Results. A total of 36,828 DOT were included for 56 physicians at two hospitals. Prescriber rank changed for all top five prescribers at each hospital after incorporating physician-specific denominator metrics as compared with DOT alone (Table 1). The largest change in rank observed was 19 spots using admissions as a denominator.

Conclusion. Incorporating physician-specific denominator metrics to account for differences in patient volume enhances peer comparison and results in significant changes in prescriber rank. Choice of meaningful denominator is highly dependent on staffing model for hospital physicians.

Table 1: Comparison of AU Metrics for Prescriber-specific Feedback Reports (Top 5 Prescribers by DOT per Metric)

| Denominators: Shifts Worked and Total Patients Seen | Prescriber | DOT (%) | Rank | DOT/ Shift | DOT/ Total Patients Seen |
|---------------------------------------------------|------------|---------|-------|------------|--------------------------|
| A                                                 | 1323 (8.2) | 21      | 1.0   | 19         |
| B                                                 | 1106 (6.9) | 20      | 0.93  | 16         |
| C                                                 | 981 (6.1)  | 19      | 1.0   | 12         |
| D                                                 | 891 (5.5)  | 18      | 0.94  | 15         |
| E                                                 | 738 (4.79)| 17      | 0.7   | 7          |

Table 2: Denominators: A, Admissions; and 1,000 Prescriber Patient Days (PD)

| Prescriber | DOT (%) | Rank | DOT/ Admissions | DOT/ 1,000 PD | Rank |
|------------|---------|------|-----------------|---------------|------|
| A          | 3,208   | 35   | 7.32            | 1,161.9       | 25   |
| B          | 2,731   | 34   | 4.76            | 956.2         | 20   |
| C          | 1,796   | 33   | 9.71            | 1,322.5       | 27   |
| D          | 1,297   | 32   | 3.38            | 1,035.9       | 22   |
| E          | 1,034   | 31   | 4.79            | 1,007.8       | 21   |

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1821. Understanding the Components and Calculation of the SAAR, Illustrative Data
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Background. The standardized antimicrobial administration ratio (SAAR) compares each hospital’s observed to predicted days of antimicrobial therapy. However, confusion exists about how hospital-level, seasonal, and hospital-peer-based variations in antibiotic use might impact an institution’s SAAR. We characterized the impact of each of these three types of variation on predicted SAARs utilizing local NHSN data.

Methods. Analysis of antibiotic consumption data from an academic medical center in Chicago, IL was conducted. SAAR and antimicrobial days per 1,000 days present (AD/1,000DP) were compiled in monthly increments from 2014 to 2016. Antimicrobial consumption was aggregated and classified into agent categories according to NHSN criteria. Month-to-month changes in both the SAAR and AD/1,000DP were evaluated. Azithromycin AD/1,000DP from 2012 through 2017 were explored for seasonal variation as defined as >20% increase in AD/1,000DP from each quarter to the overall mean AD/1,000DP for all months. A simulation was performed to explore the potential effect of seasonality on the SAAR. Demographic covariates within the SAAR model were altered while holding constant observed antibiotic use; thus we were able to observe the potential impact of demographics. Finally, a simulation explored the effect of altered consumption at other hospitals on a local institution’s SAAR.

Results. Across all antibiotic agent categories for both ICU (n = 4) and general wards (n = 4), the average matched-month percent change in AD/1,000DP was highly predicted and correlated with the corresponding change in SAAR (Figure 1, Pearson’s r = 0.99). The monthly mean ± SD AD/1,000DP was 235.0 (range 47.2–661.5), and the mean ± SD SAAR was 1.09 ± 0.26 (range 0.79–1.09) across the NHSN antibiotic agent categories. Five quarters were found to have seasonal variation in AD/1,000DP for azithromycin (Figure 2). Simulations demonstrated that changing antimicrobial use at comparator hospitals does not impact the local SAAR, and seasonal variation may cause fluctuating SAARs.

Conclusion. Month-to-month changes in the SAAR mirror monthly changes in an institution’s AD/1,000DP: Seasonal variation can impact the SAAR, and the effect changing peer hospital antibiotic consumption is not currently captured by the SAAR methodology.

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1824. Care Transformation in Infectious Diseases: Using a Novel Approach for Tracking Antimicrobial Stewardship Metrics
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Background. A key component of antimicrobial stewardship (AS) programs is the use of adequate metrics to monitor antimicrobial utilization. Limitations have been described in the literature for traditional metrics such as Defined Daily Doses (DDD) and Days of Therapy (DOT), including practitioner’s unfamiliarity with the terminology in relation to their meaning. This abstract describes an innovative approach developed by our organization that resulted in improved utilization of high-cost antimicrobials and increased the engagement of practitioners based on real-time (RT) analytics using a novel metric: Defined Daily Goal (DDG).

Methods. A RT medication utilization dashboard (DB) for daptomycin (DAP) was created in October 2017 by clinical analysts and pharmacists. The DB provides a list of patients with active orders for DAP and compares the sum of active orders to the sum of available orders to meet the DDG. At Florida Hospital Orlando (FHO), the DDG goal based on national benchmark data were 6.8 days of therapy (DOT)/1,000 patient days (PDs) or a total of 240 orders/month. The average PDs/month was calculated to be 35, 380, thus the DAP DDG for FHO was determined to be 8 orders/day to meet a goal of 6.8 DOP/month. This goal of 8 DAP orders/day was built into the DB for daily AS team review. This calculation allowed for a conversion of our monthly DOT goal to a DDG equivalent.

Results. From October to December 2017, the DB identified an average of 230.7 orders/month at FHO, which was below the goal of 240 orders/month. Visualizing the daily goals for the number of allotted orders for DAP using a DDG format, this allowed the AS team to effectively meet the DOT/1,000 PDs goal. Focusing on the DDG combined with standard AS activities, resulted in a significant reduction of DAP utilization.

Conclusion. When discussing utilization goals with ID specialists and general practitioners, the use of the DDG concept proved to be intuitive and facilitated understanding around specific metrics.

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