

Round Table Discussion Summary
Philadelphia Antibiotic Stewardship Collaborative Meeting
September 26th, 2016

Format: Ten tables with groups of 9-10 health professionals (physicians, pharmacists, nurses, microbiologists, epidemiologists, and other) discussed the following questions. Tables were mixed based on experience, hospital size, and profession.

Discussion Questions:

1. The following questions refer to the Joint Commission Standard and Centers for Medicare and Medicaid Services (CMS) Survey questions included in your folders.

a. How have you planned for the new Antimicrobial Stewardship (AS) Standard and Survey at your hospital (if you have)?

- i. Group felt that Joint Commission Standard has engaged hospital leadership to acquire and solidify resources.
- ii. Great deal of variability in current AS programs among facilities. Some AS programs are pharmacy-led, involve administrative support, or are rolled into infection prevention committees.
- iii. Facilities feel they can establish policies to meet Joint Commission requirements, but enforcement will be a challenge. Different hospitals take policy to mean different things; some are very strict that it is a policy that must be approved by a medical board that includes all of the CMS/Joint Commission elements, others a mission statement or guidelines, and others a contract for a physician leading stewardship.
 1. The Joint Commission will hold the hospital accountable for the policy: if elements in the policy are not fulfilled, the hospital could be cited so the policy needs to be careful about “overpromising”.
- iv. If the hospital is more interested in stewardship, they may turn to ID physicians and pharmacists to make a business plan. How do you make a business case for your proposals or program? What should you ask for? Just funding for a physician and pharmacist with IT support? An operating budget?

b. What challenges have you had (or anticipate having) with complying with CMS and Joint Commission?

- i. Lack of personnel/administration
 1. Some hospitals do not have a dedicated ID pharmacist.
 2. Lack of data analyst/IT personnel/epidemiologist to do data management and analysis.
 3. Lack of dedicated FTEs for stewardship (some only have dedicated support 3 days/week).
- ii. Policy approval

1. Some facilities feel equipped to disseminate information to providers and nurses but are not presently backed by written policies.
- iii. Education
 1. Many hospitals noted that patient and provider education takes a long time and can be difficult.
 2. Once interventions are in place (ie: 48 hr time out, antibiotic indication, etc) important to survey front line providers and ask what is most useful/helpful.
- iv. Need for antibiotic orders to include indications
 1. One hospital mentioned that 30% of the time there is nothing about indication.
 2. Indications should be short but specific- and there needs to be a way to analyze this data.
 3. Some mentioned adding a field to the ordering system to make it require an indication (but this would require IT support).
- v. Communication
 1. Long term care facilities expressed a greater need for communication with hospital IPs, docs, pharmacists, etc to support their efforts. They are concerned about meeting upcoming requirements and even implementing the CDC recommendations.
 2. Lots of variation between hospitals and documentation-prescribing issues can come from the outside in.
 3. Lack of communication/poor communication among several departments of the hospital- there can be hierarchical issues- some providers do not want to take recommendations.
- vi. Leadership
 1. Some hospitals are unclear who is leading the stewardship.
 2. Concern that appointed stewardship leader may not attend many of the AS meetings (will there be an attendance requirement?). Concern for situations when physician lead may be covering multiple hospitals.

c. What creative solutions have you employed (e.g. 48-hour time-out, monitoring antibiotic use)?

- i. 48 Hour Time-Out
 1. Many hospitals mentioned that the 48-hour time-out is difficult to implement (patient safety risk, technical issues (IV to PO conversion, renal dose adjustment will reset the clock each time order is changed), and who to target the alert to (in the case that multiple providers are tending to the same patient)).
 2. There was a suggestion to move from 48 to 72 hours- may be more doable because most microbiology results do not come back for 72 hours.
 3. Nurses may help with facilitating 48 hour time out, if providers can get behind the idea.

4. EPIC pop up screen may be a work around?
- ii. Newsletter which includes a post test for CME credits (then auditing the completion of the posttest).
- iii. One hospital targeted one drug/outcome across region (ie: fluoroquinolone use and *C. diff*) and found a decrease in utilization. Challenge is access to data that is comparable across different hospitals/health systems/practices (ie: SNF/LTC vs acute care setting).
- iv. Pediatric collaborative has taken the approach of doing a point prevalence study to enter data once quarterly on antibiotic prescribing behavior.
- v. For patient education- one page flyer to be put in discharge packages, ads in waiting room areas.
- vi. One hospital's AS program involves an ID pharmacist and an ID physician having sit down stewardship rounds with each medical and surgical team 5 days per week.
- vii. One group used electronic alerts to monitor all prescriptions prospectively so that all were monitored for appropriateness everyday by the stewardship team.

2. Are there medical-legal concerns about stewardship at your hospital?

- a. Does your institution limit which healthcare providers make recommendations to clinicians based on potential legal ramifications?**
 - i. There was concern about pharmacists being asked to act outside the scope of their practice because they are seen as the antibiotic experts.
 - ii. There was also a concern of liability insurance especially among the pharmacists who may carry their own insurance or are covered under the hospital, but there are many clinical pharmacists who may not have coverage.
- b. How does your stewardship team document interventions/recommendations and are there challenges associated with this method?**
 - i. Documentation seems to be a concern and there are a variety of practices; some people feel that documentation makes the stewardship team less liable. Some feel that documentation is important because it would otherwise be a "he said/she said" type of scenario.
 - ii. Many facilities do not document stewardship activities in the patient's medical record.
 - iii. One hospital mentioned that when documentation does occur in pharmacy systems only or via feedback programs (e.g. pre-post data presentation at an Infection Control Committee meeting).
 - iv. Some AS programs qualify their recommendations in the permanent chart with "consider" or other qualifications. Important to include disclaimers such as recommendation based on review of medical chart, have not seen patient, does not replace an ID consult
 - v. Some institutions still using home grown excel spreadsheets to gather intervention data - can be time consuming but easier to manipulate.

- c. **Do you have any automatic antibiotic stop orders or a restricted formulary, requiring pre-approval?**
- i. Antibiotic stop orders can be a problem, when antibiotics are sometimes not reordered and drop off, poor outcomes can result. One hospital noticed this especially in the heme-onc ward, and changed the automatic stop orders to 30 days for heme-onc patients. It is ultimately the primary team's responsibility to ensure that the antibiotic regimen indicated is continued.
 - ii. Some hospitals have limitations to only dispense the 1st dose or 24 hours of antibiotics prior to approval for restricted drugs.
3. **With new antibiotics on the horizon and some already there to treat multi-drug resistant (MDR) pathogens (ceftazidime-avibactam, ceftolozane-tazobactam, imipenem-relebactam, dalbavancin, oritavancin, ceftaroline, etc.), how has your stewardship program incorporated these (or may plan to incorporate, if drug is not yet available)? How can we plan for their use to make sure we conserve them for patients that need them?**

Did not formally discuss due to time limitations.

- **Novel idea:** AS program at one hospital works with the community to visit LTCFs and other practices in their catchment area, to decrease AMR in general in their community and enhance communication among facilities.