receiving a lipoglycopeptide without insurance, the variable direct cost avoidance was $4,560 per case, or $1,060 per day.

**Conclusion.** The use of lipoglycopeptides offers patient convenience and financial benefits, warranting its consideration for use in the ED at tertiary academic medical centers.

**Disclosures.** All authors: No reported disclosures.

1879. A Point Prevalence Study of Antibiotic Utilization in 61 Geographically Diverse Acute Care Hospitals (2017)
Kristi Kuper, PharmD, BCPS1; Patrick Kinn, PharmD, MPH2; Michael Postelnick, RPh BCPS AQ ID3; Amanda Gibson, PharmD4; Amy Paky, PharmD, MS, PhD2 and Lucas T Schulz, PharmD, BCPS (AQ-ID)5; 1Center of Pharmacy Practice Excellence, Vizient, Irving, Texas, 2University of Wisconsin Health, Madison, Wisconsin, 3Department of Pharmacy, Northwestern Medicine, Chicago, Illinois, 4University of Utah Health, Salt Lake City, Utah, 5Department of Pharmacotherapy and Outcomes Science, Virginia Commonwealth University, Richmond, Virginia

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**Background.** Antibiotic utilization for geographically diverse areas can be difficult to obtain. The purpose of this study was to characterize patterns of US antibiotic use over a defined period to provide comparative data for benchmarking and to assist with identifying antibiotic stewardship opportunities.

**Methods.** Data were obtained as part of a larger study evaluating antibiotic time out practices. Participating institutions submitted de-identified patient-level antibiotic use data from a single day (between October 16, 2017 and November 17, 2017). Indication, expected duration, and antibiotic stop dates were documented. Antibiotics were classified by American Hospital Formulary Service (AHFS) therapeutic category and evaluated to identify duplicate anti-anaerobic, anti-MRSA, and AHFS classes. Hospital teaching status and US Census region were recorded.

**Results.** A total of 6,184 courses of therapy (8,996 individual antibiotics) were evaluated from 61 hospitals. Sixty-four percent of therapy courses submitted were from academic medical centers. Distribution by census region was Midwest (44.7%), Northeast (15.11%), South (23.2%), and West (16.9%). Over half (53.7%) of therapy was empiric and 33.4% was directed. Duplicate anti-anaerobe and duplicate anti-anaerobe therapy were identified in 1.5% of total courses (each). Duplicate anti-MRSA therapy occurred in 0.29% of therapy courses. Three percent of patients developed a *Clostridium difficile* infection during their hospitalization.

**Conclusion.** Vancomycin and piperacillin-tazobactam were the most common antibiotics used which is consistent with other analyses, but anti-anaerobic use as a percentage of overall use was higher than expected. Duplicate anti-anaerobe and β-lactam therapy is less frequent, but still represents an opportunity for stewardship.

**Disclosures.** All authors: No reported disclosures.

1880. Does the Label Matter: Initial Use of Newly Approved Antimicrobial Agents in Community Hospitals Without Robust Antimicrobial Stewardship Programs
Tina Khadem, PharmD1 and J Ryan Bariola, MD2; 1Outreach Antimicrobial Stewardship, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania, 2Division of Infectious Diseases, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania

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**Background.** With the use of novel Gram-negative agents for pneumonia, there is need for early trials to characterize patterns of US utilization of these agents. Does the initial use of these agents differ between academic and community hospitals?

**Methods.** Newly approved antimicrobial agents were used at these six community hospitals within 1–2 years after FDA approval. Agents with primarily Gram-positive activity were more often used for FDA approved indications. Given frequent use of novel Gram-negative agents for pneumonia, there is need for early trials to determine their role for this indication. In the meantime, ASP’s should consider off-label indications such as pneumonia when developing local criteria for use.

**Results.** A total of 6,184 courses of therapy (8,996 individual antibiotics) were evaluated from 61 hospitals. Sixty-four percent of therapy courses submitted were from academic medical centers. Distribution by census region was Midwest (44.7%), Northeast (15.11%), South (23.2%), and West (16.9%). Over half (53.7%) of therapy was empiric and 33.4% was directed. Duplicate anti-anaerobe and duplicate anti-anaerobe therapy were identified in 1.5% of total courses (each). Duplicate anti-MRSA therapy occurred in 0.29% of therapy courses. Three percent of patients developed a *Clostridium difficile* infection during their hospitalization.

**Conclusion.** Vancomycin and piperacillin-tazobactam were the most common antibiotics used which is consistent with other analyses, but anti-anaerobic use as a percentage of overall use was higher than expected. Duplicate anti-anaerobe and β-lactam therapy is less frequent, but still represents an opportunity for stewardship.

**Disclosures.** All authors: No reported disclosures.

1881. Empirc Pseudomonal Monotherapy vs. Combination Therapy for Community-Onset Pneumonia in Older Adults
Obagari Obodoozie-Oloegbu, BPharm, MSc, PhD1; Chengwen Teng, PharmD, MS2; Eric M. Mortensen, MD, MSc3 and Christopher R. Frei, PharmD, MSc4; 1The University of Texas at Austin College of Pharmacy and University of Texas Health Science Center Long School of Medicine, San Antonio, Texas, 2University of Connecticut Medical Center, Farmington, Connecticut

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**Background.** Patients with pseudomonal pneumonia have a poor prognosis; therefore, IDSA guidelines recommend empiric antipseudomonal combination therapy when *Pseudomonas* is suspected, at least until treatment can be adjusted based on susceptibilities. However, combination antipseudomonal therapy is controversial. This study compared all-cause 30-day mortality in older patients who received antipseudomonal monotherapy (PMT) or antipseudomonal combination therapy (PCT) for the treatment of community-onset pneumonia.

**Methods.** This population-based cohort study used data from over 150 Veteran Health Administration hospitals. Patients were classified as low, medium, or high risk of drug-resistant pathogens according to a published rule. Patients were assigned to PCT or PMT groups based on antibiotics received in the first 48 hours of hospital admission. Separate multivariable logistic regression models were constructed to determine whether the choice of PCT or PMT was associated with 30-day mortality, after accounting for divergent baseline characteristics. Adjusted odds ratios (aORs) and 95% confidence intervals (95% CI) were calculated for the overall, low, medium, and high-risk groups.

**Results.** Of the 31,027 patients who met study criteria, 23% received PCT and 77% received PMT. Patients belonged to low (59%), medium (24%), and high (18%) risk groups. 30-day mortality was 18% overall, and increased among the groups: low (13%), medium (21%), and high (36%). Patient age (median of 78 years), race (>80% white), and sex (>98% male) were similar in patients receiving PCT and PMT. The unadjusted mortality difference between PCT and PMT was most pronounced in the
between the groups were analyzed by chi-squared test. To identify variables associated with AKI in a multivariable analysis, a repeated measures, mixed-effects logistic regression was utilized.

Results. There were 185 patient encounters included in the analysis. RIFLE-defined AKI occurred in treatment groups as follows: VPT 31/98 (31.6%); VC 5/50 (10.0%); LPT 4/12 (33.3%); and LC 4/25 (16.0%). There was a significant difference in rates of AKI among the four groups (P = 0.019). In pooled analyses, no difference was identified between patients receiving V or L (P = 0.73); however, patients who received PT had a higher incidence of AKI compared with those that received C (P = 0.002). In logistic regression analyses, independent predictors of AKI were receipt of PT vs. C (odds ratio [OR] 3.2, 95% confidence interval [CI] 1.3–8.0) and SOFA score ≥ 9 (OR, 4.5; 95% CI 1.6–12.7).

Conclusion. No differences in AKI incidence were found between patients receiving vancomycin or linezolid, however, patients receiving piperacillin–tazobactam and those with SOFA score ≥ 9 had a higher rate of AKI.

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1884. Assessment of Potential Antimicrobial-Related Harms in Hospitalized Adults With Common Infections
Nicholas J. Mercuro, PharmD1,2; Rachel Kenney, PharmD, BCPS (AQ-ID)2; Nagaravendra Vemulapalli, MD3; Mariam Costandi, MD3; Charles T Makowski, PharmD3; Berta Reniz, MD3,4; and Susan J. Davis, PharmD1,2;2; Pharmacy Practice, Wayne State University, Detroit, Michigan, 1Henry Ford Health-System, Detroit, Michigan

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Background. Recent data suggest antibiotic-related harm occurs in 1 in 5 hospitalized patients. The purpose of this study was to critically evaluate potential adverse drug–events (ADE) associated with antimicrobial administration in hospitalized family medicine (FAM) patients.

Methods. Retrospective cohort of adults receiving antimicrobial therapy for respiratory, urinary, and skin infection on an inpatient FAM ward between January 2017 and March 2018. Primary endpoint: potential ADEs up to 30-day post-therapy, identified using inpatient and outpatient electronic medical records. ADEs were classified as mild, moderate, or severe. Naranjo scores were used to classify causality. Other endpoints included risk associated with ADE, subsequent 30-day readmissions, and infections due to multidrug-resistant organisms up to 90-days post-therapy.

Results. 1,499 antibiotic days were assessed in 150 hospitalized adults. Fifty-four patients with at least one potential ADE (68 total) were identified. By Naranjo score, 10 (6.7%) patients had “probable” antibiotic related ADEs (score 5–8), all others were “possible” (score 1–4). Excluding patients with diarrhea receiving concomitant laxatives, 36 patients (24%) suffered from 50 potential ADEs, approximately 3.33 per 100 antibiotic days (Table 1). Thirteen (9.3%) had serious ADEs; 6 were receiving concomitant medications which may have contributed to harm, primarily nephrotoxins (5/6). Alteration of antimicrobial therapy was attributed to ADEs in 12/54 cases (22.2%) while 6 (11.1%) led to 30-day hospital or emergency department (ED) revisits. ADEs were not associated with any specific antimicrobial. Patients with ADEs were more likely to have ED/hospital revisits (OR = 2.42 [1.16–5.05]) and receive more total antibiotic days (11 [6–15] vs. 8 days [6–12 days], P = 0.036) compared with those who did not.

Conclusion. One in four hospitalized FAM patients receiving antimicrobials experienced potential serious harm. While varying in nature and severity, antimicrobial ADEs contribute to serious harms. These findings underscore need for improved awareness and judicious use.

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