Antibiotics	Adjusted OR	95% CI	p-value
Penicillins	Reference	-	-
Cephalosporin/clindamycin	0.93	(0.34, 2.56)	0.88
Macrolides	2.79	(1.19, 6.56)	0.02
Other antibiotics	1.09	(0.23, 5.18)	0.91

Table. 1.

clarithromycin, erythromycin), or other (remaining antibiotics). A return visit was defined as a new visit to primary care, urgent care, or the emergency department with a diagnostic code for an ARI ≤30 days from the index visit. Logistic regression was used to adjust for nonantibiotic covariates and to compare treatments. Results are reported as odds ratio (OR ± 95% CI; *P* value). **Results:** Of 12,666 patients with a diagnostic code for acute pharyngitis, 2,923 (23.1%) had GAS testing performed. Of those, 582 (19.9%) were GAS-positive and 460 (15.7%) received antibiotics. The mean age was 39.0 years (±SD, 11.7) and 73.7% were male. Antibiotics included penicillins for 363 patients (78.9%), cephalosporins for 21 (4.6%), clindamycin for 32 (7.0%), macrolides for 47 (10.2%), and other for 17 (3.9%). Penicillin allergy was documented in 48 patients (10.5%), and these patients received cephalosporins (18.8%), clindamycin (35.4%), macrolides (41.7%), and other antibiotics (4.2%). Return visits occurred in 47 cases (10.4%). Limited chart review indicated that 6 of 10 macrolide recipients (60.0%) with return visits had recurrence or unresolved symptoms. After adjustment for calendar month and facility, odds of a return visit for treatment with a macrolide relative to penicillins was 2.79 (OR, 1.19; 95% CI, ±6.56; $P = .02$). The audit-feedback intervention was not associated with ARI-related return visits (OR, 0.53; 95% CI, 0.26–1.06; $P = .07$). **Conclusions:** Return visit rates were higher for GAS pharyngitis patients treated with a macrolide than for those treated with penicillins. Macrolides were the most commonly prescribed non-penicillin therapy irrespective of penicillin allergy. Further work is necessary to determine the reason for the increase in return visits.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.875

Presentation Type:
Poster Presentation

Increasing Mupirocin Resistance Among MRSA Nasal Surveillance Isolates in the Chicago Area

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Background: In 2005, our healthcare system began universal admission screening for nasal colonization with MRSA and decolonization of MRSA positive patients with mupirocin. In 2010–2012, we studied the impact of nasal MRSA decolonization and concluded that it does not add benefit when contact precautions are used; plus, it resulted in increased rates of mupirocin resistance up to 9.4% in 2012. In September 2012 routine decolonization of hospitalized patients was discontinued. In the 2 years following discontinuation of mupirocin use for decolonization of MRSA carriers, the rate of mupirocin resistance gradually declined. We undertook a contemporary review of mupirocin resistance rates to ensure that the rates were stable. **Methods:** NorthShore University HealthSystem, Illinois, consists of 4 hospitals in the northern suburbs of Chicago, with 750 beds and 60,000

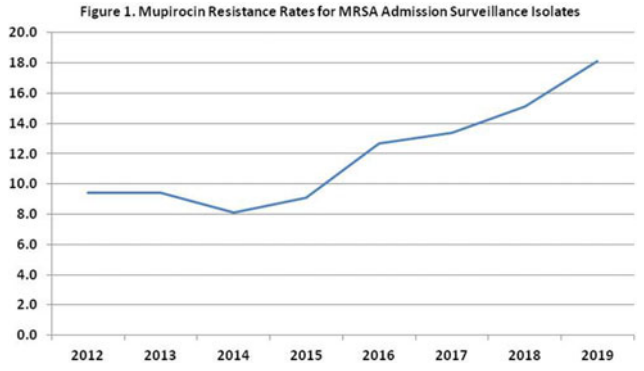

Fig. 1.

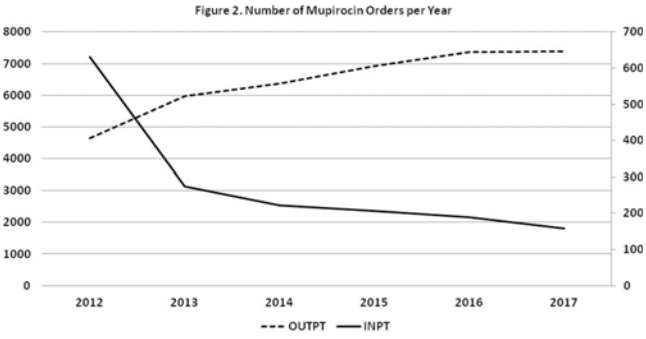

Fig. 2.

annual admissions. Admission nasal swab samples were collected from at-risk hospitalized patients based on a risk-adjusted algorithm. Nasal swabs were tested using the BD MAX MRSA assay. Positive samples were cultured onto BD BBL CHROMagar MRSA to recover the organism and were tested for the *mupA* gene, which confers high-level mupirocin resistance using an in-house PCR test. Data for mupirocin orders were provided by the pharmacy. **Results:** Mupirocin resistance rates and prescription orders are shown in Figs. 1 and 2. **Conclusions:** Mupirocin resistance rates plateaued between 2012 and 2014 and then increased from 9.1% in 2015 to 18.1% in 2019, despite discontinuation of routine decolonization of hospitalized patients. The reason for the increase is unclear; inpatient mupirocin orders were stable from 2015 to 2017.

Funding: None
Disclosures: None
Doi:10.1017/ice.2020.876

Presentation Type:
Poster Presentation

Increasing Voluntary Public Health Reporting to the NHSN Antimicrobial Use Option

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Background: The CDC NHSN launched the Antimicrobial Use Option in 2011. The Antimicrobial Use Option allows users to