POSTER ABSTRACTS

219. Characteristics of Antimicrobial Stewardship (AS) Activities in Community Hospitals Upon Enrollment in the Duke Antimicrobial Stewardship Outreach Network (DASON)

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Background. Community hospitals that wish to improve antimicrobial stewardship (AS) activities face barriers such as lack of dedicated personnel, resources, and/or administrative support.

Methods. We conducted an in-depth needs assessment at 10 community hospitals during months 1-2 of enrollment in the Duke Antimicrobial Stewardship Outreach Network (DASON). The DASON liaison pharmacist conducted in-person standardized interviews at each member facility to characterize AS activities and infrastructure at baseline. Results were compiled using descriptive statistics.

Results. The 10 participating hospitals had a median [IQR] bed size of 280 [220-310] and 9,849 [7,567-14,424] admissions per year. Infectious diseases (ID) physicians and ID-trained pharmacists were available in 8 (80%) and 5 (50%) facilities, respectively. Three hospitals (30%) provided dedicated PharmD funding for AS; none provided dedicated ID physician funding. Two (20%) facilities had a preexisting formal AS program. Committees with antimicrobial use oversight existed in 6 (60%) facilities, but AS subcommittees (20%) and formalized policies (30%) were uncommon. Ongoing AS activities most commonly included pharmacy-driven dose optimization (100%); empiric antibiotic selection guidelines (90%); auto-stop policies (90%); and IV-PO conversion (70%). Four (40%) hospitals performed post-prescription review; two (20%) used formulary restriction and preauthorization. Three (30%) hospitals conducted regular antimicrobial use evaluations, while 5 (50%) conducted formulary reviews annually. Few hospitals measured or reported outcomes to assess the utility of AS activities. Survey respondents cited multiple barriers to implementation: higher priority IT and clinical initiatives, personnel and staffing constraints, lack of education regarding AS, and opposition from prescribers.

Conclusion. Formalized programs and dedicated resources for AS were uncommon in community hospitals, despite ongoing AS activities and the presence of ID experts. Outcome measurements and data-driven assessments of the utility of AS activities were lacking. Efforts to support, formalize, measure, and optimize AS programs in community hospitals are greatly needed.

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