Antibiotic indications were symptomatic apical periodontitis or localized acute apical abscess (51.3%), symptomatic irreversible pulpiteae (17.8%), prevention of implant failure (11.7%), pericoronitis (4.3%), acute apical abscess with systemic involvement (3.9%), and others (11%). Of the 230 antibiotic prescriptions, 27.8% were appropriate, 3.9% inappropriate, 66.1% indeterminate, and 2.2% not enough information.

Conclusion. Commonly prescribed antibiotics in this study were amoxicillin or amoxicillin/clavulanate for a mean duration of 5 days. The most common indication was symptomatic apical periodontitis or localized acute apical abscess. Two-thirds of antibiotics were prescribed without sufficient evidence to support or not support use.

Disclosures. All authors: No reported disclosures.

2079. Outpatient Antimicrobial Stewardship Initiative to Reduce Unnecessary Use of Antibiotics in Patients with Upper Respiratory Infections: Findings Shared by a Metropolitan Community Hospital in NYC

Jilan Shah, MD; Dora Inaguirre-Anariba, MD, MPH; Hariprasad Rao, MD; Yash Patel, MD; Kyaw Zin Win, MD, MHA; Olawale Samuel. Akande, MBA, CPHQ; Laurie Ward, MD, Olga Badem, MD; Wyckoff Heights Medical Center, Brooklyn, New York

Session: 238. Antibiotic stewardship: Non-Inpatient Settings Saturday, October 5, 2019: 12:15 PM

Background. Antibiotic-resistant infections are one of the greatest public health issues with more than 2 million infections and 23,000 deaths per year in the United States. Reducing inappropriate antibiotic use is essential to reduce both antibiotic resistance and adverse events. The most important modifiable risk factor for antibiotic resistance is inappropriate prescribing of antibiotics. At least 30% of outpatient antibiotic prescriptions in the United States are unnecessary. We aimed to pilot our outpatient antimicrobial stewardship initiative to track and reduce antibiotic prescriptions among adult patients presenting with common acute respiratory infections in our hospital’s outpatient primary care settings.

Methods. A retrospective and prospective cohort study from October, 2017 to March, 2019. Implemented a robust outpatient antimicrobial stewardship initiative with a dedicated team and data analyst based on CDC core elements for outpatient antimicrobial stewardship and a prior UHF initiative. Data of common respiratory tract infections and the respective rates of antibiotic prescriptions from 3 adult primary care sites were collected from the EHR. Serials of educational interventions were performed between June, 2018 to September, 2018. We disseminated resources from the CDC and DOH like electronic lectures for providers and periodic provider feedback reports.

Results. Our findings revealed that the physician compliance rate of antibiotics not prescribed for common respiratory tract infections remarkably improved from 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1). The chi-square test showed 40, and 72% to 85% after implementing our interventions (Figure 1).

Conclusion. Introduction of a robust and multifaceted Outpatient Antimicrobial Stewardship initiative with a dedicated team can substantially decrease outpatient antibiotic prescription rates for respiratory tract infections in metropolitan community hospital-based primary care settings.

Disclosures. All authors: No reported disclosures.

2080. Impact of an Emergency Department Post-discharge Blood Culture Follow-up Program

Axel Vazquez Deida, PharmD1; Veronica Salazar, PharmD, BCPS2; Lilly Lee, MD, SM, FACEP3; Lilian Abbo, MD, FIDSA1; Jackson Memorial Hospital, Miami, Florida; University of Miami Miller School of Medicine, Miami, Florida

Session: 238. Antibiotic stewardship: Non-Inpatient Settings Saturday, October 5, 2019: 12:15 PM

Background. Blood cultures are the gold standard in the identification of laboratory-confirmed bloodstream infections (LCBI) but contamination can lead to unnecessary interventions. This study sought to assess the number of unwarranted admissions in patients with contaminated blood cultures post-discharge and at low risk for LCBI before and after the implementation of a multidisciplinary emergency department (ED) blood culture follow-up program.

Methods. This was a two-phase retrospective cohort study at a tertiary care, 1,550-bed, academic hospital and level I trauma center in southeast Florida. Phase 1 assessed interventions made on patients 18 years of age or older discharged from the ED or a hospital observation unit with a positive blood culture result post-discharge from March 2018 to July 2018. Phase 2 assessed interventions made from December 2018 to March 2019 post-implementation of the multidisciplinary follow-up program. The criteria for low risk of LCBI were lack of risk factors for infection and < 2 positive blood cultures with a commensal bacteria with no symptoms of fever or hypotension on the date of specimen collection and 3 days before or after such date.

Results. Among patients at low risk for LCBI (46% of 24 patients in phase 1 vs. 59% of 22 patients in phase 2), unwarranted admissions due to contaminated blood cultures occurred in 27.3% of patients in phase 1 vs. 0% of patients in phase 2 (P = 0.08). Phase 1 represented a period in which systematic reporting and evaluation of positive results and patient follow-up were not in place. Phase 2 consisted of daily pharmacist-led blood culture reviews with callback nurse follow-up and therapeutic care plan development with ED physicians. The number of contaminant isolates was relatively high (Figures 1 and 2). Pharmacist-led interventions were diverse (Figure 3). The program led to an estimated total cost avoidance of $16,410.80 in a median of 4.5 months due to unnecessary admissions.

Conclusion. Implementation of a multidisciplinary ED post-discharge blood culture follow-up program can be an effective strategy in improving patient care and avoiding unnecessary antibiotic therapy. Further interventions aimed at reducing blood culture contamination could have a direct impact on improving ED antimicrobial stewardship.

Disclosures. All authors: No reported disclosures.