

The Front Door of Resistance

Practical Stewardship Approaches for the ED

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Disclosures

No relevant disclosures.

Learning Objectives

- Describe how emergency department workflows uniquely influence stewardship opportunities and challenges.
- Identify practical, evidence-based stewardship interventions that can be integrated into ED practice.

Front Door of Resistance

Because the ED sets the course—getting antibiotics right at the front door prevents downstream harm and resistance.

The challenge:

- ED antibiotic decisions are often empiric and made under diagnostic uncertainty.
- Early choices can “lock in” downstream therapy decisions (admit vs discharge, continued inpatient/outpatient antibiotics).
- The ED is high-throughput—small workflow fixes can yield disproportionate benefit.

AMS Categories of Approaches

Systems-level approaches (workflow / infrastructure)

- Rapid Diagnostics paired with treatment algorithms
- Clinical pathways, guidelines, and order sets
- Clinical decision support embedded in ED workflow
- Behavioral “nudges” and prescribing transparency*
- Stewardship infrastructure tailored to ED operations

Patient-level approaches (prescribing patterns / follow-up)

- Dose, duration, route optimization
- Prospective audit-and-feedback / real-time review
- UA stewardship*
- Post-discharge culture review and follow-up

**Often a hybrid approach*

Intersection of Approaches

Systems-Level Approaches

- Rapid Diagnostics paired with treatment algorithms
- Clinical pathways, guidelines, and order sets
- Clinical decision support embedded in ED workflow
 - Behavioral “nudges” and prescribing transparency*
- Stewardship infrastructure tailored to ED operations



- Post-discharge culture review & follow-up
- UA stewardship*
- Prospective audit-and-feedback / real-time review
- Dose, duration, route optimization

Patient-Level Approaches

**Often a hybrid approach*

“Product of the system”

Focus on systems-level approaches

- Rapid Diagnostics paired with treatment algorithms
- Clinical pathways, guidelines, and order sets
- Clinical decision support embedded in ED workflow
- Behavioral “nudges” and prescribing transparency*
- **Stewardship infrastructure tailored to ED operations**

**Often a hybrid approach*

Stewardship infrastructure tailored to ED operations

- Dedicated ED stewardship champion(s) + multidisciplinary ED ASP roles (pharmacy / EM / ID / micro / IT)
- Measurement & feedback loops using ED-relevant metrics (guideline concordance, revisit rates, culture follow-up completion, antibiotic starts for viral syndromes)
- Provider education targeted to high-yield ED syndromes and cognitive pitfalls (often part of multifaceted interventions)

Practical ideas (systems-level)

- Name the owner(s): identify an ED stewardship champion (EM physician/APP) and a pharmacy lead (even 0.1 FTE).
- Pick 1–2 target syndromes (often UTI and CAP/URI) based on volume + mismatch with guidelines.
- Define 3 “must-track” metrics (guideline concordance; antibiotic starts for likely viral syndromes / FQ use for uncomplicated cystitis; culture callback completion or time-to-review).
- Build a 15-minute weekly cadence: ED ASP huddle (pharm + ED champion + nurse rep) to review a few cases + one trend.
- Start with one EHR change: default duration or a discharge order sentence (fastest “systems win”).

Mantra: “Start small, measure one thing, meet briefly, iterate monthly.”

“Boots on the ground”

Focus on patient-level approaches

- Dose, duration, route optimization
- Prospective audit-and-feedback / real-time review
- UA stewardship*
- **Post-discharge culture review and follow-up**

**Often a hybrid approach*

Practical ideas (post-discharge culture review & follow-up)

- Start small: begin with urine cultures + STI NAATs; add blood cultures later.
- Set a daily cadence: fixed review time (e.g., weekdays 10:00) + weekend/holiday plan.
- Create triage rules: same-day call for resistant organisms / untreated STI / high-harm delays; escalate bacteremia, immunocompromised, pregnancy, clinical deterioration.
- Standardize the work: result review note + patient call script + escalation pathway.
- Track 3 metrics: time-to-review; time-to-notification; % interventions completed (plus 72-hr revisit as balancing).

Evidence takeaway: Pharmacist-led/privileged models can speed patient notification and improve follow-up performance.

A pharmacist can help!

- Arkansas pathway: pharmacists can perform drug therapy management under a physician's written protocol.
- When protocolized, pharmacists can act on susceptibilities faster (less "phone tag," more reliable completion).
- Minimum protocol elements:
 - named authorizing practitioner(s) + pharmacist(s)
 - scope; decision criteria/algorithm
 - documentation + communication plan
 - review/reporting cadence.

What can you do tomorrow?

Reflection (60 seconds)

- Choose ONE systems-level approach you could initiate in the next 60 days.
- Choose ONE patient-level follow-up approach you could initiate in the next 60 days.
- Write down: your first step, the owner, and one metric.

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