

Deliverables for FY2018 DPHHS Antimicrobial Stewardship (AMS) Project Participants (grant period November 1, 2017 – July 31, 2018):

Overview:

This project is designed to help acute care hospitals, associated long term care and outpatient care facilities meet the requirements of the proposed federal rule 42 CFR 482 and 485 and the resulting Joint Commission standards (June 2016) and Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COP) elements requiring antimicrobial stewardship programs for accreditation of hospitals, critical access hospitals, and nursing care centers. The project will also help hospitals illustrate cost savings from a business model standpoint justifying ongoing support for the approach. More information on AMS is located at [CIDRAP AMS in Hospitals and Long Term Care Facilities](#)

Payments will be made with an initial payment of \$2,000.00 upon signing to participate in the program with remaining funds to be disbursed after the end of the grant period based upon completion of the required activities.

All participating hospitals will receive funding based upon activities a particular hospital is able to accomplish. It is recognized that not all hospitals will be able to meet all the requirements. Funding is designed to support activities that reflect a genuine desire to do so. Funding will be based upon achievement of the seven core elements in the whole. Adjustments to funding will be based upon performance based invoices based upon compliance for required activities impacting success including:

1. Supporting DPHHS designated telehealth based programs (Hospital pays telehealth provider and is reimbursed by DPHHS)
2. Pursuit of and attainment of the National Healthcare Safety Network (NHSN) Antibiotic Use and Resistance (AUR) module access meeting meaningful use optional requirements.
3. Attendance at in person and webinar based training events
4. Data provision to support state level indicators for *C. difficile* and Days of Therapy per thousand patient days (below)
5. The number of seven core elements achieved and maintained during the grant period

Summary:

For Federal Fiscal Year 2018

(August 1, 2017 – July 31, 2018), the following activities and reporting will be required for participants in the DPHHS Antimicrobial Stewardship Funding:

Activity Requirements:

1. Participate and submission of activity
2. Actively work to implement and maintain all 7 CDC Core Elements of Antimicrobial Stewardship at a level to meet Joint Commission standards.

3. Participation in DPHHS designated telehealth based program that supports the 7 CDC Core Elements of Antimicrobial Stewardship. ***This activity is required for Critical Access Hospitals to receive funding designated for this purpose and is optional for Prospective Payment System Hospitals.*** Funding can be invoiced to support the designated telehealth activities.
4. Pursuit of and/or attainment of access to the NHSN Antibiotic Use and Resistance (AUR) module. ***This activity is required for Prospective Payment System (PPS) Hospitals and is optional for Critical Access Hospitals (CAH).*** Funding can be used to support EMR system related activities to support communications with the NHSN interface.
5. Annual participation in a data validation process, performed by DPHHS (or contractors of DPHHS), for your facility's tracking and ***reporting of the CDI Lab ID Event to NHSN. This activity is required for Prospective Payment System (PPS) Hospitals and is optional for Critical Access Hospitals(CAHs).***
6. Submit quarterly reporting as identified below.
7. In line with the Joint Commission standards and CMS COP elements and as part of the hospital leadership commitment, the hospital must have an antimicrobial stewardship multidisciplinary team that includes the program's leader and the following members, **when available** in the setting:
 - Practitioner
 - **Note 1:** *Part-time or consultant staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.*
 - **Note 2:** *Telehealth staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.*
 - Infectious disease physician
 - Infection preventionist(s)
 - Hospital Quality Staff
 - Pharmacist(s)

Quarterly Reporting:

1. Current *C. difficile* infection rate, for last 90 days (or quarter) - (FACWIDEIN Standardized Infection Ratio (SIR) or # of CDI per 10,000 patient days as reported via HIIN)
2. Current Days of Therapy (DOT) per thousand patient days antibiotic usage metric, for last 90 days (or quarter)
3. Date of your participation in the data validation review process with DPHHS (or DPHHS contractor) for ***NHSN CDI LabID Event.***
4. Complete the Readiness Assessment for electronic submission of antibiotic usage/resistance data to NHSN.
5. Attendance at informational technical assistance webinars/telehealth/in person support events.

Detail: Semi-Annual Reporting: - Core Elements:

Provide the date of implementation for the following core elements/activities (leave blank if not implemented or implementation is in progress):

1. Hospital Leadership Commitment: Written letter of support from Leadership (one time)
2. Program Leadership: Date and name of person assigned to lead ASP (one time or upon change)
3. Physician Leadership: Date and name of physician assigned to champion ASP (one time or upon change)
4. Drug Expertise: Date and name of pharmacist assigned to provide expertise to ASP (one time or upon change)
5. Action: Date of implementation for each action item when completed on provided deliverables reporting form (Can be previous year implementation). At minimum, one task under each letter section should be completed.
 - a. Policies:
 - i. A policy that requires prescribers to document dose, duration and indication for all antibiotic orders in HER (Provide copy)
 - ii. Facility specific treatment recommendations based on national guidelines to assist with antibiotic selection for common clinical conditions (Provide Copy)
 - b. Broad Interventions:
 - i. A formal procedure for all clinicians to review the appropriateness of all antibiotics 48 hours after initial order (Provide Copy)
 - ii. Identified specific antibiotic agents that need to be approved by physician or pharmacist prior to dispensing (Provide Copy)
 - iii. Physician or pharmacist reviews courses of therapy for specific antibiotic agents
 - c. Pharmacy Driven Interventions
 - i. Automatic changes from intravenous to oral antibiotic therapy in appropriate situations?
 - ii. Dose adjustments in cases of organ dysfunction?
 - iii. Dose optimization (pharmacokinetics/pharmacodynamics) to optimize the treatment of organisms with reduced susceptibility?
 - iv. Automatic alerts in situations where therapy might be unnecessarily duplicative?
 - v. Time-sensitive automatic stop orders for specified antibiotic prescriptions?
 - d. Diagnosis and infections specific interventions
 - i. Does your facility have specific interventions in place to ensure optimal use of antibiotics to treat the following common infections? (Provide copies of intervention policies/procedures)
 1. Community-acquired and health care acquired pneumonia
 2. Urinary tract infection
 3. Intra-abdominal infections
 4. Skin and soft tissue infections
 5. Surgical prophylaxis
 6. Empiric treatment of MRSA
 7. Non-*C. difficile* infection antibiotics in new cases of CDI
 8. Culture-proven invasive infections (blood stream)
6. Tracking: Date of implementation of tracking and monitoring of at least one aspect of antibiotic prescribing (One time)

7. Reporting: Date of implementation of sharing facility-specific reports to staff on improving antibiotic use and resistance. (Ongoing)
8. Progress on the development of a facility level antibiogram or statement of use of regional or state level antibiogram.

Quarterly Reporting: - Outcome and Process Measures

1. **C. difficile infection rate** NQF 1717/NHSN, last 90 days (quarter) recommended, or as last reported via HIIN or NHSN– (include date range of data, and method; facility wide or specific locations).
 - a. **# CDI per 10,000 patient days (HIIN measure)**
 - i. **Numerator:** Total number of observed hospital-onset *C. difficile* lab identified events among all inpatients in the facility, excluding well-baby nurseries and NICUs
 - ii. **Denominator:** Total number of patient days
 - iii. **Calculation:** numerator/denominator x 10,000 = *C. diff* rate

Standardized Infection Ratio (SIR) as reported quarterly for NHSN CDI LabID Event (for facilities entering data into NHSN. (Facilities are not required to do both)

2. **Days of Therapy (DOT)** per thousand patient days, NQF 2720/NHSN, (quarterly beginning 04/01/2018 for calendar year quarters in 2018) recommended (facility wide at a minimum).
 - a. **Numerator:** The number of days (admission based calculation) that a patient received an antimicrobial agent (regardless of dose). Any dose of an antibiotic that is received during a 24 hour period represents 1 DOT. The DOT for a given patient on multiple antibiotics will be the sum of DOT for each antibiotic that the patient is receiving standardized to 1000 patient days.
 - b. **Denominator:** Days present for each patient based upon the admission date - the number of patients who were present for any portion of each day of a calendar month for each location
 - i. **Calculation:** numerator/denominator x 1000 = days of therapy per thousand patient days.

Details and training to be provided to support calculations for 1. and 2.

Quarterly Reporting Data Validation Process (required 1 time per year)

1. Date facility participated in DPHHS/HAI data validation review for NHSN *C. difficile* (CDI) lab ID event measure (*For facilities entering CDI data into NHSN*)

Baseline and end of year Reporting NHSN electronic Submission Readiness Assessment

1. Respond to readiness assessment survey for electronic submission to the NHSN AUR module. This survey will only provide data on the level of readiness for hospitals over time. The program will also assess those hospitals that achieve reporting into the NHSN AUR module that also serves as an optional meaningful use measure. (2017 baseline: One hospital)