Conclusion. Candida CLABSI was infrequent but had significant mortality in our cohort. Our results suggest that adherence to SOC per IDSA guidelines and involve- ment of IDC may improve survival of patients with Candida CLABSI. Future studies are needed to validate these findings.

Disclosures. All authors: No reported disclosures.

192. Treatment Bundle Improves Outcomes in the Management of Candidemia at Large Urban Academic Medical Centers

Gregory Cook, PharmD; Shreena Advani, PharmD; Saira Rab, PharmD; Sheetal Kandhal, MD MPH; Manish Patel, PharmD; and Jordan Wong, PharmD; 1Pharmacy, Grady Health System, Atlanta, Georgia; 2Medicine, Emory University, Decatur, Georgia

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Background. A candidemia treatment bundle (CTB) may increase adherence to guideline recommended candidemia management and improve patient outcomes. The purpose of this study was to evaluate the impact of a best practice alert (BPA) and order-set on optimizing compliance with all CTB components and patient outcomes.

Methods. A single center, pre-/post-intervention study was completed at Grady Health System from August 2015 to August 2017. Post-CTB intervention began August 2016. The CTB included a BPA that fires for blood cultures positive for any Candida species to treatment clinicians upon opening the patient's electronic health record. The BPA included a linked order-set based on treatment recommendations including: infectious diseases (ID) and ophthalmology consultation, repeat blood cultures, empirical echinocandin therapy, early source control, antifungal de-escalation, intravenous to oral (IV to PO) switch, and duration of therapy. The primary outcome of the study was total adherence to the CTB. The secondary outcomes include adherence with the individual components of the CTB, 30-day mortality, and infection-related length of stay (iLOS).

Results. Forty-five patients in the pre-group and 24 patients in the CTB group with candidemia were identified. Twenty-seven patients in the pre-group and 19 patients in the CTB group met inclusion criteria. Total adherence with the CTB occurred in 4/24 (17%) patients in the pre-group and threequarters in the CTB group (18% vs. 100%, P = 0.07). The bundle of empirical echinocandin therapy (81% vs. 100%, P = 0.07) and IV to PO switch (22% vs. 32%, P = 0.5) also improved in the CTB group. Repeat cultures and antifungal de-escalation were similar among groups. Thirty-day mortality decreased in the CTB group by 10% (26% vs. 16%, P = 0.48). Median iLOS decreased from 17 days in the pre-group to 10 days in the CTB group (P = 0.05).

Conclusion. The CTB, with a BPA and linked order-set, improved guideline recom- mended management of candidemia specifically increasing the rates of ID consultation and early source control. There were quantitative improvements in mortality and iLOS.

Disclosures. All authors: No reported disclosures.

193. Validation of an Empiric Candidemia Treatment Algorithm

Connor M. Stack, MD; Lovisa B. Olafsdottir, MD; Monica V. Mahoney, PharmD; BCPS-AQ ID; Christopher McCoy, PharmD, BCPS-AQ ID; Howard S. Gold, MD, FIDSA, FSHEA; Mary Lasalvia, MD, MPH; David S Yassa, MD; Sharon B Wright, MD, MPH, FIDSA, FSHEA; and Graham M. Snyder, MD, SM; 1Department of Medicine, Division of Infectious Diseases; 2Beth Israel Deaconess Medical Center, Boston, Massachusetts; 3Department of Pharmacy, Beth Israel Deaconess Medical Center, Boston, Massachusetts

Session: 44. Clinical Mycology
Thursday, October 5, 2017: 12:30 PM

Background. JUDicious use of echinocandins may limit the development of resistance in Candida species. Guidelines endorse the use of echinocandins as initial therapy in candidemia, with fluconazole as an alternate choice in select patients. We compared the ability of providers to predict the need for echinocandin therapy in Candida blood stream infections to that of a proposed institutional treatment algorithm designed to optimize empiric antifungal use.

Methods. In this retrospective study (10/2015-10/2016), patients were included with candidemia cultured in ≥2 blood cultures, without candidemia at baseline. The empiric treatment (the first antifungal prescribed for ≥24 hours after index blood culture draw) was considered “overly broad” if an echinocandin was administered to a fluconazole-susceptible isolate and “inappropriate” if fluconazole was administered to a fluconazole-non-susceptible isolate. An institutional algorithm was created recom- mending empiric echinocandin use based on the presence of ≥1 risk factors (Table 1). Provider choice and the recommended agent according to the algorithm were com- pared with the final fluconazole susceptibility of the organism.

Results. Of 102 patients (100% receive azole therapy, primarily micafungin. Fluconazole was recommended by the algorithm in 25% of cases but initially prescribed in only 9% (Figure 2). Providers prescribed both orally broad and invasive candidemia treatment at 3%, echinocandin de-escalation at 4%, and threshold de-escalation at 4%.

Conclusion. An algorithm using risk factors for fluconazole-non-susceptible Candida was able to predict appropriate empiric antifungal therapy better than provider decision making in cases of candidemia. Implementation of this algorithm into local treatment guidelines may improve empiric antifungal prescribing.