

primary team including optimal antibiotic treatment (for CDI and any concomitant infection), and consultant involvement including ID, surgery, and GI, when appropriate. Using retrospective chart review, CDI patient management and outcomes were compared before and after implementation of the MD-CAT. Differences in the time to consults and frequency of interventional treatment was compared using Chi-square or Wilcoxon Rank-sum test.

Results. We compared 48 patients with CDI in the pre-intervention with 89 patients in the post-intervention period. Demographic and clinical characteristics of the groups were similar. MD-CAT intervention was associated with frequent (73%) modification or discontinuation of concomitant antibiotics. Median time to GI and ID consults was significantly shorter in the post group ($P = 0.007$ and $P = 0.004$, respectively). Five of 89 (5.6%) of patients received FMT or colon-preserving surgical intervention in the post-intervention group compared with no patients in the pre-intervention group. There was no difference in 30-day all-cause mortality or CDI recurrence between groups.

Conclusion. Early, multi-disciplinary action on patients with CDI increased the proportion of patients undergoing active specialty consultation and improved use of concomitant antibiotics. A larger sample size is needed to determine the effects of such a team on other clinical outcomes.

Figure 1: Time to GI Consult

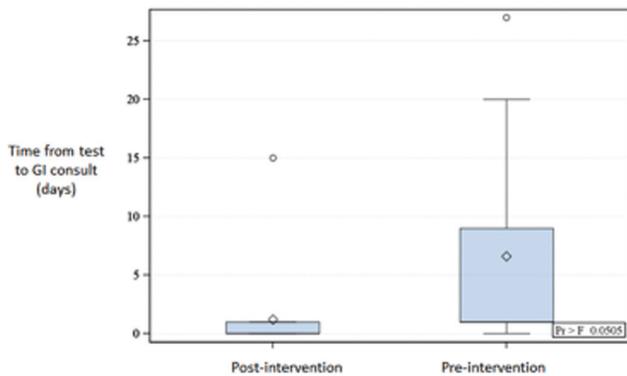
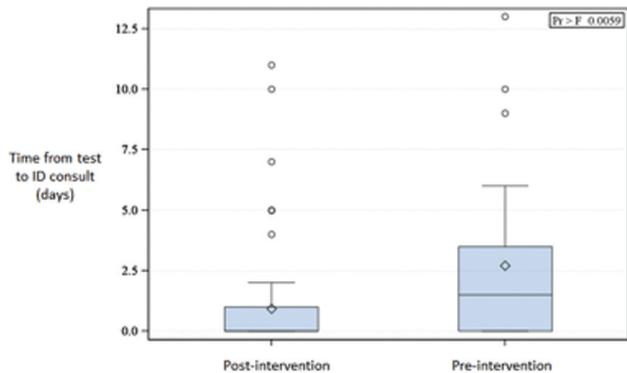


Figure 2: Time to ID Consult



Disclosures. All authors: No reported disclosures.

1294. Clostridium difficile (CD) Action Team (CDAT): An Intervention to Improve Care for Patients with a Positive CD PCR

Theodore Markou, MD¹; Valeria Fabre, MD²; Kathryn Dzintars, PharmD³; Edina Avdic, MBA, PharmD, BCPS AQ-ID³; Stephanie Shulder, PharmD³; Jennifer Andonian, MPH⁴; Clare Rock, MD MS⁵ and Sara E. Cosgrove, MD, MS⁶; ¹Infectious Disease, Johns Hopkins Hospital, Baltimore, MD, ²Infectious Diseases, Johns Hopkins Hospital, Baltimore, Maryland, ³Department of Pharmacy, The Johns Hopkins Hospital, Baltimore, Maryland, ⁴Department of Hospital Epidemiology and Infection Control, The Johns Hopkins Hospital, Baltimore, Maryland, ⁵Infectious Diseases, St. James's Hospital, Dublin, Ireland, ⁶Johns Hopkins Medical Institutions, Baltimore, Maryland

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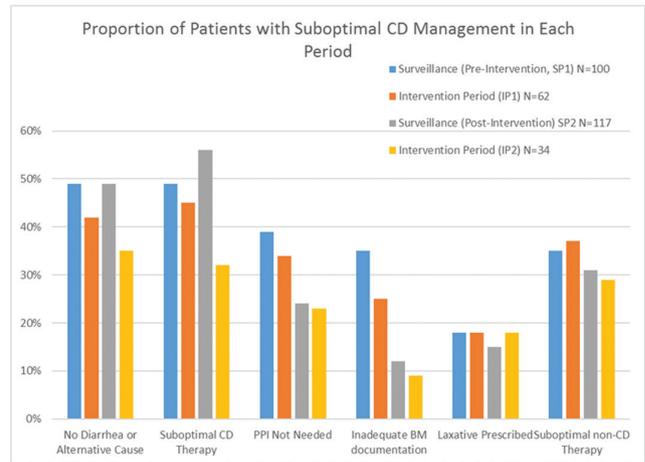
Background. CD infections (CDI) may be viewed by healthcare workers (HCW) as an unpreventable consequence of antibiotics (abx). The purpose of CDAT was to use patient cases in real time to educate HCW on CD diagnostic, treatment and prevention practices including appropriate abx and proton-pump inhibitors (PPI) use.

Methods. From 7/17/16 to 5/6/17, Johns Hopkins abx stewardship team reviewed positive CD PCRs in inpatient to determine whether they had CDI or colonization

(no diarrhea or an alternate cause) and if prevention and management was optimal. Included in this time are 2 surveillance periods (SP) (SP1: 7/17-9/27/16 and SP2: 12/18/16-3/30/17). During SP1, there was no contact with HCW. SP2 followed the intervention, and allowed assessment of sustained practice changes. During the intervention periods (IP) (IP1: 10/9-12/17/16 and IP2: 3/31-5/6/17), teaching points for optimizing care for each case were shared and discussed in person with the HCW team, including prescribers and nursing. Compliance with recommendations at 48 hours was assessed. Chi-square test was used to compare sub-optimal management for each variable in different time periods.

Results. We assessed 217 cases in the SPs and 96 cases in the IPs. 75 of 96 cases reviewed in the IPs required intervention. CDAT spoke to 74 teams, which led to a change in the care of patients in 49 cases (65%). Compliance with recommendations were as follows: 1) stop or modify CDI therapy, 53%, (39 cases); 2) stop PPI therapy, 52% (15 cases); 3) stop laxatives, 53% (9 cases); 4) stop or modify non-CDI abx, 46% (16 cases); and 5) improve BM documentation, 58% (11 cases). The Figure shows proportions of patients with suboptimal CD management without (SPs) or before (IPs) CDAT intervention in each period. There were no changes in practice between the SP1 and IP1. Between the SP1 and IP2, significant improvement in BM documentation was seen ($P = 0.007$). No differences were observed for other variables, although there was a trend towards improved CD therapy ($P = 0.09$).

Conclusion. Overall, prescribers did not independently change practice as a result of daily contact with CDAT; however, they were responsive to CDAT recommendations. BM documentation, the only nursing intervention, improved significantly.



Disclosures. All authors: No reported disclosures.

1295. Know When to Test: Optimizing Diagnostic Practices for Clostridium difficile Infection (CDI) Among Patients at a Tertiary-Care Cancer Center
Anoshé Aslam, MPH¹; Janet Eagan, RN, MPH, CIC¹; Janice Kaplan, RN, CIC¹; Elizabeth Robiloti, MD, MPH¹; Tracy McMillen, BS¹; Monika Kamalska-Cyganik, MS, MA¹; Suzanne Kelson, MPH¹; Reshma Nevrekar, BS¹; Wazim Narain, PhD¹; Peter Stetson, MD, MA¹; Mini Kamboj, MD¹ and N. Esther Babady, Ph.D²; ¹Memorial Sloan Kettering Cancer Center, New York, New York, ²Clinical Microbiology Service, Department of Laboratory Medicine, Memorial Sloan Kettering Cancer Center, New York, New York

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Background. Polymerase chain reaction (PCR) based diagnostic testing for the detection of toxigenic Clostridium difficile infection (CDI) does not distinguish between carriers and patients with true CDI. As a result, CDI is over-diagnosed in hospitalized patients with diarrhea. Unnecessary testing generates false positives and several downstream sequelae.

Aim: The aim of this study was to reduce unnecessary testing for CDI through an electronic alert, targeted education, and implementation of evidence-based laboratory testing policy.

Methods. In order to quickly identify laxative induced diarrhea and avoid CDI testing, an electronic alert was created in the electronic medical record (EMR) system. The alert was built on a logic that identified patients who had received laxatives within 48 hours of a CDI PCR test order. The alert additionally provided the rationale for avoiding testing in patients on laxatives and guidance on appropriate testing for CDI. The following steps were taken simultaneously to complement these efforts: 1) Infection Control conducted hospital-wide education for licensed independent practitioners on a CDI testing algorithm 2) Laboratory based policy was instated to reject all formed stools (Bristol Stool Chart types 1 through 4) for CDI testing.

Results. In the 6 month pre-intervention period, there were 29 CDI tests per 1000 patient-days. In the post-intervention period, CDI tests decreased to 19 per 1000 patient-days, a 35% decrease ($P < 0.0001$). The decline in testing has been sustained for 7 months. The following observations were also made: 1) HAI rate reduction of 28%; 2) decrease in oral vancomycin use.