Final Joint Commission standards for Antimicrobial Stewardship Programs

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Joint Commission standards for Antimicrobial stewardship (AMS) for hospitals, critical access hospitals, and nursing care centers becomes effective January 1, 2017.

Elements of Performance

1. Leaders establish AMS as an organizational priority
   examples: budget plans, infection prevention plans, accountability documents

2. Regular education of staff and independent practitioners about appropriate antibiotic use and resistance issues

3. Patient education about appropriate use of antibiotics
4. Antimicrobial Stewardship Multidisciplinary team

- Infectious disease physician
- Infection preventionist
- Pharmacist
- Practitioner

Note: part-time or consultant staff as well as Telehealth staff are acceptable as members of the AMS team.
5. AMS program Core elements

- Leadership commitment - people, financial and IT if needed
- Accountability - single leader (program champion) responsible for AMS outcomes
- Drug expertise
- Action - implementing recommendations and prospective evaluation - such as antibiotic “time out” after 48 hours
- Tracking
- Reporting - such as antibiotic use, resistance patterns, etc
- Education
6. Protocols established

Examples
- Intravenous to oral conversion
- Use of prophylactic antibiotics in surgery
- C. Difficile management
- Community acquired pneumonia
- Assessing appropriate management of UTIs

7, 8 - collect and analyze data and take action on improvement opportunities
2014 survey of >4000 acute care hospitals - National Healthcare Safety Network (NHSN)

- 39% of hospitals meet each of the core elements
- States varied from 7% to 58% - CA highest as already required in 2014 all hospitals to improve antibiotic use
- Strongest predictor of a hospital having a comprehensive AMS was written support from facility administration
- Largest hospitals (>200 beds) most likely to be compliant (56%), but even in small hospitals (<50 beds) 22.4% meet the standards. So it can be done!
Focus should be on improved individual patient outcomes rather than emphasizing the abstract concept of antimicrobial resistance.

“...that is a failing strategy: physicians accept resistance as a reality to which their prescribing may contribute, yet they tend to minimize its importance in their own practices; they may choose broader-spectrum drugs as a hedge against it; and they may navigate a complex workplace dynamic of social and psychological influences in which antibiotic overtreatment becomes a way of prioritizing individual patient care (the practical) over the treat of resistance (the abstract)”

In contrast ... “a more patient-centered rationale and operational focus (for the AMS) in which resistance is emphasized as a threat primarily, if not exclusively to patients who receive them may help”
Example of a successful AMS in a smaller community hospital
What it takes to succeed