Results. Median overall antimicrobial use was similar between the pre-, during- and postintervention periods at 1,089, 1,100, and 1,146 DOT/1,000 DAR, respectively. For the five most commonly used drugs, reductions in DOT/1,000 DAR were observed between the pre- and during-intervention groups for amoxicillin/sulbactam (26%) and metronidazole (12%), while ceftriaxone, ceftepime, and vancomycin use was unchanged.

Conclusion. While no change in median total antibiotic use was observed, a reduction in anti-anaerobic agent use noted, consistent with local efforts to reduce inappropriate antibiotic prescribing for aspiration pneumonitis. Actively involving medical residents and fellows in establishing evidenced-based approaches to antimicrobial stewardship is key to improving antibiotic utilization and minimizing the development of antimicrobial resistance.

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204. Impact of Education and Data Feedback Interventions on Outpatient Prescribing for Urinary Tract Infections
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Session: 51. Antimicrobial Stewardship: Interventions to Improve Outcomes Thursday, October 4, 2018: 12:30 PM

Background. Urinary tract infections (UTIs) are the most common outpatient indication for antibiotics and an excellent target for outpatient antimicrobial stewardship (AS) interventions. This study evaluated the impact of education and data feedback on outpatient UTI diagnosis and prescribing.

Methods. A clinic-specific antibiogram, diagnosis and treatment guideline, and educational session were provided at one urgent care (UC) and one primary care (PC) clinic in Durham, NC in August and November of 2017. Educators reviewed the appropriate diagnosis, treatment, and duration of therapy for UTIs, including avoidance of treatment for asymptomatic bacteriuria and choice of first-line agents with lower collateral damage. Adult encounters with a UTI diagnosis code from November 2016 to November 2017 and from August 2016 to August 2017 were included in the pre-intervention cohort for UC and PC, respectively. The post-intervention cohort included encounters following education intervention in April 2018. Summary data of UTI diagnoses and guideline concordant prescriptions were fed back to clinics February 2018. The primary endpoint was proportion of first- or second-line antibiotic choice for UTI according to clinic-specific guidelines. Pre- and postintervention phase and trend changes were assessed by an interrupted time series approach.

Results. Data were collected on 2,660 and 1,016 UTI encounters at UC and PC, respectively. Guideline concordant prescribing increased at UC from 29% at baseline to 47% in the 8 months after education and at PC from 54% at baseline to 62% in the 8 months after the education (Figures 1 and 2). The mean number of UTI diagnoses per month decreased at UC from 54 to 27 (0.7% per month) and at PC from 25 to 13 (0.2% per month). Among the top five prescribed antibiotics, the percentage of guideline-concordant agents given for a guideline-discordant duration of treatment for asymptomatic bacteriuria and choice of first-line agents with lower anti-anaerobic agent use noted, consistent with local efforts to reduce inappropriate antibiotic prescribing for aspiration pneumonitis. Actively involving medical residents and fellows in establishing evidenced-based approaches to antimicrobial stewardship is key to improving antibiotic utilization and minimizing the development of antimicrobial resistance.

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205. Reduction of Antibiotic Prescribing Within a Veterans Affairs Emergency Department Through Peer Comparison
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Background. Reduction in inappropriate antibiotic use in Emergency Departments can have a major impact on overall outpatient antibiotic use. Peer comparison has been used to successfully reduce antibiotic prescribing in primary care clinics at our hospitals and others.

Methods. An educational session was held for Emergency Department physicians (EDPs) at VA Pittsburgh. EDPs were then sent monthly comparison charts of their oral antibiotic prescribing rates as well as peer rates. An intervention period of January–March 2018 was compared with a seasonal baseline of the same months in 2017. A random sample of oral antibiotic prescriptions was reviewed in-depth for adherence to consensus guidelines.

Results. During the baseline period of January–March 2017, 427 oral antibiotic prescriptions were written by 16 EDPs during a total of 3,722 patient encounters, with an antibiotic prescription index of 114.1 per 1,000 patient encounters. In comparison, 301 prescriptions were written by the same 16 EDPs during 4,874 patient encounters in the postintervention period (January–March 2018), with an antibiotic prescription index of 61.7 per 1,000 patient encounters (45.9% decrease; P = 0.0001). Azithromycin and fluoroquinolone indices decreased from 29.6 to 16.6 (43.9%; P < 0.0001) and 10.5 to 8.0 (23.8%; P = 0.2) per 1,000 encounters, respectively. Among randomly reviewed prescriptions, there was a trend toward a decrease in inappropriate antibiotic prescribing from 47.6% (20/42) to 30% (9/30) (P = 0.15). Among the randomly reviewed prescriptions that were indicated, there were non-significant decreases in the percentages of guideline-discordant agents (22.7% (5/22) to 14.2% (3/21); P = 0.7)), and in the percentage of guideline-concordant agents given for a guideline-discordant duration (29.4% (5/17) to 22.2% (4/18); P = 0.7)). Likewise, there were non-significant decreases in inappropriate antibiotic prescribing for UTIs (94.1% (16/17) to 75% (3/4); P = 0.35).

Conclusion. In an emergency department setting, initial education followed by monthly peer comparison of overall antibiotic prescribing rates significantly reduced overall antibiotic prescribing. Ongoing data review will reveal if trends toward reductions in inappropriate antibiotic prescribing are significant.

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206. Respiratory Viral Testing Is Associated with Lower Frequency of Antibiotic Prescribing for Acute Upper Respiratory Infections at a Large Ambulatory Care Center
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Background. Inappropriate outpatient antibiotic prescribing for acute upper respiratory infections (URIs) is a high priority target for antimicrobial stewardship and has not been described for cancer patients. The goal of this study was to characterize patterns of factors and factors associated with antibiotic prescribing among ambulatory oncology patients with URIs.

Methods. We selected outpatients >18 years old seen at an ambulatory cancer center with ICD-10 diagnosis code consistent with URI from October 1, 2015 to September 30, 2016 for chart review. Patients without documented URI symptoms or with lower tract infection at the first clinical encounter for the URI (day 0) were excluded. We obtained demographic, clinical, antimicrobial prescribing and