Background. Diagnostic tests are a crucial part of clinical care. However, they can often result in unnecessary testing with no patient impact. Diagnostic stewardship seeks to modify the process of ordering, performing and reporting diagnostic tests to improve resource utilization and patient outcomes. We have identified infectious diseases viral molecular tests that are meant for outpatient management that are often ordered during a hospital stay. Our objective was to quantify how often these tests were ordered and acted upon, as well as the cost associated with them.

Methods. HIV quantitative PCR, HIV genotype and HCV genotype were selected as the target tests to be evaluated in this study. We measured the number of times these tests performed at Memorial Hermann Hospital TMC from January to December 2017. The total number of these tests were calculated. We computed the total charges for each test and then calculated the total number of times these tests were performed at Memorial Hermann Hospital TMC from January to December 2017. The individual and total cost of these tests were calculated. We sampled charts to determine whether the test had been ordered during or after the hospitalization.

Results. During the study period, a total of 512 HIV viral loads, 29 HIV genotype types, and 58 Hepatitis C genotypes were ordered. The total expense on the HIV viral load tests was $43,228, total expense on HIV genotypes was $8,669, and for Hepatitis C genotype was $43,055. Our chart sampling showed that HIV viral load was not acted on 65% of the time, HIV genotype test was not acted on 62% of the time and HCV genotype was not acted on 50% of the time.

Conclusion. Three molecular viral tests that were acted upon less than 50% of the time they were ordered, collectively added an expense of $94,952 over the course of a year. A diagnostic stewardship program based on education and selective restriction of diagnostic testing may result in avoidance of unnecessary testing and substantial savings.

Disclosures. All authors: No reported disclosures.

1917. Diagnostic Errors in Bacterial Osteomyelitis in Children
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Background. Delayed or erroneous diagnoses of bacterial infections may cause adverse outcomes in children. Bacterial osteomyelitis has a low incidence, is only infrequently encountered by primary care pediatirians, and has obscure symptoms in children that make an early and accurate diagnosis challenging. The aim of this study was to determine the incidence and causes of diagnostic errors in pediatric patients in whom bacterial osteomyelitis was finally diagnosed.

Methods. Children who received a definitive diagnosis of acute or chronic bacterial osteomyelitis were enrolled at Tokyo Metropolitan Children's Medical Center, Tokyo, Japan, Infectious Diseases, Tokyo Metropolitan Children's Medical Center, Tokyo, Japan, General Pediatrics-Nephrology, Tokyo Metropolitan Children's Medical Center, Tokyo, Japan.

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Background. Acute respiratory infection (ARI) diagnoses encompass syndromes such as pneumonia and bronchitis, and are among the leading causes of hospitalization. While outpatient care could present an opportunity to prevent subsequent hospitalization, few studies have measured healthcare utilization preceding hospitalization. We characterized outpatient visits in the 2 weeks prior to ARI hospitalization using commercial insurance and Medicare claims in MarketScan from 2012 to 2014.

Methods. We included inpatients with an ICD9 discharge diagnosis for ARI (460–466), pneumonia (480–486), or influenza (487–488) and evaluated outpatient records ≤14 days prior to admission, excluding the day of admission. We defined an outpatient visit as health encounters with a reasonable potential for medical care receipt (e.g., medical device delivery). We used the prevalence of 12 months of medical records to define patients' Charlson Index and health care utilization, including any prior hospitalizations and preventive and ambulatory care sensitive condition (ACSC) visits. Severe outcomes were defined as intensive care unit admission or death. We used multivariable logistic regression stratified by age group to evaluate demographic, clinical, health utilization, and outcome factors associated with outpatient care prior to admission.

Results. We identified 407,096 ARI hospitalizations, among which 60% of patients had ≥1 outpatient visit prior to admission; 36% of visits occurred 1 day prior to admission. Children aged <1 were more likely to have a preceding visit compared with other age groups (67% vs. 57% to 59%, P < 0.001). In all age groups, persons with preventive care and ACSC visits in the past year, a Charlson score ≥1, female sex, non-capitated health plans, and salaried employment were more likely to have a preceding outpatient visit. Patients with severe outcomes were significantly less likely to have a preceding visit, while specific diagnoses varied by age group (figure).

Conclusion. In a population of insured individuals, only 60% received outpatient care in the 2 weeks prior to ARI hospital admission. A greater understanding of health-care seeking behaviors for potentially preventable hospitalizations is needed.

Disclosures. All authors: No reported disclosures.