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Outpatient diagnostics, antimicrobial stewardship, and health equity

Closing gaps in the fight against antimicrobial resistance

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The spread of antimicrobial-resistant (AMR) infections poses a global public health threat, with over 1 million resistant infections diagnosed annually.¹ With more than 200 million antimicrobials prescribed in outpatient settings, including primary care clinics, urgent care centers, emergency departments (ED), and skilled nursing facilities, it is evident that these treatment settings facilitate the spread of AMR infections.^{2,3} These are areas of unmet need as most antimicrobial stewardship (AMS) programs, designed to optimize unnecessary antimicrobial prescribing, have traditionally focused on addressing gaps in inpatient settings.⁴ Given the lack of oversight in outpatient AMS, it is unsurprising that there have been growing reports of inequities in the diagnosis and management of AMR infections, specifically among marginalized populations.^{3,5,6}

While identifying as part of a marginalized group is not a biological risk

factor for developing an AMR infection, marginalization is often accompanied by systems of oppression such as racism and classism.⁷ These systems can lead to inequities in the social determinants

of health (SDoH), such as education, socioeconomic status (SES), and access to healthcare.^{8,9} For example, individuals who identify as racially and ethnically marginalized (REM) are

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LEARNING OBJECTIVES

Upon completion of this article, the reader will be able to:

1. Discuss how gaps in outpatient antimicrobial stewardship (AMS) have contributed to antimicrobial resistance and health inequities.
2. List and describe the various tests used in rapid detection of microbial infections and the benefits of diagnostic advancements in the outpatient space.
3. Discuss potential gaps in the use of rapid diagnostics tests in outpatient settings.
4. Describe equitable strategies and solutions that can be integrated for successful AMS efforts in outpatient settings.



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