



Quality Payment Program (QPP) and Antibiotic Stewardship (AS) Webinar Transcript

>> Hello and welcome to QPP and antibiotic stewardship. My name is Suzanne and I will be in the background answering WebEx technical questions. If you experience technical difficulties, please dial 18663239 and note that as an attendee you are part of a larger audience and due to privacy rights we have chosen not to display the number or list of attendees to everyone on the call today. As a reminder today's call is being recorded. We will be holding a Q&A session at the end of the presentation. You may ask an online question by typing your question into the Q&A panel located on the right side of the screen. Just type your question into the text field and click send and directed to all panelists. With that I invite you to sit back, relax, and enjoy the presentation. I would like to introduce your speaker. Eli DeLille infection prevention is the quality improvement specialist. Eli, you have the floor.

>> Thank you, Suzanne and welcome everyone to QPP and antibiotic stewardship webinar. Before introduced today speakers I have one more housekeeping item I would like to mentioned. At the conclusion of today's event there will be a short post webinar evaluation at Willow display when you close out of the webinar. We ask you take a few minutes to answer the questions as we user feedback to continuously improve these webinars. If you would like to have continuing education for the event, fill out the survey and certificates will be sent out in the next month. We have two expert designers with great information to share regarding QPP and antibiotic stewardship. The first presenter is Chris Fechner. He is a health informatics specialist and specializes in working directly with physician offices regarding the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 or 29 legislation has more than four years of experience with Medicare reimbursement programs and is a Subject Matter Expert of the Merit-based Incentive Payment System or MIPS program. Chris, I'll turn it over to you.

>> Thank you. Eli and I will be talking about MIPS and how it relates to antibiotic stewardship. A brief of -- overview of what my talk will talk about. I will introduce my company HSAG and give an overview of what the MIPS program is and how it ties into antibiotic stewardship and what we can do with the MIPS programs and eventually we will have a wrap-up and questions.

>> Health Services Advisory Group (HSAG) is the Medicare Quality Innovation Network-Quality Improvement Organization generally known as a QIN-QIO for Arizona, California, Florida, Ohio and the U.S. Virgin Islands. We are committed to improving healthcare quality and have been doing so for more than 35 years and are very experienced in that area. There are QIN-QIOs in every state and territory and we are united in a network under the Centers for Medicare & Medicaid Services otherwise known as CMS. Additionally, as QIN-QIO's, we are your partners in every state for antibiotic stewardship. A quick FYI, the Medicare QIO program is the largest federal program dedicated to improving healthcare quality at the community level. We are not only well experienced but we are well-funded as well.

>> Again a brief overview of the states we work in which are highlighted and as you can see between those states and territories that is nearly 25 percent of the nation's Medicare beneficiaries that are covered.

>> Jumping straight into an overview of the MIPS program.

>> There are four categories in MIPS with different weights for each category, which we will go into when we break down the individual categories but the four categories are quality, improvement activities, and advancing care information which I will refer to as ACI in future slides. All of those will be added up and combined into a final MIPS score.

>> The first question people ask about MIPS is how will this affect my payments? In 2017 it will be plus or minus 4 percent and in 2018 that will go up to plus or -5 percent and eventually in 2020 it will be plus or -9 percent moving forward. I apologize about the percentages and looks like some formatting got mixed up. Plus or -



4 percent in 2017 will affect 2019 payments and plus or -9 percent moving forward from 2020 and beyond. This is just Medicare part B payments.

>> In 2017, you will be gathering data for your MIPS submission throughout the year. You will submit it by March 31, 2018 and CMS will take the data and give you feedback on how you did and eventually on January 1, 2019 your payment from your 2017 data will be adjusted based on how well you did.

>> The next question other than how does it affect my payments is am I actually eligible? You are eligible in 2017 if you sell more than \$30,000 to Medicare part B and you also see 100 or more Medicare patients. That means if you only build \$29,000, -- you do not need to report to MIPS and if you only see 29 patients you don't need to build to MIPS. These are the physician types listed below. They are physician assistants, nurse practitioners, CNS, and CNA's.

>> Some people might wonder what the definition of a physician is. Basically if you have a doctor degree you will be considered a physician. In 2019 they will be opening MIPS up into different clinician types. If you are clinical psychologist, occupational therapist, or something similar, watch out for 2019 when you might have to start reporting.

>> There are some caveats for clinicians that don't see many patients face to face. If you are a certified registered nursing anesthetist (CRNA), you might be considered a non-patient facing individual and that will affect what categories you are required to report on. You are still required to report if you are a non-patient facing clinician but it might make your reporting easier if you were looking to report a group and you are a group of clinicians who do not see patients face-to-face, as long as more than 75 percent of the clinicians billing under the groups' Tax Identification Number (TIN) meet the definition of non-patient facing then your group meets that as well. There are more flexible reporting requirements for these non-patient facing clinicians which one we get to the individual categories we will going to.

>> 2017 is a special year for MIPS because it's the first one and as such CMS has declared it a transition year. That means there are special options available for you.

>> This is in 2017 specific but you will always have the option to report as an individual or group. Individual means you will be submitting data for your specific national provider ID (NPI) and your tax identification number as well. If you are doing a group, that means two or more clinicians send their data together under a single TIN. If you work with an Advanced Payment Model (APM), the APM entity will submit all the data together. One caveat is if you are submitting as a group, your entire TIN must submit data even if the individual providers within might not be eligible. If a clinician is not eligible but the rest of the group is, he would still have to submit his data as part of the group. Additionally, you cannot split it up into two separate rooms within a TIN so if you are multi-specialty it might be difficult to find quality measures that meet things that your family practice is doing but maybe not your cardiologist. Something to watch out for.

>> Going into 2017's specifics, this is a transition year and there are four ways you can participate in MIPS and avoid payment adjustment. The first is to participate in an advanced APM. CPC+ or Medicare shaves programming [Indiscernible] are a couple other options but things like that or if you participate in MIPS then you have three options. One is the test pace which is to submit some sort of data. Any data by March 31, 2018 will be accepted and you can submit one measure for one patient for one claim and still be considered meeting the MIPS criteria for 2017. You will not get a payment adjustment because there isn't much data but you will not be subject to the negative payment adjustment. You can definitely avoid that in 2017 without having to put in too much effort. If you are looking to get a positive payment adjustment, you can do a partial year if you are ready for a full year. Partial year is 90 days' worth of data. As long as you start collecting by October 2, you will be eligible for a partial year. You can earn both the +4 percent payment adjustment if you do well enough and will also be eligible for an exceptional performance bonus if you reach 70 or more MIPS points. Full year is similar to partial year except you submit a full year's worth of data. There is no additional incentive for submitting a full year versus a



partial year. The advantage is you might be eligible for more quality measures than you were with the partial year. I will get into that in a little bit.

>> If you are doing the test submission, all you need to do is submit one quality measure and that could be for just one patient and on one claim. That is definitely the easiest way to go. You could choose to submit one improvement activity and that needs to be over 90 days of data. Your other option would be submitting the base score for your ACI measures, but that would require at least four or possibly five depending which route you submit. I highly recommend the quality measure for the improvement activity. You will avoid the negative downward adjustment; you will not get any sort of positive reimbursement.

>> If you do the partial year, you need at least 90 days of data so as long as you start gathering by October 2 you will meet 90 days' worth of data. You are eligible for a positive reimbursement if you do well enough and are also eligible for the exceptional performance bonus if you reach 70 MIPS points.

>> The full-year participation, like the partial year, you are eligible for a positive payment adjustment and the exceptional bonus depending how well you do. You are not eligible for any additional on top of the partial year so you won't get more money just for submitting a year's worth of data. CMS recommends doing this because you will most likely be eligible for additional quality measures by submitting longer sets of data. As quality measures you must report on a minimum of 20 cases per measure. It is possible that you might not see enough patients for a specific quality measure that you want to report on in 90 days. That is the only incentive for doing a full year versus the 90-day submission. The key take away is the positive adjustments are based on performance data and not the amount of information or length of time submitted. It's can you get your scores up and that will most likely be better in 90 days than in a full-year.

>> The last thing I mentioned is advanced APMs and they are a subset of APMs and not all are going to be eligible for the track outside of the MIPS program. APMs may offer practices an opportunity that are not immediately able to take on the risk and requirements of advanced APMs. That is the distinction between what an APM and an advanced APM is. The QPP does not change in any particular APM reports value so you would still be affected by their standards. You would get the bonus for doing an advanced APM on top of it.

>> If you are looking to do full participation in 2017 as opposed to test, what goes into that? We talked about the four categories earlier which are quality, which is worth 60 percent of your score this year, the cost category is worth zero in 2017 and we will talk about that briefly. Improvement activities will be worth 15 percent and ACI is 25 percent.

>> Quality measures. What goes into that? Quality measures are replacing the Physician Quality Reporting System (PQRS) and the quality portion of the value modifier. If you are familiar with either of those programs. CMS envisions this will provide an easier transition because many providers have been doing PQRS for years at this point. The quality measures themselves are essentially the same as they were in PQRS. There are 271 different options and plenty to choose from. CMS has some built in specialty sets that you can filter based on what your specialty is and CMS has picked out some measures they feel fit your specialty. You are required to report on six measures with at least one of them being an outcome measure. What that means is something that is scored based on how the patient does a not whether or not you followed a certain clinical standard. For example, controlling high blood pressure looks at the patient's blood pressure as opposed to whether or not you prescribed a medication. If for some reason you do not find six measures that are part of your clinical specialty or don't fall into your scope of practice, that is acceptable as long as you can show why and submit as many as you can. CMS will adjust their scoring based on how many you end up submitting. Currently it is out of 60 points so 10 points per measure. If you only submit four it will be out of 40 points. 10 points per measure and it will change based on how many you are able to submit. There are some measures that we feel tie into antibiotic stewardship and I have pulled them out and we will talk about them in a bit.

>> Moving on to the improvement activity category. It is worth 15 percent of your final score in year one and moving forward. This is a completely new category so it's not really analogous to any previous reimbursement



programs. CMS made these activities to focus on care coordination, beneficiary engagement, patient safety among other things. There are 92 options for these activities and you need to get 40 total points. You can choose to submit these by using attestation like yes or no I did this or you can submit through qualified clinical data registry or PCI if it's available.

>> There are some special considerations for improvement activities. If you are a small practice which means once to Doug which means 1 to 15 clinicians, they are double weighted. And the double facing clinicians have the same weighting taking into effect along with practices in rural locations and areas with professional shortage areas. Everything is double weighted so instead of needing four medium waited to get to your full 40 points you would just need two or instead of two high-priority measures which are worth 20 points you just need one at 40 points.

>> Like I mentioned earlier, there are different areas of focus and they are called subs -- subcategories and there are eight different ones plus additional credit you can earn for being part of an APM. There is in any difference between subcategories in the sense that you don't need to choose activities from different categories. You can choose them all from the same area if you choose. It's just a way to break them down and make it easier to search. The scoring is in the bottom right with high-priority worth 20 points, medium is worth 10 points and there are 40 total points to get in this improvement activity category. We believe there are two improvement activities that tie into antibiotic stewardship so depending on your practice size if you are a small practice you could completely meet the improvement activity requirements based on doing an antibiotic stewardship program. I will show exactly what those measures are in a few slides.

>> Our final category is ACI. This is replacing meaningful use and is worth 25 percent of your final score. Unlike meaningful use it's not entirely all or nothing. If you don't meet one measure you are not entirely out of luck. It is focusing on stage three measures sold those focused on interoperability, health information exchange, and electronic care coordination. Similar to improvement activities you can submit the attestation, to CDR, qualified registry and EHR. If you do not use EHR for example if you are in a rural area where you don't have access to Internet or you are a non-patient facing clinician and don't enter anything in your EHR, you can have it re-weighted to quality. 25 percent would jump into quality and would now be worth 85 percent of your score as opposed to the 60 percent that it is currently worth.

>> The way ACI works is there is a base score and a performance score. The base score will get you half of the points eligible in this category. There are 100. you can get and meeting the base score will get you 50. If you don't meet the base score for some reason you do not get any points in the ACI category. This park is all or nothing but you can still get additional points based on how well you do. For 2017 there are four measures that you must do. One is conduct a security risk analysis. Another is due at least one order using E prescribing. The next is to provide patient access to an electronic portal and finally health information exchange is sending a summary of care document to a provider that you refer to. Moving forward in 2018, there will be a different set of required measures. As far as the differences between the base score, there aren't very many. There is only one additional measure and that is to request a summary of care. If someone sends you a referral, you need to be able to incorporate that into your EHR but it is not required in 2017.

>> The performance categories in 2017 are listed at the bottom. You notice that some of them match up with the base score so I highly recommend focusing on those particularly providing patient access and health information exchange. Those are also both double weighted in 2017 and awarded up to 20 points in your performance score. Whereas things are typically worth 10 points and it is just a straight rate calculation. If you end up meeting your measure at 90 percent to 100 percent you will get 10 points, 80 percent to 90 percent is nine and so forth. There is no threshold to meet so it's not like you have to do 10 percent or you get no points. You still get one point toward your performance score. One other thing to call out is there are more than 100 points possible in ACI, but unfortunately everything will be capped at 100. Even if you do amazing, you still get 100 and the 25 points for your MIPS overall score. There are too many direct correlations between ACI and antibiotic stewardship, but the e-prescribing part of the base score will tie in pretty well.



>> A brief note about resource use. It is also known as the cost category and in 2017 you will not be scored on it. They will still calculate it and give you feedback but it will not be part of your overall score.

>> How does this tie into antibiotic stewardship? Here the different quality measures we believe really tie in well. You notice that most of them are eligible through the registry so theoretically if you report to the registry you could meet your entire quality measure portion just by doing an antibiotic stewardship program but there are certainly choices out there if you are doing a different submission method. You don't necessarily need to meet all these measures in your program but these are the different measures you might want to look at tying into. Similarly, these two improvement activities both are medium weight and specifically around antibiotic stewardship programs. If you have a large practice you could be halfway there and if you are a small practice it would entirely meet your requirements. The e-prescribing as part of the base score and not a performance weighted activity but will still help you get those 50 base score points.

>> On that note I am done with my portion of the presentation so I will turn it over to Eli to introduce Dr. Burdette.

>> Thank you Chris and I appreciate your presentation. I will introduce Dr. Steven Burdette who is a professor of medicine with Wright State University and served as the program director for the infectious diseases Fellowship. He completed medical school, internal medicine residency and that was at Wright State. Is a medical director for Kettering health network and the director of infectious disease at Greene Memorial Hospital and serves as the Chairman of the antimicrobial stewardship for and spends a significant amount of time reviewing antibiotic prescribing patterns at a level one tertiary care center and provides real-time recommendations to improve the treatment of various infectious diseases. Dr. Burdette has offered over PubMed reference authors, 15 book chapters and a member of the clinical affairs committee for the Infectious Diseases Society of America. Dr. Burdette, the floor is yours.

>> Thank you very much, Eli. If we could switch the slides over.

>> Thank you very much. In the next 20 or 25 minutes my goal is to give you all some practical events you might already be doing. As we transitioned with Premier Health from the inpatient antibiotic stewardship and started looking into the ambulatory sector, there are a lot of things already being done we did not know about and could honestly take credit for. Hopefully as we work through the core elements of the ambulatory antibiotic stewardship, a lot of this stuff you are ready will be doing.

>> We will look at commitment, action, tracking, and education. What I will do is focus on the ambulatory and there are a few places where I bounce over into inpatient side in terms of data tracking and whatnot. I will try to clarify that.

>> The first of the core measures is a commitment from the organization. In your facility demonstrate dedication to accountability for optimizing antibiotic prescribing and patient safety related to antibiotics. Some of the sub bullets is the Singer legal -- single leader to direct antibiotic stewardship communicate with all staff the expectations of the program. I want to emphasize that antibiotics are not benign. Antibiotics harm people. Chemotherapy is only given by oncologists. Only surgeons perform surgery but every single doctor no matter what the specialty typically prescribes antibiotics and not everyone appreciates the complications of antibiotics. When you look at a stewardship program within a hospital, yes it involves doctors but also involves your pharmacist, nursing staff, and everyone has a role in this. The role has to be passed on to the patient's so they know antibiotics are not benign. When you look at the commitment, someone has to carry the torch of antibiotic stewardship so someone might need that put in their job description. It takes time to run an antibiotic stewardship program. It takes time to be the voice and face of controlling antibiotics, whether in a hospital or a practice. That should be accounted for within someone's time and their contract.

>> At a facility level I am a firm believer that infectious diseases specialists should be running the ship at that point. From an ambulatory standpoint most practices on this call today don't have an infectious disease doctor so



you need to find someone who's interested and educated in antibiotic prescribing. They must practice what they preach. My car license plate is discontinuing antibiotics. I believe in appropriate durations and I believe antibiotics have a role but so many times within the hospital setting and within a practice antibiotics are given and are not necessarily needed. Someone has to be able to practice what they preach. You have to have a face to the program. You need someone that can be the reference and resource when people have questions and someone will lead development of guidelines or spearhead data collection, it needs to be someone who is willing to have difficult conversations. When you have a provider who gives 90 percent of sore throat an antibiotic, it can be difficult to have those conversations. You have to be willing to have those. One of the big challenges administratively is bridging the gap between inpatient and outpatient antibiotic stewardship. Within the inpatient setting, pharmacies in most places run the ship and they may typically provide resources with the pharmacist at work with providers. They have a lot of skin in the game so to speak. The outpatient setting is not pharmacy driven and will be much more on the shoulders of the providers of the organization to spearhead and drive the antibiotic stewardship.

>> Moving on to the next of the core elements is looking at the facility implementing one policy or practice to improve antibiotic prescribing. You have a list of things that fall under that. Evidence-based diagnostic criteria and treatment recommendations would meet one of the improvement activities under MIPS and they specifically talk about upper respiratory tract treatment in children, diagnostics of pharyngitis and bronchitis treatment in adults. We will go over these more in a second. Practicing delayed prescribing practices and if there are any pediatric practices on this call, you have been doing that for years with otitis but developing some sort of process and policy on how to handle this. In my required patient education. When you are not going to treat a pharyngitis or an otitis media with antibiotics immediately, providing the patient with education as to when to call back and went to fill the prescription and whatnot. Communication skills or clinicians, doctors our master communicators and this is a conference call so you can tell that was sarcasm. Communication skills for clinicians and coming up with training for that. The next is requiring explicit written -- written justification for non-recommended antibiotics. I have opinions on [Indiscernible] I will share and might be one area that you could roll those out. Clinical decision supports and triaging systems to avoid unnecessary visits.

>> When it comes to guidelines, the Infectious Diseases Society of America has many practice guidelines that are available. They currently have things that overlap with the ambulatory core measures and have guidelines for streptococcal pharyngitis, rhinosinusitis, community acquired pneumonia in infants and adults, and the community-acquired pneumonia guidelines are in the process of being updated. They are probably another year or so away from rolling those out. While we have internally developed some of our own guidelines for these conditions, smaller practices might not have to reinvent the wheel and there are documents out there you can mirror your practice after.

>> I mentioned earlier the diss -- the delayed prescribing practices used with otitis and I discourage anyone for rolling that out for an infection with a serious complication. If you don't treat a urinary tract infection they could go on and develop [Indiscernible] and you don't want to use delay treatment for pneumonia because complications such as lung abscess, you want to stay away from those. Most cases of bronchitis and pharyngitis especially when you are strip testing negative do not require antibiotic therapy. You may not need to give them at all but this might be an area that in some cases they require therapy and maybe you can roll out delayed watchful waiting practice in those situations.

>> In terms of required explicit justification for non-recommended antibiotics, I recommend everyone establish local treatment guidelines based on your own antibiotic sensitivity. Antibiotics that work in Dayton, Ohio for a condition may not be the same ones that would work in New York City or in Sacramento, California. You really need to look at your local sensitivities and develop guidelines based on what works for you. One of the big challenges is educating the providers on those recommendations. If it is a small practice you can go over it in a practice meeting but if you are in in a hospital setting or large Accountable Care Organization (ACO), you may have hundreds of doctors you have to educate and that can be a real challenge to undertake. That is one of the



hurdles I am dealing with at the institution where I am at in regards to we have guidelines on certain things but how do I let doctors know about those guidelines? You need to figure out which antibiotics you would like to restrict and in what situations. I am very much on the anti-quinolone bandwagon and there is the FDA warning that came out that said don't use quinolones for mild infections such as cystitis, sinusitis and things like that. When you over use quinolones you do induce resistance and there is a high rate of collateral damage with quinolones. This might be some area you might want to rollout tracking and saying you should not use [Indiscernible] for a mild cystitis and perhaps making providers justify why they are using it and perhaps it's an allergy issue or perhaps it's intolerance to something like a history of resistant bacteria words justified. Try to be careful with your quinolone administration and that is a nice area of focus that antibiotic stewardship's can look at.

>> This is a clinical guideline we developed locally for cellulitis. We made this available to providers and when we reach out to doctors with recommendations on the inpatient standpoint, they can have a document to go to justify why we have made the recommendations that we have.

>> We also came out with guidelines for C. diff. Our guidelines are different than what the IDSA recommendations are from 2010. There's been quite a bit of literature that came out on C. diff since then so we have more aggressive algorithm than what the IDSA recommends. As long as you back it up with literature and support, we do have some leeway with some of these conditions to do things you think make a better outcome for your patient.

>> Here is the FDA drug warning and if you had not seen it when it comes to quinolones. When you look for low hanging fruit in a practice, if you can hit up your quinolone prescribing, I think it can have a lot of benefit in terms of C. diff and other collateral damage and tendon rupture's.

>> There are clinical decision support's that can be rolled in and incorporated into your electronic health record. Some electronic health records can use things like up-to-date or other order sets to dry prescribing and treatment practices. It is all dependent on what your electronic health record can do. Many of these decision support tools are somewhat pricey. It depends on the size of the practice and the resources they have available.

>> This is my antibiotic stewardship 101 slide. If a practice is a provider or if a group is going to do something to impact patient's outcomes, you can look at duration and antibiotic therapy. Literature shows short course therapy is just as effective as long course therapy and most of the studies have shown they do not have the associated collateral goal damage from antibiotics. The key with short of course therapy as you have people that fail. You will have people that they'll short course treatment for pneumonia and fail long course treatment for pneumonia. The rates of failure in general are no different when you go to short course. I don't want providers to say I gave that last pneumonia five days of antibiotics and they were admitted for a failure and I'll never do it again. Chances are they would probably fail a longer course as well. You will have failures when you go short course but no decrease in the rates of failures by giving a longer course of antibiotics. Most community-acquired pneumonia especially in the outpatient setting, five days is enough. Is a Spanish study that shows whether you use the Beta lactam with a macro light or quinolone if they have a racket -- rapid response in a hospital, five days is enough. With the inpatient antibiotic stewardship program, we push five days and see no collateral damage from that. Hospital acquired pneumonia you can treat for a week and pyelonephritis is uncomplicated and someone that doesn't have an access or bacteremia you can go shorter courses. Chronic Obstructive Pulmonary Disease (COPD) exacerbation can be treated for five days. Sinusitis some of the old recommendations say 14 days but studies show five days is enough and cellulitis can be treated for a short is six days. If folks want to pick low hanging fruit and really impact patient outcomes, start looking at duration of antibiotic therapy because you can really make an impact. Perhaps the amoxicillin given for the sinus infection, maybe at five days they don't develop C. diff but when you are on it for 14 days the extra floor on the extra days of therapy could be significant. Look at the shorter course therapy and assess your patients to see who qualifies for that.

>> Moving on to the next of the four criteria which is does your facility monitor at least one antibiotic -- one aspect of antibiotic prescribing? Some of the options they suggest are self-evaluate antibiotic prescribing practices



and the United Kingdom is done quite a bit of research on this. There are some self-evaluations you can download if you Google self-evaluation antibiotic prescribing. Most literature drives you to the United Kingdom and you could look at that. Educating doctors and providers on antibiotic prescribing to let them know about shorter courses of therapy. Many doctors prescribe 14 days of antibiotics for pneumonia because they always have. Rolling out information to impact that and also try to look at antibiotic prescribing for one or more high-priority conditions. This falls under the MIPS or treatment of bronchitis, adult sinusitis. You could kill two birds with one stone. Tracking and reporting percentages of antibiotic back visits leading to antibiotic prescribing. And track and report complications of antibiotics prescribing which needs to be done at a healthcare level and not on a patient by patient basis.

>> We looked at our visits and when we had the stewardship meeting the other day we said what data do we have for ambulatory patients? Within an hour of the meeting they provide us data that show the number one cause for e-visits is sinus related issues, cough and dysuria. Those are the three most common visits within our organization from an e-visits standpoint. Then we were able to look at antibiotic prescribing not by diagnosis which is the next level we want to get to, but what percentage of folks with sinusitis got azithromycin or amoxicillin? What percentage of patients with dysuria developed ciprofloxacin? We don't have that data yet but a lot of the programs, if you talk to your I.T. folks and your analytics folks, some of the data might already be there and you just have to ask specific questions and you could be well on your way to meeting core element number three. Once you take this down to the prescriber level or to the diagnostics level, now you can start impacting patient care and start figuring out where do I need to educate? Of certain doctors or nurse practitioners or PAs give 80 percent of patients with bronchitis an antibiotic, maybe you need to focus on educating those providers. A lot of data has probably already been placed at your fingertips if you look for it.

>> Bouncing into the inpatient side for a second, for those hospitals who are on the line, if you don't use Davis therapy to determine antibiotic utilization or at least using some other measures such as defined daily doses and I prefer days of therapy and if you don't friend those, I don't know how you are adequately assessing your antibiotic utilization. Do not you spend data to determine your antibiotics. Hospitals negotiate contracts and you can get a great deal on saline but to do that your [Indiscernible] of cost has to go up. It is a very poor measure of your antibiotic use and I discourage wholeheartedly using spend as your way to measure your antibiotic prescribing. We use days of therapy and it is challenging. Hopefully one NHA developed their feeds we can get it more electronically by right now we get it manually. Our days of therapy gives us the insight to what's going on. You see the couple year trend in ICUs and you see at the end an increase up and turns out we had some gaps in our coverage of our stewardship program. When we stopped looking, the doctor started prescribing what they wanted to and that is consistent in all programs. When stewardship is not looking, people tend to fall back in their old ways. Following days of therapy is critical.

>> Also look at quality measures. We track length of stay, mortality and C. diff rates in the ICU and we cut antibiotic use inpatient 30 percent in the ICUs and have not seen an improvement much in terms of C. diff. We haven't seen any change in mortality or length of stay so we decreased antibiotics, decreased potential complications without causing negative outcomes and to us that is evidence that while we are aggressive we are being too aggressive and leading to poor patient outcomes.

>> Getting into the ambulatory side and tracking and reporting complications of antibiotic prescribing is difficult because if you don't have a closed healthcare system, so if your patients bounce between two, three, or four hospitals it may not be related. One system could get them Augmentin and they could develop C. diff and you get blamed for it even though you didn't prescribe the antibiotic. This can be a little difficult to track. C. diff is the easiest complication. You could be very specific and look at renal failure from Bactrim and look at patients seen for rashes from Beta lactams on those would be few and far between. If you wanted to track something, C. diff would probably be the easiest.

>> In the emergency department, this is an area of focus and emergency departments fall under the ambulatory documents. You can look at antibiotic prescribing patterns and duration of therapy for your local guidelines as



well as a rule out CURB-65 which is a scoring tool to see if someone gets admitted for pneumonia or can be treated as an outpatient. Another thing you can look at which is apropos to some of the other commission measures and things that are being tracked with CMS is sepsis and how often you use appropriate antibiotic selection in patients. No matter what most doctors tell you Vanc and pip/tazo are not the answer for every patient. They are associated with a significant increase in renal failure from antibiotics and probably not the right choice but I guess in most facilities it is what is given for most septic patients. This could be another area you could look at and potentially even tie into your sepsis data you are already collecting and just ask a few more questions to look into that.

>> Coming down the home stretch, education and expertise. Does your facility provide resources to clinicians and patients on evidence-based antibiotic prescribing? We want to educate them when they are and are not needed and the fact that antibiotics are not benign.

>> Health Services Advisory Group that are sponsoring this call have a lot of antibiotic resources on their website. They are also your partner in helping develop your internal tools for managing antibiotic stewardship from an ambulatory standpoint so feel free to reach out to them with questions or need for any help.

>> There is the California Medical Association (CMA) Foundation which is out of California and they have made some of their treatment guidelines available including sinusitis and pharyngitis and nonspecific URI guidelines and they have SEAP document and an acute bronchitis document as well. They have patient education handouts and some posters that can be put up in the office. My challenge to everyone on this call is when you use outside resources, no matter where you get them from, please investigate them internally to make sure you agree with them. Maybe you have a different prescribing pattern locally that is appropriate or perhaps you have antibiotic resistance issues. Please don't just take the CMA foundation or IDSA -- I mentioned we took the IDSA C. diff document and we updated what we felt was the latest evidence. Please investigate internally before you roll something out for everyone to utilize and making treatment decisions.

>> This is something from the CMA foundation for best practices in the management of someone with bronchitis and cough. As you can see, it's a nice detailed document that you have access to.

>> As I mentioned many times antibiotics are not benign and a lot of times antibiotics are given for viral infections. This is information you can put in your office and provide to your patients as well is put on the computer. This is from the Centers for Disease Control and Prevention (CDC) Get Smart campaign and they have documents out there that tell you that these diagnoses need antibiotics because they are bacterial and these diagnoses are viral and do not need antibiotics. Make this available to your patients because it's very helpful. They also have charts, fact sheets, and other things that can be provided to patients for education to try to break the lifelong habit of going to the doctor to get an antibiotic because it will fix you. I can tell you how many patients I have seen that have had such life-changing or maybe life ending complications from antibiotics. It is heartbreaking when you see it for something that is viral. We have to work with patients to let them know when antibiotics will help and when they will not.

>> This is from Get Smart week coming up in November on the 13th through the 19th and they have more information on the CDC Get Smart in terms of patient education around antibiotics.

>> My last slide is there are now multiple tools and this is from my office. When my patients are waiting for me to come in, there are interactive tools and the one on the left is a slide on tuberculosis. You can click on it. There is one on methicillin-resistant Staphylococcus aureus (MRSA). It is interactive and you can watch videos. There are things like are you ready for your examination? Questions to ask when you see the doctor. These are many times free and provided by companies. The material is free and auto updated. I am not here to plug any one device but we just rolled these out a few months ago and I can't emphasize the positive reinforcement we have had from patients. Sometimes when I walk in the room I have to tap them on the shoulder and you can watch these videos later. Very positive and the patients enjoyed having that as a way of education.



>> That wraps up my time and to reemphasize, work through the core elements of antibiotic stewardship that are available from the outpatient standpoint. Hopefully some of the nuggets I have given you in the last 30 minutes, there are a lot of things you have probably already done but may not be taking credit for it. Hopefully by putting these things on your radar, it will make it not so daunting of a task to take your antibiotic stewardship program from the outpatient setting and make it more robust. With that I throw it back to Eli.

>> Thank you Dr. Burdette. Great presentation and at this time we have two questions and I think one was addressed by your presentation and talks about what type of education is out there for physicians around antibiotic stewardship? You provided a list of resources and we will send a copy of the presentation also people have that to reference. I encourage you to go to the HSAG website and we have links to a tremendous number of resources including continuing education for physicians. The next button is one that Chris was most prepared to take and that is office visit 99212 counts towards measures or does it map starting with 99213? Chris can you weigh in on that?

>> Yes, I had to take myself off mute. Yes 99212 is a valid office visit code and will count towards measures and along with 99213.

>> [Event concluded]