Implementing UTI Stewardship in Critical Access Hospitals Through a Collaborative Tele-Antimicrobial Stewardship Program: One Size Fits One

Zahra Kassamali Escobar[1,2], Whitney Hartlage[1], Natalia Martinez-Paz[1], John B. Lynch[1,3], Jeannie D. Chan[1,3], Rupali Jain[1,3], Paul S. Pottinger[1,3], Alyssa Y. Castillo[4], Chloe Bryson-Cahn[1,3]

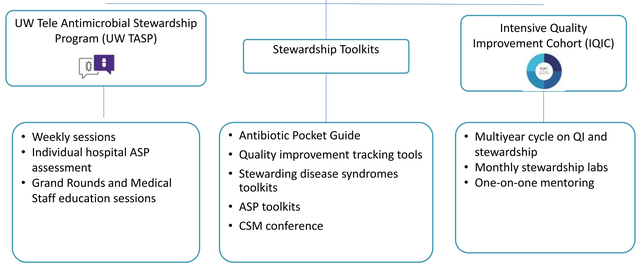
[1]UW Center for Stewardship in Medicine, Seattle, WA USA; [2] Fred Hutchinson Cancer Center, Seattle, WA, USA; [3]Division of Allergy and Infectious Diseases, University of Washington School of Medicine, Seattle, WA, US; [4]University of Colorado, Denver, CO, USA

Contact: zescobar@uw.edu

Poster: 954

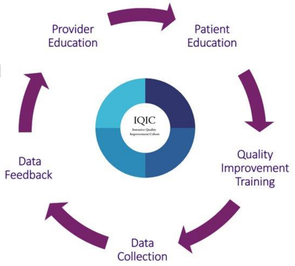
BACKGROUND

- Critical access hospitals (CAHs) provide 24-hour emergency services and do not exceed 25 inpatient beds.[3]
- UW Center for Stewardship in Medicine (CSiM) works with critical access and rural medicine partners to empower individuals and teams by:
  -Providing education
  -Mentoring
  -Building community and encouraging resource sharing
- In 2021-2022 CSiM partnered with flex and state programs to design and implement an intensive quality improvement cohort (IQIC) to focus on local solutions and stewardship of asymptomatic bacteriuria (ASB)



METHODS

- **Intensive Quality Improvement Cohort (IQIC) Program Design (1-year curriculum)**
  1.) 8 monthly hour-long sessions: half didactic, half discussion
  2.) Quarterly one-on-one coaching session between CAH team and CSiM faculty
  3.) Set a Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goal
  4.) Document action in a Plan-Do-Study-Act (PDSA) Format
- **Inclusion Criteria:**
  -Critical access hospitals (≤ 25 beds)
  -Participation in the weekly UW Tele-Antimicrobial Stewardship Program (UW-TASP) sessions
- **Outcome: Assess Feasibility of Implementation**
  -Antimicrobial stewardship intervention(s) implemented
  -Hospital attendance at didactic sessions
  -Set goal and document it in a Plan-Do-Study-Act (PDSA) Framework
  -Collect local data to identify prevalence and treatment of ASB



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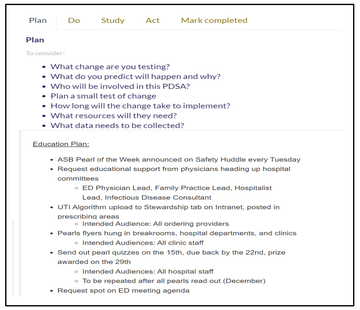
RESULTS

Figure 1: Curriculum and Plan-Do-Study Act Web Tool



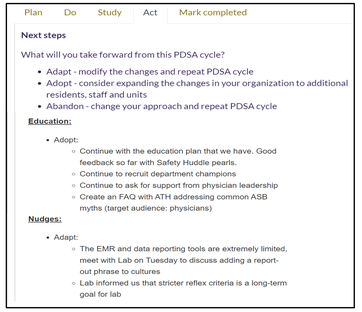


Figure 2: Participating Hospitals, N = 19

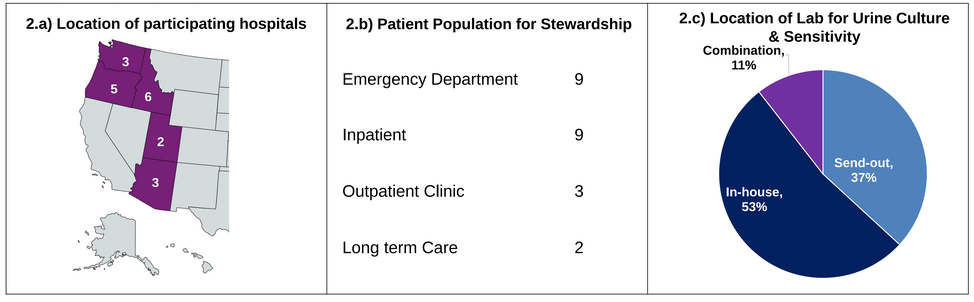
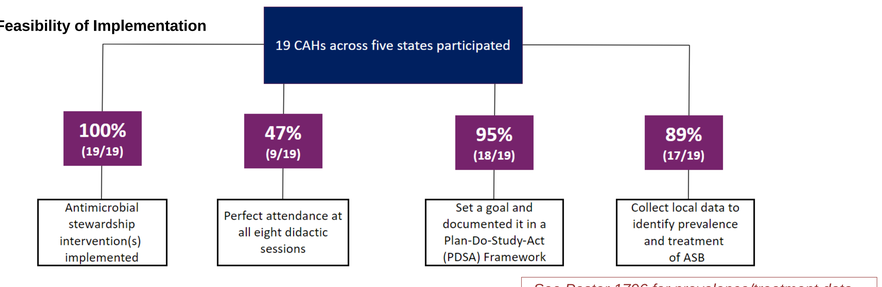


Figure 3: Feasibility of Implementation



See Poster 1796 for prevalence/treatment data

Figure 4: Categories of SMART goals set to address Asymptomatic Bacteriuria

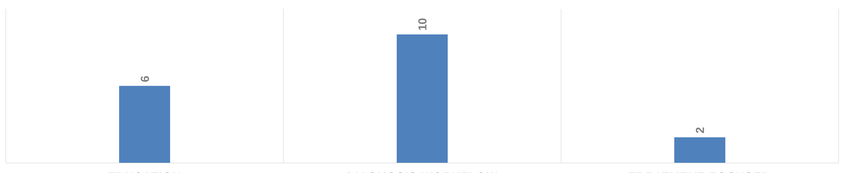
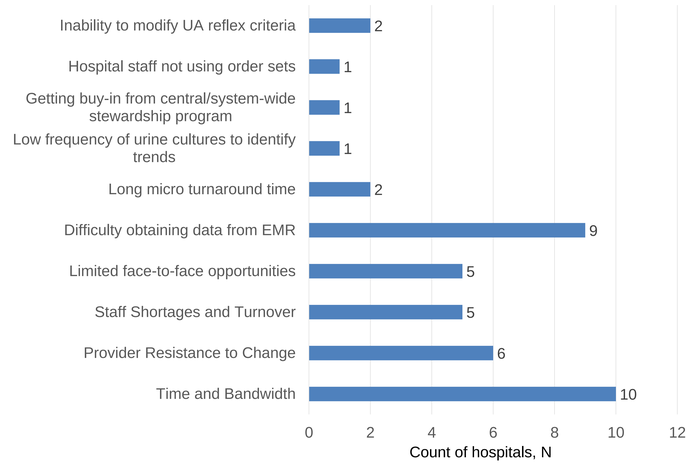


Figure 5: Barriers to antimicrobial stewardship identified by participating hospitals:



SUMMARY

- Training the stewards to manage and identify ASB versus UTI as well as to use quality improvement tools was successful in launching stewardship initiatives among CAHs
- The most common barriers identified included bandwidth and resistance to change among clinical staff

CONCLUSIONS

- Our pilot showed that we can centralize education for antimicrobial stewardship and quality improvement
- Collecting local data from critical access hospitals was feasible and informs interventions specific to each institution
- On-the-ground experience and processes within each hospital are unique. This merits a tailored antimicrobial stewardship strategy

DISCLOSURE

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- **Conflicts of Interest:** All authors have no relevant conflicts of interest