Methods. We performed a two-arm, cluster-randomized, crossover quality improvement study over 8 months to compare the impact of weekly ICU rounds with an ASP team vs. usual care. The primary outcome was antibiotic use (AU) in days of therapy (DOT) per 1,000 days present during and following ICU exposure. Our cohort consisted of ICU patients in 5 ICUs in Duke University Hospital. The unit of randomization was rounding team, which corresponded to half of the ICU bed capacity (each unit). Each team was randomized to the intervention for 4 months followed by usual care for 4 months (or vice versa). The intervention involved multidisciplinary review of eligible patients to discuss antibiotic optimization. Patients not on antibiotics, followed by infected diseases, post-transplant, on ECMO, or with a ventilator assist device were excluded from review. Intervention impact was assessed with multivariable negative binomial regression rate ratios (RR). AU was assessed over time before and after the study period to assess global and unit-level trends.

Results. We had 6,883 ICU-exposed patients. Intervention effect was not significant for the primary outcome (table). The intervention order was not significant in the model. Eligible patients were lower in the cardiothoracic ICU (CTICU) compared with other units (table); the intervention led to a significant decrease in AU when the CTICU was removed (RR = 0.93 [0.89–0.98], P = 0.0025). Intervention impact was differential among ICUs, with the greatest effect in surgical and least in CTICU (table). Nit-level AU decreased in all ICUs, driven by 4 of the 5 ICUs (table, figure). Conclusion. The effect of ASP rounds on AU was mixed for different types of ICUs. The direct effect on AU (intervention vs. control) was small because the analysis addressed the whole ICU population and thus was subject to biases from exposures after an ICU stay, ineligible patients, and lack of blinding. However, we observed an overall decline in AU during the study period, which we believe represents indirect effects of increased ASP activity and awareness. Additional ASP resources to round more than weekly may result in greater effect.

Disclosures. All Authors: No reported Disclosures.

1879. A 20/20 Vision: Successful Integration of a Prescribing Dashboard for Outpatient Antimicrobial Stewardship to Target 20% Reduction by the Year 2020 Erin Gentry, PharmD, BCPS; Marc Kowalkowski, PhD; Ryan Burns, MS; Chloe Sweeney, RN, BSN, CPHQ; Cliff Collins, MS; Leigh Ann Medaris, MD; Melanie Spencer, PhD, MBA; Elizabeth Handy, BSN, MBA, CMPE and Lisa Davidson, MD; Atrium Health, Concord, North Carolina Session: 197. Stewardship Success Stories Friday, October 4, 2019: 4:35 PM Background. At least 30% of antibiotics prescribed in the ambulatory setting are unnecessary, including high rates of overuse for acute respiratory infections (ARI). We designed and evaluated whether a multifaceted outpatient stewardship program leveraging multidisciplinary stakeholder engagement, education tools, and an innovative prescribing dashboard decreased antibiotic prescribing in ARI.

Methods. In November 2017, the Carolinas Healthcare Outpatient Antimicrobial Stewardship Empowerment Network (CHOSEN) launched an antibiotic awareness campaign in over 150 ambulatory practices in the Charlotte metropolitan area, reaching over one million patients. The campaign included online and in-person tools for patients and providers, educational videos, and social and mass media exposure. In March 2018, a provider level prescribing dashboard was introduced to target inappropriate antibiotic prescribing in ARI (acute sinusitis, nonsuppurative otitis media, nonbacterial pharyngitis, URI, cough, allergy, and influenza). Data were collected for family medicine (FM), internal medicine (IM), urgent care (UC) and pediatric medicine (PM); 10% and 20% relative reduction targets (years 2019 and 2020, respectively) were set for each service line. We compared pre (April 2016–March 2018) vs. post (April 2018–March 2019) intervention prescribing rates (calculated as the number of encounters with antibiotics vs. total) as rate ratios and used segmented regression models to assess change over time. Results. There were 1,061,355 pre and 448,390 post-intervention encounters. Postintervention prescribing rates (antibiotics per 100 encounters) decreased for all service lines, FM (49.4 to 39.3), IM (49.7 to 41.2), UC (49.8 to 44.4), and PM (40.6 to 36.1) vs. pre-intervention (all rate ratios, P ≤ 0.01). All service lines met the target 2019 ARI reduction goals. Post-intervention PM, IM and UC showed immediate decreases in prescribing (figure). After an initial increase, UC showed a significant month-to-month decrease (figure).

Conclusion. Integration of a prescribing dashboard within a multifaceted antibiotic awareness campaign reduced inappropriate outpatient antibiotic prescribing for ARI and achieved interim targets consistent with 2020 reduction goals.

Disclosures. All Authors: No reported Disclosures.