their doctor’s opinion, then convenience and route of administration; least important were treatment location, adverse events, and cost.

Conclusion. In these patients presenting to the ED with ABSSSI, the majority were admitted to the hospital and received IV ABX. Patient preferences for treatment location varied, but many valued therapies that could prevent admission. These data suggest opportunities for improving ABSSSI care by engaging the patient and offering treatment alternatives they may not be aware of.

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701. Frequently Identified Gaps in Antimicrobial Stewardship Programs in Critical Access Hospitals

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Background. Nebraska (NE) Infection Control Assessment and Promotion Program (ICAP) is a CDC funded project. ICAP team works in collaboration with Nebraska Antimicrobial Stewardship Assessment and Promotion Program, Nebraska Medicine, Omaha, Nebraska, Nebraska Infection Control Assessment and Promotion Program, Nebraska Medicine, Omaha, Nebraska, Department of Pharmacy, Nebraska Medicine, Omaha, Nebraska, Division of Infectious Diseases, University of Nebraska Medical Center, Omaha, Nebraska.

Methods. NE ICAP conducted on-site surveys in 36 CAH from October 2015 to February 2017. ASP activities related to the 7 CDC recommended core elements (CE) including leadership support (LS), accountability, drug expertise (DE), action, tracking, reporting and education were assessed using the CDC Infection Control Assessment Tool for acute care hospitals. Descriptive analyses evaluated CAH characteristics and frequency of CE implementation. Fisher’s exact, Mann–Whitney, and Kruskal–Wallis tests were used for statistical analyses examining the association of various factors with level of ASP activities.

Results. The 36 surveyed CAH had a median of 20 (range 10–25) beds and employed a median of 0.4 (range 0.1–6) infection preventionist (IP) Full-time equivalent (FTE)/25-bed. Frequency of CE implementation varied among CAH with action (70%) and DE (56%) being the most (69%) and least (28%) frequently implemented elements, respectively. Close to half (47%) of surveyed CAH had implemented ≥4 CE but only 14% of facilities had all 7 CE. Median bed size and IP FTE/25-bed were similar among CAH with 0–2.5, 3–7 or >7 CE in place. CAH with LS or accountability for ASP implementation had a median higher median numbers of the remaining CE compared with CAH without LS or accountability (5 vs. 2, P < 0.01 and 4 vs. 2, P < 0.01, respectively). Facilities with the presence of LS, accountability and drug expertise were more likely to have all 4 remaining CE implemented than others (56% vs. 8%, P < 0.01).

Conclusion. LS, accountability, and DE are important factors for the implementation of the remaining 4 CE in CAH. Although LS was the least frequently implemented CE, when present was associated with implementation of most of the other CE. Acquiring LS will facilitate implementation of additional ASP efforts in CAH.

Disclosures. All authors: No reported disclosures.

702. Frequently Identified Gaps in Antimicrobial Stewardship Programs in Long-Term Care Facilities

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Methods. NE ICAP conducted on-site surveys in 36 CAH from October 2015 to February 2017. ASP activities related to the 7 CDC recommended core elements (CE) including leadership support (LS), accountability, drug expertise (DE), action, tracking, reporting, and education were assessed using a CDC Infection Control Assessment Tool for acute care hospitals. Descriptive analyses evaluated CAH characteristics and frequency of CE implementation. Fisher’s exact, Mann–Whitney, and Kruskal–Wallis tests were used for statistical analyses examining the association of various factors with level of ASP activities.

Results. The 36 surveyed CAH had a median of 20 (range 10–25) beds and employed a median of 0.4 (range 0.1–6) infection preventionist (IP) Full-time equivalent (FTE)/25-bed. Frequency of CE implementation varied among CAH with action (70%) and DE (56%) being the most (69%) and least (28%) frequently implemented elements, respectively. Close to half (47%) of surveyed CAH had implemented ≥4 CE but only 14% of facilities had all 7 CE. Median bed size and IP FTE/25-bed were similar among CAH with 0–2.5, 3–7 or >7 CE in place. CAH with LS or accountability for ASP implementation had a median higher median numbers of the remaining CE compared with CAH without LS or accountability (5 vs. 2, P < 0.01 and 4 vs. 2, P < 0.01, respectively). Facilities with the presence of LS, accountability and drug expertise were more likely to have all 4 remaining CE implemented than others (56% vs. 8%, P < 0.01).

Conclusion. LS, accountability, and DE are important factors for the implementation of the remaining 4 CE in CAH. Although LS was the least frequently implemented CE, when present was associated with implementation of most of the other CE. Acquiring LS will facilitate implementation of additional ASP efforts in CAH.

Disclosures. All authors: No reported disclosures.

703. Structure of Antimicrobial Stewardship Programs in Leading U.S. Hospitals

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Background. Antibiotic use has drastically changed the course of modern medicine. However, the overuse and often inappropriate use of antibiotics has led to the development of resistant strains of bacteria. Increasingly, healthcare systems struggle to deal with the burden of fighting infections that no longer respond to common antibiotic-based treatments. One strategy used to combat antibiotic resistance is the implementation of hospital-based Antimicrobial Stewardship Programs (ASP). ASP structure among the top U.S hospitals may provide insight into which of the Infectious Diseases Society of America (IDSA) and the Society for Healthcare Epidemiology of America (SHEA) ASP recommendations are most efficacious given limited resources.

We thus administered a survey to better understand the elements of an ASP that are utilized at these top-rated hospitals.

Methods. We surveyed the 50 highest ranking hospitals in various specialties using the top 50-150 hospitals from the 2016 US News lists of top hospitals. This corresponded to 137 adult and 70 pediatric sites. We inquired as to which components of the 2016 IDSA and SHEA ASP guidelines were implemented at each site. Appropriate persons at each hospital were contacted by telephone and email.

Results. Overall, 102 of 207 hospitals responded (49.3%). Of these 87.2% had an active ASP, and 57.1% were active for more than 5 years. Interventions most widely adopted included prospective auditing of antimicrobial usage (n = 65, 87.8%), pre-authorization of antimicrobials (n = 61, 82.4%), and antimicrobials restricted to infected disease physicians (n = 52, 70.3%). The most widely implemented optimization strategies included promoting transition from intravenous to oral antibiotics (n = 68, 93.2%) and strategies to minimize antibiotic therapy duration (n = 56, 76.7%). The least common interventions included antibiotic time-outs (n = 17, 23.8%) and ASP intervention in cases with high risk of Clostridium difficile infection (n = 27, 36.5%). The least common optimization strategy was the use of time-sensitive stop orders (n = 27, 37%).

Conclusion. Most leading U.S hospitals selectively implement IDSA and SHEA recommendations. Understanding the structure of ASPs in these hospitals will assist other hospitals in implementing ASPs.

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704. Antimicrobial Stewardship Practices Reported by California Hospitals Following New Legislative Requirements: Analysis of National Healthcare Safety Network Annual Survey Data, 2014–2015

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