higher than the Centers for Medicare and Medicaid Services (CMS) national SIR of 0.997. **Methods:** Hospital-onset CDIF cases from both hospitals were reviewed. Current electronic decision support in the electronic health record (EHR) was evaluated for CDI laboratory orders. Literature was reviewed for best practice of appropriate specimen collection and testing. Interventions were implemented at facility A in November 2016 and facility B in June 2018. **Results:** In total, 67 HO CDIF cases were reviewed from both facilities (October 2015–September 2016 for facility A and April 2017–June 2018 for facility B), and 46% were due to inappropriate testing. A CDI testing order set with decision support and best practice alerts was implemented based on national best-practice guidelines (Fig. 1). Physician and nurse education were completed on appropriate testing for CDI, including symptoms and timely specimen collection. Real-time review of appropriate testing was validated by the infection prevention team, and outliers were communicated to the ordering provider. After implementation, decreases in HO-CDIF SIRs occurred at both facilities (facility A SIR, 0.36; facility B SIR, 0.56). Both facilities have been able to sustain an SIR below the current CMS national average of 0.784. **Conclusions:** By implementing a sophisticated order-entry process that includes electronic decision support based on best practices, clinician education, and real-time feedback to providers, patients are appropriately tested for CDI. This intervention has allowed for appropriate classification within the NHSN and has decreased the overall HO-CDIF SIR.

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Presentation Type:
Poster Presentation

Implementation Methods for a Collaborative Pharmacist-Led Antimicrobial Stewardship Intervention at Hospital Discharge

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Background: Unnecessary and prolonged antibiotic use is an important driver of antimicrobial resistance, increasing patient harm and resource utilization. Antimicrobials prescribed at hospital discharge represent an important opportunity to intervene and optimize therapy. **Objective:** We describe the implementation of a pharmacist-led multidisciplinary antimicrobial stewardship (AMS) intervention at transition of care (TOC) to improve antibiotic selection and duration. **Methods:** This intervention an IRB-approved multihospital, quasi-experimental, 3-phase stepped-wedge project in a 5-hospital health system. The setting included a large, urban, academic medical center in Detroit, Michigan, and 4 community hospitals in southeastern Michigan. AMS is provided by a pharmacist and infectious diseases physician at each site. For

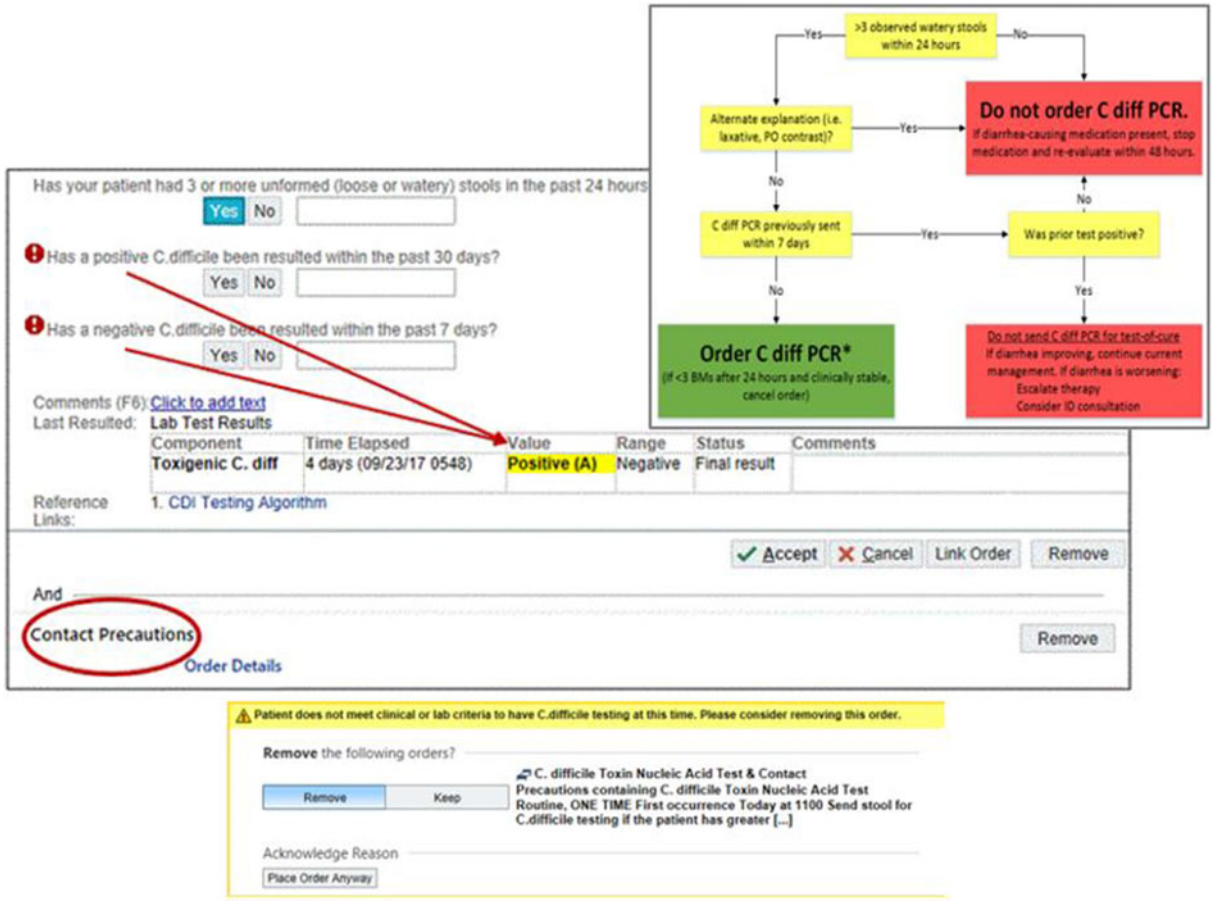

Fig. 1.

Protocol Implementation and Adherence

Total Number of Patients Served

	November	December	January	February	March	April	May	June	July	August
# of patients served (notes placed)	65	74	118	80	197	178	161	205	215	265

Adherence Rates and Implementation Periods (N=25 per block)

Unit/Block	November		December		January		February		March		April		May		June		July		August	
Phase A units *Academic, General medicine*	54%	57%	80%	60%	85%	83%	46%	75%	70%	83%	87%	70%	31%	83%	83%	77%	55%	79%	75%	71%
Phase B units *Mixed academic & community, general & specialty medicine*	*Pre-intervention Period*								83%	46%	78%	71%	55%	57%	63%	78%	36%	29%	75%	53%
Phase C units *Community, general medicine*	*Pre-intervention Period*														36%	45%	29%	45%	45%	64%

Fig. 1.

the AMS TOC intervention, pharmacists implemented 3 strategies: (1) early identification of patients to be discharged on oral antibiotics; (2) collaborative planning and communication regarding guideline-recommended antibiotic selection and duration; and (3) facilitation of discharge antibiotic prescription with appropriate stop date. Process improvements were modified to fit the academic and community hospital practice models. The process was implemented in general and specialty practice wards at each hospital site. Prior to implementation in October 2018, pharmacists were trained on tools to standardize identification, collaboration, and documentation. Pocket cards were used to augment education and electronic medical record (EMR) templates standardized documentation. Physicians and nurses on participating units were educated on the rationale and process. Following initiation, ongoing feedback was provided regularly to pharmacists to discuss challenges and to identify solutions. Process measures included the total number of patients receiving the intervention monthly, as indicated by pharmacist AMS TOC notes placed. Protocol adherence was evaluated in 25 randomly selected patients in each study phase each month. Adherence was defined as a pharmacist preparing discharge prescriptions and a placing note in the EMR. **Results:** Over the study period, 1,558 patient encounters received AMS TOC facilitation by a pharmacist. Monthly protocol adherence ranged from 29% to 87% (higher in academic institutions than community) (Fig. 1). Months of low protocol adherence were associated with times of reduced staffing and onboarding a large group of new employees or trainees. Additional barriers included discharges over weekends. The most common area needing clarification was how to count days of therapy to determine the appropriate stop date. A guide of how to count days of therapy was created to assist. **Conclusions:** Pharmacist-led antimicrobial stewardship at discharge is a feasible intervention in both academic and community settings. Identifying potential barriers and assessing strategies with multidisciplinary healthcare teams allows for optimal implementation and intervention rollout.

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Implementation of Two-Step *Clostridioides difficile* Testing Algorithm and Management of Possible Carriers

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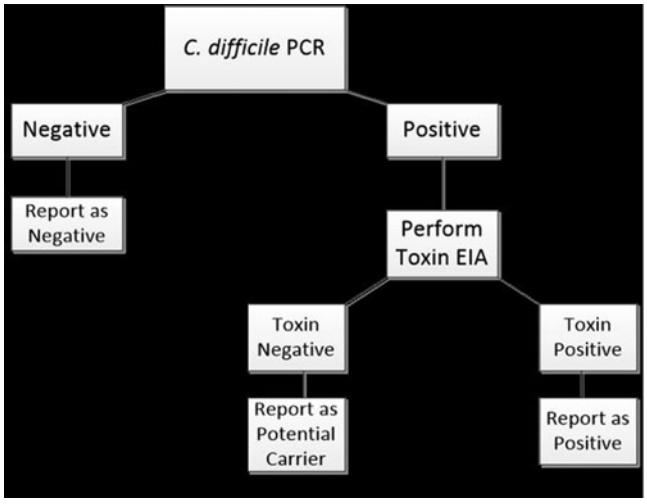

Fig. 1.