Table1. Desirability of Outcome Ranking (DOOR) Combining Physician and Patient Survey Results[a]				
Final Ranking	Clinician ranking (median (IQR))	Patient ranking (median (IQR))	p value*	Description of clinical outcome 2 weeks after initial emergency department visit
1	1.0 (1.0 to 1.0)	1.0 (1.0 to 1.0)	0.183	Not hospitalized, no PNA symptoms, no anitibiotic AE
2	3.0 (3.0 to 3.0)	4.0 (3.0 to 4.5)	0.002	Not hospitalized, no PNA symptoms, nausea and vomiting requiring antiemetic during hospitalization
2	3.0 (2.0 to 4.0)	2.0 (2.0 to 3.0)	0.04	Not hospitalized, non-limiting residual PNA symptoms, no antibiotic AE
2	3.0 (2.0 to 4.0)	4.0 (3.0 to 6.0)	0.02	Not hospitalized, no PNA symptoms, non-limiting nausea and diarrhea after hospitalization
3	5.0 (5.0 to 6.0)	5.0 (3.0 to 7.0)	0.200	Not hospitalized, limiting residual PNA symptoms, no antibiotic AE
3	6.0 (5.0 to 6.0)	7.0 (6.0 to 7.5)	0.053	Not hospitalized, no residual PNA symptoms, C difficile infection requiring visit and treatment
3	7.0 (6.0 to 7.0)	5.0 (4.5 to 6.0)	<0.001	Not hospitalized, no residual PNA symptoms, MDRO UTI requiring IV antibiotics
4	8.0 (8.0 to 8.0)	8.0 (7.0 to 8.0)	0.03	Hospitalized, any or none PNA symptoms, any or none antibiotic AE
5	9.0 (9.0 to 9.0)	9.0 (9.0 to 9.0)	0.04	Patient has died

*Comparisons made using Mann Whitney U test, p<0.05 considered significant. [a]Rankings ordered based on physician median and IQR, similar rankings color coded. Abbreviations: PNA, pneumonia; AE, adverse event; MDRO UTI, multi-drug resistance organism urinary tract infection.

Table 2. Selected quotes from PFAC meeting paired with clinical outcome cases		
Clinical Outcome Case	Physician and patient ranking difference	PFAC patient or family exemplar quote
Patient has died.	Patient ranked more desirable	"Sometimes, when very ill, patients might feel like they've had enough. Chronic discomfort can make death seem like a relief. The severity of symptoms can be very subjective."
Not hospitalized, no PNA symptoms, nausea and vomiting requiring antiemetic during hospitalization. AND Not hospitalized, no PNA symptoms, non-limiting nausea and diarrhea after hospitalization.	Patient ranked more undesirable	"There's a difference in perspective between doctors and patients. Doctors might not prioritize what patients have to live with in terms of symptoms. Patients are focused on what's bad for them personally."
Not hospitalized, no residual PNA symptoms, C difficile infection requiring visit and treatment.	Patients ranked more undesirable (p=0.053)	"I agree that C. diff is the worst. It's a significant risk throughout a patient's life once infected. I rate it very high on the severity scale."
Requiring readmission, any or none PNA symptoms, any or none AE.	Patients ranked more desirable	"As someone that works in a health system, when I see what the docs think are worse, those are things that in a health system you're conditioned to think are worse."

Abbreviations: PFAC, patient and family advisory committee; PNA, pneumonia; AE, adverse event.

not potentially life-threatening as less desirable than physicians. Physicians tended to rank quality linked metrics such as readmission as worse than patients. When designing future trials using DOOR scores, researchers should consider including patients in DOOR score design as their perspectives may differ from clinicians.

Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship
Effect of UTI treatment guideline implementation on antibiotic duration and selection

Jonathan Huang[1], Sujit Suchindran[2], Benjamin Albrecht[3], Sarah Green[4], Julianne Kubes[5] and Lucy Witt[6]
[1]Emory University School of Medicine; [2]Emory University School of Medicine; [3]Emory University Hospital; [4]Emory University Hospital; [5]Emory Healthcare and [6]Emory University

Background: Clinicians have variable prescribing practices for treating urinary tract infections (UTI), resulting in broader and longer treatment

Figure 1: Inpatient DOT
Following implementation, increase by 31.5 DOT/month with a sustained increase by 6.25 DOT/month with no statistically significant change
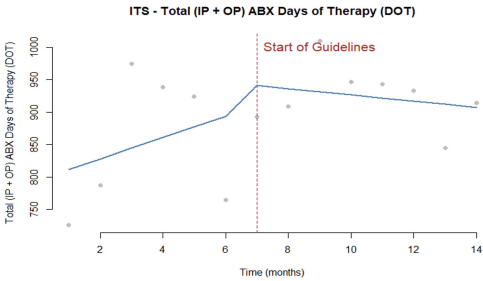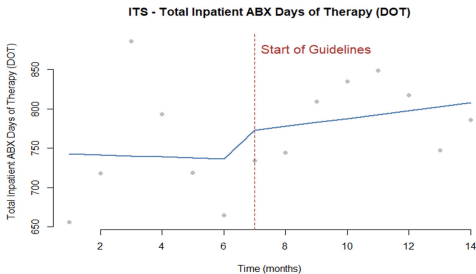

Figure 2: Total DOT (Inpatient + Outpatient)
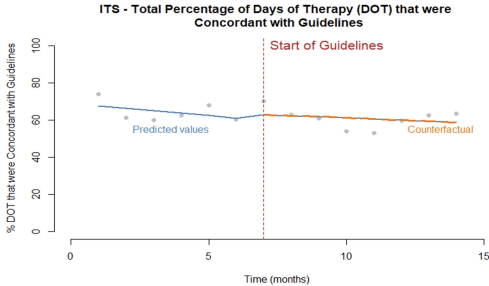Following implementation, sustained decrease by 21.1 DOT/month with no overall statistical significance

Figure 3: Inpatient Guideline Concordance Prescribing
Following implementation, increase by 2.5% per month with a sustained increase by 0.7% per month with no statistically significant change

Clinical Outcome	Pre-Guidelines (n = 978)	Post-Guidelines (n = 1420)	Estimate or OR (95% CI)	P value	Adjusted Estimate or OR (95% CI)[a]	P value
LOS, mean (SD)	12.4 (20.4)	11.0 (16.2)	-1.4 (-2.9, 0.07)	0.06	-1.2 (-2.6, 0.13)	0.08
Positive C.difficile test w/in 90 Days, n (%)	9 (0.9%)	17 (1.2%)	1.3 (0.59, 3.1)	0.52	1.3 (0.60, 3.1)	0.51

Table 1: Crude and Risk-Adjusted Secondary Outcomes
LOS (length of stay) and rates of C. diff were not statistically significant

durations than necessary. In March 2023, guidelines for UTI treatment were developed and disseminated across our hospital system. **Methods:** We evaluated inpatients at Emory University Hospital (EUH) who received antibiotics with an indication of UTI between November 2022 and March 2024 to investigate implementation effect on treatment duration and choice. We characterized days of therapy (DOT) by performing interrupted time series analysis, adjusting for demographic and clinical variables. Additionally, we looked at percent use of guideline concordant antibiotics chosen before and after implementation. **Results:** A total of 978

cases of UTIs were evaluated pre-guideline implementation among 621 (63.5%) females with 490 (50.1%) Black patients. A total of 1420 cases of UTIs were evaluated post-guideline implementation among 843 (59.4%) females with 693 (48.8%) Black patients. With inpatient UTI DOT, following implementation there was an increase by 31.5 DOT/month with a sustained increase by 6.25 DOT/month with no statistically significant change. Total UTI DOT (including outpatient) showed a sustained decrease by 21.1 DOT/month with no overall statistical significance. With inpatient UTI guideline concordance, following implementation there was an increase by 2.5% per month with a sustained increase by 0.7% per month with no statistically significant change. Total UTI guideline concordance (including outpatient) showed a sustained increase by 1.4% per month with no overall statistical significance. **Conclusion:** Guideline implementation for UTI treatment did not lead to statically significant change in DOT or guideline concordant prescribing at EUH.

Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship
A validation study on a standardized assessment algorithm for antimicrobial prescribing appropriateness

Caroline Chen[1], Josephine Wen[2], Courtney Ierano[2], Jenna Maleki[3], Tim Spelman[3], Rodney James[3], Karin Thursky[4] and Lisa Hall[5]
[1]National Centre for Antimicrobial Stewardship; The Royal Melbourne Hospital; [2]National Centre for Antimicrobial Stewardship; [3]National Centre for Antimicrobial Stewardship; [4]University of Melbourne and [5]The University of Queensland

Background: Since 2013, the Australian Hospital National Antimicrobial Prescribing Survey (Hospital NAPS) has provided a standardized framework for hospitals to assess the quality of antimicrobial prescribing. As part of the program's continuous quality improvement, a revised appropriateness algorithm was developed and is scheduled for implementation in 2025. This study aims to validate this algorithm by evaluating accuracy and inter-rater reliability (IRR) in assessing guideline concordance and appropriateness. **Methods:** A prototype of the revised assessment algorithm was developed using Qualtrics®, including an assessment of antimicrobial-level guideline concordance, appropriateness and reasons for non-optimal prescribing, as well as overall indication-level guideline concordance and appropriateness. An eLearning module was developed to ensure consistency of training for assessors. Fourteen clinical vignettes (ten general and four specialist) across a range of real-world clinical scenarios and with varying levels of complexity were developed. Gold standard assessments were determined by an independent group of infectious diseases (ID) and antimicrobial stewardship (AMS) clinicians. Existing Hospital NAPS users were invited to participate. General vignettes were split into two equal groups and assigned to assessors in an alternating manner. Those with expertise in haematology/oncology or paediatrics were assigned additional specialist vignettes. Results were analyzed for accuracy against the gold standard, and for IRR using Fleiss' Kappa coefficient. **Results:** A total of 102 assessors, across a range of professions, remoteness areas and years of auditing experience, completed their assigned vignettes. Assessors correctly identified the antimicrobial regimen for auditing in 91.9% of assessments, with incorrectly identified assessments excluded. A total of 681 antimicrobial-level and 534 indication-level assessments were analyzed. Figure 1 summarizes the accuracy and IRR for the main outcome measures of guideline concordance and appropriateness. Accuracy and IRR were higher for appropriateness compared with guideline concordance, and at the overall indication-level compared with the antimicrobial-level. Auditors correctly identified all gold-standard reasons for non-optimal prescribing in 68.3% of assessments. Across all measures, accuracy and IRR was higher amongst assessors with specialist ID/AMS experience compared to those without, from metropolitan compared with regional settings, and amongst those with 4 or more years of auditing experience. Pharmacists without ID/AMS expertise scored as highly as doctors

Figure 1: Summary of accuracy and inter-rater reliability for antimicrobial-level and indication-level guideline concordance and appropriateness.

Outcome measure	Accuracy % (95% CI)	Inter-rater reliability	
		Fleiss' Kappa	Interpretation
Antimicrobial-level assessment			
Guideline concordance	81.3 (78.3, 84.3)	0.47	Moderate
Appropriateness	83.4 (80.5, 86.2)	0.54	Moderate
Overall indication-level assessment			
Overall guideline concordance	83.3 (79.6, 86.8)	0.46	Moderate
Overall appropriateness	88.4 (85.6, 91.1)	0.59	Moderate

and pharmacists with ID/AMS expertise. **Conclusion:** The revised Hospital NAPS algorithm provides a valid measure of guideline concordance and appropriateness. Higher accuracy and IRR were observed for appropriateness compared with guideline concordance, highlighting the importance of appropriateness as a measure for stewardship surveillance in reflecting quality of patient care.

Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship
Assessment of a Prescription Feedback Intervention on Diagnosis, Management, and Safety Outcomes of Acute Bacterial Sinusitis

Christine Kim[1], Michael Sportiello[2], Troy Anlage[3], Charles Springer[4], Monica Masterson[5], Colin Samoriski[6], Paulina Sudnik[7], John Bennett[8], Ankit Dahal[9], Lauraliz Delacruz[9], Jonathan Gigas[10], Jenny Kim[1], O, Alison Livada[10], Robert Fortuna[11], Jineane Venci[12] and Alexandra (Sasha) Yamshchikov[13]
[1]University of Rochester; [2]University of Rochester Medical Center; [3]University of Rochester Medical Center; [4]University of Rochester Medical Center; [5]URMC; [6]University of Rochester Medical Center; [7]URMC; [8]University of Rochester School of Medicine & Dentistry; [9]University of Rochester School of Medicine and Dentistry; [10]University of Rochester; [11]University of Rochester; [12]University of Rochester Medical Center and [13]university of rochester

Introduction: Although most rhinosinusitis cases are viral, misdiagnosis of an underlying bacterial cause is common, leading to excessive antibiotic utilization. Interventions to improve diagnosis and prescribing for sinusitis may reduce antimicrobial resistance and improve patient outcomes. **Methods:** Antibiotic prescriptions by 237 URMC Primary Care Network(PCN) clinicians between 9/1–11/31/2022 (baseline n=23,048) and 12/1/2023–2/29/2024 (post-intervention n=18,885) were extracted as part of a network-wide education and prescription feedback intervention focusing on antibiotic utilization rates, and guideline-concordant prescribing for sinusitis defined from local antibiograms and national guidelines. Random subsets of pre- and post-intervention prescriptions

Figure 1: Distribution of Antibiotics Prescribed for Treatment of Bacterial Sinusitis