

reported driver of AO (90.1%). Most respondents agreed that national APG are appropriate (95.4%) and that quality improvement (QI) is warranted (93.4%). Respondents reported following APG always (18.5%) or more than half the time (61.0%). Respondents answered a mean of 1.89 out of 4 knowledge questions correctly, with higher scores among those reporting following APG more than half the time (1.97 vs 1.58, p < 0.0001).

Statements	Strongly Agree	Somewhat Agree	Neither agree nor disagree	Somewhat Disagree	Strongly Disagree
Overuse of antibiotics is a problem in my state.	243 (41.0%)	260 (43.8%)	77 (13.0%)	10 (1.7%)	3 (0.5%)
Overuse of antibiotics is a problem in the region where I practice.	183 (32.3%)	268 (47.3%)	92 (16.2%)	19 (3.4%)	5 (0.9%)
Overuse of antibiotics is a problem in our practice.	62 (10.7%)	184 (31.6%)	112 (19.2%)	139 (23.9%)	85 (14.6%)
When deciding whether to prescribe antibiotics, my experience as a clinician is more important than guidelines.	23 (3.9%)	144 (24.3%)	166 (28.0%)	187 (31.6%)	72 (12.2%)
National guidelines are appropriate to use for my patient population.	379 (63.8%)	189 (31.8%)	17 (2.9%)	9 (1.5%)	0 (0.0%)
National guidelines are based on appropriate interpretation of the evidence.	425 (71.4%)	153 (25.7%)	14 (2.4%)	1 (0.2%)	2 (0.3%)
I believe quality improvement initiatives to improve antibiotic prescribing in primary care are warranted.	362 (61.1%)	194 (32.7%)	32 (5.4%)	5 (0.8%)	0 (0.0%)
I personally would welcome feedback about my antibiotic prescribing practices in comparison to my peers.	317 (53.3%)	168 (28.2%)	91 (15.3%)	12 (2.0%)	7 (1.2%)
More education about antibiotic prescribing for common infection would be helpful for me in my practice.	267 (44.9%)	220 (37.0%)	80 (13.5%)	22 (3.7%)	6 (1.0%)

Overall attitudes about antibiotic prescribing, antibiotic prescribing guidelines, and acceptance of Quality Improvement. N=595.

Statements	# of providers who agree N = 595
Many patients/parents are unsatisfied without an antibiotic prescription.	536 (90.1%)
Providers recall adverse outcomes when antibiotics were not prescribed in time.	161 (27.1%)
Providers worry about missing an important diagnosis.	294 (49.4%)
Providers do not adhere to national guidelines.	269 (45.2%)
It is often difficult to determine if the patient has a bacterial or viral infection.	248 (41.7%)
Outpatient providers do not have enough time with their patients	233 (39.2%)

Respondents' reported drivers of antibiotic overuse. Respondents were permitted to select more than one driver.

How often do you follow the recommendations in antibiotic prescribing guidelines?	# of providers N = 595	Correct responses (mean ± SD)*
Overall		1.89 ± 1.08
Always or more than half of the time	473 (79.5%)	1.97 ± 1.07
Half of the time or less or not familiar	122 (20.5%)	1.58 ± 1.10

*Average scores based on the 4 answered questions (Q1, Q2, Q5, and Q6 in Supplemental Table 1). Comparing the scores of providers who followed the guidelines more than half of the time with those who did not: p < 0.0001.

Content question performance by self-reported guideline compliance; scores represent the number correct out of four questions.

Conclusion. Respondents agree that AO is a problem but place responsibility externally. Confidence in APG was high; most respondents endorsed following APG most of the time. Performance on knowledge questions suggests a need for education. Most respondents would welcome QI focused on AO, including education and personalized feedback. Similar work is needed in other regions and among other prescriber groups. The results will inform outpatient antibiotic stewardship.

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92. Clinical Decision-Making about Chronic Antibiotic Suppression after Prosthetic Joint Infection Treatment: Qualitative Insights for Antibiotic Stewardship

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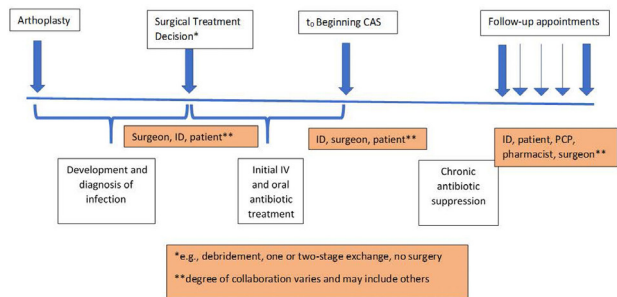
Session: P-06. Antimicrobial Stewardship: Non-Inpatient Settings

Background. Patients who develop prosthetic joint infections (PJI) may be prescribed chronic antibiotic suppression (CAS) (> 6 months of antibiotics) after initial antibiotic treatment for the PJI. Patients at low risk of recurrent infection may be good targets for antibiotic stewardship. De-implementation of CAS could potentially reduce the emergence of antibiotic resistant organisms and decrease antibiotic-associated adverse events. Our ongoing study aims to characterize clinical decision-making processes about CAS prescribing and identify points for antibiotic stewardship interventions to stop CAS prescribing for patients who will not benefit.

Methods. We conducted semi-structured interviews with 33 physicians and nurses at 8 Veterans Affairs hospitals, chosen for variation in hospital size, complexity, region, and CAS prescribing. Interviewees included orthopedic surgeons, infectious disease (ID) physicians, hospital epidemiologists, nurses, nurse managers, and primary care physicians (PCPs). We conducted inductive, consensus-based thematic analysis on interview transcripts, using the program MAXQDA.

Results. Participants reported a complex decision-making process that included a range of collaborative approaches with other clinicians and patients. Their risk-benefit calculation for CAS usually included the type of revision surgery performed, the evidence base, the organism, and patient factors. Surgeons and ID physicians, the primary CAS prescribers, collaborated variably and sometimes consulted pharmacists or antibiotic stewards. Participants emphasized the importance of clinician autonomy and buy-in to order to effect practice change based on evidence, rather than top-down policies. They identified other significant time points that occurred before or after the CAS prescribing decision (initial PJI treatment decisions, follow-up appointments) and identified other decision makers about CAS maintenance (e.g., patients, PCPs). (See Figure 1).

Figure 1. Decision Points Relevant to Prescribing or Maintenance of Chronic Antibiotic Suppression after PJI. PJI, prosthetic joint infection; ID, Infectious Diseases physician; PCP, primary care physician; IV, intravenous



Conclusion. Interventions to optimize CAS prescribing should incorporate clinician concerns about prescriber autonomy and a preference for collaborative decision-making as well as understanding the range of decision makers across time.

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93. Developing Urinary Tract Infection Clinical Vignettes for the Nursing Home Setting: A Mixed-Methods Approach

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Session: P-06. Antimicrobial Stewardship: Non-Inpatient Settings

Background. Little is known about how providers choose antibiotics for nursing home residents when concerned about urinary tract infections. To better assess this in a simulated setting, we used a mixed-methods approach to develop robust clinical vignettes.

Methods. First, we developed 7 vignettes and distributed them to resident physicians as a survey, randomizing participants' response type to rank-order or free-text entry. Second, we shared 5 vignettes with nursing home prescribers and conducted semi-structured interviews that asked providers to explain their thinking out loud (Think Aloud structure). Interviews were continued until content saturation was achieved. Two authors (LT & RJ) determined appropriateness of decisions about antibiotic initiation and antibiotic choice; two authors (LT & JI) coded feedback on the vignettes with adjudication by a third (RJ).

Results. Of 23 residents (11 rank-choice; 12 free-response) that participated in the pilot survey, only 6 (26%) completed 7 vignettes, with a mean completion of 69.4%. Completion of all vignettes was similar between groups, however, greater attrition at the first question was observed in respondents randomized to rank-choice (4/11) compared to free-response (6/12). Of the original 7 vignettes, 5 free-response cases were chosen for further development. We conducted semi-structured interviews with 7 nursing home prescribers, 4 of whom were physicians. The prescribers had a median