Ten Simple Rules for Presenting Guidelines to Medical Staff

Whitney Hartlage, PharmD

Antimicrobial Stewardship Pharmacist

Harborview Medical Center, Seattle, WA

Before We Dive in...

- Presented a ton of guidelines over the years...
- That said, every place is a ***little different***

- These 10 rules aren't an exhaustive list
- Try to capture what I found most useful (and learned the hard way)

Rule 1: Know Your Audience

- Tailor **content** and **tone**
- ***Emphasize*** what's most relevant to their clinical decisions

Topic: IV to PO Conversions for Common Infections	
Nurses	• Patient advocacy & when to consider for their patients • Benefits of PO • Difference in nursing administration times
Pharmacists	• Automatic IV to PO antimicrobial conversion protocol for pharmacists • Data supporting IV versus PO • Benefits of PO
Physicians	• Data supporting IV versus PO • Benefits of PO • Important metrics: decrease length of stay
C-suite or other leadership teams	• Important metrics: decrease length of stay, costs, workflow considerations

Rule 2: Start with the "Why"

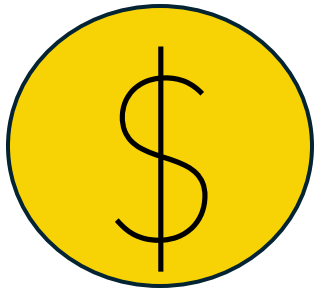
- Open with the purpose: why were the guidelines updated? Why do they matter now?

- Frame your talk with impact in mind

Patient safety

Outcomes

Resistance



Costs

Rule 3: Summarize, Don't Dump

- Don’t read the guideline out loud or show lengthy paragraphs
- Use clear visuals, bullet points, or short summaries

Extended-spectrum β-lactamase (ESBL) Resistance

Background

- ESBLs are enzymes that inactivate most penicillins, cephalosporins, and aztreonam.
- ESBLs do not inactivate non-β-lactam agents (e.g., ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole), however, the organisms that carry ESBL genes often harbor additional genes or mutations in genes that mediate resistance to a broad range of antibiotics.
- ESBL producing organisms generally remain susceptible to carbapenems.
- The most prevalent organisms to harbor ESBL genes include *Escherichia coli*, *Klebsiella pneumoniae*, *Klebsiella oxytoca*, **and** *Proteus mirabilis.*

Rule 3: Summarize, Don't Dump

- Don’t read the guideline out loud or show lengthy paragraphs
- Use clear visuals, bullet points, or short summaries

Extended-spectrum β-lactamase (ESBL) Resistance

Background

- ESBLs are enzymes that inactivate most penicillins, cephalosporins, a
- ESBLs do not inactivate non-β-lactam agents (e.g., ciprofloxacin, levo trimethoprim-sulfamethoxazole), however, the organisms that carry harbor additional genes or mutations in genes that mediate resistan of antibiotics.
- ESBL producing organisms generally remain susceptible to carbapen
- The most prevalent organisms to harbor ESBL genes include *Escheric pneumoniae*, *Klebsiella oxytoca*, **and** *Proteus mirabilis.*

Infection	Recommended and Alternative Treatments
Cystitis *Infection of the bladder/lower urinary tract in those with or without a urinary catheter*	**Preferred treatment:** Nitrofurantoin 100 mg PO q12h x 5 days Trimethoprim-sulfamethoxazole 1DS PO q12h x 3 days **Alternative treatment**: **PO:** Ciprofloxacin 400 mg IV q8h-q12h **OR** 250 – 750 mg PO q12h X 3 days Levofloxacin 750 mg IV/PO q24h x 3 days Fosfomycin 3 g PO x 1 dose for ***E.coli*** **isolates only** (not routinely reported on urine panel, add on order to test for susceptibility) **IV:** Single-dose of aminoglycoside (amikacin 15 mg/kg/dose IV x once, gentamicin 5 mg/kg/dose IV x once, or tobramycin 5 mg/kg/dose IV x once) Ertapenem 1 g IV q24h, Meropenem 1 g IV q8h

Rule 4: Highlight Key Changes or Controversies

- Be upfront about what's new, what's still uncertain, and why
- Controversial topic(s)? Be honest and transparent- builds trust

STANFORD EMERGENCY DEPARTMENT & CLINICAL DECISION UNIT
EMPIRIC ANTIBIOTIC GUIDELINES FOR ACUTE BACTERIAL SKIN AND SKIN-STRUCTURE INFECTIONS

PURULENT CELLULITIS (cutaneous abscess, carbuncle, furuncle)

Common pathogen: *Staphylococcus aureus*

Duration of Therapy: 5 days

Condition/Severity	Admit/CDU/Discharge	Cultures?	Antibiotic Recommendation
Mild Typical abscess +/- cellulitis with no systemic signs of infection	Discharge	Yes – wound I&D	I&D *plus* Antibiotics: TMP-SMX DS 1-2 PO BID Alternative: Doxycycline 100 mg PO BID
Moderate Purulent infection with *only one* systemic sign of infection: – temp>38°C – HR >90 bpm – RR>24 bpm – abnormal WBC >12K or <400 cells/mcg/L – Lymphangitis	Discharge	Yes – wound I&D	TMP-SMX DS 1-2 PO BID Alternative: Doxycycline 100 mg PO BID
	CDU if any factors below[1,2]: • Concern for poor adherence to therapy • Exacerbation of comorbidities • Significant clinical concern *Note: cutaneous inflammation and systemic features often worsen after initiating therapy and failure to improve at 24 hours NOT considered clinical failure*	Yes – wound I&D	**EMPIRIC ANTIBIOTICS**: TMP-SMX DS 1-2 PO BID Alternative: • Doxycycline 100 mg PO BID **DEFINITIVE ANTIBIOTICS**: MRSA: TMP-SMX DS 1-2 PO BID MSSA: cephalexin 500mg PO Q6h or cephalexin 1g PO Q8h
Severe • Hypotension • 2 or more systemic signs of infection – temp>38°C – HR >90 bpm – RR>24 bpm – abnormal WBC >12K or <400 cells/mcg/L – Lymphangitis • Immunocompromised**	Admission	Yes - blood	**EMPIRIC ANTIBIOTICS:** Vancomycin Per Pharmacy Alternatives: Consult pharmacy for restricted antibiotics **DEFINITIVE ANTIBIOTICS:** MRSA: Vancomycin MSSA: Cefazolin 2g IV Q8H

Rule 4: Highlight Key Changes or Controversies

builds trust

Emergency Department Antibiogram for Staphylococcus Aureus from Wounds

		Clindamycin	Oxacillin	TMP-SMX	Tetracycline	Vancomycin
STAPH AUREUS (MRSA)	40	77.5% (40)	0% (40)	95% (40)	97.5% (40)	100% (40)
STAPH AUREUS (MSSA)	124	81.5% (124)	100% (123)	100% (123)	94.3% (123)	100% (123)

Note: Displays % Susceptible (Number Tested)

STANFORD EMERGENCY DEPARTMENT & CLINICAL DECISION UNIT
EMPIRIC ANTIBIOTIC GUIDELINES FOR ACUTE BACTERIAL SKIN AND SKIN-STRUCTURE INFECTIONS

PURULENT CELLULITIS (cutaneous abscess, carbuncle, furuncle)

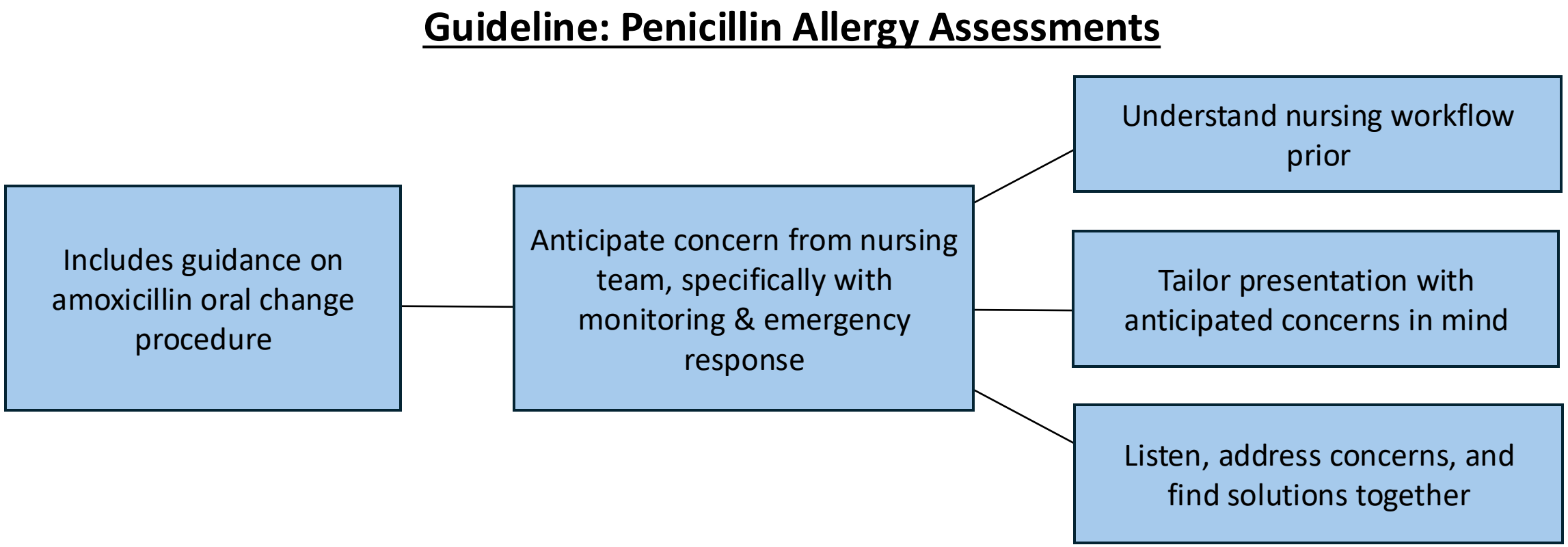
Common pathogen: *Staphylococcus aureus*

Duration of Therapy: 5 days

			MSSA: cephalexin 500mg PO Q6h or cephalexin 1g PO Q8h
Severe • Hypotension • 2 or more systemic signs of infection – temp>38°C – HR >90 bpm – RR>24 bpm – abnormal WBC >12K or <400 cells/mcg/L – Lymphangitis • Immunocompromised**	Admission	Yes - blood	**EMPIRIC ANTIBIOTICS:** Vancomycin Per Pharmacy Alternatives: Consult pharmacy for restricted antibiotics **DEFINITIVE ANTIBIOTICS:** MRSA: Vancomycin MSSA: Cefazolin 2g IV Q8H

Rule 5: Preempt Common Pushback

- Anticipate skepticism or barriers and address them early



Rule 6: Consider the Messenger

- We are heavily influenced by ***who*** delivers the message
- Use trusted local champions or credible voices

Rule 6: Consider the Messenger

- We are heavily influenced by ***who*** delivers the message
- Use trusted local champions or credible voices

npr

A Taylor Swift Instagram post helped drive a surge in voter registration

September 22, 2023 · 4:19 PM ET

- Vote.org reported a **1,226% jump in registration participation in the hour after the post**.

"When Taylor Swift speaks, people listen."

Rule 7: Match the Presentation Format to the Goal

- Visual of some sort needed for audience to follow
- Informing versus engaging

Treatment Guideline for Multidrug-Resistant Organisms

Last update 4/26/24

It is recommended that infectious diseases specialists are involved in the management of patients with infections caused by antimicrobial-resistant organisms. When determining empiric treatment for a patient, clinicians should also consider previous organisms identified from the patient and associated antibiotic susceptibility data in the last six months, antibiotic exposure within the past 30 days, and antibiogram guided local susceptibility patterns for the most likely pathogens. Empiric decisions should be refined based on the identity and susceptibility profile of the pathogen. Treatment recommendations in this document assume that the causative organism has been identified and that *in vitro* activity of the antibiotics are demonstrated. Consult Infectious Diseases Consult This guideline is also intended for **non-cystic fibrosis** patients and will focus on the following:

- AmpC β-lactamase producing Enterobacterales (AmpC-E)
- Carbapenem-resistant *Acinetobacter baumannii* (CRAB)
- Carbapenem-resistant enterobacterales (CRE)
- Extended-spectrum β-lactamase-Producing Enterobacterales (ESBL-E)
- *Pseudomonas aeruginosa* with Difficult-to-Treat Resistance (DTR-*P. Aeruginosa)*
- *Stenotrophomonas maltophilia*
- Suggested dosing of antibiotics for the treatment of infections caused by antimicrobial resistant organisms assuming normal renal and liver function. Discuss with clinical pharmacy if dose adjustments are desired.

Document

PowerPoint

Rule 8: Get Buy-In Ahead of Time

- Align with key leaders and departments

- Can preempt drama, confusion, and resistance

Diabetic Foot Infection Guidance

- "Development: This document was developed collaboratively between the Antimicrobial Stewardship Program, Emergency Medicine, Infectious Diseases, Podiatry, Hospitalists, and Vascular Surgery in January 2019. It was reviewed and updated in 2024."

Rule 9: End with a Clear Ask and Next Steps

- Be explicit: what is needed from their standpoint for approval or implementation?
- Include follow-up plans and next steps

1) Order set updates	**2) Didn't reach consensus, need to meet again**	**3) Taking to another service/group for review**
4) Review additional data or in more detail	**5) Messaging and dissemination**	**6) Track adherence**

Rule 10: Leave Time for Questions and Discussion

- Create space for reflection and address questions
- Invite feedback, concerns, or real-world scenarios from the audience

"***Was there anything that felt unclear or confusing?***"

Rule 10: Leave Time for Questions and Discussion

- Create space for reflection and address questions
- Invite feedback, concerns, or real-world scenarios from the audience

"*Was there anything that felt unclear or confusing?*"

"***I am particularly interested in hearing your thoughts and feedback on our section addressing diagnostic considerations in pneumonia.***"

Rule 10: Leave Time for Questions and Discussion

- Create space for reflection and address questions
- Invite feedback, concerns, or real-world scenarios from the audience

"*Was there anything that felt unclear or confusing?*"

"*I am particularly interested in hearing your thoughts and feedback on our section addressing diagnostic considerations in pneumonia.*"

"***What concerns do you have now or anticipate may come up with our outpatient management recommendations?***"

Rule 10: Leave Time for Questions and Discussion

- Create space for reflection and address questions
- Invite feedback, concerns, or real-world scenarios from the audience

"*Was there anything that felt unclear or confusing?*"

"*I am particularly interested in hearing your thoughts and feedback on our section addressing diagnostic considerations in pneumonia.*"

"*What concerns do you have now or anticipate may come up with our outpatient management recommendations?*"

"***Does anyone have any experience with using oral beta-lactams for gram-negative bacteremia?***"

Rule 10.5: Think Beyond Data – How Can You Change Hearts and Minds

JOURNAL ARTICLE CORRECTED PROOF

Practicing With Intent: How to Teach an Old Dogma New Tricks FREE

Matthew C Phillips ✉, Kusha Davar, Sarah Freling, Steven Y C Tong, Todd C Lee, Emily G McDonald, Travis B Nielsen, Noah Wald-Dickler, Alfredo J Mena Lora, Rachael A Lee ... Show more

Clinical Infectious Diseases, ciaf270, https://doi.org/10.1093/cid/ciaf270
Published: 24 June 2025 **Article history** ▾

"**Clinicians are ultimately humans**.....experienced physicians have a career's worth of positive emotional experiences recollecting patients who had good outcomes on IV or prolonged courses of antibiotics. No physician can experience the counterfactual that the patient they are currently treating would have improved and had the same rewarding outcome with a shorter course of therapy or had they been transitioned to oral antibiotics. **These kinds of experiences and embedded emotions establish an equilibrium in which dogmas provide comfort and evidence-based treatments provide insecurity**."

Phillips M, et al. *Clin Infect Dis*. 2025.

Conclusion

- Effective guideline presentations require intention
- Clarity, honesty, and data driven decisions build trust
- Success happens before and after the presentation

Thank you!

- Email: whithart@uw.edu