APPENDIX

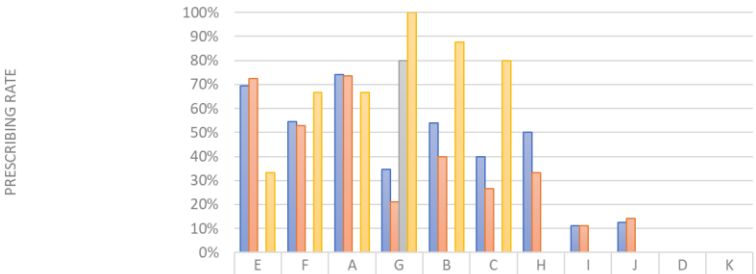
Figure A

Front

OUTPATIENT ANTMICROBIAL STEWARDSHIP REPORT CARD

How does your antibiotic prescribing for common infections compare to your peers?

Dr. {BLANK} your identifier is **A**



	E	F	A	G	B	C	H	I	J	D	K
Uncomplicated ARI Antibiotic Prescribing Rate	69%	55%	74%	35%	54%	40%	50%	11%	13%	0%	0%
Bronchitis / URI NOS Antibiotic Prescribing Rate	72%	53%	74%	21%	40%	27%	33%	11%	14%	0%	0%
Pharyngitis 1st or 2nd line Antibiotic Prescribing Rate	0%	0%	0	80%	0	0%	0	0	0	0	0
Rhinosinusitis 1st or 2nd line Antibiotic Prescribing Rate	33%	67%	67%	100%	88%	80%	0%	0	0	0	0

QUICK FACTS

- 70% of patients with rhinosinusitis improve on their own
- ~15% of pharyngitis cases may benefit from antibiotics
- 90% of acute bronchitis cases are caused by viruses
- 100% of cases of the common cold (or URI-NOS) are caused by viruses

Back

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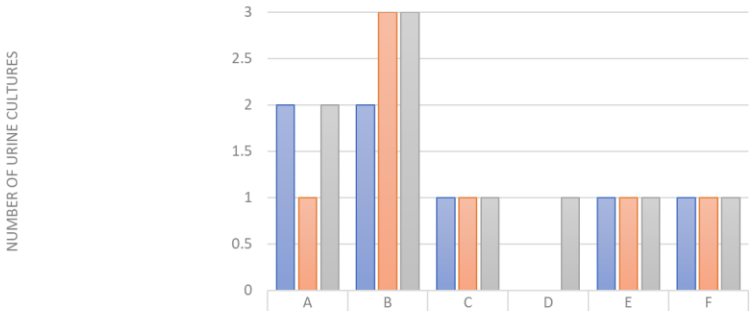
OUTPATIENT ANTMICROBIAL STEWARDSHIP REPORT CARD

How does your antibiotic prescribing for common infections compare to your peers?

Dr. {BLANK} your identifier is **A**



	A	B	C	D	E	F
Sum of Number of positive urine cultures with symptoms	2	2	1	0	1	1
Sum of Number of positive urine cultures that received a prescription	1	3	1	0	1	1
Sum of Number of positive urine cultures	2	3	1	1	1	1

QUICK FACTS

- Bacteriuria should not be treated in the absence of symptoms
- 100% of catheterized patient's will become colonized within 2 weeks
- Cloudy/foul smelling urine alone is not an indication to treat

7 Figure B

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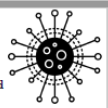
Acute Respiratory Infections

RHINOSINUSITIS

Acute rhinosinusitis (ARS)
Up to 4 weeks of purulent nasal discharge accompanied by nasal obstruction, facial pain-pressure-fullness, or both

- ***Purulent nasal discharge*** — cloudy or colored
- ***Nasal obstruction*** — nasal obstruction, congestion, blockage, or stuffiness
- ***Facial pain-pressure-fullness*** — may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

VIRAL RHINOSINUSITIS



Symptoms or signs of acute rhinosinusitis are present less than 10 days and the symptoms are not worsening

Headache
- Ibuprofen 200-400mg PO Q4-6h x 7 days
- Naproxen 500mg PO Q12h x 7 days
- Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days

Nasal Congestion
- Saline Nasal Spray or Nasal Irrigation x 7 days
- Phenylephrine 10-20mg PO Q4h x 7 days
- Oxymetazoline Nasal Spray 2-3 sprays in each nostril BID (duration <3 days) x 7 days
- Fluticasone Nasal Spray 2 sprays in each nostril daily x 7 days

Cough
- Dextromethorphan 30mg PO Q4-6h x 7 days
- Guaifenesin IR 200-400mg PO Q4h x 7 days
- Benzonatate 100-200mg PO Q8-12h x 7 days
- Albuterol Inhaler (if wheezing present) 2 Inhalations Q4-6h x 7 days

Rhinorrhea and/or sneezing
- Diphenhydramine 25 mg PO QHS x 7 days
- Cromolyn Nasal Solution 1 spray per in each nostril 3-6 times/day x 7 days
- Ipratropium Nasal Solution 2 sprays in each nostril 3 times per day x 7 days

ACUTE BACTERIAL RHINOSINUSITIS

symptoms or signs of acute rhinosinusitis fail to improve within 10 days or more beyond the onset of upper respiratory symptoms OR symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (double worsening)

No penicillin allergy	Amoxicillin/clavulanate 875 mg/125 mg PO BID x 5 days
Non-severe penicillin allergy	Cefpodoxime 200 mg PO BID x 5 days
Severe Penicillin allergy	Doxycycline 100 mg PO BID x 5 days
Symptomatic treatment	See VRS for treatment

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PHARYNGITIS

- Fever
- Cervical lymphadenopathy
- Tonsillar exudate
- Absence of cough

Rapid Strep Test + — Antimicrobial Treatment +/- symptomatic treatment	Rapid Strep Test - — Symptomatic Treatment ONLY
No penicillin allergy	*Headache, and/or muscle/joint pain*
Penicillin VK 500 mg PO BID x 10 days OR Amoxicillin 500 mg PO BID x 10 days	Ibuprofen 200-400mg PO Q4-6h x 7 days Naproxen 500mg PO Q12h x 7 days Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days
Non-severe penicillin allergy	*Throat Discomfort*
Cephalexin 500 mg BID PO x 10 days	Menthol Throat Lozenges x 7 days Flanol Throat Spray x 7 days
Severe penicillin allergy	*Nasal congestion*
Clindamycin 300 mg PO TID x 10 days	Saline Nasal Spray or Nasal Irrigation x 7 days Phenylephrine 10-20mg PO Q4h x 7 days Oxymetazoline Nasal Spray 2-3 sprays in each nostril BID (duration <3 days) x 7 days Fluticasone Nasal Spray 2 sprays in each nostril daily x 7 days
Symptomatic treatment for the following (See under Rapid Strep Test -)	*Rhinorrhea and/or sneezing*
- Headache - Throat discomfort - Nasal congestion - Rhinorrhea and/or sneezing	Diphenhydramine 25 mg PO QHS x 7 days Cromolyn Nasal Solution 1 spray per in each nostril 3-6 times/day x 7 days Ipratropium Nasal Solution 2 sprays in each nostril 3 times per day x 7 days

ACUTE BRONCHITIS

- Cough lasting 3 weeks
- Chest radiograph ruled out pneumonia if HR > 100 beats/minute respiratory rate > 24 breaths/min and temperature > 100.4 F

Headache and/or muscle/ joint pain
- Ibuprofen 200-400mg PO Q4-6h x 7 days
- Naproxen 500mg PO Q12h x 7 days
- Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days

Nasal Congestion
- Saline Nasal Spray or Nasal Irrigation x 7 days
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Urinary Tract Infections & Asymptomatic Bacteriuria

URINARY TRACT INFECTIONS MYTHBUSTERS

Reasons to treat for UTI

Cloudy, smelly urine — MYTH

TRUTH — Should not be used alone

TOP TEN MYTHS REGARDING THE DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS

Lucas Schulz, PHARMD,* Robert J. Hoffman, MD,† Jeffrey Pothof, MD,‡ and Barry Fox, MD§

*Infectious Diseases and Critical Care Clinical Pharmacy, University of Wisconsin Hospital and Clinics, Madison, Wisconsin, †Hospital Medicine, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, ‡Department of Emergency Medicine, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, and §Infectious Diseases, University of Wisconsin School of Medicine and Public Health, Clinical Science Center, Madison, Wisconsin
Reprint Address: Jeffrey Pothof, MD, Department of Emergency Medicine, University of Wisconsin School of Medicine and Public Health, 800 University Bay Drive 300-71, Madison, WI 53792

Candida in the urine — MYTH

TRUTH — Usually a colonizer

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TOP TEN MYTHS REGARDING THE DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS

Lucas Schulz, PHARMD,* Robert J. Hoffman, MD,† Jeffrey Pothof, MD,‡ and Barry Fox, MD§

*Infectious Diseases and Critical Care Clinical Pharmacy, University of Wisconsin Hospital and Clinics, Madison, Wisconsin, †Hospital Medicine, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, ‡Department of Emergency Medicine, University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin, and §Infectious Diseases, University of Wisconsin School of Medicine and Public Health, Clinical Science Center, Madison, Wisconsin

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ORDERING UAs

When to order Urinalysis + Treat Asymptomatic Bacteriuria Based on C+S Results

DO ORDER + TREAT for	DON'T ORDER + TREAT for
✓ Pregnant women	× Healthy non-pregnant women
✓ Patients undergoing endourological procedures	× Functionally impaired adults (community or LTCF)
	× Patients with diabetes
	× Solid organ transplant other than kidney
	× Spinal Cord Injury
	× Patients with short-term (<30 days) urethral catheters
	× Patients undergoing elective nonurological surgery
	× Patients with implanted urologic devices

UNCOMPLICATED URINARY TRACT INFECTION

SYNDROME	TREATMENT	DURATION	
Acute Uncomplicated Cystitis		MALE	FEMALE
syndrome involving dysuria, frequency, urgency, and sometimes suprapubic tenderness.	Nitrofurantoin 100 mg PO BID OR Trimethoprim-sulfamethoxazole BID OR Cefpodoxime 300 mg PO BID	7 days 7 days 7 days	5 days 3 days 7 days
	Test of cure urine cultures NOT recommended by IDSA guidelines		
Acute Uncomplicated Pyelonephritis			
flank pain, tenderness, and fever. sometimes associated with dysuria, urgency and frequency	Ciprofloxacin 500 mg PO BID OR Trimethoprim-sulfamethoxazole PO BID OR 1 gm Ceftriaxone IM/IV once then cefpodoxime 300 mg PO BID x 14 days	7 days 14 days 14 days	
Complicated: presence of factors that predispose to persistent or relapsing infection, such as foreign bodies (e.g., calculi, indwelling catheters or other drainage devices); obstruction; immunocompromission; renal failure; renal transplantation; and urinary retention from neurologic disease			
Patients with high grade fever, rigors or chills, hemodynamic instability, or other signs of urosepsis should be admitted to the hospital for IV antibiotics.			

Patient Education Strategies

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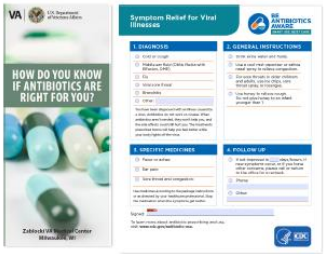
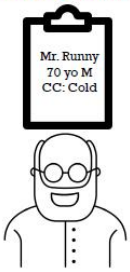
PATIENT EDUCATION

- Patient education pamphlets
- CDC watch & wait prescriptions
- Provide symptomatic treatment as an alternative



PATIENT SCENARIO



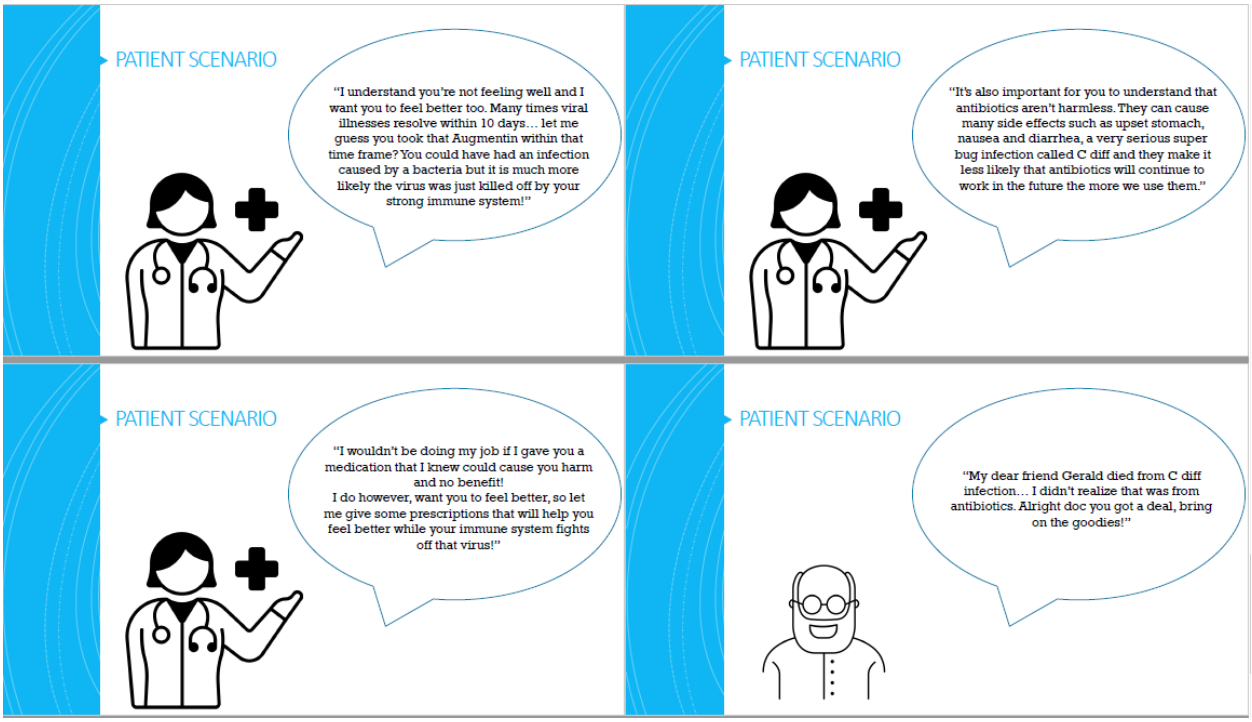
"Hey doc, I've been stuffed up and leaking green goo for 3 days. Not to mention this terrible headache I've got. I need to get better so I can take care of my grandkids. Usually I take some Augmentin and feel all better but I got none left. What do ya say doc? Hit me will a refill?"

PATIENT SCENARIO

"Mr. Runny, it sounds as though you have rhinosinusitis. More than 90% of these infections are caused by viruses, which antibiotics (like Augmentin) do not kill. Unfortunately we don't have good medications to kill viruses yet, but these usually resolve on their own."

PATIENT SCENARIO

"No offense doc, but I know my body. Augmentin always works. Just give me that, I didn't drive all the way down here to leave with nothing!"



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15 Figure C

GUIDELINES FOR THE EMPIRIC THERAPY & TREATMENT OF COMMON OUTPATIENT INFECTIONS

Created by: Grace Mortrude, PharmD
ZVAMC Antimicrobial Stewardship Task Force
Last updated: November 2019

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RHINOSINUSITIS

Acute rhinosinusitis (ARS): Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both

- *Purulent nasal discharge* is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection and may be reported by the patient or observed on physical examination.
- *Nasal obstruction* may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination.
- *Facial pain-pressure-fullness* may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse.

SYNDROME	TREATMENT
VIRAL RHINOSINUSITIS (VRS)	
Symptoms or signs of acute rhinosinusitis are present less than 10 days and the symptoms are not worsening	**Symptomatic Treatment ONLY**
	Headache
	Ibuprofen 200-400mg PO Q4-6h x 7 days Naproxen 500mg PO Q12h x 7 days Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days
	Cough
	Dextromethorphan 30mg PO Q4-6h x 7 days Guaifenesin IR 200-400mg PO Q4h x 7 days Benzonatate 100-200mg PO Q8-12h x 7 days Albuterol inhaler (if wheezing present) 2 inhalations Q4-6h x 7 days
	Nasal congestion
	Saline Nasal Spray or Nasal Irrigation x 7 days phenylephrine 10-20mg PO Q4h x 7 days Oxymetazoline Nasal Spray 2-3 sprays in each nostril BID (duration <3 days) x 7 days Fluticasone Nasal Spray 2 sprays in each nostril daily x 7 days
	Rhinorrhea and/or sneezing
	Diphenhydramine 25 mg PO QH5 x 7 days Cromolyn Nasal Solution 1 spray per in each nostril 3-6 times/day x 7 days Ipratropium Nasal Solution 2 sprays in each nostril 3 times per day x 7 days
ACUTE BACTERIAL RHINOSINUSITIS (ABRS)	
Symptoms or signs of acute rhinosinusitis fail to improve within 10 days or more beyond the onset of upper respiratory symptoms OR symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (double worsening)	**Antimicrobial Treatment +/- symptomatic treatment**
	No penicillin allergy
	Amoxicillin/clavulanate 875 mg/125 mg PO BID x 5 days
	Non-severe penicillin allergy (e.g. mild rash)
	Cefpodoxime 200 mg PO BID x 5 days
	Severe penicillin allergy (e.g. anaphylaxis)
	Doxycycline 100 mg PO BID x 5 days
	Symptomatic treatment
	See options for symptomatic treatment above for: - Headache - Cough - Nasal congestion - Rhinorrhea and/or sneezing

REFERENCES:
1. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, Brook I, Ashok Kumar K, Kramper M, Orlandi RR, Palmer JN, Patel ZM, Peters A, Walsh SA, Corrigan MD. Clinical practice guideline (update): adult sinusitis. Otolaryngol Head Neck Surg. 2015 Apr;152(2 Suppl):S1-S39. doi: 10.1177/0194599815572097. PubMed PMID: 25832968.

PHARYNGITIS

SYNDROME	TREATMENT	
Signs and Symptoms	**Rapid Strep Test +**	**Rapid Strep Test -**
- Fever - Cervical lymphadenopathy - Tonsillar exudate - Absence of cough	Antimicrobial Treatment +/- symptomatic treatment	Symptomatic Treatment ONLY
	No penicillin allergy	*Headache, and/or muscle/joint pain*
	Penicillin VK 500 mg PO BID x 10 days OR Amoxicillin 500 mg PO BID x 10 days	Ibuprofen 200-400mg PO Q4-6h x 7 days Naproxen 500mg PO Q12h x 7 days Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days
	Non-severe penicillin allergy	*Throat Discomfort*
	Cephalexin 500 mg BID PO x 10 days	Menthol Throat Lozenge x 7 days Phenol Throat Spray x 7 days
	Severe penicillin allergy	*Nasal congestion*
	Clindamycin 300 mg PO TID x 10 days	Saline Nasal Spray or Nasal Irrigation x 7 days phenylephrine 10-20mg PO Q4h x 7 days Oxymetazoline Nasal Spray 2-3 sprays in each nostril BID (duration <3 days) x 7 days Fluticasone Nasal Spray 2 sprays in each nostril daily x 7 days
	See symptomatic treatment for the following	*Rhinorrhea and/or sneezing*
	- Headache - Throat discomfort - Nasal congestion - Rhinorrhea and/or sneezing	Diphenhydramine 25 mg PO QH5 x 7 days Cromolyn Nasal Solution 1 spray per in each nostril 3-6 times/day x 7 days Ipratropium Nasal Solution 2 sprays in each nostril 3 times per day x 7 days

REFERENCES:
2. Stanford T. Shulman, Alan L. Bisno, Herbert W. Clegg, Michael A. Gerber, Edward L. Kaplan, Grace Lee, Judith M. Martin, Chris Van Beneden, Clinical Practice Guideline for the Diagnosis and Management of Group A Streptococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of America, *Clinical Infectious Diseases*, Volume 55, Issue 10, 15 November 2012, Pages e86–e102, https://doi.org/10.1093/cid/cis629
1. U.S. Department of Veterans Affairs Veterans Health Administration PBM Academic Detailing Service. Identification and Management of Acute Respiratory Tract Infections (ARI) Without Overusing Antibiotics. Accessed on 10/22/19.

ACUTE BRONCHITIS

SYNDROME	TREATMENT
Signs & Symptoms: - Cough lasting 3 weeks - Chest radiograph ruled out pneumonia if HR > 100 beats/minute - Respiratory rate > 24 breaths/min and temperature > 100.4 F	**Symptomatic Treatment ONLY**
	Headache, and/or muscle/joint pain
	Ibuprofen 200-400mg PO Q4-6h x 7 days Naproxen 500mg PO Q12h x 7 days Acetaminophen 650-1000mg PO Q4-6h (max: 4000mg/day) x 7 days
	Cough
	Dextromethorphan 30mg PO Q4-6h x 7 days Guaifenesin IR 200-400mg PO Q4h x 7 days Benzonatate 100-200mg PO Q8-12h x 7 days Albuterol inhaler (if wheezing present) 2 inhalations Q4-6h x 7 days
	Nasal congestion
	Saline Nasal Spray or Nasal Irrigation x 7 days phenylephrine 10-20mg PO Q4h x 7 days Oxymetazoline Nasal Spray 2-3 sprays in each nostril BID (duration <3 days) x 7 days Fluticasone Nasal Spray 2 sprays in each nostril daily x 7 days
	Rhinorrhea and/or sneezing
	Diphenhydramine 25 mg PO QH5 x 7 days Cromolyn Nasal Solution 1 spray per in each nostril 3-6 times/day x 7 days Ipratropium Nasal Solution 2 sprays in each nostril 3 times per day x 7 days

REFERENCES:
1. U.S. Department of Veterans Affairs Veterans Health Administration PBM Academic Detailing Service. Identification and Management of Acute Respiratory Tract Infections (ARI) Without Overusing Antibiotics. Accessed on 10/22/19.

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URINARY TRACT INFECTIONS

ASYMPTOMATIC BACTERIURIA

- Patients without indwelling catheters: $\geq 10^5$ colony-forming units (CFU)/mL in a voided urine specimen without signs or symptoms attributable to UTI
- Patients with indwelling urinary catheters: $\geq 10^5$ CFU/mL remains the most appropriate diagnostic criteria for bladder bacteriuria without signs or symptoms attributable to UTI

When to order Urinalysis + Treat Asymptomatic Bacteriuria Based on C&S Results

DO ORDER + TREAT for	DON'T ORDER + TREAT for
✓ Pregnant women	× Healthy non-pregnant women
✓ Patients undergoing endourological procedures	× Functionally impaired adults (community or LTCF)
	× Patients with diabetes
	× Solid organ transplant other than kidney
	× Spinal Cord Injury
	× Patients with short-term (< 30 days) urethral catheters
	× Patients undergoing elective nonurological surgery
	× Patients with implanted urologic devices

UNCOMPLICATED URINARY TRACT INFECTION

SYNDROME	TREATMENT	DURATION	
Acute uncomplicated cystitis		MALE	FEMALE
Syndrome involving dysuria, frequency, urgency, and sometimes suprapubic tenderness.	Nitrofurantoin 100 mg PO BID *OR* Trimethoprim-sulfamethoxazole 1 DS Tab BID *OR* Cefpodoxime 200 mg PO BID	7 days 7 days 7 days	5 days 3 days 7 days
Acute uncomplicated pyelonephritis			
Flank pain, tenderness, and fever. Sometimes associated with dysuria, urgency and frequency	Ciprofloxacin 500 mg PO BID *OR* Trimethoprim-sulfamethoxazole PO BID *OR* 1 gm Ceftriaxone IM/IV once then Cefpodoxime 400 mg PO BID	7 days 14 days 10-14 days	
Complicated UTI: presence of factors that predispose to persistent or relapsing infection, such as foreign bodies (e.g., calculi, indwelling catheters or other drainage devices); obstruction; immunosuppression; renal failure; renal transplantation; and urinary retention from neurologic disease			
Patients with high grade fever, rigors or chills, hemodynamic instability, or other signs of urosepsis should be admitted to the hospital for IV antibiotics.			

REFERENCES:
2. Lindsay E Nicolle, Kalpana Gupta, Suzanne F Bradley, Richard Colgan, Gregory P DeMuri, Dimitri Drekonja, Linda O Eckert, Suzanne E Geerlings, Béla Köves, Thomas M Hooton, Manisha Juthani-Mehta, Shandra L Knight, Sanjay Saint, Anthony J Schaeffer, Barbara Trautner, Björn Wullt, Reed Siemieniuk, Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America, *Clinical Infectious Diseases*, Volume 68, Issue 10, 15 May 2019, Pages e83–e110, https://doi.org/10.1093/cid/ciy1121
3. Kalpana Gupta, Thomas M. Hooton, Kurt G. Naber, Björn Wullt, Richard Colgan, Loren G. Miller, Gregory J. Moran, Lindsay E. Nicolle, Raul Raz, Anthony J. Schaeffer, David E. Soper, International Clinical Practice Guidelines for the Treatment of Acute Uncomplicated Cystitis and Pyelonephritis in Women: A 2010 Update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases, *Clinical Infectious Diseases*, Volume 52, Issue 5, 1 March 2011, Pages e103–e120, https://doi.org/10.1093/cid/ciq257
4. Jack D. Sobel, Patricia Brown, Urinary Tract Infections, Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases, 72, 962-989.e4
5. Drekonja DM, Rector TS, Cutting A, Johnson JR. Urinary tract infection in male veterans: treatment patterns and outcomes. JAMA Intern Med. 2013 Jan 14;173(1):62-8. doi: 10.1001/2013.jamainternmed.829. PubMed PMID: 23212273.
6. Cattrall JWS, Robinson AV, Kirby A. A systematic review of randomised clinical trials for oral antibiotic treatment of acute pyelonephritis. Eur J Clin Microbiol Infect Dis. 2018 Dec;37(12):2285-2291. doi: 10.1007/s10096-018-3371-y. Epub 2018 Sep 6. PubMed PMID: 30191339.
7. Vogler S, Pavich E. Pyelonephritis treatment in the community emergency department: Cephalosporins vs. first-line agents. Am J Emerg Med. 2018 Nov;36(11):2054-2057. doi: 10.1016/j.ajem.2018.08.016. Epub 2018 Aug 8. PubMed PMID: 30119986.
8. Lin K, Ortwine J, Mang N, Wei W, Prokesch BC. Oral cephalosporins versus fluoroquinolones for the empiric treatment of acute uncomplicated pyelonephritis. Poster presented at: ID Week. 2019, Oct 2-5; Washington, DC.