Table. Susceptibilities of delafloxacin and comparators tested against isolates from community-acquired respiratory pathogens

Organism/ Antimicrobial agent	No. of isolates	mg/L			CLSI/ FDA [a]		
		MIC_{50}	MIC_{90}	MIC range	%S	%I	%R
S. aureus							
MSSA							
Delafloxacin	1,217	≤0.004	0.12	≤0.004 to 4	91.8	3.9	4.4
Levofloxacin	1,217	0.25	4	≤0.12 to >4	88.3	0.2	11.4
Moxifloxacin [b]	1,108	≤0.06	1	≤0.06 to >4	88.6	2.1	9.3
S. pneumoniae							
Delafloxacin	2,909	0.015	0.03	≤0.004 to 0.25	97.6		
Levofloxacin	2,909	1	1	0.25 to >4	99.4	0.1	0.5
Moxifloxacin	2,618	≤0.12	0.25	≤0.12 to 4	99.6	0.3	0.1
H. influenzae							
Delafloxacin	1,765	≤0.001	0.002	≤0.001 to >0.25	97.2		
Levofloxacin	1,765	≤0.015	0.03	≤0.015 to >2	99.7		
Moxifloxacin	1,602	0.03	0.06	0.008 to >2	99.6		
H. parainfluenzae							
Delafloxacin	46	0.004	0.015	≤0.001 to >0.06	91.3		
Levofloxacin	46	0.03	0.06	≤0.015 to 1	97.8		
Moxifloxacin	13	0.06	0.25	0.015 to >2	92.3		
E. coli							
Delafloxacin	321	0.06	>4	0.008 to >4	57.0	1.6	41.4
Levofloxacin	321	≤0.12	>4	≤0.25 to >4	59.8	0.6	39.6
Ciprofloxacin	319	0.06	>4	≤0.03 to >4	57.4	3.4	39.2
K. pneumoniae							
Delafloxacin	337	0.12	4	≤0.004 to >4	76.9	5.9	17.2
Levofloxacin	337	≤0.12	1	≤0.12 to >4	86.4	3.9	9.8
Ciprofloxacin	336	≤0.03	2	≤0.03 to >4	82.4	5.1	12.5
P. aeruginosa							
Delafloxacin	1,248	0.5	4	≤0.004 to >8	67.1	10.7	22.2
Levofloxacin	1,248	0.5	>4	≤0.12 to >4	64.0	11.2	24.8
Ciprofloxacin	1,248	0.25	4	≤0.03 to >4	71.6	7.5	20.9

[a] Criteria as published by FDA (delafloxacin) or CLSI (2021).
[b] Moxifloxacin not tested in 2015

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156. Correlation Between WHO (World Health Organization) Case Definition of Severe Pneumonia and Lung POCUS (Point of Care Ultrasound) vs Chest X-ray (CXR) Findings to Diagnose Pediatric Community-Acquired Pneumonia (CAP) in Limited Resource Settings

Ingrid Y. Camelo, MD, MPH[1]; Rachel Pieciak, MPH[2]; Ilse castro-aragon, MD[3]; Bindu Setty, MD[3]; Lauren Etter, n/a[4]; Christopher Gill, MD MS[5]; [1]UMass- Baystate Medical Center/Baystate Children's Hospital, Northampton, Massachusetts; [2]MPH, Boston, Massachusetts; [3]Boston Medical Center, Chestnut Hill, Massachusetts; [4]Boston University, Boston, Massachusetts; [5]Boston U. School of Public Health, Boston, MA

Session: O-31. Respiratory Infections

Background. Childhood pneumonia is one of the leading causes of death in low-income countries. The diagnosis of pediatric pneumonia is a critical epidemiological duty for treatment effectiveness and vaccine surveillance. Previous studies have demonstrated an important lack in correlation between CXR findings and the clinical WHO case definition of severe pneumonia. Lung Point of Care Ultrasound (POCUS) has demonstrated in multiple studies to be more sensitive and specific for diagnosing pneumonia in the pediatric population. With no exposure to radiation, extensive availability in limited-resource settings, and easy interpretation, this modality can be a breakpoint in making a more accurate correlation between pneumonia clinical findings and diagnostic imaging.

Methods. 50 children from 1-59 months meeting the WHO case definition of severe pneumonia were enrolled at the Emergency Department at University Teaching Hospital (UTH) in Lusaka, Zambia. Children underwent lung POCUS and CXR. Correlation between symptoms and all abnormalities (consolidation, effusion, and interstitial patterns) seen in both imaging modalities were analyzed by calculating the proportion of children with abnormalities on CXR and ultrasound. Each participant was assigned a score based on findings. 0 = normal, 1 = consolidation only, 2 = Consolidation and non-consolidation (interstitial and/or effusion) and 3 = non-consolidation (interstitial and/or effusion) only.

Results. 44 (90%) of children had abnormalities on CXR and 46 (94%) on POCUS. Five children (10%) had normal findings on CXR vs 3 (6%) on Lung POCUS. 4 (8%) had consolidation only on CXR vs 0 (0%) on POCUS. 19 (39%) had consolidation and non-consolidation (interstitial and/or effusion) on CXR vs. 20 (41%) on POCUS. 21 (43%) had non-consolidation (interstitial and/or effusion) only on CXR vs. 26 (53%) on POCUS.

Score	Definition	CXR (%)	POCUS (%)
0	"Normal"	5 (10%)	3 (6%)
1	Consolidation ONLY	4 (8%)	0 (0%)
2	Consolidation AND non-consolidation (interstitial and/or effusion)	19 (39%)	20 (41%)
3	Non-consolidation (interstitial and/or effusion) ONLY	21 (43%)	26 (53%)

Figure 1. Scores Asigned Based on Imaging Findings for CXR and Lung POCUS

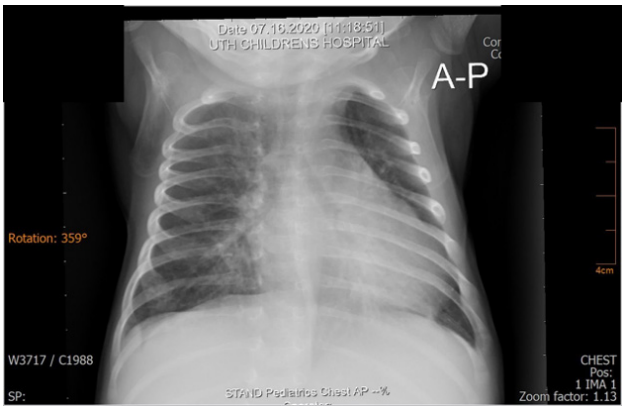

Figure 2. Chest X Ray Anterior Posterior (AP) view showing Bilareral Interstitial Pattern

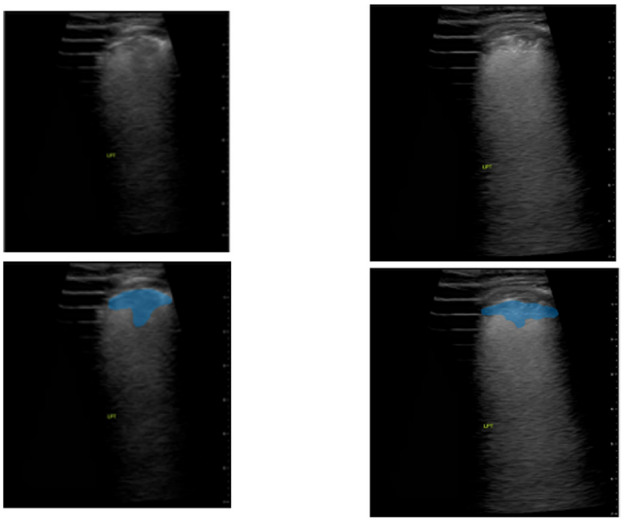

Figure 3. Lung POCUS (Point of Care Ultrasound) findings of bilateral Consolidation and non-consolidation pattern and bilateral interstitial pattern (only finding on CXR)

Conclusion. More children with clinical pneumonia had normal findings on CXR than on POCUS. POCUS was a better imaging technique to show consolidation and non-consolidation patterns than CXR. The higher proportion of children diagnosed with consolidation and non-consolidation patterns on POCUS suggest that CXR might not be the ideal gold standard to diagnose pneumonia in children.

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157. Impact of Pharmacist-Generated Oral Antimicrobial Test Prescription on Discharge Medication Access and Outcome

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Session: O-32. Stewardship in Ambulatory Settings

Background. Cost barriers to accessing discharge oral antimicrobials (ABX) may delay discharges and result in suboptimal discharge ABX. Use of electronic test prescriptions (eTP) or "price checks" is controversial due to potential for erroneous dispensing. This study evaluated discharge ABX access and outcome after implementation of a standardized, inpatient pharmacist-initiated ABX eTP process in collaboration with discharge pharmacy.

Methods. IRB approved, retrospective, cross-sectional cohort pilot-study. Inclusion: home bound adults admitted for ≥ 72 hours from 1/1/18-2/28/19 and discharged on oral ABX. Patients with an ABX eTP prior to discharge were compared to those discharged on ABX but no eTP. Data were reported using descriptive statistics and bivariate analysis. Primary endpoint: discharge delay after medical stability. Secondary endpoints: medication access, unplanned encounters, and % of patients discharged on first-line ABX.

Results. 84 patients included: 43 no-ETP and 41 eTP. 75 ABX eTP evaluated among 41 patients. Patients in the no-eTP group had higher Charlson comorbidity index ($P = 0.004$) and immunosuppression (24% vs. 12%; $P = 0.014$). Median length of stay, days: 6 (5 – 9) eTP vs. 8 (5 – 15) no-eTP ($P = 0.026$). Most common eTP requested by pharmacist: linezolid (17, 23%) and oral vancomycin (12, 16%) (Figure 1). eTP results were documented in the medical record in < 24 hours for 66 (88%) of inquiries. 49 (65%) prescriptions were approved by insurance; 16 (21%) had no out of pocket cost and 8 (11%) required prior authorization (PA) (Table 1). Linezolid (5, 35%) and public insurance (10, 71%) were frequently associated with barriers. 29 (70%) patients were discharged on the same ABX as the eTP. There were no discharge delays or erroneous dispensing. 14 (33%) no-eTP and 15 (37%) eTP patients experienced unplanned healthcare encounters after discharge. 9/84 (11%) patients were discharged on suboptimal ABX. Non-white race 8/9 (89%) $P = 0.047$ and public insurance 8/9 (89%) $P = 0.063$ were associated with suboptimal discharge ABX.

Figure 1. Oral Antimicrobial Test Prescription Pattern (n=75)

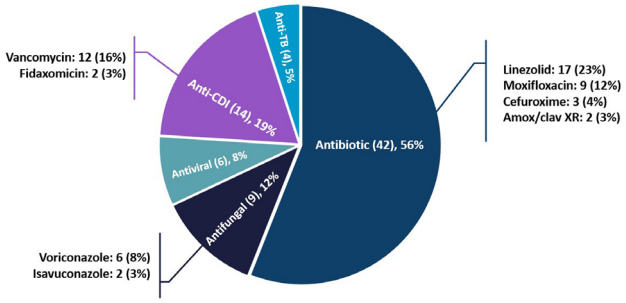

Table 1. Oral Antimicrobial Test Prescription Result (n=75)

ETP result	N (%)
Approved without an out of pocket cost	16 (21)
Approved with an out of pocket cost	33 (44)
Cost (median [IQR])	$14 ($4 - $55)
Denied	14 (19)
Denied, PA required	8 (11)
Denied, other reason	6 (8)
Other barriers	12 (16)

Conclusion. A standardized eTP process appears to be a safe way to evaluate out of pocket cost without prolonging length of stay. Future work will focus on inequity in access to first line ABX.

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158. Impact of Fluoroquinolone Cascade Reporting of Urine Samples on Antibiotic Prescribing Rates in a Network of Urgent Care Clinics

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Session: O-32. Stewardship in Ambulatory Settings

Background. Cascade reporting is a type of selective reporting in which susceptibility results of certain antibiotics (either with broader spectrum or cost) are only reported if an organism is resistant to other prespecified agents. This strategy has been successfully deployed in inpatient settings but its impact in outpatient settings is less well characterized. Therefore, we aimed to evaluate the impact of cascade reporting of the antimicrobial susceptibility of fluoroquinolones on prescribing rates of select antibiotics in a network of urban Urgent Care clinics.

Methods. On July 2019, the susceptibility reporting policies for urine cultures growing Enterobacterales were changed to routinely reporting a limited antibiotic panel including first and second generation cephalosporins, nitrofurantoin and