the UK Center for Clinical and Translational Science, and the study was approved by the local IRB. The primary outcome of interest was antibiotic duration; secondary outcomes of interest were PCT orders, discharge antibiotic prescription, and inpatient length of stay. **Results:** In total, 432 patients (277 in 2019 and 155 in 2020) were included in this analysis. The average patient age was 61.2 years (SD, ±13.7); 47.7% were female; and 86.1% were white. Most patients were primarily diagnosed with pneumonia (58.8%), followed by COPD with complication (40.5%). In-hospital mortality was 3.5%. The minority of patients had any orders for PCT (29.2%); among them, most had only 1 PCT level measured (84.1%). The median length of hospital stay was 4 days (IQR, 2–6), and the median duration of antibiotic therapy was 4 days (IQR, 3–6). **Conclusions:** The utilization of PCT in LRTIs occurs in the minority of patient cases at our institution and mostly as a single measurement. The development and implementation of a PCT-guided therapy could help optimize antibiotic usage in patients with LRTIs.

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Antimicrobial Stewardship in Acute-Care Hospitals: A Report of the California Healthcare-Associated Infections Honor Roll

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Background: Antimicrobial stewardship has been demonstrated to improve patient outcomes and reduce unwanted consequences, such as antimicrobial resistance and *Clostridioides difficile* infection. The California Department of Public Health (CDPH) Healthcare-Associated Infection (HAI) Program developed an honor roll to recognize facilities with the goal of promoting antimicrobial stewardship programs and encouraging collaboration and research. **Methods:** The first open enrollment period in California was from August 1 to September 1, 2020, and was only open to acute-care hospitals (ACHs). Enrollment occurs every 6 months. Applicants completed an application and provided supporting documentation for bronze, silver, or gold designations. The criteria for the bronze designation were at least 1 item from each of CDC's 7 core elements for ACHs. The criteria for silver were bronze criteria plus 9 HAI program prioritized items (based on published literature) from the CDC Core Elements and demonstration of outcomes from an intervention. The criteria for gold designation were silver criteria plus community engagement (ie, local work or collaboration with healthcare partners). Applications were evaluated in 3 phases: (1) CDPH reviewed core elements and documentation, (2) CDPH and external blinded antimicrobial stewardship experts reviewed outcomes as scientific abstracts, and (3) CDPH reviewed each program for overall effectiveness in antimicrobial stewardship and final designation determination. Designations expire after 2 years. **Results:** In total, 119 applications were submitted (30% of all ACHs in California), of which 100 were complete and thus were included for review. Moverover, 33 facilities were from northern California and 67 were from southern California. Also, 85 facilities were part of a health system or network, 14 were freestanding, and 1 was a district facility. Facility types included 68 community hospitals, 17 long-term acute-care (LTAC) facilities, 17 academic or teaching hospitals, 4 critical-access hospitals, and 4 pediatric hospitals. There was an even distribution of hospital bed size: 35 facilities had <250 beds. The final designations included 19 gold, 35 silver and 43 bronze designations. There was 44% incongruency in applicants not receiving the designation for which they applied. Community hospitals were 63%–74% of all designations, and no LTACs received a gold designation. Moreover, 63% of hospitals with gold designations had >250 beds, and 47% of hospitals with bronze designations had <1 25 beds. **Conclusions:** The number of applicants was higher than expected because the open enrollment period occurred during the COVID-19 pandemic. This finding demonstrates the high importance placed on antimicrobial stewardship among ACHs. It also provides insight into how facilities are performing and collaborating and how CDPH can support facilities to improve their ASP.

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Identification of Potentially Unnecessary Micafungin Use Patterns: Opportunities for Antifungal Stewardship Interventions

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Background: Echinocandins are used as first-line therapy for suspected and confirmed *Candida* spp, and its indiscriminate use may drive selection for echinocandin resistance. We evaluated patterns of use of

Table 1. Micafungin courses and microbiology results during study period

Variable	n=2532 (IQR)	*p* value
Blood cultures (BC)		
Negative	1879 (74)	
Positive	653 (26)	
Candida spp.	149 (23)	
Other organisms	504 (77)	
Median length of treatment, days		
Negative	3 (2-7)	
Positive, not *Candida* spp.	3 (1-5)	p<0.001
Candida spp.	5 (3-11)	
Treatment over 5 days		
Negative	768 (41)	p<0.001
Positive, not *Candida* spp.	143 (28)	
Tracheal aspirate cultures	n=487	
No yeast isolated	387 (79)	
Yeast isolated	100 (21)	
Candidemia	9/94 (10)	
Positive BC, not *Candida* spp.	13/94 (14)	
Negative BC	72/94 (76)	
Length of treatment, days		
No yeast isolated	3 (2-7)	0.56
Yeast isolated	3 (2-7)	
Treatment over 5 days		
No yeast isolated	142 (37)	0.75
Yeast isolated	35 (35)	
Urine cultures	n=844	
No yeast isolated	795 (94)	
Yeast isolated	49 (6)	
Candidemia	7/46 (15)	
Positive BC, not *Candida* spp.	8/46 (17)	
Negative BC	31/46 (67)	
Length of treatment, days		
No yeast isolated	3 (2-6)	0.87
Yeast isolated	3 (1-6)	
Treatment over 5 days		
No yeast isolated	281 (35)	0.7
Yeast isolated	16 (33)	

micafungin to identify opportunities for antifungal stewardship. **Methods:** We identified all micafungin completed orders and microbiological test result data from July 2018 to November 2020 among hospitalized patients in Barnes-Jewish Hospital. Continuous micafungin courses with <48 hours of interruption were considered independent courses. We evaluated micafungin use in 3 scenarios in which its use may be unnecessary: (1) patients with blood cultures negative for *Candida* spp, (2) patients with recovery of yeast or *Candida* spp from tracheal aspirates, and (3) patients with recovery of yeast or *Candida* spp from urine cultures. We only included micafungin courses if they were initiated within 5 days of blood culture collection or up to 4 days after tracheal or urine culture collection to account for incubation and decision to initiate treatment. **Results:** We found 3,381 micafungin courses in 3,287 admissions. Of these, 2,532 courses had blood culture collection around micafungin initiation and were included in the first analysis: 1,879 (74%) were negative, 149 (6%) had *Candida* spp isolated in the blood, and 504 (20%) had positive blood cultures for other organisms. Micafungin was given for a median duration of 3 days (IQR, 2–7) to those with negative blood cultures and for 3 days (IQR, 1–5) to those with positive blood cultures without candidemia ($p < 0.001$), and prolonged durations of more than 5 days was seen in 768/1879 (41%) and 143/504 (28%) of courses, respectively ($p < 0.001$). A total of 487 micafungin courses were initiated after tracheal aspirate culture collection. Those with yeast isolated (n = 100, 21%) received similar micafungin duration compared to those that had no yeast isolated [3 (2-7 IQR) vs. 3 (2-7) days, respectively; $p = 0.56$). Finally, a total of 844 micafungin courses started after urine culture collection. A total of 49 (6%) had yeast isolated from the urine and treatment duration was similar to those that did not [3 (1-6 IQR) vs. 3 (2-6) days, respectively; $p = 0.87$). **Conclusions:** Echinocandin treatment courses did not differ when a yeast was identified from a tracheal isolate or urine specimen. However, a substantial proportion of treatment courses were prolonged in those with negative *Candida* spp in the blood, suggesting opportunities for antifungal stewardship interventions.

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Veteran Satisfaction for Upper Respiratory-Tract Infection (URI) Visits Is Not Associated with Antibiotic Receipt But Is Associated with Antibiotic Expectation

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Background: Antibiotics are not recommended but are often prescribed for upper respiratory-tract infections (URIs). Prescribers cite patient expectation as a driver of inappropriate antibiotic prescribing; prior literature has demonstrated higher satisfaction scores in patients who receive antibiotics compared to those who do not. We assessed whether veteran satisfaction at URI visits was associated with antibiotic receipt or with reported expectation for antibiotics. **Methods:** We surveyed veterans with documented URI encounters in the Veterans' Affairs Tennessee Valley Healthcare System between January 1, 2018, and December 31, 2019. Patients not evaluated in person, with documented dementia, or who died prior to the study start date were excluded. Veterans were asked to recall their URI visit and to complete the Patient Safety Questionnaire (PSQ)-18 (Rand Corporation) and questions assessing antibiotic expectations. The PSQ-18, an 18-item survey that assesses patient satisfaction, uses a 5-point Likert scale (ie, strongly disagree, disagree, uncertain, agree, strongly agree), yielding a composite score of 18–90. Higher scores represent more satisfaction with care. Demographic and visit-specific information were extracted via chart review. We used multivariable linear regression to assess differences in composite PSQ-18 satisfaction scores between those who did and did not receive an antibiotic, adjusted for patient and visit characteristics, and to assess differences in satisfaction scores for those who did and did not report expecting antibiotics, adjusted for antibiotic receipt. **Results:** We identified 1,435 patients seen for URI at 17 sites. After exclusions, 1,343 veterans were eligible for chart abstraction. After excluding 42 responders who responded after study close or returned blank surveys, the final analytic cohort included 432 (32.2%) of 1,343 responders; 225 (52.1%) received an antibiotic and 207 (47.9%) did not. Mean total satisfaction for veterans who received an antibiotic was 67.8 (SD, ±9.4) compared to 66.7 (SD, ±9.7) for those who did not (Figure 1). Increased total satisfaction was not significantly associated with antibiotic receipt (0.65; 95% CI, −2.0 to 3.3). Most veterans (72.0%) disagreed that visit satisfaction depended on antibiotic receipt. However, only 30.8% reported that they would not expect an antibiotic for URI visits. A significant reduction in total satisfaction (−4.1; 95% CI, −6.3 to −1.9) was associated with expecting compared to not expecting an antibiotic. **Conclusions:** Our findings suggest that prescribing an antibiotic is not associated with increased veteran satisfaction for URI visits but is associated with expecting an antibiotic. Future work will evaluate methods to change veteran antibiotic expectations.

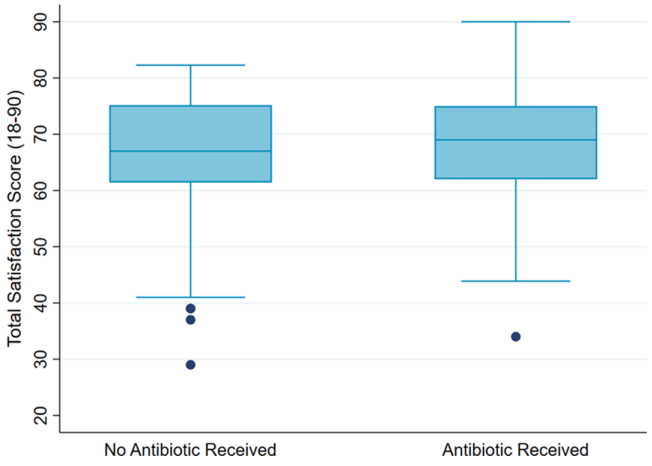

Figure 1.

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Evaluation of Procalcitonin Use in Patients Discharged from the Emergency Department with Acute Respiratory Infection

Garrett Fontaine; David Banach and Jeffrey Aeschlimann

Background: Acute respiratory infections (ARIs) contribute significantly to inappropriate antimicrobial prescription. The rate of such prescriptions in US emergency departments (EDs) has remained stable over time. The use of procalcitonin (PCT) testing has been shown to lower risk of mortality and to reduce antibiotic consumption. It also has the potential to aid ED physicians in stratifying ARI patients