excel files or PDFs for hospital-specific customization. This information is often utilized by participating hospitals at committee meetings or for presentations to track progress and inform quality improvement efforts. They also assist the Clinical Data Abstractor to identify errors in their abstraction and resolve them in real time. These reports also allow hospitals to review individual fallout cases and their clinical scenarios to inform individual clinicians or groups of clinicians of their performance and provide targeted education.

[Response Ends]

4a.07. Summarize the feedback on measure performance and implementation from the measured entities and others. Describe how feedback was obtained.

[Response Begins]

Throughout measure development, we received feedback on the measure performance/validity through three mechanisms: 1) Expert Feedback from Data Design and Publications Committee and Michigan Hospital Medicine Safety (HMS) Consortium Hospital Experts/Representatives, 2) “Fall-out” Feedback, and 3) October 2021 Hospital Survey.

Feedback from the Data, Design, and Publications Committee and “Fall-out” feedback has been described in the “validity” section. Briefly, measure performance feedback allowed us to refine the measures to the current version. The Data, Design, and Publications Committee approved the measures for use across HMS.

In October 2021, we systematically assessed the perceived use and usability of the inappropriate diagnosis of UTI measure by soliciting feedback from HMS hospitals participating at that time (N=40) via an online survey. Specifically, we asked all participating hospitals (N=40) to answer the following questions:

Q1. Please briefly describe how you have used or are planning to use the [inappropriate diagnosis of UTI] measure to improve care.

Responses: The 40 responses to this open-ended question largely fell into a few broad categories. The majority of hospitals are using strategies related to audit, feedback and education. Examples include “have used it to provide feedback to clinicians in cases of inappropriate use, as one more tool discouraging antibiotic use”; “present data to physicians, review ASB fallouts with ED physicians”; or “we discuss the measure with providers, especially when discussing fallouts, and then asking what or if we could have done anything differently”. There are a few hospitals that are using this data to update their tools or order sets. For example, “we have used numbers to modify ordering reflect UA, removing urine cultures from order set” or “revising clinical decision support tools”.

Q2. What perceived barriers do you see/foresee to using the [inappropriate diagnosis of UTI] measure to guide care improvement?

Responses: One-third of hospitals (45.0%, 14/40) of hospitals indicated that they don’t see/foresee any barriers. Another third (30.0%, 12/40) noted issues with physician pushback/buy in. Statements made here include “physician resistance – change is difficult for many” or “physicians continuing to prescribe antibiotics based on old practices”. There was also a broad category that related specifically to the treatment of patients who were confused or had “altered mental status” for a UTI (15.0%, 6/40), which includes “continued misinformation about elderly patients confused equates to UTI,” or “patients with dementia or other clinical conditions who present to the ED, especially those who have a history of UTI in the past are often cultured despite having no symptoms”. Finally, several participants noted challenges with education and feedback, such as “The time required to educate and provide feedback to providers on how they are meeting the ASB measure goals.”

[Response Ends]

4a.08. Summarize the feedback obtained from those being measured.

[Response Begins]

In summary, feedback from hospitals on measure performance was used to inform the development and refinement of the measures as currently submitted. In addition, feedback on measure implementation was broadly positive—that the measures were useful to guide care and improve diagnosis and antibiotic use. Based on feedback that time was a barrier to data collection, we limited the amount of data to be collected (average time for case collection 15-30 minutes) and decreased the number of cases we request be abstracted to still achieve a high reliability (N=59 cases). Thus, the measure submitted in this proposal should have even higher feasibility with similar usability as the measure tested in the Michigan Hospital Medicine Safety Consortium.

[Response Ends]

4a.09. Summarize the feedback obtained from other users.

[Response Begins]

In addition to the hospital feedback described above, we conducted a Patient Engagement Panel in order to understand patient perspectives about antibiotic treatment during hospitalization with infection. Seven individuals who were hospitalized or had a close family member who was hospitalized for an infection and received antibiotics participated in a 90-minute focus group. A discussion guide was used to assess participants' knowledge and perceptions about: how diagnoses are made and what information is needed; antibiotic risks and benefits; certainty of diagnosis and timing of treatment initiation; whether knowing how well a hospital accurately diagnoses infections would influence treatment choices. A brief summary of the Patient Engagement Panel is presented below.

Table 1. Summary of Patient Engagement Panel

| Question/Topic | Responses | Impression |
|---|---|--|
| Understanding of how infection diagnosis was made | Patients were aware of the necessity of tests (e.g., chest X-rays), labs (e.g., urine and blood tests), and clinical signs and symptoms (e.g., fever, O ₂ saturation, pain, cough) in determining the diagnosis of infection. They relied on physicians' knowledge, but in some instances understood there may disagreement. | Patients understood that a process is involved in diagnosis; that diagnosis is reliant on lab results (which take time); and that there may be some uncertainty and thus differing opinions of physicians. |
| Risks and Benefits of Antibiotics | Patients universally agreed that antibiotics are beneficial: quickly reducing symptoms and clearing infections; necessary for treatment of severe illness. The discussion of risks identified many concerns: antibiotic resistance, allergic reactions, disruptions to gut microbiome, side effects from drug:drug interactions. | Patients understood there were both benefits and risks of antibiotic treatment. |

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| Question/Topic | Responses | Impression |
|---|--|--|
| What does over-diagnosis mean? Under-diagnosis? | Patients expressed several ideas about what “over-diagnosis” is: “prescribing medication whether needed or not”, “when a minor issue is overemphasized and overtreated”, “antibiotics given without tests being done”. The idea of “under-diagnosis” was expressed as: “settling on a routine diagnosis when something more significant is happening”, “not utilizing antibiotics”, “not enough concern when treating a routine” infection. | Patients understood that “over-diagnosis” relates to treatment that may not be necessary and that “under-diagnosis” involves the possibility of missing the diagnosis and not receiving the appropriate treatment. |
| How do you know if a hospital is doing a good job? What would help you to know? | Patients were aware that hospitals are rated on certain performance measures. They also expressed some skepticism about these due to: not knowing what the ratings are based on, variations in individual physicians (e.g., a top-rated hospital could still have a low-rated physician and vice versa), concern that hospitals could “game” the system of measurement. Even so, patients expressed interest in being able to access ratings of performance for aspects of healthcare. | Patients were receptive to information about hospital performance measures, especially if they had some assurances that they could be trusted. They were interested in measures of diagnostic performance as a way to make informed decisions about hospitals. |

Based on the focus group discussion, the measure is consistent with their understanding and expectations of diagnosis and treatment of infection.

Summary of patient feedback: Based on the focus group discussion, the measure is consistent with their understanding and expectations of diagnosis and treatment of infection. There were no issues or concerns raised that would necessitate modifications of the measure.

[Response Ends]

4a.10. Describe how the feedback described has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

[Response Begins]

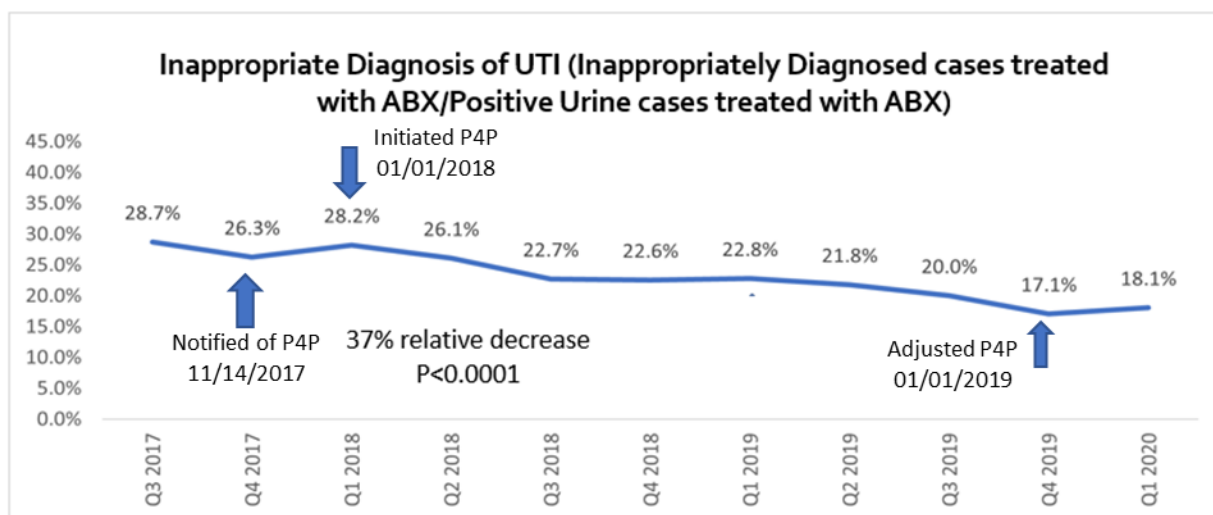
Feedback from HMS hospitals, the technical expert panel, and the patient engagement panel was all used to refine the measure. Major changes include: a) simplification of measure, b) refinement of measure specifications, c) streamline/decrease in amount of data requested for assessment, and d) defining minimum cases necessary for abstraction to decrease number of cases required to be submitted. We also received feedback on the naming of the measure. When we first began measure development, the measure had been named “over-diagnosis of UTI” which we changed to “inappropriate diagnosis of UTI” based on feedback from diagnostic error experts in our technical expert panel and to avoid confusion as “over-diagnosis” has alternate meanings in the diagnostic error community.

[Response Ends]

4b.01. You may refer to data provided in Importance to Measure and Report: Gap in Care/Disparities, but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included). If no improvement was demonstrated, provide an explanation. If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

[Response Begins]

Since 2017, when the measure first began being reported to 49 participating HMS hospitals, we have seen a 37% relative decrease ($P < 0.001$) in the percentage of patients inappropriately diagnosed out of all patients treated for UTI (see Figure). This represents an improvement in diagnosis, reduction in unnecessary antibiotic use, and improved care. The arrows show times when HMS pay-for-performance measures were announced, initiated, and the adjusted to continuously drive improvement.



The percent of inappropriate diagnosis of UTI cases in 49 participating HMS hospitals decreased significantly from 28.7% in 2017 to 18.1% in 2020 ($P < 0.001$) and coincides with initiation of pay-for-performance measures.

In addition, since 2017, we have seen a statistically significant (though minor) decrease in antibiotic duration for patients inappropriately diagnosed with UTI (driven mostly by fewer cases of excess duration longer than 8 days). Though no antibiotic therapy is ideal for this patient population, there is often diagnostic uncertainty that drives brief empiric therapy. Stopping this therapy as soon as possible can reduce the risk of harm. In fact, in a paper published in *JAMA Internal Medicine*, we found that unnecessary antibiotic use for patients inappropriately diagnosed with UTI is associated with a longer hospital length of stay (adjusted relative risk 1.33 [1.22-1.46] or ~1 day longer length of stay).¹

1. Petty LA, Vaughn VM, Flanders SA, et al. Risk Factors and Outcomes Associated With Treatment of Asymptomatic Bacteriuria in Hospitalized Patients. *JAMA Intern Med.* 2019;179(11):1519–1527. doi:10.1001/jamainternmed.2019.2871

[Response Ends]

4b.02. Explain any unexpected findings (positive or negative) during implementation of this measure, including unintended impacts on patients.

[Response Begins]

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There were no unexpected findings. Expected findings included decreased rates of inappropriate diagnosis of UTI, decreased unnecessary antibiotic use, and decreased length of stay.

In October 2021, we systematically assessed the perceived use and usability of the inappropriate diagnosis of UTI measure by soliciting feedback from HMS hospitals participating at that time (N=40). Via online survey, we asked all hospitals to answer the following questions:

1. What unintended consequences do you see/foresee to using the [inappropriate diagnosis of UTI] measure to guide care improvement? (Q547)

Over half of respondents said none/unknown (24/40;). One-quarter (n=10) noted lack of appropriate treatment, including delays in treatment or missing alternative diagnoses. For example, “may be missing diagnosis of acute infection” or “possible delays in antibiotics in patient who actually require them”.

Other respondents noted issues related to dementia/altered mental status or patient dissatisfaction if they do not receive antibiotics.

[Response Ends]

4b.03. Explain any unexpected benefits realized from implementation of this measure.

[Response Begins]

Generally, there were no “unexpected benefits.” Expected benefits included decreased rates of inappropriate diagnosis of UTI, decreased unnecessary antibiotic use, and decreased length of stay.

In October 2021, we systematically assessed the perceived use and usability of the inappropriate diagnosis of UTI measure by soliciting feedback from HMS hospitals participating at that time (N=40). Via online survey, we asked all hospitals to answer the following question:

1. If you have already started work based on the [inappropriate diagnosis of UTI] measure, what unexpected benefits have been realized from implementing this measure?

Responses: 6: N/A, 5: none, 3: unsure/not sure; 2: question not answered; 1: Early stages of project

A number of respondents (12) identified improved antibiotic use, either in terms of fewer patients treated inappropriately or through a reduction of complications due to antibiotic overuse. Five individuals noted a culture of less testing, particularly as it relates to urine cultures. Three individuals identified increased awareness in general around treatment of UTI and asymptomatic bacteriuria. Other responses included improved patient care, and alignment of system-wide culturing.

[Response Ends]

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

If you are updating a maintenance measure submission for the first time in MIMS, please note that the previous related and competing data appearing in question 5.03 may need to be entered in to 5.01 and 5.02, if the measures are NQF endorsed. Please review and update questions 5.01, 5.02, and 5.03 accordingly.

5.01. Search and select all NQF-endorsed related measures (conceptually, either same measure focus or target population).

(Can search and select measures.)

[Response Begins]

0138: National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

0684: Percent of Residents with a Urinary Tract Infection (Long Stay)

[Response Ends]

5.02. Search and select all NQF-endorsed competing measures (conceptually, the measures have both the same measure focus or target population).

(Can search and select measures.)

[Response Begins]

[Response Ends]

5.03. If there are related or competing measures to this measure, but they are not NQF-endorsed, please indicate the measure title and steward.

[Response Begins]

N/A

[Response Ends]

5.04. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s), indicate whether the measure specifications are harmonized to the extent possible.

[Response Begins]

No

[Response Ends]

5.05. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

[Response Begins]

NQF 0138, National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure, provides the Standardized Infection Ratio (SIR) of healthcare-associated CAUTIs. The target population, patients with chronic catheter use, is a subset of the target population for the Inappropriate Diagnosis of UTI measure. The focus of the NQF 0138 measure is primarily to prevent CAUTI by reducing foley catheter use and improving insertion practices. Our measure addresses inappropriate treatment of patients with antibiotics

when they do not actually have UTI or CAUTI. Thus, rather than preventing CAUTI, our measure is focused on preventing an inappropriate diagnosis of CAUTI and subsequent antibiotic use. The measures include overlapping populations but have different goals and outcomes.

NQF 0684, Percent of Residents with a Urinary Tract Infection (Long Stay), reports the percentage of long-stay nursing home residents who have a urinary tract infection the 30 days prior to assessment, based on data from the Minimum Data Set (MDS) 3.0 OBRA, PPS, and/or discharge assessments during the selected quarter for the purpose of reducing UTIs in nursing home residents. The Inappropriate Diagnosis of UTI measure determines the proportion of hospitalized medical patients with a positive urine culture who do not meet criteria for UTI and is focused on improving diagnostic accuracy. Data collection burden does not overlap for these measures, as they address different target populations and facilities.

[Response Ends]

5.06. Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality). Alternatively, justify endorsing an additional measure.

Provide analyses when possible.

[Response Begins]

N/A

[Response Ends]

Appendix

Supplemental materials may be provided in an appendix.:

Available in attached file

Attachment: 3690_3690_UTI Appendix_FINAL 4.4.22-508 (1).pdf

Contact Information

Measure Steward (Intellectual Property Owner): University of Michigan

Measure Steward Point of Contact: Gupta, Ashwin, ashwing@med.umich.edu

Measure Developer if different from Measure Steward: Michigan Hospital Medicine Safety Consortium

Measure Developer Point(s) of Contact: Vaughn, Valerie, valerie.vaughn@hsc.utah.edu

Additional Information

1. Provide any supplemental materials, if needed, as an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be collated one file with a table of contents or bookmarks. If material pertains to a specific criterion, that should be indicated.

[Response Begins]

Available in attached file

[Response Ends]

Attachment: 3690_3690_UTI Appendix_FINAL 4.4.22-508 (1).pdf

2. List the workgroup/panel members' names and organizations.

Describe the members' role in measure development.

[Response Begins]

Measure Development Co-leaders and Measure Stewards:

- Valerie Vaughn, MD MSc- Assistant Professor & Director of Hospital Medicine Research, University of Utah; hospitalist lead, Antimicrobial Use Initiative, Michigan Hospital Medicine Safety Consortium
- Ashwin Gupta, MD- Section Chief of Hospital Medicine, VA Ann Arbor Health System; Assistant Professor of Internal Medicine, Division of Hospital Medicine, Michigan Medicine; QI consultant, Antimicrobial Use Initiative, Michigan Hospital Medicine Safety Consortium

Measure Development Team

- Project management:
 - Jennifer Horowitz, MA- Research Area Specialist Senior
 - Elizabeth McLaughlin MS, RN- Research Senior Supervisor
 - Andrea White, PhD – Clinical Research Coordinator Senior
- Data analysis:
 - Danny Nielsen, MS- Database Analyst/Programmer Senior
 - David Ratz, MS- Biostatistician
 - Tanim Basu, MS, MA-Statistician Senior
- Administrative support:
 - Jennifer Minock, MHA- Project Intermediate Manager
- Project oversight:
 - Scott Flanders, MD- Professor of Internal Medicine, Chief Clinical Strategy Officer, Michigan Medicine; Program Director Michigan Hospital Medicine Safety Consortium
- Content expertise:
 - Tejal Gandhi, MD- Associate Professor of Internal Medicine, Division of Infectious Diseases, Michigan Medicine; infectious disease lead, Antimicrobial Use Initiative, Michigan Hospital Medicine Safety Consortium
 - Lindsay Petty, MD- Assistant Professor of Internal Medicine, Division of Infectious Diseases, Michigan Medicine; infectious disease lead, Antimicrobial Use Initiative, Michigan Hospital Medicine Safety Consortium

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- Tim Hofer, MD, MSc- Professor of Internal Medicine, Division of General Medicine, Michigan Medicine; Associate Director for Analytic and Information Resources at the VA Center for Practice Management and Outcomes Research, Ann Arbor
- Barbara Jones, MD, MSCI- Assistant Professor of Internal Medicine, Division of Pulmonary Medicine, University of Utah

Table 1. Technical Expert Panel

| Name, Credentials | Organizational Affiliation, City, State |
|------------------------------------|--|
| David Newman-Toker, MD, PhD | Society to Improve Diagnosis in Medicine (SIDM), Baltimore, MD |
| Larissa May, MD, MSPH, MSHS | American College of Emergency Medicine (ACEP), Fair Oaks, CA |
| Teena Chopra, MD, MPH | Infectious Disease Society of America (IDSA), Detroit, MI |
| David Hyun, MD | Pew Research Center, Washington D.C. |
| Daniel Morgan, MD, MS | Society of Healthcare of America (SHEA), Baltimore, MD |
| Jason Pogue, PharmD, BCPS, BCIDP | Society of Infectious Diseases Pharmacists (SIDP), Plymouth, MI |
| David Baker, MD, MPH, FACP | The Joint Commission, Oakbrook Terrace, IL |
| Patty Gray, RN, CIC, FAPIC | Association for Professionals in Infection Control and Epidemiology (APIC), Scottsdale, AZ |
| Arjun Srinivasan, MD (CAPT, UPHPS) | Centers for Disease Control and Prevention (CDC), Atlanta, GA |
| Michael Liss, MD, MAS, FACS | American Urological Association (AUA), San Antonio, TX |
| Michael Pulia, MD, MS | Emergency Medicine, University of Wisconsin Madison, Middleton, WI |

Technical Expert Panel members and affiliations

[Response Ends]

3. Indicate the year the measure was first released.

[Response Begins]

2017- to Michigan Hospital Medicine Safety Consortium Hospitals

[Response Ends]

4. Indicate the month and year of the most recent revision.

[Response Begins]

1/2022- revised measure submitted in this application

[Response Ends]

5. Indicate the frequency of review, or an update schedule, for this measure.

[Response Begins]

Annually and as needed with changes or additions to the evidence base

[Response Ends]

6. Indicate the next scheduled update or review of this measure.

[Response Begins]

1/2023

[Response Ends]

7. Provide a copyright statement, if applicable. Otherwise, indicate "N/A".

[Response Begins]

N/A

[Response Ends]

8. State any disclaimers, if applicable. Otherwise, indicate "N/A".

[Response Begins]

N/A

[Response Ends]

9. Provide any additional information or comments, if applicable. Otherwise, indicate "N/A".

[Response Begins]

N/A

[Response Ends]