Conclusion. Public Health Departments can facilitate assessment of ACH ASPs within their jurisdiction to identify ways to advance the ASP agenda and combat AMR. A variety of strategies were used by Chicago ACHs to promote ASP initiatives during USAAW. Challenges continue with inadequate funding, especially in outpatient settings.

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126. Outpatient Antimicrobial Stewardship Utilizing a Decentralized Model

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Session: P-07. Antimicrobial Stewardship: Program Development and Implementation

Background. The majority of human antimicrobial utilization occurs in the outpatient setting. Despite being mainly viral in etiology, upper respiratory tract infections (URIs) were the most common indication for outpatient antimicrobial prescriptions at our institution.

Methods. Through our electronic health record (EHR), we were able to determine our rate of antibiotic prescriptions for inappropriate URI diagnosis at our primary care practice sites. We selected staff volunteers from each of our primary care practice sites to serve as stewardship champions. They were given training in stewardship best practices, and an URI stewardship toolkit which included viral URI prescription pad, EHR order panel, and patient education signage. They were tasked with providing education and feedback to their practice sites. We meet with them on a monthly basis to disseminate prescribing data and education. They also provided feedback from practice sites to the stewardship committee.

Results. Our decentralized model was put in place in November 2020. In the 6 months prior to the intervention, the average prescribing rate was 29.1%. In the 6 months after the intervention, the average prescribing rate decreased by 15% to 24.8%. During the intervention phase, there was an increase in number of non-COVID URIs diagnosed at our primary care sites.

Temporal Trend in Inappropriate Antibiotics Prescribing Rates for Viral URIs Pre- and Post- Intervention

The total number of visits for presumed viral upper respiratory infections to primary care sites from May 2020 until May 2021. Intervention started in December 2021 (arrow). Pre-intervention average was 29.1%. Post-intervention age was 24.8% which is a 15% decline in prescribing rate.

Viral Upper Respiratory Infections Visits

Conclusion. We have been able to lower our inappropriate prescriptions for URIs utilizing a decentralized model of stewardship champions. This result was especially notable as the intervention phase corresponded with the end of COVID-19 precautions and an increase in non-COVID URIs diagnosed. The advantage of this approach includes an advocate embedded at each practice site who is familiar with the opportunities and challenges of the site, and a two-way flow of information from practice sites to the stewardship committee. This model provided additional benefit during the COVID-19 pandemic as the ability of centralized staff to travel to off campus sites was curtailed.

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127. Living on the Edge: The Impact of MIC Distributions on Empiric Antibiotic Selection

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Session: P-07. Antimicrobial Stewardship: Program Development and Implementation

Background. Due to variability in the precision of an MIC, concern may exist in optimizing PK/PD using standard doses when the MIC is at the susceptibility breakpoint (SBP). This is notable when treating infections in critically ill patients. Evaluating MIC distributions among commonly used antibiotics and accounting for isolates at the SBP represents an additional enhancement to inform empiric therapy. The aim of the study was to evaluate antibiotic susceptibility for commonly used β-lactams against Pseudomonas aeruginosa (PA) in a syndromic antibiogram, incorporating MIC distribution.

Methods. 20 US institutions submitted yearly up to 250 consecutive targeted Gram-negative pathogens from hospitalized patients as part of the Study for Monitoring Antimicrobial Resistance Trends (SMART) in 2016-2019. MICs were determined by broth microdilution and interpreted using 2021 CLSI breakpoints. The syndromic antibiogram included PA from a blood or respiratory source based on patient location. Based on CLSI guidance, an empiric antibiotic susceptibility threshold of ≥ 90% was deemed optimal.

Results. 2,500 PA blood (n=680) and respiratory (n=1,820) isolates were evaluated; piperacillin/tazobactam (P/T), cefepime (FEP), meropenem (MEM), and ceftolozane/tazobactam (C/T) susceptibilities were 69.6%, 74.2%, 75.3%, and 95%, respectively (Figure 1). Isolates with MICs at the SBP were observed in 12.1%, 18.7%, 7.5%, and 6.5% for P/T, FEP, MEM, and C/T, respectively. Susceptibilities were lower when stratified by ICU, 64.8%, 71.2%, 70.7%, and 93.7% for P/T, FEP, MEM, and C/T, respectively with a similar frequency of SBP isolates (Figure 2).

Figure 1. Syndromic antibiogram evaluating P. aeruginosa blood and respiratory isolates.

Figure 2. Syndromic antibiogram evaluating Pseudomonas aeruginosa blood and respiratory isolates stratified by ICU. *MIC breakpoints used to determine susceptibility included: P/T MIC ≤ 16/4 μg/ml, FEP ≤ 8 μg/ml, MEM ≤ 2 μg/ml, C/T ≤ 4 μg/ml

Conclusion. Our analysis demonstrated that first line antipseudomonal agents, P/T and FEP, have susceptibility rates lower than the CLSI recommended threshold. A significant portion of the MICs within the susceptible range are at the SBP. Due to the frequency of baseline resistance and challenge in achieving adequate PK/PD in critically ill patients, clinicians may be concerned with relying on certain antibiotics when the MIC is at the SBP. Antimicrobial stewardship programs should consider incorporating MIC distributions into syndromic antibiograms to better inform empiric therapy recommendations.