antibiotic. Among screen pos. cases, final antibiotics definitely covered in 75% and possibly in 25%.

**Conclusion.** Conclusions: The MDR Enterobacterales screening tool for abdominal infections had limited impact on final antibiotic choice, but was useful when positive. Further directions include assessment of provider understanding of the MDR screen results and investigation of utility of screen in other infection types.

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

89. Follow-Up Blood Cultures (FUBC) in the Management of Gram-Negative Bacilli (GNB) Bloodstream Infections (BSIs): Frequently Obtained and Rarely Helpful

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**Session:** P-05. Antimicrobial Stewardship: Diagnostics/Diagnostic Stewardship

**Background.** While GNB BSIs remain a major cause of morbidity and mortality, no clear guidelines exist on the utilization of FUBCs to guide management. Despite the recognition of persistent bacteremia as a risk factor for increased mortality, early studies on FUBCs were low yield in this setting, and thus had low utility. More recently, some controversy has arisen with multivariate analyses suggesting FUBC acquisition may be associated with lower mortality. We sought to characterize the utilization and yield of FUBCs for GNB BSIs at our institution.

**Methods.** We performed a retrospective review of 514 episodes of consecutive blood cultures from unique adult inpatients with GNB BSI between July 2017-July 2019. Exclusion criteria included prior positive culture, polymicrobial Gram stain, or discharge, death, or comfort measures only within 24 hours of Gram stain. FUBCs were defined as blood cultures collected between 24 hours to 7 days after the index blood culture. Baseline clinical and microbiologic characteristics were compared between groups, as well as clinical outcomes.

**Results.** Of 514 episodes, 338 (66%) had FUBCs performed, with a median of 2 FUBCs/episode. The majority of FUBCs (522/338; 95%) were negative, with 9 (3%) yielding the same organism and 9 (3%) yielding a different organism. Most initial FUBCs were obtained prior to index antimicrobial susceptibility results (227/338; 67%). Patients with FUBCs performed had a higher median Pitt bacteremia score (2 vs 1; p = 0.015) and were more likely to have hospital onset (36% vs 22%; p = 0.002), severe neutropenia (16% vs 4%; p < 0.001) and a catheter-associated source (13% vs 4%; p = 0.001). 30-day mortality did not differ between patients with or without FUBCs (10% vs 11%; p = 0.84).

**Conclusion.** FUBCs were frequently obtained, but were of low yield even in comparison to recent similar studies. Though FUBCs were performed in more severe cases, a difference in mortality was not observed. Delaying the decision of whether to obtain FUBCs until after index antimicrobial susceptibility results are available would reduce unnecessary testing in most cases. Further study could better define where FUBCs after antimicrobial susceptibility testing would be most helpful.

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90. Deimplementation: Use of Electronic Clinical Decision Support to Reduce Unnecessary Erythrocyte Sedimentation Rate (ESR) Ordering

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**Session:** P-05. Antimicrobial Stewardship: Diagnostics/Diagnostic Stewardship

**Background.** In recent years, several de-implementation initiatives have focused on diagnostic testing. One such initiative, the Choosing Wisely campaign, recommends against routine use of erythrocyte sedimentation rate (ESR) for assessment of acute undiagnosed infection or inflammation. With the development of newer biomarkers of inflammation, particularly C-reactive protein (CRP), there is a decreasing role for ESR in screening for acute-onset conditions; however, ESR continues to be commonly ordered.

**Methods.** We examined ESR and CRP ordering practices at the Children’s Hospital of Philadelphia (CHOP) from July 2019 to July 2020 and found that 80% of ESR orders were placed concurrently with an order for CRP. We aimed to reduce ESR ordering by 20% at CHOP by using electronic clinical decision support in the form of embedded order guidance for ESR orders placed in the Emergency Department (ED) and inpatient setting. We examined the effect of the clinical decision support by assessing ESR ordering rate, defined by ESR orders per monthly patient days for the inpatient setting and ESR orders per monthly ED visits for the ED setting. We then examined differences in ordering rates using a quasi-experimental model with a concurrent control (basic metabolic panel).

**ESR Electronic Decision Support Intervention**

**Inpatient setting**

**ED setting**

Inpatient and ED versions of the embedded electronic clinical decision support for ESR orders.

**Results.** Prior to implementation of the electronic decision support intervention, the median monthly rate of ESR orders was 13.6 per 1000 patient days and 70.3 per 1000 ED visits. During the initial month after implementation, we found that ESR ordering was 12.5 in inpatient and 46.4 in ED, reflecting decreased rates of ordering. The median monthly rate of basic metabolic panel orders (courtesy control) was 194.5 per 1000 patient days and 110.0 per 1000 ED visits. This was unchanged after intervention.

**Conclusion.** We conclude that electronic clinical decision support is a potentially effective deimplementation method for improving diagnostic test utilization, even with non-disease specific testing such as inflammatory markers. However, continued post-implementation data monitoring and analysis is needed to determine if this is a true difference and sustainable trend.

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91. Knowledge, Attitudes, and Practice of Antibiotic Prescribing among Nurse Practitioners

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**Session:** P-06. Antimicrobial Stewardship: Non-Inpatient Settings

**Background.** Antibiotic overuse (AO) in ambulatory care is an important public health problem. Nurse practitioners (NPs) account for a growing proportion of outpatient antibiotic prescriptions: 14.6% in 2016. Our objective was to assess NPs’ attitudes about antibiotic prescribing practices and knowledge and use of antibiotic prescribing guidelines (APG) in their practice.

**Methods.** We distributed a survey via email to NPs listed as licensed by the North Carolina Board of Nursing. Surveys were distributed three times; duplicate responses were not permitted. Respondents who reported not prescribing antibiotics in the outpatient setting were ineligible. Three randomly selected respondents received gift cards. Questions assessed degree type, practice type, years in practice, and attitudes about antibiotic prescribing practices antibiotic stewardship. Respondents answered four questions assessing knowledge of APG. Analyses were descriptive; scores on knowledge questions were compared using T-tests.

**Results.** Survey requests were sent to 10,094 listed NPs; there were 846 complete responses (8.4%), of which 672 respondents (79.4%) reported prescribing antibiotics in outpatient care. Of those, 595 (88.5%) treat adult patients. Most respondents agreed that AO is a problem in their state (84.5%); 41.3% agreed that it was a problem in their practice. Patient/family satisfaction was the most frequently