processes [allergy assessment (n = 2), order sets (n = 2), and implementation of rapid diagnostics (n = 1)]. Five of 16 ASPs documented full compliance with JC and CDC requirements, and 11/16 documented partial compliance (none were compliant prior to IDT implementation). Front-line pharmacists reviewed 3,593 stewardship alerts during the first 7 months, leading to 826 interventions across 16 facilities. The IDT pharmacist reviewed 1,198 alerts leading to 318 interventions.

Conclusion. We established or augmented ASPs in 16 Intermountain SCHs through local empowerment, central data sharing, and IDT mentorship. Future goals include documenting improvement in antibiotic use and patient outcomes.

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772. Volume-adjusted antimicrobial prescribing rate: An automated method for identifying antimicrobial over-prescribers in ambulatory care

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Background. A major target for outpatient antimicrobial stewardship has been the unnecessary use of antimicrobials, particularly for acute respiratory tract infections (ARTIs). The objective of this study was to determine whether data electronically extracted from the medical record (i.e., volume-adjusted antimicrobial prescribing rate) could identify outpatient providers who are more likely to prescribe unnecessary antimicrobials.

Methods. At a single VA medical center, patient visits during 2016 to primary care were retrospectively reviewed if associated with an ICD-10 code for cystitis or an ARTI. Using manual chart-review, an over-treatment rate was calculated for each provider by determining the frequency at which antimicrobials were prescribed when not indicated. A volume-adjusted antimicrobial prescribing rate was determined by extracting data on all antimicrobials prescribed by each provider and adjusting for the total number of patient-visits for that provider.

Results. Manual audits to determine antimicrobial necessity were performed on 633 ED visits and 247 primary-care visits. Antimicrobials were not indicated in 51% (324) of ED visits and 58% (144) of primary care visits. For 14 ED providers, the median antimicrobial-prescribing volume was 13.7 prescriptions per 100 provider-visits (IQR 12.5-14.8), and the median over-treatment rate was 47% (IQR 28-64%). Among 7 primary care providers, the median volume-adjusted antimicrobial prescribing rate was 8.1 prescriptions per 100 provider-visits (IQR 7.3-8.6), and the median over-treatment rate was 33% (IQR 31-59%).

There was a positive correlation between a provider’s volume-adjusted antimicrobial prescribing rate and their overall rate of over-treatment in both the ED (r = 0.67, P < 0.01) and primary care (r = 0.80, P = 0.03).

Conclusion. In this small study, electronically-extracted data on a provider’s rate of volume-adjusted antimicrobial prescribing strongly correlated with the frequency at which unnecessary antimicrobials were prescribed, particularly in primary care. Comparing providers within a given outpatient setting on their volume-adjusted antimicrobial prescribing rate may be an efficient way to identify over-prescribers.

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773. Hiding in Plain Sight: Observations from a Review of Positive Urine Cultures Prior to an Antimicrobial Stewardship Program Campaign Targeting Asymptomatic Bacteriuria

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Background. Data have shown that many patients with asymptomatic bacteriuria (ASB) receive unnecessary antibiotics, increasing rates of adverse events and resistance. Positive urine culture (PUC) and urinalysis (UA) results have been shown to prompt treatment without symptoms or compelling indication (pregnancy or prior to urologic procedure). We reviewed clinician action based on PUCs across 28 acute-care hospitals of varied size, scope, and antimicrobial stewardship program (ASP) maturity prior to an ASB educational campaign.

Methods. We conducted a retrospective sampling of inpatient PUCs collected February 1–28, 2017. Patients were excluded if pregnant, undergoing urologic procedure, aged < 18 years, neutropenic, or were admitted on active urinary tract infection (UTI) therapy or with nephrolithiasis. A CDC UTI assessment form was adapted to collect: demographic, clinical, and laboratory data. The presence of UTI symptoms, microbiological results, antimicrobial therapy and duration, and rate of ASP intervention.

Results. Data from the First 200 included patients at 14 hospitals are shown. Most patients (84/200 (42%)) presented with only non-specific symptoms (NSS) or no symptoms (62/200 (31%)) vs. (vs) at least 1 specific urinary symptom (SUS) (54 / 200 (27%)).

Ceftriaxone was the most common empiric therapy in those with no symptoms (17/40 (42.5%)) or NSS (35/74 (47%)) who were treated. Interventions were documented on 18/200 (9%) patients, despite daily use of clinical decision support (CDS) at 58% of hospitals.

Conclusion. ASB presents many targets and challenges. UA and UC were often performed in patients with no symptoms or NSS. Thus, optimal ordering of UA and UC should be targeted to avoid unnecessary cost and therapy. Treatment of patients with no symptoms appeared to be more common in rural vs. urban hospitals and may help focus education. Low ASP intervention rates, despite use of CDS, may indicate challenges in identifying ASB patients. Many patients received ceftriaxone, which may not be targeted for initial review by ASP. Due to high volume at many sites, daily review of all PUCs may not be feasible.

Figure 1. Presenting Symptoms.

Figure 2. Results by Presenting Symptoms.

Figure 3. Empiric Treatment by Urban Vs. Rural Hospital.

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774. The Experience of Stewards in Using a Visual Analytic Tool to Benchmark and Track Therapy Duration for Pneumonia, Urinary Tract Infections, and Skin and Soft-tissue Infections

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