**Attachment 3. United Hospital Fund Outpatient Antibiotic Stewardship Chart Abstraction Tool**

**Goal:** The goal and purpose of this form is to provide a structured format to assess antibiotic use for adult patients with an acute respiratory infection (ARI).

**Instructions:** Please use this patient-level chart abstraction tool to guide your chart review of 30 patients’ medical records for **adult patients (≥ 18 years of age)** with ARIs. Please conduct a random sample of 30 patients between the period of **October 1, 2015 and March 31, 2016**. Five patients from each month during that period should be randomly sampled (e.g., five from October 2015, five from November 2015, etc.), for a total of 30 patients. The abstraction tool should be used once per chart review. **Our suggested timeframe to complete these chart reviews is from Monday, June 20, 2016 through Friday, July 29, 2016.** Once you have completed the chart abstraction, make sure you enter the information for each patient into SurveyMonkey by **Monday, September 19, 2016**. **Do not** send protected health information or patient identifying information to UHF.

**IMPORTANT:** Please use only the following ICD-10 codes to identify your adult patients with acute respiratory infections: **J00** (acute nasopharyngitis/common cold); **J01** (acute sinusitis); **J02** (acute pharyngitis); **J03** (acute tonsillitis +/- pharyngitis); **J06.9** (acute URI, unspecified); **J20** (acute bronchitis); **J40** (bronchitis not specified as acute or chronic).

**Section 1 - Patient Characteristics/History:**

**Q1** Practice site name:

**Q2** Hospital or health system affiliation:

**Q3** Patient age (in years) at time of the ARI:

**O** 18-29

**O** 30-39

**O** 40-49

**O** 50-59

**O** 60-69

**O** 70 or older

**Q4** Does the patient have a documented history of allergies to antibiotics?

**O** Yes

**O** No

**O** Unknown

If yes, please specify which antibiotics:

**Q5** Patient Sex:

**O** Female

**O** Male

**O** Other (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Q6** What is the patient’s race? (*if this information is available in this patient’s chart*)

**O** White

**O** Black or African American

**O** American Indian or Alaskan Native

**O** Asian

**O** Native Hawaiian or Other Pacific Islander

**O** Mixed

**O** Other (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**O** Unknown

**Q7** Is the patient of Hispanic, Latino, or Spanish origin? (*if this information is available in this patient’s chart*)

**O** Yes

**O** No

**O** Unknown

**Q8** What is the primary language spoken by this patient? (*if this information is available in this patient’s chart*)

**O** English

**O** Spanish

**O** Unknown

**O** Other (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Q9** Was an interpreter used during the visit? (*if this information is available in this patient’s chart*)

**O** Yes

**O** No

**O** Unknown

**Q10** What type of insurance does this patient have? (*if this information is available in this patient’s chart*)

**O** Medicare

**O** Medicaid

**O** Commercial

**O** Uninsured

**O** Unknown

**O** Other (Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Section 2 - Diagnosis Information:**

**Q11** During which month was this patient diagnosed with an ARI?

**O** October 2015

**O** November 2015

**O** December 2015

**O** January 2016

**O** February 2016

**O** March 2016

**O** Other (please specify:) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q12** What is this patient’s ICD-10 ARI diagnosis code?

**O** J00 (acute nasopharyngitis/common cold)

**O** J01 (acute sinusitis)

**O** J02 (acute pharyngitis)

**O** J03 (acute tonsillitis +/- pharyngitis)

**O** J06.9 (acute URI, unspecified)

**O** J20 (acute bronchitis)

**O** J40 (bronchitis not specified as acute or chronic)

**Q13** Is the diagnosis code from Q12 the patient’s primary or secondary diagnosis?

**O** Primary

**O** Secondary

**O** Unknown

**Q14** What type of provider made the clinical assessment for this patient (If more than one provider performed the assessment, please check all that apply)?

*Note that if this patient was prescribed an antibiotic, the provider who prescribed the antibiotic may be different than the provider who performed the assessment. The prescribing provider should be indicated in* ***Q15****.*

**O** Physician Attending

**O** Resident

**O** Nurse Practitioner

**O** Physician Assistant

**O** Student

**O** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q15** What type of provider prescribed the antibiotic for this patient (If more than one provider prescribed the antibiotic, please check all that apply)?

*Note that this provider may be different than the provider in* ***Q14****.*

**O** Physician Attending

**O** Resident

**O** Nurse Practitioner

**O** Physician Assistant

**O** Student

**O** Not applicable (N/A) – no antibiotic prescribed

**O** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q16** Was this patient a scheduled patient or a walk-in?

**O** Scheduled

**O** Walk-in

**O** Unknown

**Q17** What symptoms were present when the patient was diagnosed (please check all that apply)?

|  |  |
| --- | --- |
| ☐ Nasal congestion or discharge | ☐ Cough |
| ☐ Ear aches | ☐ Shortness of breath |
| ☐ Muscle aches or body aches | ☐ Cervical lymphadenopathy |
| ☐ Headache, facial, or sinus pain | ☐ Sore throat |
| ☐ Fever | ☐ Other (please specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Unknown |

**Q18** For the symptom which was present for the longest period of time, indicated in Q17 above, how long did the patient report experiencing that symptom?

**O** Less than 3 days (< 3 days)

**O** Between 3 and 7 days (3 days -- ≤ 7 days)

**O** Between 8 and 14 days (8 days -- ≤ 14 days)

**O** Greater than 14 days (> 14 days)

**O** Unknown

**Q19** What comorbidities were present when the patient was diagnosed (please check all that apply)?

|  |  |
| --- | --- |
| ☐ HIV infection | ☐ Diabetes/other endocrine disease |
| ☐ AIDS | ☐ Rheumatologic or connective tissue disease (e.g., SLE, RA) |
| ☐ Liver/gastrointestinal disease | ☐ Malignancy |
| ☐ Pulmonary disease (e.g., COPD, asthma) | ☐ Transplant (solid or stem cell) |
| ☐ Chronic kidney disease (including dialysis) | ☐ Chronic immunosuppression for other disorder |
| ☐ Cardiovascular disease | ☐ Neurologic disorder (e.g., multiple sclerosis) |
| ☐ Dementia | ☐ None |
| ☐ Unknown | ☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Q20** *If malignancy is selected as a comorbidity for this patient,* please indicate whether solid or hematologic (if known).

**O** Solid

**O** Hematologic

**O** Unknown

**O** Not applicable (N/A)

**Q21** *If transplant is selected as a comorbidity,* please indicate type and date of transplant below (if known).

Type of transplant:

Date of transplant:

**Q22** *If this patient also has cancer,*is this patient on chemotherapy?

**O** Yes (Please specify the last day patient received chemotherapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**O** No

**O** Not applicable (N/A)

**Q23** *If this patient also has cancer,* is this patient neutropenic?

**O** Yes

**O** No

**O** Not applicable (N/A)

**Section 3 - ARI Course and Treatment Information:**

**Q24** Did this patient get testing for Acute Respiratory Illness in the clinic?

**O** Yes (check all that apply)

**O** No

**O** Unknown

**Q25** If yes, please indicate which type(s) of testing the patient received (please check all that apply):

**O** Strep screen

**O** Rapid flu testing

**O** Rapid RSV testing

**O** Sputum cultures

**O** Nasopharyngeal cultures

**O** Nasopharyngeal PCR testing for viruses

**O** Nasal cultures

**O** Oropharyngeal cultures

**O** Not applicable (N/A)

**O** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q26** Was this patient prescribed an antibiotic for the diagnosis specified in Q12?

**O** Yes

**O** No

**O** Deferred, pending culture results

**Q27** Was there a 14-day “look forward” to see if there was a documented telephone encounter or a revisit for the same reason/complaint?

**O** Yes

**O** No

**O** Unknown

**Q28** Please select all antibiotics and corresponding duration that the patient was prescribed after the ARI diagnosis: (please check all antibiotics prescribed and indicate appropriate duration for each)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Antibiotic** | **Duration** | | | | |
| Less than or equal to 5 days **(≤ 5 days)** | Greater than 5 days but less than or equal to 7 days **(> 5 days -- ≤ 7 days)** | Greater than 7 days but less than 10 days  **(> 7 days -- < 10 days)** | Greater than or equal to 10 days but less than 14 days **(≥ 10 days -- < 14 days)** | Greater than or equal to 14 days **(≥ 14 days)** |
| ☐ Penicillin or Amoxicillin | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Amoxicillin/ Clavulanic acid (e.g., Augmentin) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ 1st generation Cephalosporins (e.g., Cephalexin, Cefadroxil) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ 2nd generation Cephalosporins (e.g., Cefaclor, Cefprozil) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ 3rd generation Cephalosporins (e.g., Cefpodoxime, Cefdinir, Cefditoren) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Fluoroquinolones (e.g., Levofloxacin, Moxifloxacin) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Macrolides (e.g., Azithromycin, Clarithromycin) | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Clindamycin | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Unknown/unavailable |  |  |  |  |  |

**Q29** Aside from antibiotics, was any other medication (either in addition to or in lieu of antibiotics) prescribed or recommended to the patient (please check all that apply)?

**O** Nasal irrigation

**O** A decongestant (e.g., Sudafed)

**O** An antiviral (e.g., Tamiflu)

**O** An antitussive agent

**O** An analgesic/anti-inflammatory medication

**O** NSAIDS/acetaminophen (antipyretic)

**O** A steroid

**O** An antihistamine

**O** Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**O** None

**Section 4 – Follow Up and Outcomes Information:**

**Q30** What type of follow up was scheduled or recommended, as documented in the patient’s chart (please check all that apply)?

**O** Phone call

**O** In-person visit

**O** No follow up provided

**O** Unable to tell

**O** Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q31** What type of follow up actually took place (please check all that apply)?

**O** Phone call

**O** In-person visit

**O** No follow up provided

**O** Unable to tell

**O** Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Q32** Was any patient education provided to this patient regarding the diagnosis or treatment?

**O** Yes (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**O** No

**O** Unknown

**Q33** *If this patient was prescribed an antibiotic to treat their ARI*, is there any documentation in the month following their diagnosis that indicates any complications with the antibiotic prescribed that required further action (e.g., such as stopping or changing treatment)?

**O** Yes (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**O** No

**O** Unknown

**O** Not applicable – patient was not prescribed an antibiotic