primary team including optimal antibiotic treatment (for CDI and any concomitant infection), and consultant involvement including ID, surgery, and GI, when appropriate. Using retrospective chart review, CDI patient management and outcomes were compared before and after implementation of the MD-CAT. Differences in the time to consult and frequency of interventional treatment was compared using Chi-square or Wilcoxon Rank-sum test.

Results. We compared 48 patients with CDI in the pre-intervention with 89 patients in the post-intervention period. Demographic and clinical characteristics of the groups were similar. MD-CAT intervention was associated with frequent (73%) modification or discontinuation of concomitant antibiotics. Median time to GI and ID consults was significantly shorter in the post group (P = 0.007 and P = 0.004, respectively). Five of 89 (5.6%) of patients received FMT or colon-preserving surgical intervention in the post-intervention group compared with no patients in the pre-intervention group. There was no difference in 30-day all-cause mortality or CDI recurrence between groups.

Conclusion. Early, multi-disciplinary action on patients with CDI increased the proportion of patients undergoing active specialty consultation and improved use of concomitant antibiotics. A larger sample size is needed to determine the effects of such a team on other clinical outcomes.

Results. We assessed 217 cases in the SPs and 96 cases in the IPs. 75 of 96 cases reviewed in the IPs required intervention. CDAT spoke to 74 teams, which led to a change in the care of patients in 49 cases (65%). Compliance with recommendations was as follows: 1) stop or modify CDI therapy, 53%; (39 cases); 2) stop PPI therapy, 52% (15 cases); 3) stop laxatives, 53% (19 cases); 4)stop or modify non-CDI abx, 46% (16 cases); and 5) improve BM documentation, 58% (11 cases). The Figure shows proportions of patients with suboptimal CD management without (SPs) or before (IPs) CDAT intervention in each period. There were no changes in practice between the SP1 and IP1. Between the SP1 and IP2, significant improvement in BM documentation was seen (P = 0.007). No differences were observed for other variables, although there was a trend towards improved CD therapy (P = 0.09).

Conclusion. Overall, prescribers did not independently change practice as a result of daily contact with CDAT; however, they were responsive to CDAT recommendations. BM documentation, the only nursing intervention, improved significantly.

Disclosures. All authors: No reported disclosures.
Conclusion. Decreasing inappropriate testing has several distinct advantages, including reducing excessive and unnecessary antibiotic use, avoiding misclassification of carriers as CDI cases, normalizing healthcare-associated CDI rates, and diminishing healthcare costs associated with preventable tests. Laboratories that use PCR only testing for CDI diagnosis should follow stringent policies to ensure that only patients with high pretest probability are tested. EMR systems are a useful and effective resource to achieve this for patients with laxative induced diarrhea.

Laxative Alert and Overrides

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1296. The Impact of Diagnostic Stewardship on Clostridium difficile Infections

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Background. Clostridium difficile infections (CDI) pose a growing threat to hospitalized patients. This study assesses the impact of changing from a nucleic acid amplification test (NAAT) to a stepwise testing algorithm (STA) by using an enzyme immunoassay (GDH and toxin A/B) and confirmatory NAAT confirmation in specific cases.

Methods. In an 885 bed academic medical center a 24 month pre-/post design was used to assess the effect of the STA for the following parameters: rates of enterocolitis due to C.diff (CDE), NHSN C.diff LabID events, CDE complications, mortality, antimicrobial prescription patterns, cult contaminates; and testing, treatment, and isolation costs. Inpatient data were extracted from ICD-9/10 diagnosis codes, infection prevention, and laboratory databases.

Results. The STA significantly decreased the number of CDE ICD9/10 codes, HO, CO, and CO-HFCA C.diff LabID event rates by 65%, 78%, 75%, and 75%, respectively. Similar reductions were noted for associated complications such as NHSN defined colon surgeries (-61%), megacolon (-64%), and acute kidney failure (-55%). CDE unrel- related complications for colon surgeries and acute kidney failure remained constant while the diagnosis of megacolon decreased but not significantly (-71%; P < 0.05). Inpatient mortality did not change with or without CDE. Significant reductions were observed in the use of oral metronidazole (total: 32%, CDE specific: 70%) and vancomycin (total: -58%, CDE specific: -61%). There were no clusters detected pre-/post STA introduction. The need for isolation decreased from 748 to 181 patients post-in- tervention (76%; P < 0.05). Annual cost savings were over $175,000 due to decreases in laboratory testing followed by isolation, and antibiotic use.

Conclusion. The switch to an STA from NAAT did not affect the diagnosis, treatment, or control of clinically relevant CDE in our institution. Benefits included avoidance of unnecessary antibiotic treatment, reduction in isolation, achieving publicly reported objectives, and costs savings. Selection of clinically relevant tests can help to improve hospitalization and treatment of patients and should be considered as part of diagnostic stewardship.

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1297. Enzyme Immunoassay for C. difficile Toxin Reduces Lab ID Events but Fails to Detect Clinically Significant C. difficile Infection

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Background. The National Health Safety Network (NHSN) requires reporting of Lab ID events for C. difficile infection (CDI) including all positive clinical tests after day three of hospitalization. Nucleic acid amplification tests (NAAT) that detect genes for toxins A or B may be overly sensitive, in some cases detecting C. difficile colon- ization. Some have advocated for two-stage testing, with positive NAAT tests followed by confirmatory enzyme immunoassay (EIA) to detect the presence of toxin and minimize the downside of false positives (i.e. additional NHSN reports or overuse of antibiotics). We aimed to better understand clinical characteristics of patients with positive NAAT and/or EIA tests.

Methods. Our hospital uses Xpert C. difficile assay (Cepheid), a NAAT method utilizing polymerase chain reaction (PCR), to diagnose CDI on unformed stool only. As part of a 6 month quality initiative, we pilot tested the C. DIFF QUIK CHECK COMPLETE test (Alere), an EIA that tests for C. difficileantigen (Ag) and toxin, on all specimens that tested positive by NAAT. We abstracted clinical data from the medical record for a subset of patients who underwent EIA testing.

Results. Over 6 months, 294 patients had a positive test by NAAT. Of these, 258 (87.8%) underwent EIA testing. 67 (26.0%) were Ag+/toxin+, 173 (67.1%) were Ag+/ toxin-, and 18 (6.8%) were Ag-/toxin-. Mortality rates were as follows: Ag+/toxin+, 17.9% (12/67); Ag+/toxin-, 13.9% (24/173); Ag-/toxin-, 27.8% (5/18), P = 0.27. Among the EIA toxin negative patients who underwent chart review, 81% had 3 or more loose stools within 24 hours, 62% had abdominal pain, nausea, or vomiting, and 27% had a WBC > 15.

Conclusion. The majority of patients testing positive for CDI by NAAT had a negative EIA test for toxin. There was no significant difference in mortality between EIA toxin positive and negative. Those with negative EIA toxin tests often had clinically significant symptoms of CDI. A two-stage CDI testing algorithm with NAAT followed by EIA for toxin may exclude patients with clinically significant CDI but would have resulted in a 75% reduction in reported NHSN LabID events.

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1298. Clostridium difficile Laboratory Identification Event Reporting – A Need for Diagnostic Stewardship

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Background. Clostridium difficile LabID event reporting uses electronic laboratory results without chart review. Nucleic acid amplification testing is common in the US. A positive result may represent colonization or C. diff infection (CDI). We review C.diffLabID events to ascertain if Hospital-Onset CDI (HO CDI). For non-HO CDI, we identify reason and use a matrix to prioritize clinical areas for intervention efforts.

Methods. Each C. diffLab ID event from Jan 2015 to June 2016 at academic center had chart review for HO CDI; defined significant diarrhea, not present on admission, with no laxatives in prior 48 hours. For non HO-CDI events, reason and receipt of antibi-otic treatment within 14 days of the positive test were retrospectively noted.

A prioritization matrix, where clinical services were ranked according to number of lab ID events (service’s contribution to the facility C. diffLabID), was multiplied by