Results. Antibacterial DOT/1000pd ranged from 345 to 776 (2.2-fold variation from lowest to highest), whereas O:E ratios ranged from 0.8 to 1.14 (1.4-fold variation from lowest to highest) (Figure 1). O:E ratios were moderately correlated with DOT/1000pd (correlation estimate 0.45; 95% CI 0.19-0.64; p=0.0008). Three high outlier hospitals and 6 low outlier hospitals were identified. Examining hospitals with comparably high DOT/1000pd but discordant O:E ratios, differences could be explained by variation in both case mix and condition-specific AU within strata defined by APR-DRGs.

Figure 1. Individual hospitals labeled on the X-axis, ordered by level of antibacterial DOT/1000pd (left axis), represented by bars. Diamonds represent O:E ratios derived by indirect standardization (right axis). Outlier hospitals (low and high) are highlighted in yellow. Dashed horizontal lines represent 10th percentile (lower) and 90th percentile (upper) limits of the O:E ratio distribution.

Conclusion. The observed variation in DOT/1000pd between hospitals is reduced when indirect standardization is applied to account for case mix differences. This approach can be adapted for more specific uses including clinical conditions, patient populations, or antimicrobial agents. Indirect standardization may enhance stewardship efforts by providing adjusted comparisons that incorporate case mix differences between hospitals.

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1349. Institutional Antibiograms Are Insufficient to Guide Clindamycin Use in Pediatric Skin and Soft Tissue Infections
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Session: P-60. Pediatric Antimicrobial Stewardship (inpatient/outpatient pediatric focused)

Background. Clindamycin (CLN) is a common empiric antimicrobial for pediatric skin and soft tissue infections (SSTI) despite decreasing susceptibility of Staphylococcus aureus (SA) to CLN on institutional antibiograms. This study inquired whether institutional antibiograms are an accurate representation of susceptibility for these SA infections. It also attempted to find patient and infection characteristics associated with being clindamycin susceptible (CLN-S).

Methods. This was a retrospective chart review of children with community-acquired (CA) SA infections in 2016 and 2017. A Staphylococcus aureus antibiogram was created based on infection type. Various patient and infection characteristics were compared between CLN-S and clindamycin-resistant (CLN-R) isolates to identify predictors of being CLN-S via binary logistic regression. Characteristics with p < 0.2 from a univariate analysis (chi-square or Fisher’s exact test) were included in the regression; p < 0.05 after the regression was considered statistically significant.

Results. 362 SA infections were included. These were 76% CLN-S, similar to the institutional antibiogram (79% CLN-S, p = 0.859). Infection types assessed were abscess (n = 264, 73% CLN-S), cellulitis (n = 134, 81% CLN-S), osteomyelitis (n = 124, 79% CLN-S), lymph node (n = 117, 57% CLN-S), and hypotension during infection (OR 0.312, p = 0.005). Characteristics associated with CLN-R included contact to person with abscess (OR 0.468, p = 0.035) and high white blood cell count (OR 3.883, p = 0.001). Characteristics associated with CLN-R included contact to person with abscess (OR 4.68, p = 0.035) and hypotension during infection (OR 0.31, p = 0.005).

Conclusion. The use of institutional antibiograms to guide CLN susceptibility in CA SA infections may be limited by the type of infection, patient characteristics, and the likelihood of MSSA vs. MRSA infection. In our patients, having an abscess was associated with CLN-S. Empiric therapy of CA SA infections in children should not be driven solely by institutional antibiograms.

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1350. Optimizing Blood Culture Use in Critically Ill Children: Year One of a Multi-Center Diagnostic Stewardship Collaborative
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Session: S685

Background. The management of blood cultures (BC) in critically ill children has traditionally been guided by institutional orders and protocols. Recent recommendations by the American Academy of Pediatrics (2016) suggest that ordering BCs in critically ill children may be unnecessary in cases of minor infections, and that the decision to order BCs should be individualized by the treating provider. The Multi-Center Diagnostic Stewardship Collaborative (MC-DSC) was established to evaluate the impact of a diagnostic stewardship program focused on BC use in critically ill children.

Methods. This multicenter retrospective cohort study included 51 children’s hospitals participating in the Pediatric Health Information System database from 2016. All inpatient, observation, and neonatal admissions were included, with a total of 2,538,948 discharges. Hospitalizations were grouped into 83 strata defined by APR-DRGs. O:E ratios were calculated by indirect standardization of mean anti-biotic DOT per case, with expected values from 2016-2018 and observed values from 2018, and compared to DOT/1000pd. Outlier hospitals were defined by O:E z-scores corresponding to below 10th percentile (low outlier) and above 90th percentile (high outlier).