Unanswered Questions from Antibiotic Stewardship LAN Event – *Understanding Physician-to-Patient Communication Strategies to Avoid Unnecessary Antibiotic Prescribing*

Wednesday, August 30, 2017

The answers below were provided by Dr. Rita Mangione-Smith with the University of Washington, Department of Pediatrics.

Question	Answer
How would the strategy of not prescribing antibiotics over the phone without an in-person visit fit into the action core element?	The review of symptoms would need to be used in place of the review of PE findings to make the case for your non-bacterial diagnosis. I would consider emphasizing that it is impossible to know if antibiotics are the right treatment without an in-person visit.
Is it illegal to give placebos?	I don't know whether it is illegal. It could be considered unethical by some people.
Regarding insurance companies promoting call-in clinics, I have had patients prescribed antibiotics over the phone and believe this is going to be a dangerous practice. Please advise.	Please see the answer to #1. I agree, this practice, if it increases would be very problematic. It would be good for insurance companies to adopt guidelines regarding the avoidance of antibiotic prescribing without an in-person visit where a PE can be performed.
Do you recommend screening patients for common syndromes on the phone to prevent a visit that results in non-prescription recommendations that could have been communicated on the phone?	Yes, I think this would be an excellent idea if it actually prevents visits. Anecdotally, I believe it would be based on my own practice experience. This is where good contingency planning really comes into play. It's important to provide reassurance that a visit is not currently needed but then also to provide clear parameters for when a patient should be seen if their condition evolves/progresses.
Have you held communication seminars for providers to describe your recommendations? If so, how was it received? Do you have data to measure before and after education?	We have a study of our DART QI Program ongoing currently. So far the seminars have been well received, but we will not have the answer to your effectiveness question until we do our study analyses in Spring of 2018.

Question	Answer
What suggestions do you have on when the parent/patient calls the next day complaining of feeling worse and wanting antibiotics, and not waiting the 3 or so days?	The best advice I could give is preventive. During the initial visit, if there is a chance the patient may feel worse before they feel better and this is a natural part of the disease course, I would be sure to cover that during the contingency planning part of the treatment plan. That way if they call back complaining symptoms are worse but they are within the parameters you discussed, you can remind them that this is expected and give them further reassurance as well as advice on what should bring them back in for a re-check.
Is the patient or parent handed a list of recommendations and when to follow-up?	No – but they certainly could be given such a list in an after visit summary. This might actually be quite helpful.
Does this study also focus on adult patients or young adults, and the differences in results?	We are not currently including adults or young adults at this time but may in future work.
How is this information getting out to our physician community?	We will publish the results of our study once they are available. We also hope to make this QI program widely available through the American Board of Pediatrics Maintenance of Certification (MOC) part 4 program. We of course will also continue to disseminate the program through venues like this one when the opportunity arises.
Is there a one-pager available outlining these communication techniques we could provide to clinicians, rather than providing just the presentation slides?	Not currently.
What are your thoughts about the use of algorithms for antibiotic prescribing?	Algorithms are helpful in decreasing variation in care and increasing the provision of evidence-based care. But algorithms are likely not enough as they don't assist providers with managing the psychosocial aspects of these visits as illustrated during the webinar.
Is there any data that shows "peer-pressure" in sharing prescribing data that changes provider prescribing practices?	Yes. Feedback reports that compare an individual provider's prescribing patterns to those of his or her colleagues have been shown to decrease rates of inappropriate prescribing. See publications by Jeffrey Gerber and colleagues in JAMA.

Question	Answer
Are there any communication techniques/recommendations specific to a university student health center where there appears to be an excessive number of students who demand antibiotics?	Not that I am aware of, but this would be a good future population to target.
Under what conditions are prophylactic antibiotics supported?	In pediatrics, they are rarely indicated if ever.
With strep or sore throat in general, do you feel that all or most patients should have cultures performed and antibiotics only be prescribed for 2 days to make sure that the correct antibiotic is prescribed?	If suspicion for Strep is low based on your physical exam and the history, I would not do a rapid test or a culture. For those cases where you suspect a patient may have Strep, I do think all patients in this category should at least have a rapid test performed before prescribing any antibiotics and if it is negative but suspicion for Strep is still high – then the approach of culturing and providing just two days of antibiotics would be a reasonable approach.
Will the metrics for the EHR report be available to everyone? I do QAPI in the clinic setting and that would be helpful information.	Yes, once our study is completed, all of the materials we developed for the QI program including the data specifications for generating the feedback reports will be made publicly available on my institutional research lab web-page at Seattle Children's.

The answers below were provided by Dr. Lauri Hicks with the Centers for Disease Control and Prevention.

Question	Answer
Do you think that incorporating the Antibiotic Stewardship Program into the Quality Assurance Program for consistent monitoring within the Skilled Nursing Facility would be a great idea to assist in the monitoring of antibiotic usage among the geriatric population?	Multiple studies have shown that 50-70% of nursing home residents are prescribed an antibiotic in a year, and up to half of those may be inappropriate (diagnosis, dose, duration). Older adults are particularly vulnerable to the adverse events from antibiotic, thus incorporating stewardship into quality assurance programs can help improve resident outcomes in Skilled Nursing Facilities and decrease preventable harm.

Question	Answer
Are these approaches applicable/ recommended for geriatric in-house residents considering their co-morbidities?	One of the main influences on antibiotic prescribing in long-term care is family and resident pressure. Improving communication when providing education to residents and families about the harms associated with antibiotic use, and setting expectations around antibiotic prescribing can help reduce barriers to inappropriate antibiotic prescribing in this setting. We are developing materials for this specific population. Here are some existing resources: https://www.cdc.gov/longtermcare/resident/index.html
Under what conditions are prophylactic antibiotics supported?	Antibiotic prophylaxis is indicated to prevent skin and soft tissue infection after surgical procedures, and may be indicated in certain patients undergoing specific dental procedures. Although prophylaxis for urinary tract infections has been shown to be efficacious in specific clinical settings, it has to be weighed against the potential for adverse events and resistance.
Our residency practice started providing antibiotics if women identified urinary tract infection symptoms and no vaginal complaints. But my current practice doesn't do this-- which is the evidence-based way to go here?	There are some studies that have showed the efficacy of self-treatment in women with recurrent urinary tract infection (one link below). This approach could be considered in specific patients with clearly documented recurrent urinary tract infections, who are highly compliant, motivated and have a good relationship and communication with their physician, and can seek further care if symptoms do not improve. This treatment approach has to be weighed against the potential for missed diagnoses, inappropriate treatment, adverse events and development of resistance. https://www.ncbi.nlm.nih.gov/pubmed/11434727
With regard to prescribing prophylactic antibiotics in long-term care, what are your thoughts on the urinary anti-infective med Methanmine Hippurate?	The efficacy of urinary antiseptics such as methenamine has not been confirmed. Further evaluation of its efficacy and potential adverse events and drug interactions may be helpful in specific patient populations.

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