CDC recommends that all hospitals establish antibiotic stewardship programs

- Core elements include infection and syndrome-specific interventions for:忘
  - Community-acquired pneumonia (CAP)
  - Catheter-associated urinary tract infections (UTI)
  - Skin and soft tissue infections
  - Empiric coverage of methicillin-resistant Staphylococcus aureus (MRSA)
  - Clostridium difficile infections.

- Treatment of culture proven invasive infections

- However, standard methods to evaluate antibiotic prescribing quality are not well established.

- During 2013–2014, the CDC Emerging Infections Program (EIP) conducted a pilot project to evaluate approaches for measuring antibiotic prescribing quality for CAP and UTI patients.

- To facilitate the quality of Inpatient antibiotic prescribing for indications of CAP or UTI.

Studies of practice patterns and prospective evaluation of antibiotic use have suggested

- Low concordance between CAP guideline-recommended culture and other diagnostic testing and actual practice in this study.

- Frequent (UTI) prescribing without clear documentation of UTI signs or symptoms (30%) or without a urine culture (17%).

- Though the availability of primary results was not evaluated, taking of therapy may be difficult in many scenarios due to low yield of cultures, and timeframes of fluid/sepsis diagnosis related to length of hospitalization.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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## Conclusion

### Low concordance between CAP guideline-recommended culture and other diagnostic testing and actual practice in this study.

### Frequent (UTI) prescribing without clear documentation of UTI signs or symptoms (30%) or without a urine culture (17%).

### Though the availability of primary results was not evaluated, taking of therapy may be difficult in many scenarios due to low yield of cultures, and timeframes of fluid/sepsis diagnosis related to length of hospitalization.

### Limitations

- Did not collect discharge prescribing information and duration, which could have informed overall prescribing quality.

- Difficult to evaluate quality of prescribing in complex scenarios (e.g., ICI patients, patients with multiple infection sites).

- Documentation in medical record not sufficient to gauge clinician rationale regarding use of diagnostic tests and some antibiotic starts.

### Next Steps

- Refinement of evaluation tools for inclusion of future, larger EIP programs.

- Follow-up evaluation of improved culture information was available to inform prescribing practice for future, larger EIP programs.

- Limitations

- Did not collect discharge prescribing information and duration, which could have informed overall prescribing quality.

- Difficult to evaluate quality of prescribing in complex scenarios (e.g., ICI patients, patients with multiple infection sites).

- Documentation in medical record not sufficient to gauge clinician rationale regarding use of diagnostic tests and some antibiotic starts.

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