Building Cross-Sector Collaborations to Promote Effective Antibiotic Use in Inpatient, Outpatient and Long-Term Care Settings

Question & Answer Session for February 7, 2017 Webinar

For Washington: Where are you getting the data for the nursing home multi-drug resistant organisms surveillance reports that you mentioned?

Aimee: The data came from three parts. First, data came from the annual facility survey that comes from the National Healthcare and Safety Network (NHSN) cohort. This is a group of nursing homes that were recruited for entering data on c.diff infections into NHSN. Secondly, the antimicrobial stewardship workgroup developed and sent out a gap analysis survey to assess antimicrobial stewardship practices, which was sent out to all nursing homes in Washington and Idaho. The third source of data was the Infection Control and Response (ICAR) assessments sent out by the Department of Health.

Marisa: With regard to MDRO, the data came from quarterly surveillance reports produced by the Department of Health Communicable Disease Epidemiology program. Right now, surveillance reports include reporting from nursing homes, and will be expanding to include other infections, and other sources. Right now, reports are limited to carbapenem-resistant Enterobacteriaceae (CRE) from testing done at the public health lab.

Evidence of effective interventions is key to rolling out stewardship interventions broadly - this continues to be a challenge and how are your programs building this evidence?

Scott: Academically, this is one of the challenges with antimicrobial stewardship, but something important to do (publish and present). We appreciated what was done in southern California (publishing pilot study, randomized trials as follow-up). We hope to disseminate our results more. It definitely helps to show physicians our results to encourage their participation, especially since it has been done before with success.

Marisa: That is one of the questions we are grappling with. One of the things we could like to do in EQUIP with long-term care is to have smaller groups of nursing homes to come together to work on intervention projects in the collaborative. They would be expected to share data among themselves. They would be tracking internally and keeping track of the data. One of the issues in Washington is that public disclosure laws are broad, and we are cautious about acquiring data that could be released publicly. We are also looking in to IRB approval for any type of project we're involved with. For the current time, we are suggesting that facilities monitor internally.

Kelly (attendee): I'm a penicillin skin testing implementation specialist. My job is to help hospitals implementing penicillin testing protocols. Availability of allergists is sometimes identified as a barrier to testing. I wanted to make you aware that this testing does not always

have to be done by an allergist. In some states, pharmacists, nurses, infectious disease physicians, fellows and residents can conduct this testing.

Can we get a link to the Jump Start Stewardship Kit?

http://www.doh.wa.gov/Portals/1/Documents/5600/JumpstartStewardshipWorkbook.pdf

Aimee: This is the link to the version for critical access. The long-term care workbook should be available by the end of February 2017, on the same website.

What were the dimensions of the poster used in the IL intervention?

Suzanne: Facilities were given options: 18x24" (which many facilities said was too large) or 16x20". We didn't want to go smaller, because print would be hard to read.

Scott: The large size also allowed for inclusion of provider pictures.

Did most facilitates frame or laminate the posters [in Illinois's intervention]?

Suzanne: Posters were laminated so that they could be easily cleaned. We do not know of any site that took the extra step of framing the posters.

Scott: We did not include signatures on the posters, which had been done in the California version.

The American Academy of Allergy, Asthma and Immunology is interested to know if any of you are doing work in the area of penicillin allergies. Some research indicates that perceived rates of allergies to penicillin are higher than is actually the case, and that testing for this allergy could allow for increased use of penicillin in combatting drug-resistant organisms.

Scott: In Nebraska, work is being done in this area. Feedback from acute care is that getting allergists into hospitals to do this testing is a challenge. Patients having hip and knee surgeries are being referred for testing in clinics, to remove this as a barrier. It's just a drop in the bucket among all patients, but it's a start. We'd love to have more access to testing. Hospital pharmacists can also be a help by adding notes in the comment section of the EHR that patients tolerate this medication well. This can prevent relabeling of a penicillin allergy during intake.

Marisa: Materials added to the CDC website for Get Smart week in November 2016 includes a 2-page infographic about allergies. We are recommending exploration of this as a potential antimicrobial stewardship intervention that facilities can implement (e.g., asking a few more questions about symptoms associated with a potential allergy).

Is anyone currently working with or interested in collaborating with private sector payers?

Suzanne: Yes, Blue Cross Blue Shield of Illinois participated on the Precious Drugs & Scary Bugs work group. They also invited us to present at a medical director meeting, which was a huge help for campaign recruitment.

Marisa: I serve on the Washington Choosing Wisely Task Force and there are many payors on the Task Force as well. Several partners in Washington have a grant from the American Board of

Internal Medicine to promote Choosing Wisely in Washington. If you are not aware of Choosing Wisely, I suggest you check out their materials. http://www.choosingwisely.org/about-us/