For secondary endpoints: improvement in sensitivity of different antibiotics for \textit{Pseudomonas aeruginosa} was noticed. Increased 48-hours antibiotic stop review (2 vs 722), increased number of cultures reviewed (380 vs 518), increased 7-days antibiotics review (24 vs 78), and increased restricted antibiotics (142 vs 432) were observed.

\textbf{Conclusion:} Transforming the ASP program at MFHSC with Cardinal Health from resulted in improved efficiency; increased number of ASP-related interventions/day, decreased antibiotics DOT, decreased antibiotics-related cost/patient/day, and increased sensitivities of drugs against \textit{Pseudomonas aeruginosa}.

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48. Association of Rapid Pathogen Identification and Pharmacist Intervention on Time to Optimal Antimicrobial Therapy for Bloodstream Infections at Two Community Hospitals

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\textbf{Session:} P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

\textbf{Background:} As many as 1 in 3 patients with bloodstream infections at community hospitals receive inappropriate empiric antimicrobial therapy. Studies have shown that the coupling of real-time intervention with rapid pathogen identification improves patient outcomes and decreases health-system costs at large, tertiary academic centers. The aim of this study was to assess if similar outcomes could be obtained with the implementation of real-time pharmacist intervention to rapid pathogen identification at two smaller, rural community hospitals.

\textbf{Methods:} This was a pre-post implementation study that occurred from September of 2019 to March 2020. This study included patients ≥ 18 years of age admitted with one positive blood culture. Patients were excluded if they were pregnant, had a polymicrobial blood culture, known culture prior to admission, hospice consulted prior to admission, expired prior to positive blood culture, or transferred to another hospital within 24 hours of a positive blood culture. Endpoints of patients prior to intervention were compared to patients post-intervention. The primary endpoint was time to optimal antimicrobial therapy. Secondary endpoints included time to effective antimicrobial therapy, in-hospital mortality, length of hospital stay, and overall cost of hospitalization.

\textbf{Results:} Of 212 patients screened, 88 patients were included with 44 patients in each group. Both groups were similar in terms of comorbidities, infection source, and causative microorganisms. No significant difference was seen in the mean time to optimal antimicrobial therapy (27.3±35.5 hr vs 19.4±30 hr, p=0.265). Patients in the post-implementation group had a significantly higher mean hospitalization cost ($24,638.87± $11,080.91 vs $32,722.07±$13,076.73, p=0.013). There was no significant difference in time to effective antimicrobial therapy, in-hospital mortality, or length of hospital stay.

\textbf{Conclusion:} There were no between-group differences in the primary outcome of time to optimal therapy, with a higher mean hospitalization cost after implementation. These results suggest further antimicrobial stewardship interventions are needed, along with larger studies conducted in the community hospital settings.

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49. Clinical Utility of Oseltamivir Restriction Policy

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\textbf{Session:} P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

\textbf{Background:} Inappropriate use of oseltamivir and antibiotics for upper respiratory tract infections may increase risk of microbial resistance. Restriction policies have been used to curtail inappropriate use of oseltamivir and antimicrobials in suspected or confirmed influenza patients. We assessed the impact of Infectious Diseases (ID) consult on the management of oseltamivir and concomitant antibiotics.

\textbf{Methods:} A single-center, retrospective study of patients ≥ 17 years, admitted for greater than 24 hours who received oseltamivir from October 1, 2018 to May 1, 2019 were evaluated. Demographics, Charlson Weighted Index of Comorbidity (CWIC), length of hospital stay (LOS), discharge disposition, rapid flu test, respiratory viral panel, sputum and blood cultures, antibiotic regimen and duration were collected. Continuous variables were analyzed using Students t-test and categorical variables with Chi square test.

\textbf{Results:} 298 patients were screened and 182 patients met the inclusion criteria. Please see table below for results. Oseltamivir was appropriately continued in 92.9% in the ID consult group compared to 89.3% in the non-ID consult group (p = 0.51). Antibiotic interventions were appropriate in 63.2% of the ID consult group compared to 40% in non-ID group (p = 0.36).

\textbf{Conclusion:} Oseltamivir interventions were appropriate and similar in between groups. Further, there was higher percentage of appropriate antibiotic interventions in the ID physician group. Duration of antibiotics was longer in the ID physicians consulted group which may be due to higher severity of illness in the group.

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50. Comparative Incidence of Acute Kidney Injury in Septic Patients Treated with Meropenem Versus Piperacillin/Tazobactam and Ceftazidime

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\textbf{Session:} P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

\textbf{Background:} Empircic antibiotic therapy for sepsis of unknown origin is typically broad spectrum and covers \textit{P. aeruginosa} and methicillin-resistant \textit{S. aureus} (MRSA). Nephrotoxicity is a well-known adverse event of IV vancomycin and literature suggests that combination with piperacillin/tazobactam may increase risk for acute kidney injury (AKI) as compared to combination with other beta-lactams. However, evidence is conflicting. The primary outcome of this study was to compare incidence of AKI in septic patients treated with IV vancomycin and piperacillin/tazobactam (VZ) vs. ceftazidime (VC). Secondary outcomes include hospital length of stay, inpatient mortality, and impact to direct variable cost.

\textbf{Methods:} Adult patients discharged with a sepsis diagnosis code who received VZ or VC for ≥24 hours in 2012–2019 were retrospectively identified. AKI was defined using RIFLE criteria. Patients were excluded for ESRD on HD, AKI occurring < 48 hours after treatment initiation or >7 days after discontinuation, pregnancy, febrile neutropenia, or meningitis. Statistical analysis controlled for many factors including age, race, gender, Elixhauser comorbidity burden, hours to first antibiotic dose, length of stay, and receipt of concomitant nephrotoxins.

\textbf{Results:} A total of 12,405 patients were evaluated; 7,818 received VZ and 3,096 received VC. Patients given VC had a 40% reduction in risk of AKI compared to those given VZ (IRR 0.600; 95% CI 0.46–0.78). These patients also had a 4% reduction in risk of AKI (IRR 0.600; 95% CI 0.46–0.78). Patients who received VZ and experienced AKI also incurred more on average than those without AKI (p = 0.005).

\textbf{Conclusion:} Compared to septic patients treated with VZ, those treated with VC had significantly decreased risk of AKI as defined by RIFLE criteria. Patients who received VC were at higher risk for a longer hospital stay and, if they also experienced AKI, inpatient mortality, VZ was associated with higher direct variable cost and patients with AKI incurred more dollars per encounter than those without AKI.

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51. Development and Assessment of a Process to Describe the Timing of Antibiotic Changes in Adult Inpatients

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