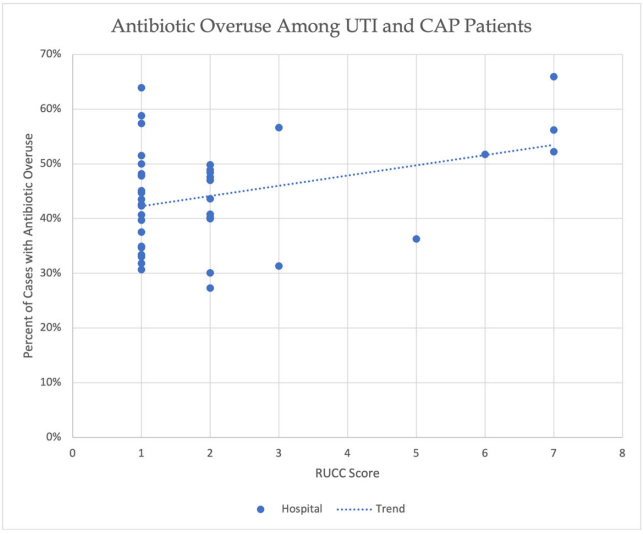

factors, symptoms, allergies, diagnostic results, and time to stability. Hospital rurality was defined using the Rural–Urban Continuum Codes (RUCC) score. We defined rural as a score ≥4 and very rural as a score of 7–9. We used *t* tests to compare the mean percentage of patients with antibiotic overuse at discharge between nonrural and rural (and very rural) hospitals. **Results:** Across 41 hospitals, we included 23,449 patients with CAP or UTI. There were 5 rural (and 3 very rural) hospitals with 2,039 (and 1,082) patients. Antibiotic overuse at discharge was present in 43.1% of patient cases in nonrural hospitals, 52.5% in rural hospitals ($P = .04$ vs nonrural) and 58.1% in very rural hospitals ($P = .007$ vs nonrural). Compared to nonrural hospitals, the mean percentage of cases with antibiotic overuse at discharge in rural hospitals was 9.4% higher (15.1% higher in very rural hospitals). Results were similar in a subgroup analysis of only patients with UTI (47.0% in rural vs 37.5% in nonrural, mean difference, 9.5%; $P = .03$) but were not statistically significant in patients with CAP (53.8% vs 48.0%, respectively; mean difference, 5.8%; $P = 0.23$). **Conclusions:** In this retrospective study, rural hospitals—especially very rural hospitals, had higher rates of antibiotic overuse at discharge than nonrural hospitals. Our findings suggest that antibiotic stewardship interventions tailored toward the unique differences in infrastructure, resources, and needs of rural hospitals are essential to community health.
Disclosures: None

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Presentation Type:
Poster Presentation - Poster Presentation
Subject Category: Antibiotic Stewardship
Validation of antibiotic stewardship metrics for genitourinary infection management in Veterans Affairs outpatient settings
Jordan Braunfeld; Matthew Samore; Jacob Crook; McKenna Nevers; Kelly Echevarria; Ben Brintz; Matthew Goetz and Karl Madaras-Kelly

Background: Diagnosis and management of suspected urinary tract infection (UTI) in outpatient settings has been shown to be suboptimal. We previously developed a set of stewardship metrics for UTIs based on electronic health record (EHR) data (*Antimicrobial Stewardship & Healthcare Epidemiology* 2022;2 suppl 1:S5–S6. doi:10.1017/ash.2022). A tier-based approach was used to more fully capture antibiotic use associated with genitourinary (GU) symptoms and diagnoses. Herein we report a preliminary analysis of validity and reliability of these metrics based on chart abstraction. **Methods:** The study cohort consisted of patients who visited Veterans Affairs emergency departments or primary care clinics between 2015 and 2022 and who had a GU diagnosis based on *International Classification of Disease, Tenth Revision* (ICD-10) codes, divided into 3 categories: tier 1 (antibiotics always indicated), tier 2 (antibiotics sometimes indicated), and tier 3 (antibiotics not indicated). Visits related to urological procedures, nontarget settings, or concomitant non-GU infections were excluded. Cases were randomly sampled for manual review from within 8 strata based on tier, use of antibiotics, and visit type. An infectious disease physician and pharmacist abstracted charts using a standardized data-collection instrument. Clinical judgments regarding diagnosis and treatment were recorded on a Likert scale without knowledge of how the patient was managed. The intraclass correlation coefficient (ICC) was used to estimate interrater reliability. **Results:** To date, 148 cases have been reviewed (50 by both reviewers). Mean (SD) age was 67.5 (15.3) years and 12.2% were female. In a majority of tier 1 and 2 visits in which antibiotics were given, the reviewers found evidence for GU infection (69.7%) and favored prescribing of antibiotics (60.6%) (Table). In contrast, most patients in the tier 3 category who received antibiotics were judged to have noninfectious conditions (eg, benign prostatic hypertrophy) and to not require antibiotics. In the subset of records examined by both reviewers, the interrater reliability of judgments of whether antibiotics were warranted was good (ICC = .704). **Conclusions:** This preliminary validation provides support for a tier-based approach for stewardship metrics for GU conditions that relies upon electronic data to identify patients for whom antibiotics are generally not indicated.
Disclosures: None

Tier	Antibiotic Prescribed	Cases reviewed (N)	Age (SD)	Female (%)	Reviewer diagnosed GU infection, N (%)	Reviewer recommended antibiotics, N (%)
1/2	Yes	33	63.1 (15)	8 (24.2)	23 (69.7)	20 (60.6)
	No	45	64.7 (18.3)	6 (13.3)	3 (6.7)	5 (11.1)
3	Yes	29	71.4 (13.1)	0	2 (6.9)	4 (13.8)
	No	41	71.5 (11.6)	4 (9.8)	1 (2.4)	0

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Presentation Type:
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Subject Category: Antibiotic Stewardship
Understanding clinician perspectives on antibiotic associated adverse events to inform feedback
Jerald Cherian; George Jones; Taylor Helsel; Zunaira Virk; Alejandra Salinas; Suzanne Grieb; Sara Keller; Pranita Tamma and Sara Cosgrove

Background: Feedback regarding antibiotic-associated adverse events (ABX-AEs) may assist clinicians with antibiotic decision making. We

Table. Categorization of Antibiotic-Associated Adverse Events by Degree of Clinical Concern

Prespecified Categorization	Votes (n)*		
Very Concerning	Very Concerning	Moderately Concerning	Mildly Concerning
Nephrotoxicity – Requiring dialysis	12	-	-
Clostridioides difficile infection – Severe	12	-	-
Neuropathy	12	-	-
Stevens-Johnson syndrome	12	-	-
Anaphylaxis	12	-	-
DRESS Syndrome	11	1	-
Moderately Concerning			
Nephrotoxicity – Not requiring dialysis	-	11	1
Clostridioides difficile infection – Non-severe	-	10	2
Hepatotoxicity	1	4	4
Encephalopathy	2	9	-
Seizures	7	5	-
Hemolytic anemia	-	10	-
Neutropenia	1	9	-
Thrombocytopenia	1	8	1
Prolonged QTc	1	10	-
Mildly Concerning			
Diarrhea, nausea, or emesis	-	1	10
Non-hives rash	-	-	10
Myositis	-	-	10

*Not all participants voted for each adverse event