Methods: This was a retrospective cohort study of adults (age >18 years) patients with a prescription for an antibiotic on discharge from Oregon Health & Science University Hospital (OHSU) to a NH between January 1, 2016 and December 31, 2018. Study data were collected from an electronic repository of patients’ electronic health record data. Outcomes of interest included having an emergency department (ED) visit, hospital admission, or inappropriate dispensation of the drug trimethoprim-sulfamethoxazole, or fosfomycin. The primary outcome measures were the total number of days treated on discharge and the total number of days treated on discharge to a NH. Results: More than 40% of antibiotic prescriptions on discharge to a NH were for greater than 7 days. This frequency and associated poor outcomes suggest extended antibiotic duration is a high-value target to improve antibiotic prescribing on discharge to NHs.

Disclosures: All Authors: No reported disclosures

66. Impact of a Pharmacist-Driven Azithromycin De-escalation Protocol for Community-Acquired Pneumonia
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Session: P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

Background: Limited antibiotic durations to the shortest effective duration is a strong recommendation with moderate-quality evidence in the 2016 IDSA Antimicrobial Stewardship Program (ASP) guidelines. An ASP bundle including a decrease in antimicrobial automatic stop dates from 14 days to 10 days along with a guideline for standard durations for 48 specific indications was implemented at a tertiary hospital pediatric in November 2019. The purpose of this review was and to assess the impact of this ASP initiative on patient outcomes and hospital cost-savings by comparison of pre-intervention and post-intervention data.

Methods: A set of antimicrobial duration recommendations for pediatric patients was created by the Antimicrobial Stewardship Program, Pediatric Hospital Medicine providers, and Infectious Disease providers specific to indication, agent, or pathogen. After education of medical care providers and distribution of the recommendations, automatic stop dates in the Electronic Medical Record (EMR) were updated from 14 days to 10 days for all antimicrobials. Concomitant advertising campaigns were shown on all hospital screensavers. Data were collected for a one month pre-intervention period of Nov.15 - Dec.15, 2018 including 133 patients and a one month intervention period of Nov.15 - Dec.15, 2019 including 125 patients.

Results: The average length of stay decreased from an average of 8.3 days pre-im-plementation to 6.7 days (p=0.043) post implementation. The ratio of actual to recommended duration also decreased from 1.56 to 1.30 (p< 0.001) when comparing pre vs. post implementation. This lead to cost savings and decreased inappropriate antibiotic exposure.

Conclusion: This intervention lead to a significant reduction in average length of stay, reduced LOS, and significantly reduced the total duration of antimicrobial therapy and the ratio of actual duration compared to recommended duration. This lead to cost savings and decreased inappropriate antibiotic exposure.

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67. Impact of a Pharmacist-Driven Collaborative Initiative on Staphylococcus aureus Bacteremia Management
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Session: P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

Background: Infectious diseases (ID) consultation has been associated with improved outcomes for Staphylococcus aureus bacteremia (SAB) largely by provid- ing guidance to follow widely accepted standards. However, ID consultation may be delayed due to numerous factors. ID pharmacists may be able to facilitate timely and optimal management of SAB in collaboration with ID providers and microbiology.

Methods: This was a single-center, quasi-experimental study of patients with SAB before (8/1/16–7/31/17) and after (8/1/18–7/31/19) implementation of pharma-cist steering committees. Parameters for multi-drug resistance before and after notification of SAB and penicillin-binding protein assay results from microbiology personnel, the ID pharmacist promptly contacted the primary team to facilitate ID consultation.
and identified opportunities to optimize treatment or diagnosis prior to consult. Recommendations were also collaboratively discussed with the ID consult service. Included patients were ≥18 years old with SAB. Excluded patients were <18 years old, under palliative care or expired prior to S. aureus specification, refused care against medical advice, pregnant, incarcerated, or had polymicrobial bacteremia.

Results: Ninety and 111 patients were included in the pre- and post-intervention cohort, respectively. Demographic data were similar between cohorts. Most SAB cases were community-acquired (72% vs 81%, p=0.137), complicated (83% vs 71%, p=0.059), and methicillin-susceptible (57% vs 65%, p=0.236). The most common source was catheter (23%) and skin and soft tissue (30%) in pre- and post-intervention cohorts, respectively. Table 1 displays compliance with evidence-based SAB measures and clinical outcomes. Compliance with the SAB bundle was significantly higher in the post-intervention cohort (91% vs 50%, p<0.001).

Table 1. Compliance with Evidence-Based Staphylococcus aureus Bacteremia Management Bundle Elements and Clinical Outcomes

| Pre-intervention cohort (n=99) | Post-intervention cohort (n=111) | p-value |
|-------------------------------|---------------------------------|---------|
| Persistent bacteremia, n (%)  | 17 (17.9)                       | 10 (9.0) | 0.041  |
| Source control if applicable, n (%) | 42 (42.7)                       | 88 (79.3) | <0.001 |
| Infection control, n (%)      | 74 (74.7)                       | 111 (100) | <0.001 |
| Time to infectious diseases consultation from first positive blood culture in hours, median (IQR) | 43.5 (22.71) | 32 (18, 44) | <0.001 |
| Echocardiogram, n (%)         | 81 (90)                         | 111 (100) | <0.001 |
| Transesophageal echocardiogram, n (%) | 73 (81.1)                       | 107 (96.4) | <0.001 |
| Transesophageal echocardiogram, n (%) | 56 (62.2)                       | 57 (51.8)  | 0.030  |
| Repeat blood cultures every 48 hours, n (%) | 55 (61.1)                       | 101 (90.9) | <0.001 |
| Duration of antibiotics in hours, median (IQR) | 95 (46, 146)                     | 66 (43, 105) | 0.009  |
| Time to definitive therapy in hours, median (IQR) | 48 (31, 66)                    | 56 (38, 83)  | <0.001 |
| Infection-related hospital length of stay in days, median (IQR) | 19.4 (15.2)                    | 13.4 (9.8)  | 0.027  |
| 30-day readmission for Staphylococcus aureus bacteremia, n (%) | 5 (5.6)                        | 3 (2.7)      | 0.471  |
| All-cause mortality within 90-days, n (%) | 16 (17.8)                      | 12 (10.8)   | 0.156  |

Conclusion: Increased compliance with evidence-based SAB recommendations decreased SAB duration, time to targeted antibiotics, and infection-related hospital length of stay after implementation of a pharmacist-driven collaborative initiative for SAB.

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68. Impact of a Pharmacy-Driven Antimicrobial Time-out on Duration of Therapy in Community-Acquired Pneumonia

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Session: P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

Background: Community-Acquired Pneumonia (CAP) is associated with substantial antibiotic use and potential for overprescribing. Previous studies have demonstrated a reduction in antimicrobial exposure following implementation of provider-driven antimicrobial time-outs (ATOs). ATOs prompt assessment of appropriateness of therapy, clinical response, and duration of therapy. In January 2018, OSF Healthcare System implemented a 48-hour pharmacy-driven ATO in the electronic health record. The purpose of this study was to determine if the implementation of the ATO decreased the duration of antibiotic therapy for CAP at a community hospital.

Methods: This was a retrospective chart review of adults hospitalized with CAP at OSF Saint Anthony Medical Center between May 2016 - October 2017 (pre-implementation; PRE) and April 2018 - September 2019 (post-implementation; POST). The primary outcome was total duration of antibiotic therapy between hospitalization and discharge prescriptions. Secondary outcomes included hospital length of stay (LOS), duration of IV therapy, and rates of treatment failure, relapse, and antibiotic-associated adverse events.

Results: A total of 808 patient charts were reviewed with 155 patient meeting inclusion criteria in both study groups. The mean duration of antibiotic therapy was reduced by 2.14 days (PRE 10.51 days vs. POST 8.37 days; p<0.001). Duration of IV therapy (3.86% vs. 3.21%; p<0.001) and rates of treatment failure, relapse, and antibiotic-associated adverse events.

69. Impact of antimicrobial stewardship interventions on post-elective caesarean antibiotic prophylaxis and surgical site infections

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Session: P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

Background: Antimicrobial stewardship programs (ASP) aim to improve appropriate antimicrobial use. This study aims to evaluate the impact of ASP interventions on post-elective caesarean (eLCSs) oral antibiotic prophylaxis use. In a subgroup of those without surgical site infection (SSI) risk factors, 30-day SSI rates were compared in those who received oral eLCSs antibiotics vs. those without.

Methods: This pre-post quasi-experimental study was conducted over 9 months (2 months pre- and 7 months post-intervention) in all women admitted for eLCSs in our institution. Interventions included eLCSs surgical prophylaxis guideline dissemination, where a single antibiotic dose within 60 minutes of surgery was recommended. Post-eLCSs oral antibiotics was discouraged in those without SSI risk factors (e.g. obesity). This was followed by ASP intervention notes (phase 1) for 3 months, and an additional phone call to the ward team for the next 4 months (phase 2).

Results: A total of 894 women were reviewed. There were 244 women in the pre-intervention phase, 274 in post-intervention phase 1 and 376 in phase 2. Pre-intervention post-eLCSs antibiotic prescribing rates was 82% (200), compared to 54% (148) in phase 1 and 49% (180) in phase 2 (p<0.001). There were 560 women without SSI risk factors. Of these, only 4 of 301 (1.3%) who received oral antibiotics, and 3 of 159 (1.9%) without oral antibiotics developed post-op SSI (p=1.000).

Conclusion: ASP can reduce post-eLCSs oral antibiotic prophylaxis. In those without SSI risk factors, use of post-eLCSs oral antibiotics did not impact SSI rates.

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70. Impact of Fluoroquinolone Susceptibility Suppression on Discharge Prescribing for Acute Uncomplicated Cystitis

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Session: P-3. Antimicrobial Stewardship: Outcomes Assessment (clinical and economic)

Background: Fluoroquinolones (FQ) are associated with multiple adverse effects and increasing resistance. Acute uncomplicated cystitis (AUC) treatment remains a frequent reason for FQ use. Previous data suggests that suppression of FQ susceptibility results can decrease inpatient use, but may not reduce prescribing at discharge. The purpose of this study was to investigate the impact of FQ susceptibility suppression on discharge prescribing for AUC.

Methods: This was a retrospective, quasi-experimental study in adult patients at a 350-bed academic medical center. The effect of suppression of FQ susceptibilities on pan-susceptible urine isolates for Klebsiella sp. and E. coli on FQ prescribing and appropriateness at discharge was compared one year before and after the intervention, starting in March 2018. Risk factors for FQ use were also examined. Exclusion criteria included pyelonephritis, urinary hardware, pregnancy, concomitant infections treated with FQ, and organisms not susceptible to FQ. Risk ratios of FQ use for suggested FQ prescribing and stratified by discharging team for adjusted rates (aRR) using a Cochran-Mantel-Haenszel approach. For secondary outcomes, Chi-Square statistics for pre-/post-groups and stratified by discharging team for adjusted rates (aRR) using a Cochran-Mantel-Haenszel approach. For secondary outcomes, Chi-Square statistics were used to assess odds of FQ use among variables.

Results: Overall discharge FQ prescribing decreased from 41.1% to 21.1% after the intervention, corresponding to a 53% lower adjusted risk (aRR 0.47 (95% CI 0.28-0.81)). One-hundred percent of FQ use was inappropriate, largely due to organism susceptibility to a guideline-preferred agent (n=33/38). After adjusting for the intervention and clustering of discharge team, the odds of outpatient FQ use was 3.4 times higher for uninsured vs. insured patients, and 13.4 times higher among those who received FQ while inpatient.

FQ Use at Discharge