QUALITY HEALTH STRATEGIES

Moderator: Carol Wicker
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6:00 am CT

Operator: Ladies and Gentlemen thank you for standing by. Welcome to the CAUTI Prevention Strategy for Providers conference call. During the presentation all participants will be in a listen only mode. Afterwards we will conduct a question and answer session.

At that time if you have a question please press the 1 followed by the 4 on your telephone. If at any time during the conference you need to reach an operator please press star 0. As a reminder this conference is being recorded Thursday, September 12, 2013. I'd now like to turn the conference over to Miss Carol Wicker. Please go ahead.

Carol Wicker: Thank you. On behalf of the Maryland Hospital Association and Delmarva Foundation for Medical Care I'm pleased to welcome our guest speaker, presenter Dr. Mohamed Fakih.

On Slide 9 - sorry, Slide 2, Dr. Fakih is an associate professor of medicine and Wayne State University School of Medicine and the hospital epidemiologist

and Medical Director of Infection, Prevention and Control at Saint John Hospital and Medical Center in Detroit.

Dr. Fakih contributions include the creation of a comprehensive toolkit to promote the appropriate utilization of catheters in the hospital setting. But before Dr. Fakih begins his presentation I'd like to share with you Maryland's current CAUTI rate. And on Slide 3 the blue line shows our monthly CAUTI rate and the red line shows our mean for the seven month period, January to July of 2013.

The dotted green line is the national benchmark that has been established for the Centers for Medicare and Medicaid services under the Partnership for Patients Initiative. So it's clear from this graph that we have a bit of work to do in Maryland to meet that national benchmark.

On Slide 4 this is the accompanying data table. The monthly mean rate was equal to or greater than two infections per 1000 device days for six of the seven months in this period. Those cells are shaded in red in the table.

But what's promising I think is the number of units that are reporting zero CAUTIs. You can see shaded in green that during five of the seven months 80% or more of the units reported zero infections.

And with that I'd like to just turn the call over to Dr. Fakih. Please go ahead.

Dr. Mohamed Fakih: Thank you Carol. Good morning everyone. Going to talk about, you know, multiple efforts to reduce CAUTI, to address it in a multi-prong approach. I'm going to start with two quotes, the first one is, "We are what we repeatedly do, excellence then is not an act, but a habit." And this is from

Aristotle. The other quote is, "Quality is everyone's responsibility." And just want to highlight the habit in everyone.

I'll start with my presentation with the story of Mr. Smith. Mr. Smith is an 82 year old gentleman who was admitted to the hospital because of mild congestive heart failure.

In the Emergency Department they placed the urinary catheter and because he - they felt that he was weak and could not move out of the bed. Although he could have used a urinal at that time.

He was transferred to the floor but could not sleep. He was prescribed a sleeping pill and then he became more restless. He tried to get out of bed, he tripped, tripped on the catheter, and fell. Now after he fell they checked him and they found that he had a head fracture and he went for surgery.

They noticed after surgery that his left leg became swollen and they diagnosed him with deep venous thrombosis. And he was started on blood thinners. Because of his immobility he developed a pressure ulcer and his physician ended up removing the catheter because he couldn't find any reason for the catheter.

But now he starts having urinary tension because of the pain medications that can lead to urinary tension. The urinary catheter was placed again, and during the placement it was a bit traumatic and the patient is on blood thinners so he develops hematuria.

A few days later he also spikes a fever as his blood pressure drops. His blood cultures and urine cultures grow E. coli and he's diagnosed to have CAUTI with septicemia. The patient stayed in the hospital for quite a bit of weeks of a

hospital stay. And by the end of his stay he was not the same Mr. Smith that we know.

Now could this happen in your hospital and are we exaggerating here or this is something that we may see? The problem with - these things can cascade, so if you have a vulnerable patient, you start with one event and then it leads to another and another and another.

So when we talk about the CAUTI or the urinary catheter harm, it's not just, you know, an infection in the urine, but it has multiple things that it's connected to.

I try to connect the multiple harms or conditions that the Partnership for Patients addresses. And what I like to say is that, "We should look at these as a combination of - it's like all of them are connected, rather than looking at each one alone." And we do tend to deal with every entity by itself, although if we work on multiple together I think it will be much more synergistic and we can help the patient better.

So as you see here in this slide, the urinary catheter harm is not only CAUTI, it can lead to pressure ulcers, immobility. And with immobility we know it increases the risk for DVT or falls.

Trauma from the catheter is another non-infectious issue related to the urinary catheter, patient discomfort and increased length of stay. And as I mentioned, there are certain medications that would cause urinary tension so the catheter would be needed at that point.

What are the objectives of our presentation? The first objective is to address how to approach CAUTI reduction in the hospital setting. The second one is

to describe how different departments and disciplines can work together so we have synergy with the goal of reducing catheter harm. The third objective is to discuss the importance of appropriate urine culture and antimicrobial use. And the last one is giving you some information about the economic impact on - of CAUTI on our patients.

So if we want to intervene in the hospital where would we intervene? My wish list would be to have a multi-departmental multidisciplinary approach, whether on the same unit or between units.

We have worked quite a bit initially when we started tackling CAUTI in the non-ICU where we had the nurse driven to remove off the urinary catheter. But the Emergency Department and also the Intensive Care Unit and the Operating Room are other areas where I think it's quite important to target CAUTI.

Let's look at this slide, Where to Intervene. So as you see, the non-ICU is where we focused before, but there are multiple units that can affect a non-ICU quite a bit. If we address these units then the non-ICU would be in a much better shape.

So if you have someone in the OR, or in the Post Anesthesia Care Unit, and we deal with a catheter that was placed in the Operating Room, we remove it right away. Then the non-ICU surgical units would have much less urinary catheter use.

If you have the Intensive Care Unit and you evaluate the need for the catheter daily, then you cut down the utilization in the ICU. But also if you evaluate the need just before exit from the ICU then the non-ICU will be affected quite a bit also as far as utilization.

The ED is a great place to intervene, and you know a few days from now the National Project is starting intervention in the Emergency Department, and there's quite a bit of units that have signed up, ED units. The nice thing about the ED, intervening in the ED, and then you can affect the whole hospital.

I'm going to talk about this things a little bit in detail later.

So this is a way I think about targeting the urinary catheter and, you know, I wanted to have a slogan. And I tried with, "Know your catheter," or, "Know your device." You can use it for a central line. So if - and it's probably applies quite a bit, it's very similar. So know your catheter.

So the first thing is know when you need it, so it the indications. The second item would be, know how to place it, which is the insertion technique. The third one would be, know how to care for it, ends of being the maintenance. The fourth one would be, know when it's no longer needed, which is the appropriate continued use.

So let's start with know when you need it. And the first item would be to clearly identify what the indications are and what they mean. So if we know what the indications are then at least we know, you know, the right reason for placing the catheter.

Many times it's the culture that dictates why the catheter is going to be placed or not, because we have this habit of placing the catheter for a certain reason. So having a clear identification of what the indications are I think will help all the healthcare workers. So that would be the first step. And include the appropriate indications into policies and competencies.

So the indications have been based on the CDC/HICPAC guidelines from 2009. And I'm going to go through them one - each one separately.

So the first one is accurate measurement of urinary output in the critically ill patients. And we see this indication applicable to patients in the Intensive Care Unit. I think clearly defining who is critically ill when you establish your indications is quite important to guide your healthcare workers to know when it is acceptable for measuring I's and O's.

The second indication is accurate urinary tension - sorry, acute urinary retention or obstruction. So you have two things in this situation, either the acute urinary tension that's either medication induced, or medical such as some diabetics would have, or trauma to the spinal cord. So there's no obstruction here, but the patient cannot empty his or her bladder.

The outflow obstruction would be similar to having a patient with prostatic hypertrophy obstruction. Urethra obstruction, let's say they have some (unintelligible) or blood clots with obstruction. So these are examples.

Now for actuary retention you can use straight cath and go in and out catheterization that is non-obstructive, if it's non-obstructive. Now for outflow obstruction it's going to be much tougher to use that, and usually the Foley catheter would be needed.

For peri-operative use in selective surgeries there's the intraoperative and the surgical site. And the intraoperative includes usually fluid management during the surgery. And either because the surgery is a long surgery or they have used large volumes of infusion, or there's a need for intraoperative urinary output monitoring.

For the surgical site peri-operative use for the catheter, it's usually a urologic surgery, some kinds of urologic surgeries, or if the surgery is contiguous to the genitourinary tract.

For peri-operative use in selective surgeries an additional issue is the - an issue with the spinal anesthesia or epidural, and spinal anesthesia and epidural anesthesia may be to urinary tension.

So it's important after the surgery is done is to taper and stop this type of anesthesia as soon as possible so you'd reduce prolonged urinary tension. And then hopefully you'd be able to remove the urinary catheter as soon as possible. Not everyone who gets an epidural catheter will leave a Foley catheter in.

Assisting healing of perineal and sacral wounds in the incontinent patients. Incontinence without a wound or a skin breakdown is not an indication for urinary catheterization. However, if you have incontinence in the presence of an ulcer or skin breakdown in perineum, and you're worried about worsening of skin integrity then the urinary catheter would be indicated for the period where you have that issue.

The final one is hospice or end of life care. And this is where we see the patient input as important, whether it's more comfortable to have the catheter or not.

The quiet immobilization is usually the first to - those that have had either an injury to the spine or the pelvic area, and movement of the thoracic or lumbar spine would risk with having the patient getting an injury related to that issue. So this is the reason for immobilization. It's usually after an orthopedic

surgeon or neurosurgeon's recommendation for immobilization. It's not the immobility related to let's say, being weak and not being able to move.

The chronic (unintelligible) catheter is defined as being present for more than a month. And you know, you see usually these patients coming from a nursing home.

The problem with this population is a lot of them may not have a clear reason why the catheter has been placed initially. Some of them would have had the catheter for let's say six months or a year. And in the - on admission the Emergency Department most of the time the reasons would not be available. So we accept that reason to use the catheter till further information is present to better evaluate if the need is still present.

What are the unacceptable reasons for placement? Urine output monitoring of Head of the ICU. In continence without sacral or perineal pressure sore for long post-operative use. This is important.

Now with push towards not having prolonged post-operative use is the skip interventions, you know, having the catheter either post-op Day 1 or post-op Day 2. This helped with post-operative use, at least to reduce the duration.

We've seen quite a bit of patients, they come from the ICU and they still have the catheter on the floor, and I think basically this is related to not having a prompt evaluation on the floor whether the catheter is need or not. And this is why it's important to evaluate catheter need prior to exit from the Intensive Care Unit. Morbid obesity and mobility confusion, dementia or patient request are other reasons.

So again, all of this tell me that if we have clear defined indications for your catheter utilization can make it much easier for my hospital.

So we're still talking about know when you need it. We talked about indications and then were you would intervene in that situation. So as I mentioned before the Emergency Department is a place where you place a lot of Foley catheters because you see a huge number of patients when they come into the hospital. More than 50% of those that are admitted.

The other place is the Operating Room where the surgeons may place the catheter before the surgery. So limiting to the indications, so avoid use unless appropriate indication is important to cut down the risk of Foley catheter exposure. And if you do that there's not the budget of Foleys, all the mechanical issues are also prevented.

Intervening ED or the OR, the - if you see when you have a lot of patients admitted from the Emergency Department, and we said more than half of the patients admitted are coming from the Emergency Department, this is an area where you can capture, you know, those that are placing these catheter and at least discuss with the ED Team what are the indications. And try to change behaviors that are not necessary.

So how do we improve the urinary catheter use in the Emergency Department? I think there's three important things to address. The first thing is to have clear guidelines on when it is an appropriate indication for placement. And these can be institutional guideline, so you have approval and agreement of the lay stakeholders, that will adopt them.

The second thing is to engage the physicians who write the orders for urinary catheter placement.

The third thing is to engage the nurses who are probably even more important than the physicians and placement of the urinary catheter. The ED nurses play a very powerful in utilization of the catheter in the Emergency Department. So physicians and nurses in the ED need to be engaged.

I'm going to briefly talk about a pilot intervention. And just to mention, there were two pilot interventions, I'm mentioning one of them here, the Ascension of one, but there was another one from Michigan Hospital Association. And both pilots are almost identical. And these were the two pilots that were the reason why the National Project went ahead is starting to implement the ED intervention through - on the causes of CAUTI.

So I'm going to give you a summary of what happened for 18 emergency departments in Ascension Health, which is one of the ten participants.

So what we have done, we have 18 emergency departments where we engaged physicians and the nurses. We made sure that they had indications that were agreed upon in the Emergency Department. And we had a baseline evaluation of urinary catheter use, and we had intervention. And then we looked for sustainability.

What we found out is that the higher the utilization at baseline the better we did as far as dropping the utilization with intervention and sustainability. Overall we dropped the utilization for about a third, and we increased the appropriateness of use. And physician order documentation improved. It was noticeable again, that - those hospitals started with higher baseline benefited more.

So baseline average utilization was about 9%, during intervention we dropped to about 6%. And with the sustainability period, which was about six months, we dropped to almost 5%.

And as I mentioned before, catheter avoidance translates into preventing exposure to the catheter. And with this we have thousands of patients that we prevented exposures to in the EDs in these 18 hospitals. The appropriate reasons for placement also increased from about 20% to 90%.

So what other qualities of the ED physician and the nurse champions? They have to be motivated and they want to help improve safety. They have the recognition and respect from colleague and are interested in reducing the harm related to the catheter. And they have to be visible to both staff and other healthcare workers.

Intervening in the Operating Room, I would suggest engaging the surgeons at you facility. Again, you think about the ED it's one unit, so you have a certain number of people you have to engage versus the whole hospital. And the Operating Room is very similar, you have the surgeons and you have the staff in the OR. So you can think about it as a similar setting like the ED.

So you have two things that you want you want to OR. First of all try not to have a catheter in if it's not needed in the operation. The second thing, if it was needed in the operation, then is there a way to remove directly after the surgery is done, or in the PACU?

So we talked about know when you need it, what about know how to place it? So this is insertion technique. And try to standard the incision and placement technique. First thing is all the elements in the kit, urinary catheter kit, are present and that's very helpful, because if you have someone who is placing a

urinary catheter they should not try to look for stuff while having the procedure, while doing the procedure. It will increase the risk of having a lower compliance with the steps.

So performance hand hygiene before and after placement. Have an antiseptic technique during the placement. And use the appropriate catheter size and have securement of the catheter before - after you're done. And have a closed drainage system in (unintelligible) patients post procedure.

This is a simplified checklist for urinary catheters. And what's nice about it, you know, there's so many steps when you're placing a catheter, this summarizes them and looks at in general, did they comply with that part of the procedure? You can use it if you want to some audits on those list after.

Know how to care for it, so the maintenance of the urinary catheter. And keep the closed system, urinary catheter closed system, and make sure there are no kinks in the catheter so you won't have backflow of the urine and urinary pack below the patient's bladder. And regular emptying of urinary pack.

You know, it's interesting that one of the issues that we have been dealing with right now is the urometer, and especially in the ICU. And how to have the urometer hooked the system without opening the closed system. Because many of these kits come without the urometer and that maybe a cost issue. So sometimes you have to look at small things in the process and need to address them. So if someone's going to the ICU, how to get the urometer at the time of placement.

So when we look at the insertion and maintenance, a dominant part of the insertion and maintenance is the nursing component. And it's important to

evaluate competencies for insertion and care, and consider periodic audits. So I showed you that simplified tool for periodic audits on placement.

I'm going to give you some information about competencies and the NICHE Study, which was published last year, 75 hospitals. And what they found out is that 64% of nurses are checked for competency as far as urinary catheter placement training and maintenance. And less than half have annual evaluation of competency.

When we looked at our system at 71 hospitals we found that the annual competency training took place in maintaining the catheter was reported to be less than 30% for nurses, and about 11% for patient care technicians. And this is a survey that we just published in the American Journal of Infection Control.

So it is interesting that almost all of them will have competencies at the time of hire, but you may be in the hospital for 10-15 years, 20 years, and that's it. You may not get evaluation of competencies again related to the catheter.

Know when it's no longer needed. So this is how most of these interventions started, they started with promptly removing catheters when it's no longer needed. And this we have seen with interventions on the non-Intensive Care Units.

So there was the study we've done in 2006 where a nurse educated other nurses and tried to incorporate the evaluation of urinary catheter use during all the three rounds, nursing rounds. And then Michigan did something very similar with 163 units. And both interventions showed significant reduction in utilization.

But you know what's interesting is that most of these units were not Intensive Care Units. And this is a Michigan experience when you see 25% reduction in utilization, and out 30% improvement appropriate indications.

So in a non-ICU we have daily evaluation of need. And you know, patients improve with time, so that's why it's very important to daily evaluate the need for urinary catheter placement. And when it's not needed then removal, prompt removal should be done. And I think incorporating the evaluation to the daily nursing assessment is quite important.

What we were worked on, and a lot of people have done the same, is providing feedback on urinary catheter use over time for units involved. So this is in non-ICU, now what about the ICU when we talk about removal of the catheters that are not needed?

The ICU has a much higher utilization than the floors, about four times higher. And we look for the captain of the ship which usually the intensivist in the ICU who daily evaluates the patient and rounds with the team.

Now this is much easier when you have a closed unit, like most units I mean that the captain of the ship intensivist is seeing all these patients. If there are 10 or 20, he's rounding on the 20. So you know there's one leader, and that leader will make a lot of these decisions. So it makes a lot of sense that that person who's rounding in the morning evaluates all these catheters and then discontinues them. Well if it works that way it would be much easier for us.

Now what's the difference between open and closed units? In an open unit you may have four or five intensivists coming in and rounding, and they're not there all the time. So it is essential to have a champion in the Intensive Care

Unit that would trigger the evaluation and makes people accountable to prompt evaluation and removal of the catheters.

So that IC champion can be a nurse manager, it can be a seasoned nurse, you know, who's very eager to engage her colleagues and the physicians to keep the importance of evaluating the urinary catheter in the ICU.

This does not mean that the physicians that are rounding on these patients should not look at the patient every day and evaluate for need, but you need to have a one point in the ICU who will drive the change in behavior in that unit.

The other part that's very important in the ICU to remove those catheters as they're no longer needed is at the time of exit out of the Intensive Care Unit. At that point the patient's much better, he's ready to go to the floor. So you think he or she is going from a higher level acuity to a lower level. And very likely a urinary catheter would not be needed.

So this is the time where you think about all the devices and see if the devices are needed or not, whether it's a urinary catheter or a central line, and this is how you can build capacity if you're working on the urinary catheter and working on the central line. When you're engaging the teams if they can work on both at the same time, then you're much more efficient. So when we have a good intervention in the ICU we end up having a lower utilization on the non-ICU units.

The ED on the OR is pretty much the same principle. So as the patients' conditions improve their transferred - they're in the ED initially, they have a catheter in, they think they're going to go to the ICU, they're already (DMOD), they're almost intubated. And (unintelligible) they improve and they

change their mind and they're going to send them to the floor. Do you keep the catheter in or do you remove it?

Now if you keep the catheter in it's going to take some time for the non-ICU people to evaluate the patient, know the patient a little bit better before they get to remove that catheter. So it makes quite a bit of sense to remove these catheters before they exit the ED if possible. Similar scenario in the Operating Room.

I'm going to give an example of what we've done at our facility and how we did it in steps. So we didn't do this all together, we did this over years. Initially we had the pilot for nurse to the month at (unintelligible) rounds to assess urinary catheter need, and discontinue these catheters as soon they don't have an indication.

And we educated the nurses on the risks of the catheter and the appropriate indications. We updated the hospital policy for urinary catheter replacement and maintenance. And we involved all the stakeholder, we involved nurses, physicians, mid-level providers and ancillary services.

We also involved multiple departments including the non-ICU, the Emergency Department and the Intensive Care Unit. We incorporated daily assessment of the urinary catheters as part of the nurses daily work. And we operationalized the evaluation of need by having twice a week prevalence data sent to us from the non-Intensive Care Units.

We still get this on paper from the non-Intensive Care Units. And we have about 20 I think units, 15 to 20 non-Intensive Care Units that we get data from. The nice thing about it is on Tuesdays and Thursdays. They're supposed

to evaluate the catheter every day, but this at least forces them to evaluate the catheter twice a week for sure.

When we talked to nurses they still say they evaluate the catheter daily. This is just an idea for you to engage the floors more and keeping the issue of the catheter as a priority.

The last thing I want to talk about is that we link the work to safety efforts. So there are multiple national safety efforts that are on their way, and there may be safety efforts related to your system or to your Partnership for Patients or other state efforts. Try to link them to your work so you get more push to prioritize your work.

With all these items that I mentioned this is what happened to our utilization in non-Intensive Care Unit. We started with a utilization of about 18%. We worked with a nurse driven removal of unnecessary urinary catheters. We then established the institutional guidelines for the ED. And initially it was mostly engaging physicians, members of department.

We had seen a significant drop in utilization after the ED intervention. Now at the same time we started, and this just 2007, the twice a week prevalence Tuesdays and Thursdays on the non-Intensive Care Units, and getting the information to the Infection Prevention Department. And we gave them feedback on the utilization. So it's almost like audits on performance and feedback.

This survey was about 230 nurse and we did it about three years ago. And we asked them, "Who is the one responsible on your unit to verify if a urinary catheter is needed?" And as you see the nurse comes in every single answer.

So the nurse caring for the patient was the most important one. And if you add it together it's more than 90% in fact of these answer said that the nurse had a role.

"How often does the Nursing Unit evaluate urinary catheter presence and appropriate need?" More than 90% of the nurses said daily. And when they were asked, "How often do we evaluate for the need?" They answered - more than 80% answered that all shifts. So it is the responsibility of the nurses and the nurses at all shifts.

I'm going to move now to discussing the ordering of urine cultures, a few slides. It's important to avoid having a pseudo-epidemic of CAUTI, so initially, you know, you work on CAUTI and you start seeing an increase in urine numbers.

You know, if someone has a urine that looks cloudy or there's sediment in the urine or smelly urine, it's, you know, it's misconceived that it is free of infection. There is no proof, there is no evidence that change in the color or smell of the urine or having sediments makes it more likely that this is infected urine.

So do not over diagnose. When you do a urine culture, base it on the clinical symptoms of the patients, not an observation of the urine. And do not do a urine culture unless you are worried about the urine being a source of infection.

Screening urine cultures are also discouraged. You know, initially some hospitals started doing screening urine cultures in admissions because they thought it would avoid some non-reimbursement issues. So what ends up happening, you end up using more antibiotics inappropriately. And you may

have collateral damage which we be (unintelligible) infection or mounted up resistance. It's also a financial issue. You may be spending more money.

So what is the risk of obtaining urine culture with no symptoms. You have a urinary catheter present in asymptomatic patients has cloudy or (unintelligible) or sediments, you do a urine culture without a clinical reason, then you get a positive urine culture and you give antimicrobial inappropriately. You have the risk of having more resistant organisms causing the (unintelligible) infection, increased cost and patient harm.

And as you know, if they are very elderly, if they develop a (unintelligible) infection, they have a mortality.

So what's the best solution? The best solution is to focus on avoiding the catheter. So if you don't have a catheter then there are no unnecessary urine cultures and no CAUTI and no patient harm.

Next couple of slides are related to the economic impact of CAUTI. So in the literature CAUTI has been associated with about $1000 cost. CAUTI with bacteriuria about $4000.

What is very interesting is that there's a new publication by Sanjay Saint's group in the Journal of Hospital Medicine, just came out a couple days ago, that describes the CAUTI calculator. And I really recommend to you looking at that.

If you go to their Web site on catheterout.org then you can put your numbers of your hospital, and what you can do is you can get an estimate when you have an intervention, how much you may be able to save as much as cost is related.

The other economic impact for CAUTI should be also noted and I think it's very tough to quantify, but I think it's very important too. So if you remember the first case we had in this presentation, you know, multiple issues that start with the urinary catheter, such as multi-drug resistance, (unintelligible).

And another thing that's very important, and I don't know how many people are talking about, but various papers saying CAUTI will be included in the outcome domain for Fiscal Year 2016, which is two to three years from now.

So what the steps to success? The first thing is to know your catheter for the elements that I discussed with you. The second is to collaborate between disciplines. I think this is key, especially in times where we don't have enough resources to build capacity. The third is to have champions and these will help you with the accountability. And fourth would be to use the data to help you focus your efforts on areas that require attention.

So if you know where you're having the issue then you focus on that area rather than blindly address all the hospital.

Incorporate catheter evaluation through the work routine, so the daily nursing evaluation of the urinary catheter. And use Partnership for Patients support. You know, there's quite a bit of information on the causes of CAUTI and I would also suggest you look at that Web site.

So coming back to the first slide that I had, so I said, you know, I quoted these two things having the work as a habit, and everyone's responsibility. And if you see the two, if we have the urinary catheter evaluation and discontinuation, as a habit of daily - daily habit to remove - to evaluate and remove the catheter.

And if we say that it's everyone's responsibility, so the nurse, the physician, ancillary services, it can be a physical therapist who is ambulating a patient and find that there's a catheter in. And knowing that the catheter will increase the risk for the patient to fall while ambulating. So all of these healthcare workers helping each other, that synergy in the work, I think it's going to make it way easier for all of us.

Okay, any question?

Operator: Ladies and Gentlemen if you'd like to register for a question please press the 1 followed by the 4 on your telephone keypad. You will hear a three tone prompt to acknowledge your request. If your question has been answered and you would like to withdraw your registration, please press the 1 followed by the 3. If you're using a speakerphone we ask that you please lift your handset before entering your request. One moment please for our first question.

And once again ladies and gentlemen, that is the 1 followed by the 4 to register for a telephone question.

Carol Wicker: This is Carol Wicker of the Maryland Hospital Association. First of all, thank you very much Dr. Fakih for your presentation this morning. For those on the phone maybe I can make one clarification that while Maryland doesn't - is not under the value-based purchasing program necessarily, CAUTIs are still looked at as a piece of reimbursement under the quality - QBR.

QBR, it's one of the potentially preventable conditions that’s looked at under that for the - from the HSCRC Cost Review Commission. So - but please ask questions while we have Dr. Fakih on the line. We have about ten minutes left.

Operator: And once again ladies and gentlemen to register for those question please press the 1 followed by the 4. We do have a question from the line of (Caroline Jackson). Please go ahead.

(Caroline Jackson): Good morning, thank you Dr. Fakih for that excellent presentation. One of the challenges that we have is, "How do you engage physicians?" You know, typically they see this as not that big of a problem in terms of revenue. They prescribe a couple of antibiotics. And most patients do get better quickly. So how do we engage them in this whole process of CAUTI reduction? And suggestions?

Dr. Mohamed Fakih: Okay, great question. I think it's - so I'm going to give an analogy. It's so interesting that there was for, in fact, instead of giving the analogy I'll just give you a paper. I've read a paper in the Annals of Internal Medicine very recently that talked about quality effort and how it's all on the shoulders of nursing, and the physicians are not engaged.

And you know, it's almost half of, I mean it's like 50% of our workforce is not really helping the other because they don't see it as much as an important issue. I think we can engage the physicians. You know, you have to give them numbers, data and, you know, the story of Mr. Smith.

So it's not just the CAUTI itself. If we look at this as, you know, urinary catheter harm, a urologist seeing a huge injury related to a placement of a catheter that was not needed will get extremely upset and will do something about it.

It's engaging the right physicians also, so you want to have someone who is interested in safety, who, you know, who see that this is something important

for their patient's care. So finding the right people I think is the tough part. It doesn't have to be, "It's just like all physicians are the same." I think physicians have not been taught about prevention as much and this trend is changing.

If you're working with the ICU I think talking to the intensivist is extremely important. Especially if that person is proactive, I think they can make a huge change in their ICU. In the ED you may be dealing, you know, with about ten ED physicians. Try to find out who would have the most interest in that area. So picking the right person I think is what I'm trying to say.

On the floor I think if we can engage the hospitals. So the hospitals see about 20 patients a day each, so they have a huge volume. So even if they just work on their patients, you can have a huge change.

So these are ideas about physicians. It is tough, I mean your point is very well taken.

Operator: And once again ladies and gentlemen to register for a question please press the 1 followed by the 4. And as a final reminder ladies and gentlemen it is the 1 followed by the 4 to register for a question.

Dr. Fakih, it looks like we have no further questions at this time. I'll turn the call back over to you Sir.

Dr. Mohamed Fakih: Okay, thank you.

Carol Wicker: Thank you Dr. Fakih. And if you will perhaps move to the next slide. For those of you who may have questions as soon as we hang up, please contact (Jeanna Sadiqui) and we'll make sure we get those answered for you.

And I don't want to delay your time any more, you've already given us plenty of time and a great session this morning. I thank you very much Dr. Fakih. And if there are - we'll do one last call for questions. If there are none, we'll give you back your last few minutes before the hour. Any last questions?

Operator: And it doesn't look like we have any queued up Ma'am.

Carol Wicker: Okay. Great. Thank you so much for your time.

Dr. Mohamed Fakih: All right. Have a good day.

Carol Wicker: Thank you, bye-bye.

Operator: Ladies and Gentlemen that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.

END