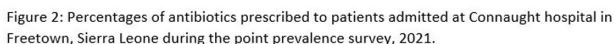
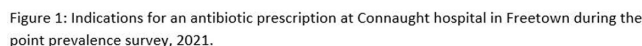


Variable	Mean of 2014 n=202	Standard of n=202	Mean of 2015 n=202	P-value
Age	33.95	10.03	33.95	0.000
Gender				
Male	107 (52.97%)	10.03	107 (52.97%)	
Female	95 (47.03%)	10.03	95 (47.03%)	
Marital status				
Married	107 (52.97%)	10.03	107 (52.97%)	
Unmarried	95 (47.03%)	10.03	95 (47.03%)	
Marital history				
Never married	107 (52.97%)	10.03	107 (52.97%)	0.147
Once married	95 (47.03%)	10.03	95 (47.03%)	
Divorced	95 (47.03%)	10.03	95 (47.03%)	0.000
Widow	95 (47.03%)	10.03	95 (47.03%)	
Religion				
Islam	107 (52.97%)	10.03	107 (52.97%)	0.147
Other	95 (47.03%)	10.03	95 (47.03%)	
Education				
High school or below	107 (52.97%)	10.03	107 (52.97%)	0.147
University	95 (47.03%)	10.03	95 (47.03%)	
Work place				
Private	107 (52.97%)	10.03	107 (52.97%)	0.147
Government	95 (47.03%)	10.03	95 (47.03%)	
Self-employed	95 (47.03%)	10.03	95 (47.03%)	0.147
Unemployed	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
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Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
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Work place history				
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Work place history				
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Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	
Work place history				
Never work	107 (52.97%)	10.03	107 (52.97%)	0.147
Worked	95 (47.03%)	10.03	95 (47.03%)	

Variable	Normal of $\hat{\beta}_{OLS}$ SE-SD	Normal of $\hat{\beta}_{OLS}$ SE-SEB	P-value
Constant	1.0000000	1.0000000	0.000
Age (years)	0.0000000	0.0000000	0.000
Age squared	-0.0000000	-0.0000000	0.000
Age cubed	0.0000000	0.0000000	0.000
Age quartic	0.0000000	0.0000000	0.000
Age quintic	0.0000000	0.0000000	0.000
Age sextic	0.0000000	0.0000000	0.000
Age septic	0.0000000	0.0000000	0.000
Age octic	0.0000000	0.0000000	0.000
Age nonic	0.0000000	0.0000000	0.000
Age decic	0.0000000	0.0000000	0.000
Age undecic	0.0000000	0.0000000	0.000
Age duodecic	0.0000000	0.0000000	0.000
Age tredecic	0.0000000	0.0000000	0.000
Age quattuordecic	0.0000000	0.0000000	0.000
Age quindecic	0.0000000	0.0000000	0.000
Age sexdecic	0.0000000	0.0000000	0.000
Age septendecic	0.0000000	0.0000000	0.000
Age octodecic	0.0000000	0.0000000	0.000
Age novemdecic	0.0000000	0.0000000	0.000
Age vigintic	0.0000000	0.0000000	0.000
Age unguic	0.0000000	0.0000000	0.000
Age sexagesim	0.0000000	0.0000000	0.000
Age sexagesim squared	0.0000000	0.0000000	0.000
Age sexagesim cubed	0.0000000	0.0000000	0.000
Age sexagesim quartic	0.0000000	0.0000000	0.000
Age sexagesim quintic	0.0000000	0.0000000	0.000
Age sexagesim sextic	0.0000000	0.0000000	0.000
Age sexagesim septic	0.0000000	0.0000000	0.000
Age sexagesim octic	0.0000000	0.0000000	0.000
Age sexagesim nonic	0.0000000	0.0000000	0.000
Age sexagesim decic	0.0000000	0.0000000	0.000
Age sexagesim undecic	0.0000000	0.0000000	0.000
Age sexagesim duodecic	0.0000000	0.0000000	0.000
Age sexagesim tredecic	0.0000000	0.0000000	0.000
Age sexagesim quattuordecic	0.0000000	0.0000000	0.000
Age sexagesim quindecic	0.0000000	0.0000000	0.000
Age sexagesim sexdecic	0.0000000	0.0000000	0.000
Age sexagesim septendecic	0.0000000	0.0000000	0.000
Age sexagesim octodecic	0.0000000	0.0000000	0.000
Age sexagesim novemdecic	0.0000000	0.0000000	0.000
Age sexagesim vigintic	0.0000000	0.0000000	0.000
Age sexagesim unguic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim	0.0000000	0.0000000	0.000
Age sexagesim sexagesim squared	0.0000000	0.0000000	0.000
Age sexagesim sexagesim cubed	0.0000000	0.0000000	0.000
Age sexagesim sexagesim quartic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim quintic	0.0000000	0.0000000	0.000
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Age sexagesim sexagesim septic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim octic	0.0000000	0.0000000	0.000
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Age sexagesim sexagesim duodecic	0.0000000	0.0000000	0.000
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Age sexagesim sexagesim sexagesim sexagesim sexagesim cubed	0.0000000	0.0000000	0.000
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Age sexagesim sexagesim sexagesim sexagesim sexagesim quintic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim sextic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim septic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim octic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim nonic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim decic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim undecic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim duodecic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim tredecic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim quattuordecic	0.0000000	0.0000000	0.000
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Age sexagesim sexagesim sexagesim sexagesim sexagesim sexdecic	0.0000000	0.0000000	0.000
Age sexagesim sexagesim sexagesim sexagesim sexagesim septendecic	0.0000000	0.0000000	0.000
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of drug administration was the mainstay. The most frequent indications for antibiotic prescription were community-acquired infection and surgical prophylaxis. Blood-culture requests were not ordered before the initiation of antibiotic treatment. **Conclusions:** This study was the first study to be conducted in Connaught hospital using the WHO PPS methodology. The survey reports a high prevalence (60%) of antibiotic use, and most treatment was done empirically. This finding is contrary to the WHO recommendation of <30% antibiotic use. This high prevalence of antibiotic use has the potential to increase the burden of AMR in the country. Therefore, there is an urgent need to strengthen Connaught hospital's antibiotic stewardship program.

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doi:[10.1017/ash.2023.242](https://doi.org/10.1017/ash.2023.242)

Poster Presentation - Poster Presentation

Sex differences in knowledge and practices regarding antibiotics and antibiotic resistance in the Puerto Rican population

Background: Antibiotic resistance is one of the biggest threats to global health, and by 2050 it is expected to cause 10 million deaths per year globally. Sex differences depend on context and sociodemographic factors; therefore, studies addressing sex differences have been inconclusive. Furthermore, to our knowledge, sex differences in the Puerto Rican population have not been analyzed. We sought to understand whether knowledge and practices regarding antibiotic use and antibiotic resistance in the Puerto Rican population differ by sex. **Methods:** A convenience sampling was performed at outpatient clinics across Puerto Rico. Those who agreed to participate completed a self-report questionnaire aimed to address demographics, antibiotic knowledge, and experiences. Bivariate analyses were performed using Stata version 17.0 software. **Results:** In total, 252 participants received the questionnaire, and 250 completed it. Most of the participants were female (71.2%), aged >56 years (40.0%), and had a high school diploma (40.4%). Women had 2.71 (95% CI, 1.1–6.8, P). **Conclusions:** Women perceived themselves to be more knowledgeable regarding antibiotic use and resistance than men. However, no difference in actual knowledge could be identified. Similarly, antibiotic-related practices did not differ by sex except for using previously saved antibiotic treatment, and men had higher odds of conducting this practice. Further studies should be conducted to understand the factors that influence these behavioral practices, and educational interventions should focus on addressing misconceptions regarding antibiotics and antibiotic resistance.

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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 \pm standard deviation	7.0 \pm 2.3	5.9 \pm 1.6	<0.001
Guideline-discordant empiric therapy, n (%)	50 (33%)	31 (19%)	0.0049
Unnecessary fluoroquinolone, n (%)	15 (10%)	0 (0%)	0
Unnecessary <i>P. aeruginosa</i> coverage, n (%)	20 (13%)	14 (9%)	0.1922
No <i>Pseudomonas</i> 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**

Kellie Arensman Hannan; Paul Frykman; Eric Mathiowetz; Jill Sathre; Nou Cheng Yang and Kelsey Jensen

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*Antimicrobial Stewardship & Healthcare Epidemiology* 2023;3(Suppl. S2):s24

doi:10.1017/ash.2023.244

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Antibiotic Stewardship**Determining trends of respiratory tract infections in a long-term care facility pilot surveillance project**

Cullen Adre; Dipen Patel; Vicky Reed; Srilakshmi Velrajan; Christopher Evans and Christopher Wilson

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*Antimicrobial Stewardship & Healthcare Epidemiology* 2023;3(Suppl. S2):s24

doi:10.1017/ash.2023.245

Presentation Type:

Poster Presentation - Poster Presentation

Subject Category: Antibiotic Stewardship**Pharmacist interventions for appropriate COVID-19 antiviral therapy in long-term care facilities: A public health initiative**

Jenna Preusker; Daniel Schroeder; Mounica Soma; Scott Bergman; Mark Rupp; Brandon Scott; Trevor Van Schooneveld; Andrew Watkins; Matthew Donahue and Muhammad Salman Ashraf

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