Healthcare Infection Control Practices

Advisory Committee (HICPAC)

DRAFT: GUIDELINE FOR PREVENTION OF CATHETER-ASSOCIATED URINARY TRACT INFECTIONS 2009

September 9, 2009 - Teleconference

List of Participants

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Patrick Brennan: Thank you. Good afternoon and welcome to this HICPAC teleconference to discuss and vote on the update to the guideline for prevention of catheter-associated urinary tract infections 2009.

During this call members of the committee will discuss and review a number of items and vote on issues that remain to be resolved in this guideline. And we hope at the end give final approval to this document that has been in the works for approximately 18 months and is the product of a lot of effort by staff members at CDC, members of HICPAC and staff for the Center for Evidence-Based Practice at the University of Pennsylvania as well as outside reviewers and colleagues around the country.

We thank you for your comments and there will be an opportunity for questions later in the call.

We are going to be using as our agenda a document that includes revisions and proposed actions for HICPAC and on that document there are a number of items for a vote.

So the first of these relates to questions regarding the evidence review process and the categorization scheme in the document. And as a result of this work HICPAC is breaking some new ground in its work in terms of categorizing its recommendations. So (Carolyn) would you like to address this issue on the modified grade categorization scheme and the methods?

(Carolyn Gould): Sure. We received several comments about the modified HICPAC categorization scheme. In the previous document the old HICPAC scheme was outlined in the table. So what we did is we created a new table that actually reflected the modified grade categorization scheme that we use for this guideline.

So on Page 10, Table 1, Category IA recommendations are recommendations that are - first let me say that all Category I recommendations are strong recommendations and should be implemented equally. It's just the evidence base behind the recommendations that determine the difference between Category IA and IB. And then Category IC is strong recommendation required by state or Federal regulation.

In the previous version we also included in Category IC recommendations that were considered accepted practices or standard of care such as aseptic technique or education that based on our search had either very low quality or no available evidence behind them. But that still needed to be strong recommendation. In this version because we received comments that people preferred to see the regulatory recommendation separated from these, we placed those accepted practices into Category IB. And so Category IC is now just recommendations required by state or Federal regulation. Incidentally we don't have any IC recommendations in this guideline. But these categories will be applied to future HICPAC guidelines.

Category IA recommendations are strong recommendations supported by high to moderate quality evidence. Category IB recommendations are also strong recommendations supported by low to very low quality evidence when the recommendations are considered accepted practices.

Category II recommendations are weak recommendations and in the current version these are stated as being supported by limited evidence. We are having discussions now about modifying this wording to clarify the type of evidence that underlies Category II recommendations. So Craig if you want to make any comments on that at this time (you) can do that.

(Craig Umscheid): One of the challenges with the Category II recommendation is that it's not a weak recommendation because it necessarily has low quality evidence supporting it. But it's a weak recommendation because there are tradeoffs between benefits and harms.

Category I recommendations are very different in that there are not tradeoffs between benefits and harms. But instead there are either net benefits or net harms, which cause us to make a strong recommendation for or against something respectively.

So to make the categorizations scheme as accurate as possible one of the proposals from our groups at Penn is to incorporate the idea of clinical benefits or harms into the categorizations scheme. And for Category II specifically to correct the idea that instead of a Category II just being based on limited evidence, they could really be based on any quality evidence suggesting a tradeoff between clinical benefits and harms.

(Carolyn Gould): Also I just wanted to mention that as we are reviewing the different wording options for Category IB versus Category II. We need to go through the recommendations and make sure that these changes don't have any implications for determining or distinguishing between a IB and a II. That's just a comment that we're going to need to do that.

Patrick Brennan: (Carolyn) is that something that we'll need to do after this call?

(Carolyn Gould): I think so.

Patrick Brennan: And the new proposed language for Category II would be a weak recommendation supported by mixed quality evidence suggesting a tradeoff between benefits and harms?

(Craig Umscheid):I think there would be a subtle shift. It would be a weak recommendation supported by any quality evidence suggesting a tradeoff between clinical benefits and harms.

Patrick Brennan: Okay. Okay. All right. I'm going to ask the members to comment at this point. If there are no comments then we'll move on to vote on this recommendation.

So the proposal would be to adopt the categorization scheme as just described by (Carolyn Gould) and (Craig Umscheid) with the revisions to Table 1 as stated including (Craig)'s comment on Category II weak recommendation - weak recommendation supported by any quality of evidence suggesting a trade off between benefits and harms.

Patrick Brennan: All right. All those in favor of adopting that scheme?

HICPAC Members:Aye.

Patrick Brennan: Any opposed? Are there any abstentions?

(Kurt): Now will these apply to future guidelines for example, the Norovirus or is it just strictly for this particular guideline?

Patrick Brennan: Yeah. This is the scheme that we would be adopting for future guidelines.

(Kurt): Okay.

(Carolyn Gould): This is (Carolyn). I just make one other clarification for Category IB. We also made a slight modification to the wording just to clarify. It should read a strong recommendation supported by low quality evidence or an accepted

practice supported by very low quality or no available evidence. And the latter description encompasses the accepted practices recommendation.

Patrick Brennan: Okay. So that's IB.

(Carolyn Gould): Yes. There's just an "or" in there.

Patrick Brennan: Okay. Thank you. Let's move on to Page 2 and the next voting item relate to considering re-categorization of the recommendations under - I believe this is the section under appropriate urinary catheter use. And for Recommendation IA, the revision has been accepted per the grading scheme and it has been re categorized as Category IB.

The next item is to reconsider the wording of Section 1A2 for consistency. And then on the following line there was a comment to add clarification to appropriate indications for continued postoperative catheter use. And that is referenced in Table 2 with the recommendations for further research.

(Carolyn Gould): (Table 2) Its Page 10 and 11.

Patrick Brennan: It's at the bottom of Page 10. So are there any comments on - we can vote on these three together since they're interrelated. Are there any comments on these three items?

Hearing none, then I'll propose that the committee accept those amendments as you see them in the document. All those in favor?

HICPAC members: Aye.

Patrick Brennan: Any opposed? Are there any abstentions? Okay. Thank you.

The next item actually wraps around onto the top of Page 3 and that is consider adding guidance regarding appropriate use in the obstetrical patient. (Carolyn) do you want to comment on this one?

(Carolyn Gould): I'll clarify. We did not specifically address the obstetrical population solely because our literature review didn't inform a recommendation specific to the OB population. So it wasn't that we purposely excluded data. So a comment that we received from one of the HICPAC members was whether we actually systematically excluded data and we did not we just didn't find any in our literature search.

Patrick Brennan: Okay. So I'm not sure that we actually need to vote on this. That explains the absence in the document. It wasn't a specific exclusion.

Let's go down to the next item under summary of recommendations and one I believe that is on Page 11. And this is a comment from one of our consultants. This is Section 1B1 and reconsider categorization of recommendation 1B1. That is now a Category II recommendation. And the category was amended for the grading scheme with associated changes to the evidence summary and the grade table.

Are there any comments on this point? This relates to consider using external catheters as an alternative to indwelling catheters. Hearing none, I propose that we accept that amendment. All those in favor?

HICPAC members: Aye.

Patrick Brennan: Any opposed? All right. The next one is also under the summary of recommendations and comments regarding clean versus sterile requirements in acute and non-acute care settings. And in this item there's added wording in Section 1B5 and 6 to clarify clean versus sterile recommendations with the sterile technique in the acute care setting being categorized as a weak recommendation in Category II.

This is open for comment. So there is a divergence in these recommendations between the acute care and the non-acute care setting. Hearing no comments, then we should vote on this. All those in favor of the proposal to amend this to a weak recommendation for a sterile technique in the acute care setting; all those in favor?

HICPAC members: Aye.

Patrick Brennan: Any opposed? Are there any abstentions? Okay. On Page 4 then, the third line from the top, there were several comments regarding - questions regarding routine changes of catheters or drainage bags. And the language in section 3E has been amended and the categorization has been changed to a weak recommendation. This is on Page 13 Roman Numeral 3E.

So catheters and drainage bags should be changed based on clinical indications such as infection, obstruction or when the closed system is compromised, Category II.

Comments on this item? Hearing none let's vote. All those in favor of the proposal to amend the language and categorize this as a weak recommendation Category 2; all those in favor?

HICPAC members: Aye.

Patrick Brennan: Any opposed? Are there any abstentions? The next line relates to questions regarding the use of prophylactic antimicrobials in perioperative patients. Several reviewers raised questions about this and the language has been amended to reflect the heterogeneity within the perioperative population, the duration of catheterization. (Carolyn) do you want to comment on this or (Craig)?

(Carolyn Gould): Sure. I can comment on this. We really just added the parenthesis that indicates potential clinical indications for antimicrobials specifically based on AUA's best practice policy statement. We added the example of patients with bacteriuria upon catheter removal post urologic surgery as an example of a potential clinical indication. But otherwise the recommendation not to use systemic antimicrobials routinely is the same.

Patrick Brennan: So antimicrobials - systemic antimicrobials should not be used routinely to prevent catheter associated UTI patients requiring either short or long-term catheterization. And that's a IB.

Comments or questions on this item? All those in favor of the amended language and the categorization say aye.

HICPAC members: Aye.

Patrick Brennan: Any opposed? Are there any abstentions? Okay. Two lines down, another summary of recommendations on Page 14 and elsewhere. The language - it was recommended that the language be changed to be more directive. So where applicable for Category II recommendations, the language should be amended to not suggested or is suggested rather than need not be.

And was that changed throughout the document (Carolyn)?

(Carolyn Gould): That’s correct.

Patrick Brennan: Okay.

(Carolyn Gould): So I don't know if it really requires a vote.

Patrick Brennan: Yeah. I think that it probably doesn't. Okay. The next item is on the next line. Reconsider the wording/recommendations on impregnated catheters. There were a number of comments on this and revisions were made in Section 3M and 3M1 along with recommendations for further research.

(Mike), was this one of the items that we talked about earlier?

(Mike): Yeah, that’s correct.

Patrick Brennan: Okay. Do you want to add anything here?

(Mike): No. I think the revised language does a nice job of making this parallel to the blood stream infection guideline where similarly there’s the opportunity to consider a treated catheter in some populations under certain circumstances.

Patrick Brennan: So this escalates the intervention if other recommended interventions have not resulted in a decrease in the catheter-associated urinary tract infection.

(Mike): Exactly. The intent was not to take a tool off of shelf entirely, but to point out that there are other strongly supported things that need to be done before resorting to this.

Patrick Brennan: Okay. And this is a Category II recommendation. Comments from the committee?

(Denise): PJ.

Patrick Brennan: Go ahead (Denise).

(Denise): That's the one that we're considering I think based partially on how the table falls out whether this should be a Category II or a IB.

Patrick Brennan: I see.

(Denise): And that's what the group needs to consider...

Patrick Brennan: Okay.

(Denise): ...with a change in the language.

Patrick Brennan: And as the - as the draft exists right now it's a Category II.

(Denise): Correct. But the discussion here was whether it should just be II or IB.

Patrick Brennan: Okay.

(Denise): And again, considering the change in the category that (Carolyn) mentioned and as we said initially when you vote for a II, also the implications in terms of reimbursement, everything that a Category I would have and a Category II would not have. So that's the whole idea about (revising) the language and for the categories and for the recommendations.

And I think this one in fact should really discuss before voting.

Patrick Brennan: Yeah.

(Denise): Because it has huge implications.

Patrick Brennan: Yeah.

(Denise): And for the (unintelligible) section guidelines is IB. And so I think in fact should spend time discussing that.

Patrick Brennan: Are you suggesting that we have this discussion offline (Denise) or...

(Denise): Oh no. We have to discuss before voting.

Patrick Brennan: I guess what I'm asking is, you know, it seems like we'll have to review the evidence on this again.

(Carolyn Gould): But based on the evidence review it’s a Category II.

(Denise): But the evidence is preventing infection as part of a package...

Patrick Brennan: So (Denise), is your point that this has less to do with the evidence on preventing infection than in the quality improvement approach and escalating the...

(Denise): No, I think we went through the discussion for - I don't think anybody was at HICPAC at that time. (So I'm) the only one with the memory from the blood stream infection (guideline) and the use of impregnated catheter. That as isolated recommendation it was weak to say we have evidence that impregnated catheters for blood stream infections should be used to prevent infection.

Patrick Brennan: Right.

(Denise): But it’s part of a package that first people would consider everything else and then if it’s not working would consider the catheter, it was voted as IB.

Patrick Brennan: Right. And that’s consistent with the approach that HICPAC has taken on other issues.

(Denise): I'm just mentioning what happened at that time.

Patrick Brennan: Yeah.

(Denise): The other thing was we didn't have (unintelligible) that what is mixed evidence. The evidence in some places it did not work. In other places it - it’s the same thing with screening for MRSA. I think we did kind of the same thing. We have Tier 1 and then Tier 2.

But I think (Carolyn) should speak about the evidence.

(Carolyn Gould): Right. Based on our evidence review and our grading scheme, the overall quality of evidence for the antimicrobial or antiseptic impregnated catheters came out to be low quality. Some of the Category (IB) recommendations are indeed low quality.

But the question is whether this would be considered an accepted practice or not to qualify - with low quality evidence to qualify to be a IB recommendation as opposed to a Category II.

But the results are indeed mixed and as we've discussed before, the overwhelming majority of papers look at bacteriuria rather than a specific clinical outcome.

And one thing that we did as we revised this guideline is we looked at our evidence review for all of the recommendations to make sure that we appropriately reduced the quality of evidence depending on the outcome for all of the recommendations. So if an outcome was solely bacteriuria then that did affect the quality for other recommendations as well.

So what we kind of come down to is that we've got low quality evidence based on our grading scheme and the question is whether that would leave us to become a Category IB or a Category II. That’s really based on whether the clinical benefits are clear and the potential clinical harms are marginal.

And I think we’re not really discussing harms in this case. None of our evidence suggested a potential harm although most papers didn't really look specifically at antimicrobial resistance. But that did not seem to be a major issue.

So we’re looking at whether the clinical benefits based on expert consensus are clear and that if it is a Category IB that would have implications - potential implications for CMS reimbursement policy implications.

(Denise): And just like (Carolyn) said, if it was based on the evidence, if it was what we had before, the language we had before in terms of recommending the use of impregnated catheter I don't think would be a question. That should be Category II.

I think the question is we're figuring out that it would be after you do everything else...

Patrick Brennan: Right.

(Denise): ...is that a potential additional benefit. So that's the main thing. That is different than the recommendation (they gave to us) before that it should be (proof) at that point.

(Barbara): Do you have any evidence - any of our papers, and I'm sorry I'm not familiar with all these, that show that there's benefit after every - after the other key efforts have been made?

(Carolyn Gould): None of the papers we evaluated looked at that specifically.

Patrick Brennan: Are there other questions?

(Craig Umscheid): The other issue that comes up here is so we talked about the benefits. So what are the harms? And the potential harms that we identified in the grade table were basically two main ones.

One was is there any evidence of any microbial resistance. And the second one was is there any evidence of increased pain, itching or burning with the use of silver catheters.

And from what I can tell looking at the most updated grade table that I have, there were studies addressing both of those and the quality of the evidence was noted as low and it looked like there was no difference in burning or any microbial resistance. But again, it was low quality evidence.

(Lillian Burns): Given the fact that it’s low quality evidence that is what I'm hearing and if there’s no clear benefits, I mean I don't know if it should be Category IB.

I struggle with this. I'm hearing it’s low quality evidence and that there’s not enough supporting evidence that there’s a clinical benefit then. I mean even then there’s - even if there is no harm, if there’s no benefit then it's...

(Carolyn Gould): I think what - just to clarify.

(Lillian Burns): I struggle with that. If there’s no benefit, I mean does it - and no harm is not the issue. It’s that you would hope that it would be a benefit to the patient.

(Carolyn Gould): I think what we’re saying is we don't know if there is a clinical benefit because most of the studies haven't looked at that question. We know that these catheters reduce the risk of bacteriuria and - or delay the onset of bacteriuria, but we don't know really about clinical outcomes. And so the recommendation for further research is in there below this recommendation for that reason. But really - so we’re not saying there’s no clinical benefit. We’re saying we don't know essentially, right.

Patrick Brennan: And the suggestion you’re making relates not to - not to a stand-alone practice but as a package of practices.

(Carolyn Gould): Right. Implementing the high priority Category I recommendations.

Patrick Brennan: First and then failing that going on to this. Is that correct?

(Carolyn Gould): That’s correct.

Patrick Brennan: Okay. Okay. Well let’s - if there are no additional comments, are there any?

(Lillian Burns): This is just (Lillian). I fully understand that. If you do make this a IB and you are saying to the professionals out there that yes to these other things, aseptic technique and all of that. The recommendation is if you don't see improvement then perhaps you should consider this type of catheter, is that my understanding. They're going to try to implement that.

(Cliff): Yeah. This is (Cliff). Could I add one thing? (Carolyn) let me just clarify with you. You said that you don't know if there's clinical benefit.

(Carolyn Gould): We don't know.

(Cliff): Most of the studies were powered to look at prevention of bacteriuria over prevention of true infection. But we also know that bacteriuria is along the pathogenesis pathway towards infection. Just like we know if MRSA - prevention of MRSA colonization or de-colonization is on the pathway.

So there is that issue of biological plausibility of an effect. So I sort of got the feeling that this is one of those things that there's biological plausibility, there's a prevention of a step along the pathway towards infection. There is not the randomized control evidence of the hard outcome.

So I got the read that this does not mean that there's no evidence. It's weak evidence that it's having some impact and that the impact may be so small that in most cases it's completely drowned out by other things. That's when we talk about this being down in Category II in general but could come up to Category I when you've tried everything else.

(Carolyn Gould): Yeah. I agree with you because I think you're right. We may not - the potential impact may be so small because most cases of bacteriuria don't result in symptomatic UTI. But exactly what you're saying...

(Cliff): If you prevent enough of them you probably could get an effect.

(Carolyn Gould): Right.

(Cliff): It's a very large study that no one has put the money into to do these things. But pass along, this is not sprinkling people with talcum powder or something that has no biological plausibility that doesn't involve it. So we're not recommending (leach) this year. I think we have to be careful.

This is not the same as - kind of like this is starting down a road towards pathogenesis which they have - they've met some (unintelligible) end points that are not agreed upon but they are agreed upon there's something intermediary towards infection.

Patrick Brennan: But I think we need to be clear on how this recommendation ought to be used because it is - it would be a Category IB or Category I recommendation which means it should be implemented but in all cases. But we need to be clear that the recommendation is not as a stand-alone recommendation.

(Cliff): Right.

Patrick Brennan: That it's as a follow on because I'm concerned about how the recommendation will be employed.

(Russ): PJ, this is (Russ). In the draft update on the catheter related blood stream infection prevention, is the (collar) for this - in other words, in that specific,

and I can't remember off hand, but the recommendation around use of antimicrobial central venous catheters, does it couch that in the phrase of a performance improvement project after you've done everything else?

Patrick Brennan: You know, I don't recall (Russ).

(Russ): Okay.

Patrick Brennan: I'd have to - I'd have to pull that out. (Lillian), do you recall?

(Lillian Burns): No. No, it’s not couched as a quality improvement.

(Russ): And then the - let’s see. I'm not sure (Craig) whether your group’s looked at probably - haven't gone into the depths on that in terms of the BSI prevention guidelines draft.

(Denise): PJ, isn't that a different - just some that they are using to...

Patrick Brennan: Yes. You’re right (Denise). The BSI guideline was initiated before HICPAC undertook this process...

(Russ): Oh that’s right.

(Lillian Burns): This is (Lillian) again. I think that was PJ. That is my concern that if it is a I, people generally will feel that is not just part of a package. They will fee that this is something - they may. I'm not saying that they will but they may be that there’s a potential that people may see it as something (unintelligible).And a lot of people based a lot of their - in the field they based a lot on the recommendations that CDC puts out in their guidelines on category. So we just need to be very careful about - and I'm glad we’re having this type of

group discussion because people will adopt it and they may not fully understand that it is part of a package.

So whatever we do, it must be clearly stated that so that they understand that this is not a stand-alone.

Patrick Brennan: Perhaps the clarification should be in M1 where it says that further research is needed on the effect of antimicrobial antiseptic impregnated catheters. And perhaps we could insert there after the word catheters as a primary intervention in reducing the risk of symptomatic UTI.

(Lillian Burns): I like the language. I like that. I think that goes a long way in making it a little bit clear to individuals reading this document just what the intent of this statement is.

Patrick Brennan: (Denise), is that - (Denise), do you have any comment on that language?

(Carolyn Gould): I agree with that language. This is (Carolyn).

Patrick Brennan: Okay.

(Craig Umscheid): But just to be clear, so the context of using catheters - the other interventions we're talking about, the priority interventions are basically - they're all placement. Somebody who's trained should place it. A closed system. It going in only for appropriate indications and coming out ASAP. So within that context, if they still have high symptomatic urinary tract infections then you'd say silver Foley catheters are okay? Or are you talking about disregarding all of those other priority recommendations?

Patrick Brennan: No. No. I would say in that - in that context where all those other things have been done then impregnated catheters would be okay. Any other comments? Okay. I'm going to suggest then that the proposal be to adopt M1 on antimicrobial antiseptic impregnated catheters as a Category IB with the amendment to Item 1 inserting the words as a primary intervention.

Further research is needed on the effect of antimicrobial antiseptic impregnated catheters as a primary intervention in reducing the risk of symptomatic UTI and so on. Any questions about that language? Okay.

So we'll vote on this. If this does not pass then we'll have to vote on this as a - as a Category II in order to adopt one or the other.

(Russ): Yeah. PJ, this is (Russ). Just to clarify. So in the paragraph under M, consider using antimicrobials, et cetera, would you categorize as your motion to change that Category II to a Category IB?

Patrick Brennan: Yes.

(Russ): And then under that M Sub Point 1 would be leave as is. No recommendation. Unresolved.

Patrick Brennan: No. It would be - there would be two - there are two changes in this proposal.

(Russ): Okay.

Patrick Brennan: So leave Item M. Leave the language in Item M as it is but change Category II to Category IB.

(Russ): Okay.

Patrick Brennan: And then in M1 insert the phrase further research is needed on the effect of antimicrobial impregnated catheters as a primary intervention. So this will be phrased as a primary intervention.

(Russ): Okay.

Patrick Brennan: Okay? Any questions - any further questions about it? All those in favor of that proposal to switch to Category IB and insert the phrase as a primary intervention say aye.

HICPAC members: Aye.

Patrick Brennan: Any opposed? Are there any abstentions? Okay. So that is amended as stated. That's a Category IB.

(Craig Umscheid): This is (Craig Umscheid). Just to be clear so the wording is going to have to change a bit on that - on that M recommendation because right now it's written as a Category II where it says consider.

(Carolyn Gould): Right. It will have to say use.

Patrick Brennan: Yeah. Drop the word consider. Say use antimicrobial. Okay. Let's go to the top of Page 5, second line, comments regarding spatial separation of patients with catheters. And there was no recommendation made here. So I don't - I don't think we have to vote on this one do we (Carolyn)?

(Carolyn Gould): Okay.

Patrick Brennan: Page - the item on Page 15.

(Carolyn Gould): Right, so...

Patrick Brennan: Spatial separation. Do we have to vote on this?

Patrick Brennan: No recommendation.

(Carolyn Gould): Yes. We took out the recommendation for - a Category II recommendation for spatial separation of patients with CAUTI and without and left in the recommendation for further research.

Patrick Brennan: Okay. Okay. Do we need to vote on that?

(Carolyn Gould): I thought so.

Patrick Brennan: Okay. Is there any questions? So this went from a Category II to a no recommendation. Unresolved issue. If there are no questions, all those in favor of this proposal say aye.

HICPAC members: Aye.

Patrick Brennan: Any opposed? Any abstentions? So last item for a vote was a modification in the language on Page 30. And that related to Category I. You see it in the middle of the page. And...

(Carolyn Gould): I can explain that if you want.

Patrick Brennan: Go ahead.

(Carolyn Gould): The - so on Page 31, Category I implications for policymakers, the previous version read the recommendation can be adopted as a policy in most situations. We changed to the recommendation might be adopted as a policy because we received a comment - a couple of comments regarding implications of (unintelligible)...

Patrick Brennan: Okay.

(Carolyn Gould): ...Category I recommendations.

Patrick Brennan: Is there any questions about that?

(Craig Umscheid): (Carolyn), just to let you - this is (Craig Umscheid). Just to let you know, in the HICPAC guideline methods document a number of individuals recommended we change that phrase too. So we actually changed it to the recommendation may be considered for policy in many situations. So we could be consistent whatever the group desires.

Patrick Brennan: Would anyone like to add that language. (Craig) is referencing the methods paper that will accompany this document when it's published.

(Lillian Burns): This is (Lillian). I'm fine with the may.

Patrick Brennan: State that again (Craig).

(Craig Umscheid): The way we wrote it was the recommendation may be considered for policy in many situations.

Patrick Brennan: Okay. (Carolyn), you okay with that?

(Carolyn Gould): I could ask around the table.

(Cliff): Yeah. When I first was hearing it I was thinking about this catheter thing. But we did - we were careful on the catheter issue to clearly state that, you know - it's true that people have taken the MRSA screening for example and made that a policy. But not in the context of the MDRO guidelines. Not of a tiered recommendation based upon other interventions and the effect that those are having in that facility in decreasing MRSA.

Now if they would get it right this time, the catheter one, then this is fine. I think - our goal here is that we got to work with policymakers on these other levels. They understand the guidelines and when they (unintelligible) them as policy they're using the framework as a guideline.

Patrick Brennan: Is there any meaningful distinction do you think between may be adopted and might be adopted?

(Cliff): It's just the most settings or some of the second part of it. It wasn't the may or might.

(Craig Umscheid): Yeah. It's the second portion. And just to give you guys a little background, these two definitions of the categories come from the actual newer grade documents that a lot of organizations are using.

And the whole point about describing what Category I means for these different populations whether it's patients or clinicians or policymakers, it tries to differentiate what the categories mean for each of those groups.

So for policymakers a Category I essentially means that the recommendation is adoptable as policy in a lot of situations. It means that, you know, not much

debate has to occur. Whereas for Category II you'll see for policymakers it say policy making will require substantial debate

(Carolyn Gould): This is (Carolyn). Can we say something along the lines of in appropriate situations or in the appropriate context?

(Mike): Yeah. This is (Mike). I think that might be a little better. You know, as tempting as it is to try and transliterate just directly from the grade document to this, I think it's also necessary to remember that there's a difference between infection control recommendations and a recommendation to adopt a new medication for a formulary or something like that. It may not always be possible to go directly across in language.

(Craig Umscheid): Yeah. No, I think that's fair although, you know, the WHO is using the grade process and a lot of the IDSA is using the grade process. So I think it has relevance for infection control.

Patrick Brennan: So (Carolyn) what was - please restate the phrase that you used.

(Carolyn Gould): I thought the recommendation either may or might be adopted as a policy in the appropriate context.

Patrick Brennan: Okay.

Woman: Instead of may be adopted, can we go back to the language consistent with the methods paper, maybe consider. It sounds less strong than adoption.

(Craig Umscheid): Well in the methods paper it's actually adopted. Now the whole point you have to remember, this is a Category I. So this should be a relative no-brainer

policy issue for most policymakers because it's all net benefits or it's all net harms.

Patrick Brennan: Okay. A good point. So let's use the word may for constancy and add (Carolyn)'s closing clause there in appropriate situations.

(Rachel): This is (Rachel). I would be very much confused by what is the appropriate situation. I think there's a big difference in the majority of situations but in the appropriate means that needs to be defined.

(Craig Umscheid): I don't want to take too much time away from the committee but the only reason I think it's important at some level to have that final clause is because it's saying that, you know - the original language was in most situations you can adopt this as policy. So we changed it to many situations to make it a little less dogmatic.

But we still wanted to emphasize that in the majority of cases that this should be a no-brainer.

Patrick Brennan: But I think that (Rachel)'s right. You know, whether we say many situations or appropriate situations, it's going to beg the question of what those situations are and I think we'll have to leave that to the policymakers.

So let's switch might to may and leave the clause off.

(Craig Umscheid): I think that's fair.

Patrick Brennan: All right. Is there any objection to that? All right. Let's vote on that proposal then to amend Item 3 at the top of Page 31 for policymakers. The recommendation may be adopted as policy. All those in favor, aye.

HICPAC members: Aye.

Patrick Brennan: Any opposed? Any abstentions? Okay. I think we've covered everything that has been marked as needing a vote. Have I missed anything?

(Russ): PJ, this is (Russ). I just had a question for (Carolyn). On - for Table 2, there's a footnote that indicates those indications are, you know, based on expert consensus. Did you get - do we as a group need to respond or did you get any comments on making sure the users of this document understand that each of these indications does not have a categorization or ranking scheme behind it?

(Carolyn Gould): I didn't get any particular comments of concern with that.

(Russ): Okay.

(Carolyn Gould): But I - we did make a few changes (unintelligible) be in the table. So if you need to discuss any of those...

(Russ): Yeah. Okay. Guess what I'm trying to convey is these are certainly good guideposts for clinicians to decide when a catheter is appropriate but I don't think it's exhaustive nor necessarily comprehensive of all indications.

(Carolyn Gould): Right. And we did - (unintelligible) clarifications for example...

(Russ): Okay.

(Carolyn Gould): ...some people suggest just to let's try to be as comprehensive as possible.

(Russ): Yeah.

(Carolyn Gould): You know, we can't address every (unintelligible).

(Russ): Right. Kind of my end game in this is I would prefer that policymakers not say these are written in concrete and ergo...

(Craig Umscheid): You could change the title of that table to possible indications for indwelling urethral catheter use. The upside is that you give people more flexibility and the downside is that you give people more flexibility.

(Russ): Yeah. Exactly. I guess I don't know what the - that's the only hesitation I have is just that it not become rigid policy requirement that, you know - if a facility has some variation from these that they not be, you know, somehow penalized or I don't know, maybe...

Patrick Brennan: (Mike), we actually should open this up for questions at this point from the public before the committee takes its final vote.

(Mike): Yeah. I think that's appropriate.

Patrick Brennan: Okay. Operator. Can you open the lines up for questions from the public?

Coordinator: I'm showing no questions from the phone lines at this time.

Patrick Brennan: Okay. I think we've worn everyone out. Let's take a final vote then on the - on the document. So the proposal would be that the committee approve the adoption of the guideline for prevention of catheter-associated urinary tract infections 2009. (Are) there any final questions or comments?

Hearing none, all those in favor of the proposal say aye.

HICPAC members: Aye.

Patrick Brennan: Aye. Any opposed? Any abstentions? Well I think that concludes the call and the work that we have to do on this. Is there anything else that you'd like to cover? (Mike).

(Mike): Great. No, I think we've covered all of the voting issues. I appreciate very much the fairness with which that was done. And I don't know of any other issues that we need to talk about today.

Patrick Brennan: Okay. (Carolyn), do you have any final comments?

(Carolyn Gould): Not right now. No. Thanks.

Patrick Brennan: I can't wait. (Denise) anything?

(Denise): Thanks for your hard work on this guys. Wonderful.

Patrick Brennan: Thank you all (for the) hard work and for the time we turned around on this document. That will conclude this call. Thank you.

END