.03). Susceptibility to ciprofloxacin was similar in patients born in the United States and other countries (79% vs 72%; $P = .50$). Of 77 *E. coli* isolates, 11 (14%) were positive for extended-spectrum β-lactamase production, including 8 isolates from patients whose country of origin was Mexico or a Central American country. **Conclusions:** More than 20% of outpatients presenting with UTI symptoms had a negative urine culture. Among outpatients with uncomplicated and complicated UTI, uropathogens had a high prevalence of resistance to ciprofloxacin and TMP-SMX, but susceptibility to fosfomycin (restricted in our system) was 100%. Resistance rates for TMP-SMX were higher in patients from Mexico and Central America. Our findings question whether TMP-SMX should remain a first-line agent in US primary-care settings.

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Current Status of Antimicrobial Stewardship Programs in São Paulo Hospitals

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Background: Antimicrobial stewardship programs (ASPs) consist of coordinated interventions designed to improve and measure appropriate antimicrobial use. Understanding the current structure of ASPs hospitals will support interventions for improvement or implementation of these programs. **Objective**: We aimed to describe the current status of ASP in hospitals in the state of São Paulo, Brazil. **Methods:** We conducted a cross-sectional survey regarding ASP of hospitals in São Paulo state, Brazil, from March to July 2018. Through interviews by telephone or e-mail, we asked participants which components of IDSA/SHEA and CDC guidelines had been implemented. Results: The response rate was 30% (28 of 93 hospitals) and 26 of the hospitals (85%) reported having a formal ASP. Policies, practices, and strategies of surveyed ASP are detailed in Table 1. The most frequently implemented strategies were (1) antimicrobial surgical prophylaxis guideline (100%), (2) empiric sepsis guideline (93%), and (3) presence of ASP team member during bedside rounds (96%). The least commonly implemented strategies included prior authorization for all antimicrobials (11%), pharmacokinetic monitoring and adjustment program for patients on IV aminoglycosides (3%). Regarding metrics of the ASP, the most common indicator was the rates of antimicrobial resistance (77%). Overall, 18 hospitals (19%) used defined daily dose and only 29% used days of therapy. Moreover, 61% of hospitals reported their results to hospital the administration and 39% of hospitals reported their results to the prescribers. **Conclusions:** Most hospitals have a formal ASP, but there are opportunities for improvement. Future efforts should prioritize tracking and reporting ASP metrics.

Strategy	N (%)
Tools to improve antimicrobial prescribing	
Antimicrobial surgerical prophylaxis guideline	28 (100)
Empiric sepsis guideline	24 (86)
ID physician available for contact	27 (96)
Presence of ASP team member during bedside rounds	26 (93)
Post prescription auditing	25 (89)
Policy requiring prescribers to document indication for all antibiotics	24 (86)
Provider feedback on prescribing	22 (84)
Prescriber education with formal classes	21 (75)
Systematic evaluation of situations in which antimicrobial spectrum may be redundant	20 (71)
Use of a computerized clinical decision support system for antimicrobial prescription	12 (43)
Prior authorization for selected antimicrobials	13 (46)
Promoting the use of and transition toward oral antimicrobials over IV antimicrobials	13 (46)
Prior authorization for all antimicrobials	3 (11)
Available aminoglycosides serum testing level	5 (18)
Pharmacokinetic monitoring and adjustment program for patients on IV aminoglycosides	1 (3)
Available vancomycin serum testing level	17 (61)
Pharmacokinetic monitoring and adjustment program for patients on IV Vancomycin	18 (67)
Guideline for dose adjustment for renal dysfunction	21 (75)
Guideline for dose adjustment for liver dysfunction	11 (39)
Use of continuous infusion for beta-lactams	19 (68)
Microbiology and laboratory support	
Automated systems for identification of microorganisms	21 (75)
Clostridium difficile tests	23 (82)
Molecular diagnosis for respiratory viruses	17 (61)
Protein C reactive	26 (93)
Procalcitonin	4 (14)
Beta-d-Glucan test	4 (14)
Galactomannan assay	12 (43)
Tracking and Reporting Antibiotic Use and Outcomes	
Rates of antimicrobial resistance profile	22 (77)
Rates of multiresistant bacteria infections	19 (68)
Antimicrobial consumption (Defined Daily Dose)	18 (64)
Adherence to recommendations	12 (43)
Purchasing data	10 (36)
Days of therapy	8 (29)
Rates of *Clostridium difficile* infection	4 (14)
Reports of indicators to Hospital administration	17 (61)
Reports of indicators to prescribers	11 (39)

Fig. 1.

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De-escalation of Antibiotics in Severe Sepsis and Septic Shock at a Large Municipal Hospital

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Background: Early de-escalation of antibiotics in sepsis may be safe and effective. In our study, we performed a retrospective chart review of patients admitted to a large municipal hospital who were treated for severe sepsis or septic shock to compare outcomes in patients who experienced early de-escalation (DEG) with outcomes of those who did not (NDG).
Methods: The observational study was conducted at Bellevue Hospital Center (an 850-bed municipal hospital affiliated with New York University School of Medicine, New York, NY). Patients admitted from January 1 to December 31, 2015, who were treated for severe sepsis or septic shock during any time of their hospital stay were reviewed for the study. De-escalation was defined as

narrowing or discontinuation of 1 or more antimicrobial therapies <3 days after sepsis onset. **Results:** Overall, 277 patients were included (DEG, 90 patients, 32%; NDG, 187 patients, 68%). The groups were similar in terms of sex, comorbidities, length of stay, and severity of illness: septic shock (47% DEG vs 49% NDG; $P = .693$) and ICU stay (27% DEG vs 32% NDG; $P = .406$). DEG patients were slightly older than NDG patients: (DEG age, 63+16 years vs NDE age, 58+16 years; $P = .028$). There was no difference in hospital mortality (8% DEG vs 12% NDE; $P = .257$). Nearly half of the patients in both groups (46% DEG and 47% NDG) had no causative microorganisms identified using conventional microbiology culture. The common sources of primary infection were respiratory, urinary tract, and gastrointestinal infections, and these were not different between groups. Also, 69% of DEG patients and 79% of NDG patients received antibiotics for >7 days ($P = .002$). Empiric intravenous vancomycin was initiated in 83% in DEG patients and 74% in NDG patients at sepsis diagnosis. Although organisms covered by intravenous vancomycin were isolated from only 17% of patients in DEG and 23% in NDG, vancomycin was continued for >5 days in 34% of DEG patients and 50.3% of NDG patients ($P < .001$). 60% of patients in DEG and 61% in NDG were seen by infectious diseases specialists (ID). Patients with infectious diseases consultations had significantly more comorbidities, were more frequently in the ICU, had higher MDRO isolation and longer hospital stays, but they were still de-escalated without a difference in mortality. **Conclusions:** Microbiology data did not contribute to early de-escalation of antibiotics in this study. This finding may be related to the high percentage of negative culture and unavailability of rapid molecular diagnostic tests. Shorter duration of antibiotics (including vancomycin) was not associated with worse outcome in these severely ill patients.

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Decision Support Tool for Screening of Tuberculosis Exposed Individuals Seeking Care at a Public Academic Health System

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Table 1.

Location	Mean Exposure			*F* Statistic	*P*
	Borderline (n = 57)	Negative (n = 747)	Positive (n = 313)		
Person-nights exposure to smear-positive TB					
Shelter 1	25.14	22.95	33.57	2.835	.059
Shelter 2	0.00	0.00	0.00	0	
Shelter 3	23.21	11.51	29.89	13.279	.000
Shelter 4	0.00	0.01	0.00	0.446	.641
Person-nights exposure to smear-negative TB					
Shelter 1	11.70	11.52	13.99	0.675	.510
Shelter 2	0.00	0.02	0.05	2.595	.075
Shelter 3	6.21	4.89	9.66	4.609	.010
Shelter 4	0.00	0.04	0.00	0.778	.460

Background: *Mycobacterium tuberculosis* (TB) is one of the leading causes of morbidity and mortality worldwide. At our health system, 50–100 patients are diagnosed with tuberculosis every year. One risk factor for TB is residence within a homeless shelter. In response to an increased number of cases in local homeless shelters, the health department sought assistance with contact tracing of individuals potentially exposed to tuberculosis. We report the results of contact tracing performed at our health system. **Methods:** The setting is a 770-bed, safety-net, academic hospital with community clinics and a correctional health center. Name, date of birth, and social security number of contacts potentially exposed during February 2009 to July 2013 were programmed into the electronic medical records to create a decision support tool upon entering the health system. The best practice alert (BPA) informed physicians of the exposure and offered a link to a screening test, T-spot.TB, and a link to an information sheet. This intervention was implemented from July 2013 to July 2015. After excluding patients with active TB, data on the magnitude of exposure in each homeless shelter and screening test results were analyzed with ANOVA using SPSS v 26 software. **Results:** Of the 8,649 identified exposed contacts, 2,118 entered our health system. Of those for whom the BPA was triggered, 1,117 had a T-spot.TB done, with 313 positive results and 57 borderline results. Table 1 shows that shelter 3 was correlated with a positive T-spot.TB. **Conclusions:** The BPA, which prompted physicians to evaluate an individual for TB, was effective at capturing high-risk, exposed individuals. Clinical decision support tools enabled our safety-net health system to respond effectively to a local public health need.

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Effect of delays in concordant antibiotic treatment on mortality in patients with hospital-acquired Acinetobacter spp. bacteremia in Thailand: a 13-year retrospective cohort

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