Inpatient Antimicrobial Stewardship Program Implementation

Kendall Van Tyle, PharmD, BCPS, ASP Chair
Northern Navajo Medical Center
Objectives

- Define antimicrobial stewardship
- Cite reasons why inpatient antibiotic stewardship programs (ASP) are important
- Recall time-line and key milestones for implementation of I.H.S. ASP for inpatient
- Compare & contrast examples of ASP elements
- List potential starting points for ASP implementation for your site
- List some resources available
Stewardship

“The management or care for something, particularly the kind that is successful”
The Goal

Prospective optimization of antibiotic therapy – period.
Antimicrobial Stewardship

- Strategic efforts to optimize antimicrobial prescribing
  - Drug
  - Dose
  - Duration
  - De-escalation
  - Indication - recognize when not needed
Something To Ponder

- Antibiotic stewardship asks us to think about the community, not only the patient being treated.

- The adverse effects of antibiotic overuse and misuse have implications beyond the patient and outside of your facility.
Why Implement ASP?

“If best infection control practices and antibiotic stewardship were nationally adopted, more than 600,000 infections and 37,000 deaths could be prevented over 5 years.”
CDC Emerging Infections Program (EIP) Assessment of Prescribing in 36 Hospitals

- Antibiotic prescribing could potentially be improved in over one third (37%) of common prescription scenarios

Examples:
- “UTI” – Asymptomatic bacteria accounted for 21% of patients receiving treatment with antibiotics
- **Vancomycin use**
  - No Gram (+) bacterial growth, but still treated >3 days: 22%
  - Culture grew only oxacillin-susceptible *Staphylococcus aureus*, but patient still treated >3 days: 5%
Rationale For Antibiotic Stewardship

- Improve Patient Care and Safety
  - Prevent *C. Difficile* infections
  - Minimize Adverse Events

- Reduce Resistance
  - Preserve antimicrobial effectiveness
  - Decrease excess deaths
Recommends that a regulatory requirement for antibiotic stewardship be in place by 2017.

“Starting July 1 (2015), acute care hospitals in California must put into effect antimicrobial stewardship programs…….”
## Section 1.C. Systems to Prevent Transmission of MDROs and Promote Antimicrobial Stewardship

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Surveyor Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.C.1 The hospital has policies and procedures to minimize the risk of development and</td>
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<td>transmission of multidrug-resistant organisms (MDROs) within the hospital (applicable</td>
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<td>to all persons in the hospital).</td>
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<td>1.C.2 Systems are in place to designate patients known to be colonized or infected with</td>
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<td>a targeted MDRO and to notify receiving units and personnel prior to movement of such</td>
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<td>patients within the hospital.</td>
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<td>1.C.3 Systems are in place to designate patients known to be colonized or infected with</td>
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<td>a targeted MDRO and to notify receiving healthcare facilities and personnel prior to</td>
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<td>transfer of such patients between facilities.</td>
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<td>Yes</td>
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</table>

If no to any part of 1.C.1 through 1.C.3, cite 42 CFR 482.42(a) (Tag A-0749)

1.C.4 The hospital can provide a list of target MDROs.

Note: Hospitals should provide a list of MDROs that are targeted for infection control because they are epidemiologically important (e.g., MRSA, VRE). Please refer to CDC's Guideline for Isolation Precautions for criteria that may be used to define epidemiology important organisms:


1.C.5 The hospital can demonstrate the criteria used to determine epidemiologically important MDROs on their list.

Yes                                      |                 |
| No                                       |                 |

1.C.6 The hospital can provide justification for any epidemiologically important organisms not on their list and otherwise not targeted in their hospital.

Yes                                      |                 |
| No                                       |                 |
| N/A                                      |                 |

No citation risk for questions 1.C.4 through 1.C.6; for information only.
“No Citation Risk – Information Only”

- 1.C.9 - The hospital has written policies...
- 1.C.10 – The hospital has designated a leader...
- 1.C.11 – Requires an indication for all antibiotic orders
- 1.C.12 – Formal requirement of antibiotic “time out’ at 48h
- 1.C.13 – Monitors consumption of antibiotics...

1.C.2.a Facility has a multidisciplinary process in place to review antimicrobial utilization, local susceptibility patterns, and antimicrobial agents in the formulary...

1.C.2.b Systems are in place to prompt clinicians to use appropriate antimicrobial agents....

1.C.2.e. The facility has a system in place to identify.....(Patients eligible for IV to PO)
Current Regulatory Need

- CMS lack of payment for hospital acquired infections – these are deemed preventable
- The Joint Commission
  - Reduce risk of HAI’s
  - Implement strategies to reduce transmission of MDROs
- NHSN event reporting for *C. difficile*
Proposed Timeline

“Rome was not built in a day”
Implementation Timeline

• Goal is full implementation within 3 years
• Follow the Core Elements of Hospital Antibiotic Stewardship Programs outlined by the CDC as a guide

Available at:
http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html

• Goals for each year are flexible
Year 1 Goals

• Leadership Support
• Physician & Pharmacist Champions
• Policies & Procedures
• Antibiogram Development
• Antimicrobial Stewardship Education Program
Year 1 – Leadership Support

• Critical for success of ASP
• Formal statements of support
• Addition of stewardship activities on PMAPs and COERs
• Supporting training and education
• Ensuring participation from the various different departments involved in ASP
  • Form an ASP workgroup/committee
• Obtaining financial support
Year 1 – Physician/Pharmacy Champions

- Identify physician champion
  - Training in infectious diseases/ASP beneficial
  - Can leverage telemedicine
  - Hospitalists may be ideal secondary to increasing presence in inpatient care

- Identify pharmacist champion
  - Training in infectious diseases/ASP beneficial

- The Pharmacy and Therapeutics committee should **NOT** be considered the stewardship team
Year 1 (cont.)

• **Policies & Procedures (Examples)**
  • Define the ASP Committee as a required committee for the hospital
    • Identify required members
    • Outline committee charges
    • Identify frequency of meetings
  • Document dose, duration, and indication
  • Facility specific treatment recommendations
  • Identify reporting requirements
    • Ex. Reports to P&T and/or medical staff
  • Avoid implementing too many policies and interventions simultaneously
Year 1 (cont.)

- **Antibiogram Development**
  - Done at least yearly for facility
  - Can be done more often if need identified
  - Can be done for individual hospital units if need identified
    - Ex. ICU, Burn Ward
- **Follow best practices**
  - Discussed later
Year 1 cont.

• **Antimicrobial Stewardship Education Program**
  • Include reasons for starting ASP
  • Describe increasing resistance
  • Describe best practices in treatment of infectious diseases

• **View as a process, not an event**
  • Continuous
  • Multiple approaches
Year 2 Goals

• Guideline development
• Implementation of Interventions
• Development of Tracking Measures
• Continue ASP Education
Year 2 cont.

• Guideline development
  • For specific indications/disease states
  • EHR indication specific order sets
    • CAP/HCAP
      • MDROs
    • UTI
    • Cellulitis/Diabetic Foot
      • MDROs
    • C. Diff
  • Treatment of culture proven invasive infections
Year 2 cont.

• Implementation of Interventions
  • Broad Interventions
    • Antibiotic “time outs”
    • Prior authorization
    • Prospective audit and feedback
  • Pharmacy-driven Interventions
    • Auto IV to PO conversions
    • Dose adjustments (ex. Renal adjustment)
    • Dose optimization
    • Automatic alerts where therapy might be unnecessarily duplicative
    • Auto-stop orders
    • Detection and prevention of ABX-related DDI
Year 2 cont.

• Development of Tracking Measures
  • Monitoring Antibiotic Prescribing
    • Monitor adherence to documentation policy (dose, duration, and indication)
    • Monitor adherence to facility-specific treatment recommendations
    • Monitor compliance with one or more of the specific interventions
  • Antibiotic Use and Outcome Measures
    • Track *C. difficile* infections
    • Produce an antibiogram report
    • Monitor use by Days of Therapy, Defined Daily Dose, and/or direct expenditure
Implementation Timeline
Year 3

• Year 3 Goals
  • Reporting of Intervention Results
  • Reporting Information to Staff on Improving Antibiotic Use and Resistance
  • Continue ASP Education
Year 1 – Foundational Project

• Create an antibiogram if none exists
• Update existing antibiogram
• Review “best practices” checklist
Obtain Raw Data

• Work with microbiology lab supervisor
• Obtain report of susceptibility results for a given time frame, usually 1 calendar year
• Use “best practices” check list at this stage to eliminate duplicate isolates and validate data
Present Data

• Will usually need to transcribe data into a more user friendly format
  • PDF – posted in E.H.R.
  • Pocket Card

• Review “best practices” check list at this stage to validate/present data appropriately
### ANTIMICROBIAL SUSCEPTIBILITY CHART (% Sensitive)
Northern Navajo Medical Center
July 1, 2014 – June 30, 2015
Prepared by: Kendall Van Tyle, PharmD, BCPS, NCPS, M(ASCP); Joyanna Wendt, MD MPH; Olivia Hodgins, MSA, MSN; Pierrette Montanez, MT(ASCP)

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</table>

- Gram (+) organisms no longer tested against first-generation cephalosporin – use Oxacillin as guide (if sensitive to Oxacillin, cefazolin/caphalaxin are first-line agents)
- All species with 10 or less isolates for date range have been removed - Morganella morganii (7) & Seratia marcescens (8).
# Antimicrobial Susceptibility Chart (% Sensitive)

**Northern Navajo Medical Center**  
July 1, 2014 – June 30, 2015  
Prepared by: Kendali Van Tyler, PharmD, DCPS, NCPS, M(ASCP); Jovana Wendt, MD MPH, Olivia Hodgins, NSA, MSN, Pierrette Montanez, MT(ASCP)

<table>
<thead>
<tr>
<th>Bacterium (total isolates)</th>
<th>Citrobacter freundii (15)</th>
<th>Enterobacter aerogenes (63)</th>
<th>Escherichia coli (1345)</th>
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<td>Amikacin</td>
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<td>Amoxicillin</td>
<td>56</td>
<td>0</td>
<td>87</td>
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<tr>
<td>Amoxicillin/Sulbactam</td>
<td>63**</td>
<td>73</td>
<td>92</td>
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<tr>
<td>Benzylpenicillin (Penicillin)</td>
<td>95**</td>
<td>17</td>
<td>0</td>
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</table>

**Beta-Lactamase (negative)**

| Cefazolin                  | 100                       |
| Cefepime                   | 100                       |
| Cefotaxime (meningitis)*   | 96                        |
| Cefotaxime (non-meningitis)| 21                        |
| Ceftriaxone (meningitis)*  | 96                        |
| Ceftriaxone (non-meningitis)| 17                      |
| Ceftazidime                | 0                         |
| Cefuroxime                 | 0                         |
| Ampicillin                 | 63**                      |
| Ampicillin/Sulbactam       | 73                        |
| Benzylpenicillin (Penicillin) | 95*                      |

**Beta-Lactamase (negative)**

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| Ceftazidime                | 0                         |
| Cefuroxime                 | 0                         |
| Ampicillin                 | 63**                      |
| Ampicillin/Sulbactam       | 73                        |
| Benzylpenicillin (Penicillin) | 95*                      |

**Footnotes:**

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**Additional notes:**

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ANTIMICROBIAL SUSCEPTIBILITY CHART (% Sensitive)

Footnotes:
*Streptococcus pneumoniae only; **D-test for inducible clindamycin resistance performed on all isolates; ***Not to be used for monotherapy - synergy only
****Erythromycin only tested on PEN Resistant Strains (9 isolates); ^Uses meningitis breakpoints, likely overestimates resistance in non-meningitis infections;
^^Does not predict susceptibility to amox/clav (typically higher); it is unclear if in vivo response to amp/sulb is better than predicted by in vitro susceptibility testing.
Trending over past 3 yrs has not substantially changed – 65%>64%>63%.

Additional notes:
- MRSA: 27% (non-duplicated, new cases – n=457); of MRSA Isolates (n=124) – 100% TMP/SMX, 98%Tetracycline, 85%Clindamycin (% Sensitive)
- Gram (+) organisms no longer tested against first-generation cephalosporin – use Oxacillin as guide (If sensitive to Oxacillin, cefazolin/cephalexin are first-line agents)
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<table>
<thead>
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<th>88</th>
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### Indian Health Service Antibiotic Stewardship
#### Antibiogram Preparation Check-List

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<tr>
<th>Facility Name: __________________</th>
<th>Dates Data Collected¹: __________________</th>
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<tr>
<th>Best Practice/Item for review</th>
<th>Y</th>
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<th>N/A²</th>
<th>Comments</th>
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<tr>
<td><strong>Only organisms with at least 30 isolates reported</strong>³</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Only diagnostic (not surveillance) isolates reported</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duplicates excluded; describe how first isolate define</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Only final, verified results reported</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage Susceptible reported (intermediate not reported)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes and Guidance**

1. Data for one calendar year, updated at least annually. Larger facilities may update every 6 mo.
2. % Susceptibility not reported/Organism not reported
3. Smaller sites may report isolates with 10 or more, or may collect data for a longer period of time and properly note
4. Kitstrains for *Staphylococcus*, *Klebsiella*, *Enterococcus*, etc. (requiring minimal and intermediate drug resistance) proficiency tests
5. Trimethoprim/sulfamethoxazole

---

Adapted from:

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Notes:

- *Proteus*, *Pseudomonas*, *Acinetobacter baumannii*, *Acinetobacter calcoaceticus*, *Acinetobacter baumannii* production of inducible ampicillinase.

---

1. Indian Health Service (IHS)
Indian Health Service Antibiotic Stewardship
Antibiogram Preparation Check-List

| Facility Name: ___________________________ | Dates Data Collected: ___________________________
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do not report susceptibility to 1st/2nd/3rd Gen Cephalosporins (except ceftazidime for pseudomonas)</td>
<td></td>
</tr>
<tr>
<td><strong>For Staphylococcus aureus/Coag-neg staph:</strong></td>
<td></td>
</tr>
<tr>
<td>• 100% Susceptibility to Vancomycin</td>
<td></td>
</tr>
<tr>
<td>• % Susceptible to Oxacillin = % Susceptible to other beta-lactams</td>
<td></td>
</tr>
<tr>
<td>• Provide subset of MRSA % Susceptible to appropriate drugs (Clindamycin, Tetracyclines, TMP/SMX)</td>
<td></td>
</tr>
<tr>
<td><strong>For Streptococcus pneumoniae:</strong></td>
<td></td>
</tr>
<tr>
<td>• Cefotaxime and Ceftriaxone reported separately for meningitis and non-meningitis breakpoints</td>
<td></td>
</tr>
<tr>
<td>• It is clear that only a subset of isolates thought to be non-susceptible to penicillin are tested against other drugs (e.g. erythromycin, ceftriaxone, levofloxacin)</td>
<td></td>
</tr>
<tr>
<td>• 100% Susceptibility to Linezolid/Vancomycin</td>
<td></td>
</tr>
<tr>
<td><strong>Nitrofurantoin reported for urine isolates only; not reported for Proteus sp, Pseudomonas sp. Or Serratia sp.</strong></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes and Guidance**

1. Data for one calendar year, updated at least annually. Larger facilities may update every 6 mo.
2. % Susceptibility not reported/Organism not reported.
3. Smaller sites may report isolates with 10 or more, or may collect data for a longer period of time and properly note.
4. Kitsman for Staphylococcus sp., ampicillin for enterococcus sp., etc.
5. Trimethoprim/sulfamethoxazole

---

Adapted from: [Source URL]
Antibiogram Checklist

Adapted from:

Year 1 - Suggestions

- Consider simply documenting what pharmacy already does/sees
  - Can be used for hypothesis generation
  - Might reveal some “low-hanging fruit”
  - Lead to ASP interventions/policies in year 2 and beyond
- Find those in your organization already involved in quality measures
Year 2 – Foundational Project

- Creation of local antibiotic use guidelines
  - Focus on common indications for facility
  - Use antibiogram data and national guidelines
- Highly recommended to adapt these to Electronic Health Record, if possible
Pain Medications...

IVPB Antibiotics

[ ] Inpatient Guideline Based Menu

PO/IM Antibiotics...

Pediatric Antibiotics (liquids etc)...

Cardiovascular Meds...

Dermatology Meds...
ALTERNATIVE OPTIONS FOR PIPERACILLIN/TAZOBACTAM (ON SHORTAGE)

[ ] Abdominal Infections
[ ] Cellulitis (No Break in Skin or Ulcer)
[ ] Diabetic Foot Wounds
[ ] Pneumonia
Diabetic Foot Wounds

CLINICAL NOTES:

~MILD
~Purulence
~One or more signs of inflammation
~Cellulitis (if present) 2cm or less around ulcer
~Limited to superficial

~MODERATE
~Any of the above w at least one:
~2cm or more cellulitis
~Lymphangiectasia
~Beneath superficial fascia
~Deep tissue abscess
~Gangrene
~Muscle, bone, tendon or joint involvement

~SEVERE
~Any above with systemic toxicity or metabolic instability

TREATMENT (MILD AND MODERATE)

[] Ampicillin/ Sulbactam 3GM IV Q6H
~OR~

[] Ceftriaxone 2GM IV Q24H PLUS Metronidazole 500MG IV Q8H
~IF MFSA SUSPECT ADD~

[] Vancomycin (Pharmacy To Dose)

TREATMENT (SEVERE)

[] Celepine 2GM IV Q24H PLUS Metronidazole 500MG IV Q8H PLUS Vanco
Year 2 Suggestions

- Consider your guidelines/E.H.R menus as an intervention
- Define and collect some baseline measures/data
  - Orders for XX drug for YY indication
  - Survey prescriber use of guidelines/menus
- Recollect data at some point post intervention
- Repeat this process for every intervention identified and implemented
Year 3 - Suggestions

• Review what worked and what didn’t
• Develop a process for continuous quality improvement
  • If an intervention succeeded, how to sustain it
  • If it didn’t – why?
    • Evaluate variables defined and measured; methods
    • Evaluate process

• PDSA cycles
  • Plan, Do, Study, Act – repeat.
Metrics
# Options

<table>
<thead>
<tr>
<th>Type</th>
<th>Metric</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumption</td>
<td>• Defined Daily Doses (DDD)</td>
<td>• Total Grams antibiotics used divided by WHO approved DDD values</td>
</tr>
<tr>
<td></td>
<td>• Grams</td>
<td>• Total Grams used from administered, dispensed, or purchased data sources/reports</td>
</tr>
<tr>
<td></td>
<td>• Days of Therapy (DOT)</td>
<td>• Number of days that the patient receives at least one dose of an antibiotic</td>
</tr>
<tr>
<td></td>
<td>• Length of Therapy (LOT)</td>
<td>• Number of days that the patient receives therapy regardless of number of drugs or doses received</td>
</tr>
<tr>
<td></td>
<td>• Expenditures</td>
<td>• Dollars spent</td>
</tr>
</tbody>
</table>
# Options

<table>
<thead>
<tr>
<th>Type</th>
<th>Metric</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Outcomes</td>
<td>Health Care Associated Infections</td>
<td>• Rate of disease-specific infections (e.g. C. Diff, MRSA, VAP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASP Intervention rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASP Intervention Acceptance rates</td>
</tr>
<tr>
<td>Resistance</td>
<td>Antibiotic Resistant Organisms</td>
<td>• % of patients with resistant organism(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Antibiogram data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• % of isolates of a pathogen with antibiotic resistance</td>
</tr>
<tr>
<td>Metric</td>
<td>Advantage(s)</td>
<td>Disadvantage(s)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Defined Daily Dose (DDD)</td>
<td>• Easy to calculate</td>
<td>• Never intended to be used as a metric to study ASP impact</td>
</tr>
<tr>
<td></td>
<td>• Can be utilized as a “benchmark” between hospitals, regions, and countries</td>
<td>• Biases against combination therapy, even when that therapy might be a narrower spectrum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assumes routine dosing – “penalized” if using clinically appropriate higher or lower dosing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not applicable to pediatrics</td>
</tr>
<tr>
<td>Grams</td>
<td>• Purchase data easy to obtain</td>
<td>• Purchase data is the least accurate</td>
</tr>
<tr>
<td></td>
<td>• Not affected by price fluctuations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Can be used to calculate DDD</td>
<td></td>
</tr>
</tbody>
</table>
## Advantages vs Disadvantages

<table>
<thead>
<tr>
<th>Metric</th>
<th>Advantage(s)</th>
<th>Disadvantage(s)</th>
</tr>
</thead>
</table>
| **Days of Therapy (DOT)**   | • Offers more clinical relevance than DDD  
• Applicable to pediatrics  
• Recommended by CDC, US National Healthcare Safety Network | • Difficult to obtain data  
• Not applicable to renal population  
• Incentivizes the use of broad spectrum monotherapy  
  • A patient receiving 2 antibiotics for 7 days = 14 DOTs |
| **Length of Therapy (LOT)** | • Most reflective of actual treatment duration  
• Accounts for dosing intervals beyond 1 day (i.e. Q48H Vancomycin)  
• Does not penalize programs for changing antibiotics based upon C&S results | • Cannot be used to compare the use of specific drugs                                                                                                                                                        |
| **Expenditures** (Cost of Therapy) | • “Easiest” metric to calculate and obtain data for  
• Easily understood by all | • Affected by cost variations; natural or otherwise  
• Affected by changes in formulary  
• Should not be used for benchmarking purposes due to cost variability |
# Advantages vs Disadvantages

<table>
<thead>
<tr>
<th>Metric</th>
<th>Advantage(s)</th>
<th>Disadvantage(s)</th>
</tr>
</thead>
</table>
| Antimicrobial-free Days         | • Avoids issues related to Broad vs Narrow spectrum therapy  
• Avoids issues related to Mono- vs Duo-Therapy  
• Focuses on whether patients are receiving an antibiotic or not | • Mostly used as a disease-specific consumption measure (i.e. ventilator-associated pneumonia)       |
| Point Prevalence “Snapshot” Surveys | • Resource-efficient  
• Typically done at a single site on a single day  
• Data collected may include % patients prescribed antibiotics, % “restricted” antibiotics prescribed, # antibiotics per patient, duration of therapy, dosing and dosage interval, time for IV to PO switch  
• Can be used to measure and compare antibiotic use at multiple sites | • Can only provide feedback on limited elements of prescribing  
• May not consistently reflect typical practice within a Unit or Hospital |
Using Bar Coded Medication Administration Data (BCMA)

- Paper published by the VA in 2012
- Compares BCMA vs. Orders data
- Used to help calculate some of the metrics described
- NHSN AU Module

http://www.cdc.gov/nhsn/PDFs/training/AUR-training.pdf

Infect Control Hosp Epidemiol 2012;33(4):4090411
<table>
<thead>
<tr>
<th>ADMINISTRATION MEDICATION</th>
<th>UNIT OF ADMINISTRATION</th>
<th>ORDER DOSAGE</th>
<th>DOSE GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBUPROFEN</td>
<td>12</td>
<td>240MG/12ML</td>
<td></td>
</tr>
<tr>
<td>CEFIRIZINE</td>
<td>5</td>
<td>5MG/5ML</td>
<td></td>
</tr>
<tr>
<td>TOBRAMYCIN</td>
<td>1drop</td>
<td>1 DROP</td>
<td></td>
</tr>
<tr>
<td>FLUCINONIDE</td>
<td>a small amount 200</td>
<td>4 SMALL AMOUNT</td>
<td></td>
</tr>
<tr>
<td>LACTULOSE RETENTION</td>
<td>300ML IN 700ML WATER</td>
<td>0.2MG</td>
<td></td>
</tr>
<tr>
<td>CLONIDINE</td>
<td>TAB</td>
<td>3MG</td>
<td></td>
</tr>
<tr>
<td>LISINOPRIL</td>
<td>TAB</td>
<td>20MG</td>
<td></td>
</tr>
<tr>
<td>FUROSEMIDE</td>
<td>TAB</td>
<td>2.5MG</td>
<td></td>
</tr>
<tr>
<td>AMLODIPINE</td>
<td>TAB 0100351079299018</td>
<td>1 SUPPOSITORY</td>
<td></td>
</tr>
<tr>
<td>BISACODYL ELEKTROLYTES/PEG-3350</td>
<td>8OZ</td>
<td>8 OZ GLASS AND DRINK</td>
<td></td>
</tr>
<tr>
<td>FENTANYL 50MC/HR</td>
<td>TAB 1 PATCH</td>
<td>1 PATCH</td>
<td></td>
</tr>
<tr>
<td>LISINOPRIL</td>
<td>TAB</td>
<td>30MG</td>
<td></td>
</tr>
<tr>
<td>BISACODYL</td>
<td>TAB</td>
<td>1 SUPPOSITORY</td>
<td></td>
</tr>
<tr>
<td>INSULIN REGULAR</td>
<td>4 units</td>
<td>MEDIUM DOSE SLIDING</td>
<td></td>
</tr>
<tr>
<td>AMLODIPINE</td>
<td>TAB 2 puffs 4000ML</td>
<td>2 PUFFS</td>
<td></td>
</tr>
<tr>
<td>ALBUTEROL 90MC MDI</td>
<td>8 OZ GLASS AND DRINK</td>
<td>2 GM</td>
<td></td>
</tr>
<tr>
<td>ELECTROLYTES/PEG-3350</td>
<td>TAB</td>
<td>20MG</td>
<td></td>
</tr>
<tr>
<td>CETAZIDIME 2QM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FUROSEMIDE</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
“Crunched” Data — Days of Therapy
ASP Resources

• CDC
  • http://www.cdc.gov/getsmart/healthcare/implementation.html

• IDSA/SHEA
  • http://www.idsociety.org/Stewardship_Policy/#sthash.gZe2Eucl.dpuf

• ASHP
  • http://www.ashp.org/menu/PracticePolicy/ResourceCenters/Inpatient-Care-Practitioners/Antimicrobial-Stewardship
Additional Resources

- I.H.S. ASP Workgroup members
- I.H.S. ASP Listserv
- Antibiogram Checklist
- Metric Databases (RPMS)
- PDSA forms
- Cited References
IHS NPC ASP Workgroup Members

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- Jon Schuchardt: Jon.schuchardt@ihs.gov  Phone: (605) 355-2281
Conclusions/Pep Talk

• Implementation is important
  • Think “patient safety”
  • Think “public health”

• Implementation is easy
  • Take it one step at a time
  • One step will lead to the next

• Implementation is rewarding
  • Impact and positive change

• Do something today.