Table 1: Baseline Patient Characteristics

Patient Characteristic	Day 3	
	Appropriate per criteria (N = 118)	P-value
Male Gender	54 (46%)	0.4971
Age	55.4 (20)	0.7231
Caucasian	91 (77%)	0.1559
Alaskan Native/Native American	16 (14%)	0.0226
MRSA Risk Factors Present	72 (61%)	0.9999
Infectious Diseases Consulted Day 3	91 (77%)	0.8246

Table 2: Vancomycin Indications

Vancomycin Indication	Day 3		
	Number Patients (N= 160)	Appropriate per criteria	Wound, tissue, and sputum cultures pending
Positive blood culture	20 (13%)	17	n/a
SSTI	82 (51%)	54	23
Pneumonia	37 (23%)	30	11
Osteomyelitis	5 (3%)	5	2
Joint infection	6 (4%)	4	2
Urinary tract infection	3 (2%)	2	n/a
Intra-abdominal	4 (2%)	3	2
Other	3 (2%)	3	1

Table 3: Multivariate Logistic Regression Model Day 3

Patient Characteristic	Day 3		
	Estimate	Odds Ratio (95% Confidence Interval)	P-value
Age	0.016	1.02 (0.99, 1.04)	0.1456
Alaskan Native/Native American	1.102	3.01 (1.21, 7.53)	0.0174
SSTI Diagnosis	1.056	2.87 (1.24, 6.80)	0.0147

Conclusion: Approximately 25% of patients receiving empiric vancomycin therapy did not meet clinical criteria for continuation beyond 72 hours. The indication most commonly associated with continued vancomycin utilization was SSTI. These results identified indications in which empiric vancomycin prescribing can be optimized, and a 72-hour antibiotic time-out may be warranted as a stewardship intervention. Timely culture obtainment and intervention when another pathogen is identified are possible strategies to ensure success of 72-hour time-out.

Disclosures: **All Authors**: No reported disclosures

228. Fluoroquinolone Prescribing for Diabetic Foot Infections following an FDA Drug Safety Communication for Aortic Aneurysm Risk

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Session: P-8. Antimicrobial Stewardship: Trends in Antimicrobial Prescribing

Background: Fluoroquinolones were commonly prescribed for hospitalized patients with diabetic foot infection (DFI) at our institution, included in 69% of empiric antibiotic regimens from 2011–2014. On December 20, 2018, the U.S. Food and Drug Administration (FDA) issued a Drug Safety Communication regarding the risk of aortic aneurysm with fluoroquinolones. The objective of this study was to assess the impact of the FDA Communication on antibiotic prescribing for DFI.

Methods: This was a single-center quasi-experimental study of hospitalized patients initiated on antibiotics for DFI before (February-December 2018) and after (February-December 2019) the 2018 FDA Communication. Patients with concomitant infections or documented beta-lactam or fluoroquinolone allergies were excluded. The primary outcome was inpatient days of fluoroquinolone therapy. Secondary outcomes included days of beta-lactam therapy and Outpatient Parenteral Antibiotic Therapy (OPAT) enrollment. Variables were compared using the Pearson's chi square, Fisher's exact, and Mann Whitney U tests, as appropriate. A logistic regression was performed to identify predictors for inpatient receipt of fluoroquinolones.

Results: A total of 198 patients were included. Baseline characteristics were similar between groups (Table 1). After the FDA Communication, the median duration of inpatient fluoroquinolones decreased from 3 [0–5.5] to 0 [0–1] days ($p< 0.001$). The duration of antipseudomonal beta-lactams increased from 0 [0–2] to 2 [0–6] days ($p< 0.001$). OPAT enrollment increased from 16.5% to 29.7% ($p=0.028$), with a corresponding increase in peripherally inserted central catheter placement (15.5% to 25.7%, $p=0.074$). There was no difference in outpatient fluoroquinolone prescribing over time. Incidence of re-infection, readmission for DFI, and antibiotic adverse events were similar between groups (Table 2).

Table 1

Table 1: Baseline characteristics – n(%)

	2018 (n=97)	2019 (n=101)	p-value
Male	69 (71.1)	78 (77.2)	0.327
Age*	66 [59-73]	64 [56-74]	0.402
Body mass index (kg/m2)*	29.5 [25.0-33.9]	29.5 [24.7-33.1]	0.736
Hospital length of stay (days)*	7 [4-10.5]	7 [5-10.5]	0.351
Comorbidities			
Type II diabetes	80 (82.5)	84 (83.2)	0.897
Hemoglobin A1C*	7.9 [7.1-9.2]	8.6 [6.9-9.8]	0.290
Hypertension	81 (83.5)	78 (77.2)	0.267
Peripheral vascular disease	47 (48.3)	48 (47.5)	0.896
AHRQ Elixhauser score *	-1 [-4-5]	0 [-4-8]	0.317

*median [IQR]

Table 2

Table 2: Outcomes – n (%)

	2018 (n=97)	2019 (n=101)	p-value
60 day mortality	0 (0)	5 (5)	0.060
OPAT enrollment	16 (16.5)	30 (29.7)	0.028
PICC line placed	15 (15.5)	26 (25.7)	0.074
PICC line complications	1 (6.7)	3 (11.5)	1.000
Re-infection at site of initial infection	27 (27.8)	23 (22.8)	0.412
Re-intervention at site of initial infection	46 (47.4)	47 (46.5)	0.900
Hospital re-admission due to DFI	27 (27.8)	17 (16.8)	0.063
Documented antibiotic adverse effects	15 (15.5)	16 (15.8)	0.942
C. difficile tested	9 (9.3)	12 (11.9)	0.552
C. difficile positive	2 (2.1)	0 (0)	0.239
Aortic aneurysm or dissection	0 (0)	0 (0)	-

Conclusion: Inpatient fluoroquinolone prescribing for DFI decreased significantly following the 2018 FDA Communication, followed by an increase in antipseudomonal beta-lactam use and OPAT enrollment. FDA statements can influence institutional antibiotic prescribing and transitions of care decisions, representing an opportunity for education by Antimicrobial Stewardship programs.

Disclosures: **All Authors**: No reported disclosures

229. Hospitalists Antimicrobial Scorecard Improves Antibiotic Prescribing at a Community Teaching Hospital

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Session: P-8. Antimicrobial Stewardship: Trends in Antimicrobial Prescribing

Background: Measuring antimicrobial consumption data is a foundation of antimicrobial stewardship programs. There is data to support antimicrobial scorecard utilization to improve antibiotic use in the outpatient setting. There is a lack of data on the impact of an antimicrobial scorecard for hospitalists. Our objective was to improve antibiotic prescribing amongst the hospitalist service through the development of an antimicrobial scorecard.

Methods: Conducted in a 451-bed teaching hospital amongst 22 full time hospitalists. The antimicrobial scorecard for 2019 was distributed in two phases. In October 2019, baseline antibiotic prescribing data (January – September 2019) was distributed. In January 2020, a second scorecard was distributed (October – December 2019) to assess the impact of the scorecard. The scorecard distributed via e-mail to physicians included: Antibiotic days of therapy/1,000 patient care days (corrected for attending census), route of antibiotic prescribing (% intravenous (IV) vs % oral (PO)) and percentage of patients prescribed piperacillin-tazobactam (PT) for greater than 3 days. Hospitalists received their data in rank order amongst their peers. Along with the antimicrobial scorecard, recommendations from the antimicrobial stewardship team were included for hospitalists to improve their antibiotic prescribing for these initiatives. Hospitalists demographics (years of practice and gender) were collected. Descriptive statistics were utilized to analyze pre and post data.

Results: Sixteen (16) out of 22 (73%) hospitalists improved their antibiotic prescribing from pre- to post-scorecard ($\chi^2(1)=3.68$, $p = 0.055$). The median antibiotic days of therapy/1,000 patient care days decreased from 661 pre-scorecard to 618 post-scorecard ($p = 0.043$). The median PT use greater than 3 days also decreased significantly, from 18% pre-scorecard to 11% post-scorecard ($p = 0.0025$). There was no change in % of IV antibiotic prescribing and no correlation between years of experience or gender to antibiotic prescribing.

Conclusion: Providing antimicrobial scorecards to our hospitalist service resulted in a significant decrease in antibiotic days of therapy/1,000 patient care days and PT prescribing beyond 3 days.

Disclosures: **All Authors**: No reported disclosures

230. Impact of 10-day versus 5-day Duration Default on Length of Antibiotic Outpatient Prescriptions from the Emergency Department

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Session: P-8. Antimicrobial Stewardship: Trends in Antimicrobial Prescribing

Background: Antimicrobial stewardship programs (ASP) traditionally focus on inpatient care; however there is a growing effort to optimize antibiotic prescribing at transitions of care. Longer than necessary discharge prescriptions increase risk of antimicrobial resistance, *C. difficile* infection and adverse events. In order to minimize unnecessary antibiotic exposure, the health system updated the electronic medical record (EMR) outpatient antibiotic prescription default from 10 days to 5 days. The objective of this study was to assess the impact of a 10-day versus 5-day EMR antibiotic outpatient prescriptions default on length of therapy for patients discharged from the Emergency Department (ED).

Methods: This is a retrospective, single-system cohort study evaluating ED discharge prescriptions before and after transition from a default duration of 10 days to 5 days. Discharge prescriptions were collected and screened from December 2019 through January 2020 in the control group and March 2020 through April 2020 in the intervention group. Outpatient prescriptions were included for primary diagnoses of urinary tract infection (UTI), community-acquired pneumonia (CAP), skin and soft tissue infections (SSTI), diverticulitis, or dental infections. The primary outcome was the incidence of prescriptions written for a < 5 day duration.

Results: The study included 3060 of 9651 (32%) prescriptions in the control group and 1610 of 4938 (33%) prescriptions in the intervention group. The mean age was 38 years old with 61% female. The most common primary diagnoses were SSTI (n=1633, 35%) and UTI (n=1633, 32%). The mean duration for discharge prescriptions was similar between groups (8.44 vs. 8.30 days). The incidence of outpatient antibiotic prescriptions for < 5 days was not significantly different between groups (10.72% vs 10.56%, p=0.996). There was an improvement in duration of therapy, with more prescriptions < 5 days for SSTI (2.96% vs. 7.64%, p=0.860) and dental infections (3.30% vs. 10.86%, p=0.808).

Conclusion: Implementation of a shorter default duration for antibiotic outpatient prescriptions from the ED did not significantly increase the incidence of prescriptions written for < 5 days. There was an improvement in duration for SSTI and dental infections after implementation.

Disclosures: **All Authors**: No reported disclosures

231. Impact of DRIP Score Documentation at Time of Physician Order Entry on Combination Antimicrobials in Treatment of Community Acquired Pneumonia

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Session: P-8. Antimicrobial Stewardship: Trends in Antimicrobial Prescribing

Background: The Drug Resistance in Pneumonia (DRIP) score is a predictive model for identifying drug-resistant pathogens in community-acquired pneumonia (CAP). The Detroit Medical Center adopted DRIP documentation at time of antimicrobial order entry for CAP in 2017. The purpose of this study was to identify the difference in overall consumption of antibiotics used for the treatment of CAP after the implementation of DRIP documentation.

Methods: A retrospective analysis of adult patients with an antimicrobial order with a documented indication of pneumonia between Jun 1-Oct 31, 2017 and Jun 1-Oct 31, 2018, was conducted. Days of antimicrobial therapy per 1000 adjusted patient days (DOT/1000 pt days) was assessed in patients before and after implementation of DRIP documentation at time of order entry. The percent concordance with institutional guidelines for empiric CAP treatment post-implementation of DRIP documentation was also evaluated.

Results: The DOT/1000 pt days increased in the post-DRIP group for ceftriaxone (36.5 vs. 76.3), doxycycline (22.3 vs. 44.5), and azithromycin (29.5 vs. 53.4). The DOT/1000 pt days decreased for carbapenems in the post-DRIP group (14.0 vs. 8.5). There was no change in vancomycin or linezolid use. Empiric therapy after implementation of DRIP documentation was concordant with institutional guidelines in 34.7% and 11.2% of patients with documented DRIP< 4 and DRIP≥4, respectively. Overall, the most common reason for non-concordance was lack of atypical coverage. Use of