Table 2. Changes in antibiotics-related perceptions among students before and after clinical practice in infectious diseases

	Students participated in the parenteral to oral conversion program		
	Pre (n=41)	Post (n=41)	*P*
Demographic data			
Age	23.68±1.90		-
Male sex	29 (70.7)		-
Perception of oral antibiotics			
Patients will likely have a lot of complaints if oral antibiotics are used for inpatients	2.37±0.73	2.61±1.05	0.127
I am familiar with which patients can be given oral antibiotics	**3.02±0.72**	**3.90±0.58**	**<0.001**
Parenteral antibiotics are more effective than oral antibiotics if it is the same antibiotics	**3.15±1.11**	**2.17±0.86**	**<0.001**
Parenteral antibiotics have a faster effect than oral antibiotics if it is the same antibiotics	4.07±0.61	4.10±0.74	0.868
The price of parenteral antibiotics and oral antibiotics is almost the same if it is the same antibiotics	**2.24±0.70**	**1.78±0.85**	**0.005**
Parenteral antibiotics have similar or fewer side effects than oral antibiotics if it is the same antibiotics	2.05±0.84	2.10±0.77	0.822
When oral antibiotics are available, oral antibiotics are beneficial to patients compared to parenteral antibiotics	4.00±0.81	4.22±0.61	0.136
Perception on conversion of parenteral to per oral antibiotics			
Patients should be able to swallow oral drugs	4.51±0.51	4.59±0.59	0.491
There should be no structural abnormality in the patient's gastrointestinal tract	4.32±0.69	4.39±0.74	0.665
Chronic diseases such as diabetes mellitus or hypertension should not exist	2.41±0.74	2.20±0.68	0.101
Oral antibiotics with the same ingredients as parenteral antibiotics must be present	**2.95±1.09**	**3.88±1.00**	**<0.001**
The causative bacteria of infection and antibiotic susceptibility results must exist	**4.07±0.82**	**3.54±1.05**	**0.016**
Fever must not exist for more than 24 hours	**3.29±0.87**	**4.00±0.87**	**<0.001**
Inflammatory markers such as white blood cell count and CRP should be normalized	**2.95±0.95**	**3.78±1.04**	**<0.001**
Vital signs such as pulse rate, respiratory rate, and blood pressure etc. should be normalized	**3.54±0.87**	**3.90±0.77**	**0.034**

Data are presented as number (%) or mean ± standard deviation.

These were collected and analyzed 'Strongly disagree' as 1 point, 'Disagree' as 2 points, 'Neutral' as 3 points, 'Agree' as 4 points, 'Strongly agree' as 5 points.

Abbreviations: CRP, c-reactive protein

Through this program, students have gained a better perception of oral antibiotics. **Conclusions:** This parenteral-to-oral conversion program showed a 24.2% acceptance rate of oral antibiotics conversions in the hospital, and it had significant educational effects on medical students regarding an appropriate perception of oral antibiotics.

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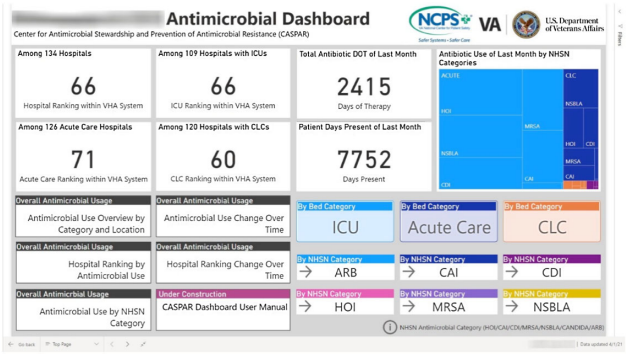
Presentation Type:
Poster Presentation - Top Poster Award
Subject Category: Antibiotic Stewardship

Qualitative Evaluation of an automated nationwide benchmarking antimicrobial utilization dashboard for the VHA

DeShauna Jones; Alexandre Marra; Daniel Livorsi; Eli Perencevich and Michihiko Goto

Background: Antimicrobial stewardship programs (ASPs) are advised to audit antimicrobial consumption as a metric to feedback to clinicians. However, many ASPs lack the tools necessary for appropriate risk adjustment and standardized data collection, which are critical for peer-program benchmarking. We evaluated the impact of the dashboard deployment that displays these metrics and its acceptance among ASP members and antimicrobial prescribers. **Materials/methods:** We conducted semistructured interviews of ASP stewards and antimicrobial prescribers before and after implementation of a web-based ASP information dashboard (Fig. 1) implemented in the VA Midwest Health Care Network (VISN23). The dashboard provides risk-adjusted benchmarking, longitudinal trends, and analysis of antimicrobial usage patterns at each facility. Risk-adjusted benchmarking was based on an observed-to-expected comparison of antimicrobial days of therapy at each facility, after adjusting for differences in patient case mix and facility-level variables. Respondents were asked to evaluate several aspects of the dashboard, including its ease of use, applicability to ongoing ASP activities, perceived validity and reliability, and advantages compared to other ASP monitoring systems. All interviews were digitally recorded and transcribed verbatim. The analysis was conducted using MaxQDA 2020.4 and the Consolidated Framework for Implementation Research (CFIR) constructs. **Results:** We completed 4 preimplementation interviews and 11 postimplementation interviews with ASP champions and antimicrobial prescribers from 6 medical centers. We derived 4 key themes from the data that map onto CFIR constructs. These themes were interconnected so that implementation of the dashboard (ie, adapting and adopting) was influenced by respondents' perception of a facility's size, patient population, and priority placed on stewardship (ie, structural and cultural context), the availability of dedicated stewardship staff and training needed to implement the dashboard (ie, resources needed), and how the dashboard compared to established stewardship activities (ie, relative advantage). ASP champions and antimicrobial prescribers indicated that dashboard metrics were useful for identifying antimicrobial usage and for comparing metrics among similar facilities. Respondents also specified barriers to acceptance of the risk-adjusted metric, such as disagreement regarding how antimicrobials were grouped by the current NHSN protocol, uncertainty of factors involved in risk adjustments, and difficulty developing a clear interpretation of hospital rankings. **Conclusions:** Given the limited resources for antimicrobial stewardship personnel, automated, risk-adjusted, antimicrobial-use dashboards provided by ASPs are an attractive method to both facilitate compliance and improve efficiency. To increase the uptake of surveillance systems in antimicrobial stewardship, our study highlights the need for clear descriptions of methods and metrics.



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A little education goes a long way: Decreasing antibiotics for community-acquired pneumonia in COVID-19 patients

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Background: Antibiotic use was common in patients with suspected or confirmed COVID-19 infection; however, data emerged demonstrating low rates of bacterial coinfection (6%–10%). Antimicrobial stewardship best practice was challenged during this time, requiring new strategies and education to limit the inappropriate use of antibiotics. At the Veterans' Affairs Maryland Healthcare System, we evaluated the use of community acquired pneumonia (CAP) specific antibiotics in COVID-19–positive patients after successive interventions. **Methods:** We conducted a pre–post evaluation of common CAP antibiotics (ceftriaxone IV/IM, cefpodoxime PO, azithromycin PO/IV, ampicillin/sulbactam IV, amoxicillin-clavulanate PO, levofloxacin) during the COVID-19 pandemic. The preintervention period was April–October 2020 and the postintervention period was November 2020–April 2021. During the preintervention period, intervention A was carried out as follows: (1) inpatient weekly virtual interdisciplinary COVID-19 rounds were led by an antimicrobial stewardship champion, (2) χprocalcitonin was implemented in clinical decision making, and (3) inpatient audit and feedback of active antibiotics was conducted by the antimicrobial stewardship team. In the postintervention period, intervention B was added as follows: (1) weekly educational COVID-19 virtual seminars were conducted for providers, and (2) targeted education was provided to emergency department and hospitalist directors. Comparisons of the proportions of antibiotics prescribed were made between the pre- and postintervention periods using X^2 statistic, and data were stratified by location. The rates of CAP antibiotic prescription per 100 COVID-19–positive patients were also compared

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