Tips for Obtaining C-Suite Buy-In for Stewardship at a Critical Access Hospital (CAH)

This document contains some tips that we hope will assist you with obtaining buy-in from your leadership team. Correlate these suggestions to that of your own individual institution's policies and procedures. Always obtain proper approvals and support prior to modifying institution policies and protocols.

Getting Started

When you talk about stewardship with your C-suite, figure out where stewardship and C-suite goals align. Frame the discussion in terms of the benefits that are most relevant to their role or their institutional and board goals (e.g. quality metrics/goals, regulations, cost-reduction).

It is additionally important to understand how your hospital is reimbursed. Refer to the portions of this document titled "Sources of Funding and Revenue" and "More Resources" for more information.

Quick Buy-In Tips:

- Start by sharing the regulatory or legal standards set forth by the organization that accredits your facility. Some suggestions from common accrediting organization are listed below:[1]
    - CMS Conditions of Participation
    - Joint Commission MM.09.01.01 (Inpatient)
    - Joint Commission MM.09.01.03 (Outpatient)
    - Medicare Interoperability Program: NHSN AUR Requirement
- Work with your financial department to get hard dollar amounts to calculate cost savings for any intervention in which you would like to share a cost-savings benefit[1]
    - Consider including general supply costs, your department's labor costs, and laboratory supply costs[1]
- Track and report workload measures[2]
    - Characterizing the number of interventions and time per intervention may be helpful in obtaining additional resources if linked to improvements in economic or outcome measures
- Learn about which quality metrics are currently a concern for your facility and come up with a stewardship initiative to help address them

    - Make sure that there is a plan in place for tracking and reporting outcomes of any proposed stewardship initiative to your C-suite
- Ask your medical staff leadership to assist you with advocating for the AMS program to facility leadership
- Track and report patient safety events and/or interventions (value-based care)
    - Ex. Tracking near misses (e.g. treating a patient for pneumonia and identifying cancer)

How Can Stewardship Help Your Leadership Team to Meet Their Goals?

Below is a list of some of the benefits that a stewardship program have been shown in evidence-based literature to have from a cost/resource/quality metric standpoint. Select the one or more that is most applicable to your facility's current needs to share with your leadership team:

Specific Quality Metrics:[3]

SEP-1 Measure	AMS programs can assist the hospital with meeting its sepsis goals by promoting timely, guideline-concordant antibiotic therapy through order sets[4]
NHSN HAI-1	IV to PO protocols may help hospitals to reduce Medicare financial penalties by reducing central-line associated bloodstream infections[5] These protocols have the additional benefit of decreasing length-of-stay for individual patients, which can increase revenue by enabling more paying admissions to the hospital[1]
NHSN HAI-3 & HAI-4	AMS programs may help hospitals to reduce Medicare financial penalties for surgical-site infections by establishing a penicillin-allergy assessment process[6]
NHSN HAI-5	AMS programs may help hospitals to avoid Medicare financial penalties by reducing the incidence of invasive healthcare-associated methicillin-resistant *Staphylococcus aureus* infections[7]
NHSN HAI-6	AMS programs may help reduce hospital-acquired *C. difficile* infections by discouraging the use or lengthy duration of certain antibiotics, which in turn can reduce Medicare financial penalties[7]
CMS Hospital Readmissions Reduction Program	AMS programs may help hospitals to avoid Medicare readmission penalties by reducing healthcare-associated infections[1,7,8]

Less IVs = Reduced Nursing Workload:

IV to PO protocols may reduce nursing workload by reducing number of infusion hours, as well as saving costs on medication and supplies

- IV to PO protocols can keep patients off of outpatient parenteral antibiotic therapy (OPAT).
- This can reduce outpatient nursing workload, eliminate barriers to patient care such as transportation difficulties & finances, and potentially result in per-patient cost savings[9].

Decreased Use of Isolation Means Less Time Putting on PPE

AMS programs can decrease and help to prevent multi-drug resistant organisms and *C. difficile* infections[6]

- This may decrease nursing workload by reducing the need for isolation or precautions
- In an 885-bed academic center, a 24-month pre-/post design was used to assess the effectiveness of a stepwise testing algorithm for *C. difficile* infection. The need for isolation decreased from 748 patients to 181 patients post-intervention[10]

Order Sets May Lead to Fewer Frustrating EMR Searches

Encouraging optimal antibiotic selection and/or diagnostic stewardship practices using order sets can help reduce physician workload.

- Putting all needed orders into one set reduces the number of clicks and searches needed
- Order sets for common infectious diseases can also reduce nursing workload – all the orders put in at once mean fewer calls to the physician

Fewer Tests Help Your Nurses and Your Lab

Initiatives focused on diagnostic stewardship of asymptomatic bacteriuria or *C. difficile* may reduce workload for overworked laboratory and nursing staff and save on supply costs for the facility

- Fewer diagnostic tests, fewer times that nursing staff has to run to the lab, less time spent by nursing in coaching patients on proper UA technique
- Increased throughput of patients in ED, as patients no longer have to wait for UA results

AMS Programs Can Reduce Costs!

- See "Cost Reduction Examples" resource located in this toolkit

Sources of Funding and Revenue

- Your pharmacy's 340B savings and revenue can assist the hospital with paying for additional resources
- Keep track of all cost savings from your intervention

To further understand how your proposal can be paid for, it is important to know how your facility is reimbursed. CAHs are exempt from the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) set up by Medicare[11]. They are paid by Medicare based on 101% of reasonable costs, not based on the more well-known diagnostic-related groups (DRG) which are inherent to the IPPS model[11]. Medicaid reimbursement is based on a fee-for-service model. Additionally, the 340B pricing program for outpatient medications is governed by its own regulations. Consult your pharmacy department for more information about this very complex topic.

More Resources:

For more detailed information, refer to the resources below. While not specific to critical access hospitals, these contain valuable information to bear in mind as you share the benefits of your program:

1. Spellberg B, et al. How to Pitch an Antibiotic Stewardship Program to the Hospital C-Suite https://academic.oup.com/ofid/article/3/4/ofw210/2593339

2. Nagel JL, et al. Demonstrating the Value of Antimicrobial Stewardship Programs to Hospital Administrators. https://academic.oup.com/cid/article/59/suppl_3/S146/319020?login=false **(NOTE: Some of the quality metrics listed in this resource may be out-of-date)**

To learn more about how a critical access hospital is reimbursed by Medicare & Medicaid:

- Medicare Learning Network - MLN Booklet: Critical Access Hospital
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf
- Washington State Legislature - WAC 182-550-2598: Critical Access Hospitals (CAHs)
  - https://app.leg.wa.gov/wac/default.aspx?cite=182-550-2598
- Washington Health Care Authority - Hospital Reimbursement
  - https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hospital-reimbursement
  - Click on the drop-down titled "Critical Access Hospitals (CAHs)" to access interim rates

Sources:

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3. National Healthcare Safety Network. 2022 NHSN Patient Safety Component Manual [Internet]. 2022 Jan [cited 2022 Nov 3]. Available from: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf
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5. 5. Thurber KM, Arnold JR, Narayanan PP, Dierkhising RA, Sampathkumar P. Comparison of intravenous and oral definitive antibiotic regimens in hospitalised patients with Gram-negative bacteraemia from a urinary tract infection. Journal of Global Antimicrobial Resistance [Internet]. 2019 Aug 18 [cited 2022 Dec 22];18:243–8. Available from: https://www.sciencedirect.com/science/article/abs/pii/S2213716519300827?via=ihub
6. Blumenthal KG, Ryan EE, Li Y, Lee H, Kuhlen JL, Shenoy ES. The Impact of a Reported Penicillin Allergy on Surgical Site Infection Risk. Clinical Infectious Diseases [Internet]. 2018 Feb 1 [cited 2022 Nov 3];66(3):329–36. Available from: https://academic.oup.com/cid/article/66/3/329/4372047?searchresult=1
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8. Emerson CB, Eyzaguirre LM, Albrecht JS, Comer AC, Harris AD, Furuno JP. Healthcare-Associated Infection and Hospital Readmission. Infection Control & Hospital Epidemiology [Internet]. 2015 Jan 2 [cited 2022 Nov 3];33(6):539–44. Available from: https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/healthcareassociated-infection-and-hospital-readmission/23C97B02D388D3D7C632DDAEB0E930E4
9. Barlam TF, Cosgrove SE, Abbo LM, MacDougall C, Schuetz AN, Septimus EJ, et al. Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America. Clinical Infectious Diseases [Internet]. 2016 Apr 13 [cited 2022 Nov 3];62(10):e51–77. Available from: https://academic.oup.com/cid/article/62/10/e51/2462846
10. Bischoff W, Bubnov A, Palavecino E, Beardsley J, Williamson J, Johnson J, et al. The Impact of Diagnostic Stewardship on Clostridium difficile Infections. Open Forum Infectious Diseases [Internet]. 2017 [cited 2019 Oct 25];4(suppl_1):S398–8. Available from: https://academic.oup.com/ofid/article/4/suppl_1/S398/4295214?searchresult=1
11. Medicare Learning Network. MLN Booklet: Critical Access Hospital [Internet]. US Department of Health and Human Services; 2011 Mar [cited 2022 Nov 3]. Available from:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf

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This document does not replace clinical judgement.