Table 1. Comparison of pre-intervention and post-intervention outcome measures

	Pre-intervention (7/1/21 – 9/30/21) N=153	Post-intervention (7/1/22 – 9/30/22) N=164	*P*
Total duration of therapy >7 days, n (%)	44 (29%)	23 (14%)	0.0013
Mean total duration of therapy, days ± standard deviation	7.0 ± 2.3	5.9 ± 1.6	<0.001
Guideline-discordant empiric therapy, n (%)	50 (33%)	31 (19%)	0.0049
Unnecessary fluoroquinolone, n (%)	15 (10%)	0 (0%)	0
Unnecessary *P. aeruginosa* coverage, n (%)	20 (13%)	14 (9%)	0.1922
No Pseudomonas coverage when indicated, n (%)	3 (2%)	1 (0.6%)	0.356
Unnecessary MRSA coverage, n (%)	6 (4%)	8 (5%)	0.6787
No MRSA coverage when indicated, n (%)	11 (7%)	1 (0.6%)	0.0022
Unnecessary anaerobic coverage, n (%)	5 (3%)	10 (6%)	0.2357
No atypical coverage, n (%)	12 (8%)	9 (5%)	0.3995

Presentation Type:
Poster Presentation - Poster Presentation
Subject Category: Antibiotic Stewardship
Reducing the rate of guideline-discordant therapy for inpatients with community-acquired pneumonia
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Background: Despite guidelines recommending shorter durations of therapy and empiric coverage of *Pseudomonas aeruginosa* and methicillin-resistant *Staphylococcus aureus* (MRSA) only for patients with certain risk factors, optimizing therapy for community-acquired pneumonia (CAP) remains a challenge for antimicrobial stewardship (AMS) teams. We investigated the impact of a multimodal AMS initiative on the rate of guideline-discordant empiric antibiotic selection and total duration of therapy for CAP. **Methods:** A quality improvement initiative was implemented at 9 community hospitals in 2022 to optimize CAP therapy. Education was provided to pharmacists and providers. Alerts were implemented within the electronic medical record to prompt the AMS team to review fluoroquinolones, antipseudomonal β-lactams, and anti-MRSA agents ordered for CAP. Clinical pharmacists reviewed antibiotic orders for CAP at hospital discharge and encouraged providers to prescribe a total antibiotic duration of 5–7 days. For the preintervention period (July–September 2021) and the postintervention period (July to September 2022), a random sample of 320 patients with an antibiotic order for CAP were evaluated retrospectively via chart review. Patients treated for an indication other than CAP were excluded. The primary outcome was the proportion of patients with a total duration of therapy >7 days. Secondary outcomes included average duration of therapy, rate of guideline-discordant empiric therapy, and type of guideline discordance. **Results:** In total, 317 patients were included. The proportion of patients with a total duration of therapy >7 days decreased from 29% to 14% ($P < .01$). Average duration of therapy and guideline-discordant empiric therapy also decreased significantly (Table 1). **Conclusions:** This multifaceted AMS initiative was associated with decreased guideline-discordant empiric therapy and decreased total duration of therapy for CAP.
Disclosures: None

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Determining trends of respiratory tract infections in a long-term care facility pilot surveillance project
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Background: Respiratory tract infections (RTIs) in long-term care facilities (LTCFs) are particularly burdensome among residents, the COVID-19 pandemic highlighted the devastating consequences of RTIs in LTCFs. This situation has prompted the need for LTCFs to have a robust, active surveillance system to assist LTCFs with RTI identification. Such a system could assist with faster implementation of appropriate antimicrobial therapy and critical infection prevention and control. The TN Emerging Infections Program worked with CDC EIP to implement a pilot project to test the feasibility of performing RTI surveillance to inform future changes to NHSN. **Methods:** We recruited 6 LTCFs to collect prospective RTI surveillance for 6 consecutive months from October 2021 through March 2022. Data were collected for all residents meeting the RTI surveillance definitions: pneumonia, lower respiratory tract infection, influenza-like illness (including influenza), and COVID-19. These data were entered by facility workers into a REDCap database with a prospective RTI LTCF event form. Monthly data collection summaries were submitted using a designated denominator form. Descriptive statistics were used to analyze RTI data, and analyses were performed using SAS version 9.4 software. **Results:** In total, 6 facilities participated in the pilot project during the capture period. The total number of RTI cases across all facilities was 195. December had the most cases (n = 50). The most common first triggers were new RTI signs or symptoms (67.69%), laboratory results (17.44%), imaging findings (6.67%), and clinician-diagnosed RTI (8.21%). The most reported symptom was new or increased cough (57.44%). Chest radiographs were performed for 50.77% of patients. Positive viral laboratory test results were documented 29.74% of the time. Antibiotic treatments were given to 70.77% of residents. The most commonly prescribed antibiotics were cephalosporins (22.56%), macrolides (17.95%), fluoroquinolones (12.31%), and doxycycline (9.23%). Also, 17.4% of cases with antibiotic regimens had cephalosporins as monotherapy. Vaccine documentation was as follows: influenza 2020–2021 (40.51%), influenza 2021–2022 (64.1%), complete COVID-19 vaccine series (82.56%), PPSV-23 vaccine (33.85%), and PCV-13 (23.59%). **Conclusions:** RTI surveillance was incorporated smoothly into the daily workflow for facilities; the biggest barrier to effective implementation was staff turnover. A scheduled weekly time to collect data and fill out forms proved most effective. A high percentage of cases was treated with cephalosporins as monotherapy, which, based on the latest guidelines, may be suboptimal. Individual reports were sent back to facilities with a comparison to the aggregated data. These data will be used to evaluate antibiotic appropriateness and to guide future RTI surveillance efforts in the LTCF setting.
Disclosures: None

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Pharmacist interventions for appropriate COVID-19 antiviral therapy in long-term care facilities: A public health initiative
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Background: Prescribing errors related to the COVID-19 oral antiviral agent nirmatrelvir-ritonavir have been reported and are primarily due to improper renal dosing and significant drug–drug interactions. These patient safety issues are particularly concerning in the long-term care facility (LTCF) population. The Nebraska Antimicrobial Stewardship Assessment and Promotion Program (ASAP) is a unique collaborative partnership involving the University of Nebraska Medical Center, Nebraska Medicine, and the Nebraska Department of Health and Human Services (DHHS). ASAP is funded through the Nebraska DHHS healthcare-associated infections and antimicrobial resistance (HAI/AR) program and was established in 2016, with a primary focus of promoting safe and effective antimicrobial use in Nebraska. In 2022, ASAP developed a statewide pharmacist-led service to assist LTCFs in evaluating prescriptions for COVID-19 oral therapeutics. We studied the impact of ASAP pharmacist intervention on COVID-19 oral antiviral prescriptions. **Methods:** ASAP created a centralized LTCF treatment