OVERCOMING THE CHALLENGES OF IMPLEMENTING ANTIMICROBIAL STEWARDSHIP IN A RURAL HOSPITAL

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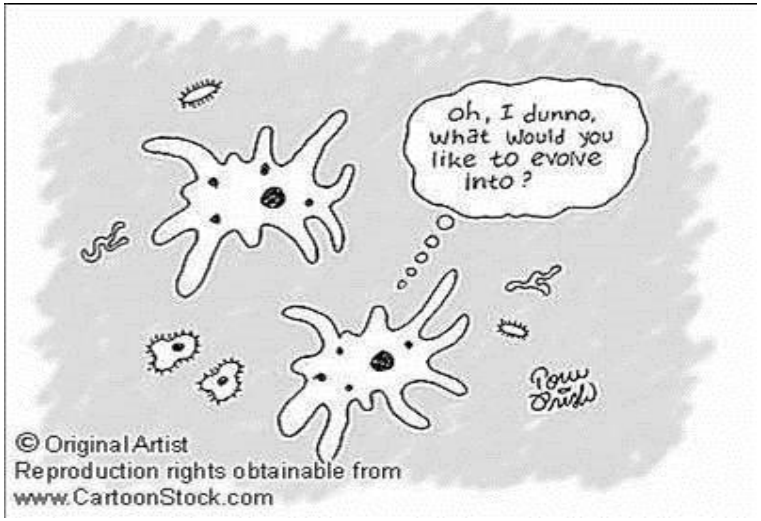


What are the challenges?

- Limitations due to staffing, infrastructure, and resources
- No IT support
- $$$$$
- Time

Are these really the challenges?

- Money does not buy happiness
- Passion
- Commitment
- Personal responsibility

Scientists discover a new superbug.

The Power of One

- One person who believes in doing something for the right reason at the right time has the greatest influence in the success of whatever that thing is

- “Unless someone like you cares a whole awful lot, nothing is going to get better” (Dr. Seuss)

- You have to believe that what you are doing is the right thing to do

Collaborative Effort – Collective Ownership

- Dedicated
- Competent
- Supported
- Accountable

Leadership Commitment

- It is one thing to sign a letter of commitment; quite another to actually be committed
- Designate a leader
- Send a letter to Board, Medical Staff, nursing educating them about what you are doing and why
  - CDC to develop template

Accountability

- Appoint ONE person responsible for program outcomes
- Ideally a pharmacist but can be whomever has the passion; empower that individual to do it
- Provide training for that individual
- That individual participates in Alaska Antimicrobial Stewardship Collaborative (A2SC)

Drug Expertise

- Training – MAD-ID; SIDP
- Participate in AK Telementoring
- Network w colleagues; we are all in it together

Action

- Eliminate double anaerobic coverage
- Community acquired pneumonia
- Urinary tract infection
- Skin & soft tissue infections
- Abx “time out” – 48-72h review for need

More Action

- Facility specific diagnostic & treatment guidelines
- These guidelines are abundant; who has time to go to all the links with the guidelines, sort through them & create your own?
- Many of them are too broad in their recommendations
  - CDC to work on 1 page algorithm templates; you put in abx per your local antibiogram

How to

- Need to develop a report listing the patients on the abx you are going to target
- SPH is small, we review all abx on all patients
- Look at the report EVERY day. Ensuring appropriateness happens with every single antibiotic order!

- Be committed! It is not optional to not review because you are too busy.
- Do it first thing in the AM so you are prepared when the physicians make rounds
- Use EHR to your advantage; build the abx into the orders
- Get nurses involved; they already ask “can we d/c the IV”; “can we change to PO”; “can we d/c the abx”

Tracking – Monitoring prescribing & resistance

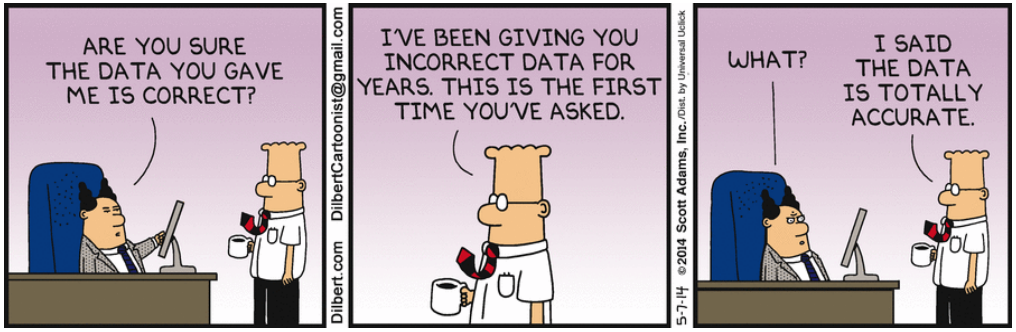
- Baseline data – if you don't have anything to compare to how do you know if you are making a difference?
- Quantify what your antibiotic burden is….how much you use
- Days of Therapy (DOT)
  - CDC encourages hospitals to avoid manual DOT calculations

DOT

- AK requires DOT

- We can probably all get data out of our EHS into an Excel file; then what?
- Find out who else uses the same EHS & how they are getting DOT data
- SPH uses Evident

Asolva Medici



- Calculates DOT
- <50 beds = $50/mo
- Converts file into NHSN submissible file
- Requires
  - CSV file w MAR medication name, date, route
  - CSV file w admission/discharge dates
  - CSV file w transfer info (if applicable)
- Leon Babakhanian <leon@asolva.com>

Monitor Abx Prescribing

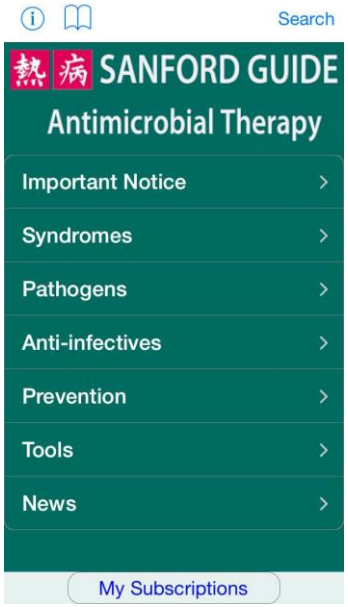
- Track for appropriate selection of therapy for CAP & SSTI
- Track number of abx starts for UTI per pt days in the context of lowering the number of starts by avoiding treatment of asymptomatic bacteriuria
- If feasible, track abx starts per indication (CAP, UTI, SSTI) per provider
- Review abx resistance patterns; # C diff

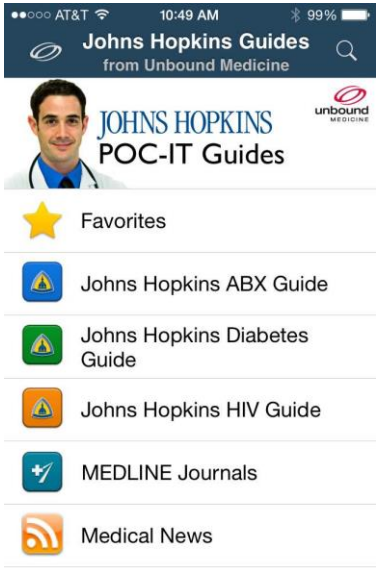
Education

- Keep stewardship a high priority
- Blogs, email blasts, employee newsletters
- Send short emails to nursing
- Keep Board informed
- Incorporate into new med staff education
- Include pt education in admission packet
- NPR announcements
- Local newspaper
  - CDC to develop templates

iPhone apps

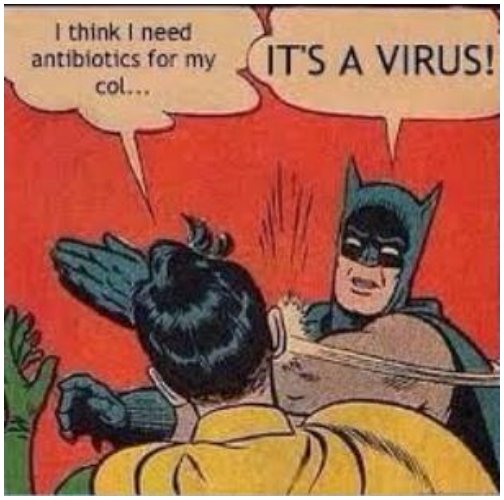
- Sandford Guide to Antimicrobial Therapy
- Johns Hopkins POC-IT ABX Guide



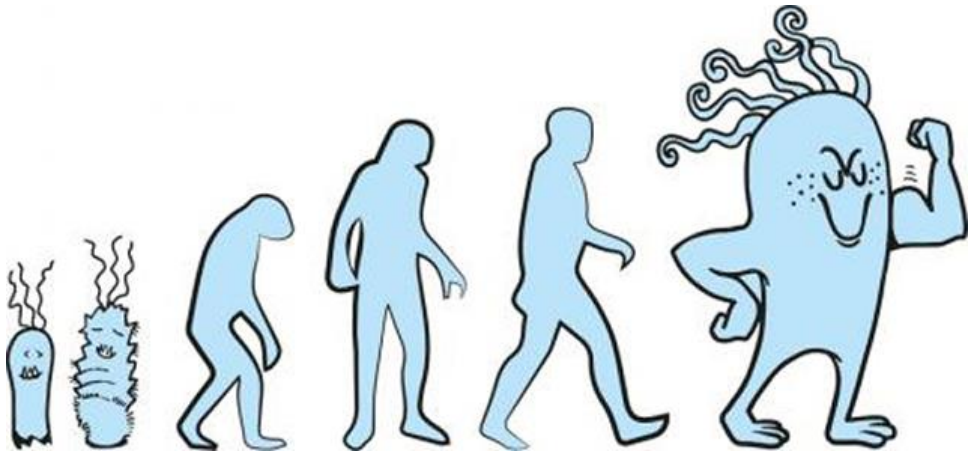


Miscellaneous

- Have micro results printed to your office location
- Talk face to face with the physician – no notes on the chart
- Everytime a locums or new ED physician appears introduce yourself & let them know
  - "I just want to let you know we have an aggressive antimicrobial stewardship program here so you may hear from us with suggestions for changing abx based on our local antibiogram & regional guidelines."
- Use non-threatening verbiage
  - "This pt has decreased renal function. Would it be ok if I adjust the abx for the renal function?"
  - "This pt is taking all oral meds ok, is it ok if we switch the azithromycin to oral"



- Pt admitted on cefazolin appears to have gut issue going on
  - “You might consider switching to pip/tazo which will provide better coverage including anaerobes…”
- De-escalation after 72h
  - “Cultures are negative, wbc is normal and the pt is afebrile….would it be ok if we discontinued the vanco?”



- Trauma pt coming into the ED w open fx..to the ortho surgeon
  - “Would you like me to get a dose of cefazolin & gent ready?”
- Pt w hx of meth use; facial sores, etc started on cefazolin for abscess
  - “This pt is high risk for MRSA, would it be ok if we switch to vanco”

- I have always favored an educational approach to change, NOT restrictive or mandates

- Everybody wants to do the right thing….you just have to convince the physician what the right thing is

Questions?

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