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 Department of Health and Human Services (NEDHHS) to assess and improve infection prevention and control programs (IPCP) in various health care settings including resource limited settings like critical access hospitals (CAH). Little is known about the existing gaps in antimicrobial stewardship programs (ASP) of CAH. Hence, we decided to study the current level of ASP activities and factors associated with these activities in CAH.

**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 prevention (IP) full-time equivalent (FTE)/25-bed. Frequency of CE implementation varied among CAH with action (52%) and drug expertise (51%) 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% had a higher median number of the remaining CE implemented compared with CAH without LS or accountability (5 vs. 2, P < 0.01 and 4 vs. 2, P < 0.01, respectively). Facilities with LS accounted for 25% of surveyed CAH and ASP had a median of 27 drug expertise positions. The lowest frequencies of CE implementation were antimicrobial time-outs (93.2%) and strategies to minimize antimicrobial therapy duration (96%). The least common optimization strategy was the use of time-sensitive stop orders (92%). The least common interventions included antimicrobial time-outs (93.2%) and strategies to minimize antimicrobial therapy duration (96%). LTCH with ≥20 IP WH/100-bed dedicated towards IPCP were more likely to have ≥5 CE in place than the LTCH with lower dedicated IP time (60% vs. 8%, P = 0.05).

**Conclusion.** Implementation of all 7 ASP CE in LTCH is uncommon. The presence of LS, accountability for ASP, and ≥20 IP WH/100-bed for IPCP are significant factors driving implementation of more ASP CE. Further guidance is needed for LTCH in dedicating appropriate IP time towards IPCP for promoting ASP as IP time varies greatly among LTCH.

**Disclosures.** 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 associated with factors driving implementation of more ASP CE. Further guidance is needed for LTCH in dedicating appropriate IP time towards IPCP for promoting ASP as IP time varies greatly among LTCH.

**Disclosures.** No reported disclosures.

### 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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**Background.** Nebraska (NE) Infection Control Assessment and Promotion Program (ICAP) is a CDC funded project. ICAP team works in collaboration with NE Department of Health and Human Services (NEDHHS) to assess and improve infection prevention and control programs (IPCP) in acute care, outpatient and long-term care facilities (LTCF). New Centers for Medicare and Medicaid Services (CMS) regulation requires LTCF to develop antimicrobial stewardship programs (ASP) by November 2017. Hence, we decided to study the current level of ASP activities and associated factors in LTCF.

**Methods.** NE ICAP conducted on-site surveys in 30 LTCF from 11/2015 to 3/2017. ASP activities related to 7 CDC recommended core elements (CE) including leadership support (LS), accountability, drug expertise, action, tracking, reporting, and education were assessed using the CDC Infection Control Assessment Tool for LTCH. Gap frequencies were calculated for CE. Fisher’s exact, Mann–Whitney, and Kruskal–Wallis tests were used for statistical analyses examining the associations of LS, accountability, bed size (BS), hospital affiliation (HA), presence of trained infection preventionist (IP), and IP weekly hours (WH)/100-bed for IPCP with level of ASP activities.

**Results.** Of the 30 LTCF surveyed, 23% had HA and 60% had trained IP. Median BS, IP WH/100-bed for IPCP, and number of CE implemented were 60.5, 6.5, and 3, respectively. Only 1 (3%) LTCF had all 7 CE in place. LTCH with LS had a higher median number of the remaining CE implemented compared with LTCH without LS (3 vs. 2, P = 0.03). Similarly, LTCH with accountability for ASP had a median of 5 remaining CE in place as opposed to 2 in LTCH without accountability (P < 0.05). LTCH with LS, accountability, and ≥20 IP WH/100-bed for IPCP were more likely to implement ≥2 of the last 4 CE, i.e., action, tracking, reporting and education (100% vs. 30%, P < 0.05). LTCH with ≥20 IP WH/100-bed directed towards IPCP were more likely to have ≥5 CE in place than the LTCH with lower dedicated IP time (60% vs. 8%, P < 0.05).

**Conclusion.** Implementation of all 7 ASP CE in LTCF is uncommon. The presence of LS, accountability for ASP, and ≥20 IP WH/100-bed for IPCP are significant factors driving implementation of more ASP CE. Further guidance is needed for LTCF in dedicating appropriate IP time towards IPCP for promoting ASP as IP time varies greatly among LTCH.

**Disclosures.** No reported disclosures.