Results. The PCR group of 116 patients (patients) were matched to 232 patients in IAT group (Table 1). Positive results for influenza were reported in 37.9% of PCR vs. 18.1% of IAT groups ($P < 0.001$); TAT 0.95 (0.75–1.4) hours in PCR vs. 0.60 (0.40–0.85) hours in IAT group ($P < 0.001$). Oseltamivir was initiated in the ED in 21% of PCR vs. 11% of IAT group ($P < 0.001$). An additional 28% in PCR group received oseltamivir at ED discharge vs. 15% in IAT group ($P = 0.004$). Antibiotics were administered in the ED to 8% in PCR group vs. 15% in the IAT group. A positive influenza test was associated with less antibiotic use OR 0.454 (95% CI 0.213–0.967), while abnormal chest radiograph (CXR) and WBC was associated with increased antibiotic use OR 3.667 (95% CI 1.743–7.715). The 30-day revisit was 3.8% and 10.8% in the PCR vs. IAT groups, respectively ($P = 0.034$).

Conclusion. Replacing IAT with PCR testing increased diagnostic yield for influenza and receipt of oseltamivir and decreased antibiotic utilization in the ED. Independent predictors for antibiotic use were abnormal CXR and WBC, while positive influenza testing was protective.

Table 1: Characteristics of Study Population

Variables	PCR (n = 116)	Antigen (n = 232)	P-value
Age	59 (53–64)	58 (54–65)	0.522
Male sex	50 (43.9)	99 (42.9)	0.860
Symptom duration (days)	2 (1–4)	2 (1–4)	0.870
Charlson score	1 (0–2)	2 (0–4)	0.206
WBC	6.3 (5.2–8.6)	6.7 (5.1–8.8)	0.739
Normal CXR	81 (87.1)	164 (83.2)	0.398

Disclosures. **All authors:** No reported disclosures.

This abstract has been withdrawn at the author's request.

212. Impact of a Prospective Audit and Feedback Antimicrobial Stewardship Initiative on Pneumonia Treatment at an Academic Teaching Hospital

Jeffrey C. Pearson, PharmD[1]; Monica V. Mahoney, PharmD, BCPS-AQ ID[1]; Graham M. Snyder, MD, SM[2]; Howard S. Gold, MD, FIDSA[2]; Parth V. Patel, BSN, RN[1] and Christopher McCoy, PharmD, BCPS-AQ ID[1]; [1]Department of Pharmacy, Beth Israel Deaconess Medical Center, Boston, Massachusetts, [2]Department of Medicine, Division of Infectious Diseases, Beth Israel Deaconess Medical Center, Boston, Massachusetts

Session: 51. Antimicrobial Stewardship: Interventions to Improve Outcomes
Thursday, October 4, 2018: 12:30 PM

Background. Antimicrobial stewardship programs (ASPs) may improve patient outcomes by reducing antimicrobial adverse effects and resistance. Pneumonia is the most common infectious reason for hospitalization and is a key target for improvement in antimicrobial use. The purpose of this study was to measure the impact of a prospective audit and feedback program for patients with pneumonia in addition to an already robust pre-authorization program at an academic teaching hospital.

Methods. We analyzed the impact of a prospective audit and feedback initiative among inpatients with pneumonia treated with antimicrobials for at least 72 hours. The primary outcome was the percent of optimal antimicrobial days of therapy received based on hospital-approved pneumonia guidelines, compared pre- and postintervention. This outcome was defined as the number of optimal days of therapy compared with the total days of therapy over the entire study period from the hospital's perspective. Secondary outcomes included the incidence rate of optimal antimicrobial days of therapy on a patient-specific level, overall antimicrobial days of therapy, length of hospital stay, rates of *Clostridium difficile* infection (CDI), and in-hospital mortality.

Results. The study included 248 patients, 125 pre- and 123 postintervention. Forty interventions were made post-implementation, with duration (47.5%) and de-escalation (35%) recommendations most commonly suggested. 50.8% of patients were male, the median [interquartile range (IQR)] age was 71 (60–83) years old, 45.6% of patients had community-acquired pneumonia, and patients had a median (IQR) Elixhauser comorbidity score of 5 (3–6). The overall rate of guideline concordance was 65.8% pre- and 77.5% postintervention ($P = 0.041$). On an individual level, patients were 17% more likely to have optimal antimicrobials postintervention [Incidence rate ratio 1.17 (95% confidence interval 1.03–1.32, $P = 0.013$)]. Length of stay, days of therapy, CDI, and in-hospital mortality rates did not differ significantly between groups.

Conclusion. Initiating a prospective audit and feedback program in addition to pre-authorization led to a significant increase in concordance with hospital pneumonia guidelines, but no difference in secondary outcomes in our patient population.

Disclosures. **M. V. Mahoney**, Melinta Therapeutics: Consultant, Consulting fee. Cutis Pharma: Consultant, Consulting fee. Tetraphase Pharmaceuticals, Inc.: Consultant, Consulting fee. Roche Diagnostics USA: Consultant, Consulting fee. **C. McCoy**, Merck Inc: Scientific Advisor, Consulting fee. Allergan: Scientific Advisor, Consulting fee.

213. Multi-centered Evaluation of an Acute Respiratory Tract Infection Audit-Feedback Intervention: Impact on Antibiotic Prescribing Rates and Patient Outcomes

Karl Madaras-Kelly, PharmD, MPH[1]; Hayli Hruza, MPH[2]; Benjamin Pontefract, PharmD[3]; Robert Mckie, MD[4]; Christopher Hostler, MD, MPH[5]; Mary Townsend, PharmD, AAHIVP[6]; Emily M. Potter, PharmD[7]; Emily Spivak, MD, MHS[8]; Sarah Hall, MD[9]; Matthew Goetz, MD[10]; McKenna Nevers, MS[11]; Jian Ying, PhD[12]; Ben Haaland, PhD[13]; Katherine Fleming-Dutra, MD[14]; Matthew Samore, MD, FSHEA[15]; [1]Pharmacy Service, Boise Veterans Affairs Medical Center, Boise, Idaho, Pharmacy Practice, College of Pharmacy, Idaho State University, Meridian, Idaho, [2]Pharmacy, Boise VA Medical Center, Boise, Idaho, [3]Pharmacy, Boise Veteran Affairs Medical Center, Boise, Idaho, [4]Vet. Med. Ctr., Boise, Idaho, [5]Infectious Diseases Section, Durham VA Health Care System, Durham, North Carolina, [6]Durham VA Medical Center, Durham, North Carolina, [7]Dwight D. Eisenhower Veterans Affairs Medical Center, Leavenworth, Kansas, [8]Internal Medicine, University of Utah Health, Salt Lake City, Utah, [9]VA Salt Lake City Healthcare System, Salt Lake City, Utah, [10]Infectious Diseases, VA Greater Los Angeles Healthcare System, Los Angeles, California, [11]Salt Lake City Veteran Affairs Medical Center, Salt Lake City, Utah, [12]Medicine, University of Utah School of Medicine, Division of Epidemiology, Salt Lake City, Utah, [13]University of Utah, School of Medicine, Salt Lake City, Utah, [14]CDC, Atlanta, Georgia and [15]University of Utah School of Medicine, Division of Epidemiology, Salt Lake City, Utah

Session: 51. Antimicrobial Stewardship: Interventions to Improve Outcomes
Thursday, October 4, 2018: 12:30 PM

Background. Audit-feedback of antibiotic prescribing rates for acute respiratory infections (ARIs) is a promising approach to reduce antibiotic use; however, the generalizability and sustainability are unknown. We describe an audit-feedback intervention and outcomes across multiple seasons in different clinic settings.

Methods. Two VA Medical Centers distributed audit-feedback reports targeting providers with frequent ARI visits in emergency department (ED) and primary care (PC) during 2015–2016 and 2016–2017. An academic detailing visit delivered by local peers accompanied the initial audit-feedback report. The intervention was expanded to ED and PC clinics ($n = 10$) in three other VA facilities in 2017–2018. Outcomes included rates of antibiotics prescribed, recurrent visits for ARIs within 30 days, and adverse events. We assessed intervention sustainability in initiating VAs, and intervention generalizability in expansion VAs. Mixed-effect logistic regression models were used to assess intervention effect on antibiotic prescribing and outcomes.

Results. Antibiotic prescribing for uncomplicated ARI visits ($n = 7,814$) declined from 53.8% to 27.9% post intervention. The intervention was associated with a reduction in odds of prescribing antibiotics in initiating facilities (odds ratio [OR] 0.6 (95% CI 0.3, 0.9), which declined further with an annual OR 0.8 [95% CI 0.7, 1.1] per year. Preliminary 6-month postintervention results were available from pilot clinics ($n = 3$) within two of the expansion VAs, which indicated similar effectiveness (OR 0.5 [0.4, 0.7]). Recurrent visits for ARIs (8.2% vs. 8.6%, $P = 0.14$) and adverse events (2.3% vs. 2.1%, $P = 0.90$) were not different pre-/post-intervention. Receipt of an antibiotic was not associated with recurrent visits for ARI (8.6% vs. 8.0%, $P = 0.45$) or adverse events (1.9% vs. 1.7%, $P = 0.11$).

Conclusion. An audit-feedback intervention sustained a reduction in antibiotic prescribing for ARIs over 3 years, and resulted in similar reductions in antibiotic use in varied ED and PC settings without affecting ARI-related return visit rates.

Disclosures. **All authors:** No reported disclosures.