

MUA and MUP, respectively. **Conclusions:** Targets to improve oral antibiotic prescribing for children in a large PBRN include antibiotic prescribing for diagnoses that never require an antibiotic. Larger comparative studies may focus on the role (if any) that MUA/MUP has on antibiotic prescribing.

Disclosures: None

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In-depth assessment of critical access hospital stewardship program adherence to the CDC Core elements in Iowa and Nebraska

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Background: Critical-access hospitals (CAHs) are required to meet the CDC 7 Core Elements of antimicrobial stewardship programs (ASPs). CAHs have lower adherence to the core elements than larger acute-care hospitals, and literature defining which core-element deficiencies exist within CAHs as well as barriers to adherence is lacking. **Methods:** We

Core Element	Core Element Fully Met	Core Element Partially Met	Deficient
Leadership Commitment, N (%)	16 (76.2)	5 (23.8)	0 (0)
Accountability, N (%)	4 (19)	10 (47.6)	7 (33.3)
Drug Expertise, N (%)	10 (47.6)	10 (57.6)	1 (4.8)
Action, N (%)	21 (100)	0 (0)	0 (0)
Tracking, N (%)	15 (71.4)	5 (23.8)	1 (4.8)
Reporting, N (%)	15 (71.4)	5 (23.8)	1 (4.8)
Education, N (%)	9 (42.9)	0 (0)	12 (57.1)

Figure 1: Adherence to the Individual CDC Antibiotic Stewardship Core Elements at Small and Critical Access Hospitals Among 21 Critical Access Hospitals in Iowa and Nebraska

Recommendation Type	Number of Hospitals Given Recommendation, n=21 (%)
Leadership Support	
Establish ASP committee meetings	7 (33.3)
Improve ASP committee representation and define committee roles	2 (9.5)
Update ASP policy	1 (4.8)
Add ASP duties to job description	1 (4.8)
Accountability/Pharmacy Expertise	
Provide physician and pharmacist leader ASP training	19 (90.5)
Establish physician leader	7 (33.3)
Establish pharmacist leader	1 (4.8)
Collaborate between contract pharmacy and hospital	1 (4.8)
Action/Tracking	
Track antimicrobial stewardship interventions	12 (57.1)
Track antibiotic use	10 (47.6)
Implement antibiotic time-out and track usage	9 (42.9)
Implement order sets and track usage	8 (38.1)
Implement treatment guideline and track adherence	3 (14.3)
Collaborate with larger hospital system for EMR support with interventions	3 (14.3)
Implement intervention for treatment durations	2 (9.5)
Implement antibiotic indication and duration into ordering process	1 (4.8)
Establish system for missed culture follow-up	1 (4.8)
Reporting	
Report antibiotic use data to NHSN	6 (28.6)
Report antibiotic use to clinicians	4 (19)
Report via quality committee	4 (19)
Education	
Provide and track educational activities	12 (57.1)
Provide education on rapid identification panels	3 (14.3)

Figure 2: Top Recommendations Stratified by Core Element

Abbreviations: ASP: Antimicrobial Stewardship Program; EMR: Electronic Medical Record; NHSN: National Healthcare Safety Network

Barriers to ASP Initiation/Improvement	Number of Hospitals, n=20 (%)
Lack of dedicated resources, including time and personnel	15 (75)
Lack of infectious disease physician or knowledge	8 (40)
EMR limitations	5 (25)
Too few patients to make an impact	4 (20)
Need for clinician support and/or prioritization	5 (25)
Skilled beds antibiotic use	2 (10)

Figure 3: Self-Identified Barriers to Successful Antimicrobial Stewardship Program Initiation and/or Improvement. One hospital with missing data. Up to 3 responses per hospital.

Abbreviations: ASP: antimicrobial stewardship program; EMR: electronic medical record

evaluated 21 CAH ASPs (5 in Nebraska and 15 in Iowa) that self-identified as potentially deficient in the Core Elements, via self-assessment followed by in-depth interviews with local ASP team members to assess adherence to the CDC Core Elements for ASPs. Core-element compliance was rated as either full (1 point), partial (0.5), or deficient (0), with a maximum score of 7 per ASP. High-priority recommendations to ensure core-element compliance were provided to facilities as written feedback. Self-reported barriers to implementation were thematically categorized. **Results:** Among the 21 CAH ASPs, none fully met all 7 core elements (range, 2.5–6.5), with a median of 5 full core elements met (Fig. 1). Only 6 ASPs (28.6%) had at least partial adherence to each of the 7 core elements. Action (21 of 21, 100%) and leadership commitment (16 of 21, 76.2%) were the core elements with the highest adherence, and accountability (4 of 21, 19%) and education (9 of 21, 42.9%) were the lowest. The most frequent high-priority recommendations were to provide physician and pharmacist leader ASP training (19 of 21, 90.5%), to track antimicrobial stewardship interventions (12 of 21, 57.1%), and to provide or track educational activities (12 of 21, 57.1%) (Fig. 2). One-third of programs were recommended to establish a physician leader. The most commonly self-identified barriers to establishing and maintaining an ASP were a lack of dedicated resources such as time of personnel (15 of 20, 75%), lack of infectious diseases expertise and training (8 of 20, 40%), and electronic medical record limitations (5 of 20, 25%) (Fig. 3). **Conclusions:** CAH ASPs demonstrate several critical gaps in achieving adherence to the CDC Core Elements, primarily in training for physician and pharmacist leaders and providing stewardship-focused education. Further resources and training customized to the issues present in CAH ASPs should be developed.

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Examining the effects of organizational influencers on the implementation of clinical innovations: A qualitative analysis

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Background: The FIRST Trial is a 5-year study funded by the Agency for Healthcare Research and Quality. Our investigation is situated within a more extensive study to restrict fluoroquinolone antibiotics by requiring providers to obtain authorization from an infectious disease physician before prescribing fluoroquinolones. Our research team is performing a systematic evaluation to identify organizational characteristics and influencers of the fluoroquinolone preprescription authorization implementation process to understand variables that may facilitate or hinder implementation success. **Methods:** To address this critical gap, we present a qualitative analysis from our ongoing, multisite research project aimed at systematically assessing the adoption of an antimicrobial stewardship intervention in the form of an EHR-integrated best-practice alert (BPA) at each site to identify work system factors that impact uptake and variability in the implementation of the BPA at each location. The evaluation provides a detailed explanation of activities through the implementation