Results. 45/111 (41%) facilities responded, including 10 international sites. Most facilities are academic medical centers (64.6%) and care for stem cell (73.3%) and solid-organ transplant (80.0%) patients. Most facilities have large, well-established ASPs (60.0% > 5 members; 68.9% duration 26 years). 43 (95.6%) facilities use antifungal stewardship strategies in their ASP, most commonly prospective audit and feedback (33/43, 73.3%) performed by a pharmacist (23/33, 71.4%). Only half of ASPs (51.3%) create guidelines for IPI management. Most (71.1%) facilities report rapid laboratory tests to diagnose IPI, but availability of PCR for fungal speciation and antifungal susceptibility testing varies (Figure 1). 29 ASPs (64.4%) perform surveillance of antifungal utilization, but only 9 (31.0%) report data to CDC’s National Healthcare Safety Network (NHSN). ASP size, ASP duration, and presence of transplant populations were not associated with a higher likelihood of using antifungal stewardship strategies (P > 0.05 for all).

Conclusion. Use of antifungal stewardship strategies is high at SRN hospitals, but many opportunities exist to disseminate guidelines for IPI management, to promote access to laboratory-based tests for rapid and accurate IPI diagnosis, and to perform surveillance for antifungal utilization with data reporting to NHSN.

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1981. Implementation of an Antifungal Stewardship Bundle Focused on Candidemia in an Indian Hospital

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Saturday, October 5, 2019: 12:15 PM

Background. In India, Candida bloodstream infections have a reported incidence of 1–12 per 1,000 admissions and a mortality rate of up to 60%. Antimicrobial stewardship programs (ASP) can improve quality of care and clinical outcomes. This study evaluates the impact of a comprehensive candidemia ASP bundle in a hospital in southern India with an established stewardship program.

Methods. A single-center, pre–post quasi-experimental study was conducted at a tertiary-care center in southern India to analyze the impact of an ASP care bundle for the management of adults with candidemia. During the intervention period (October 2017–December 2018), the ASP provided recommendations to providers in accordance with the 2016 IDSA Guidelines for the Management of Candidemia, which included the following bundle: (1) appropriate selection and dosing of antifungal therapy; (2) repeat blood cultures every 48 hours until clearance; (3) removal of central venous catheters and other potential removable foci of infection; (4) echocardiogram; (5) ophthalmologic evaluation; and (6) appropriate duration of therapy. The primary outcome was initiation of appropriate antifungal therapy. Additional clinical outcomes were also compared with a historical cohort.

Results. One hundred and four patients with candidemia were included: 52 in the pre-intervention and 52 in the post-intervention group. Overall, baseline demographic and categorical variables among these groups. A cost analysis was also performed.

Conclusion. The addition of stool toxin testing to NAAT combined with education and clinical decision support lead to a dramatic reduction of treatment for NAAT positive but toxin-negative patients. This form of diagnostic stewardship had a significant impact on therapy decisions and can be a powerful antimicrobial stewardship approach to decrease unnecessary treatment of C. difficile colonization.

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1983. Adherence vs. Non-adherence: Clinical Outcomes of an Antimicrobial Stewardship Directed Treatment Protocol for Clostridioides difficile Infection

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Saturday, October 5, 2019: 12:15 PM

Background. The 2018 Infectious Diseases Society of America (IDSA) C. difficile infection (CDI) treatment guideline recommends as first-line therapy in adults, instead recommending vancomycin or fidaxomycin. At our 1500-bed academic medical center, a new CDI treatment protocol was initiated by the antimicrobial stewardship program (ASP) to guide treatment based on disease severity and risk factors for recurrence. In this study, we compared the clinical cure rate and 30-day recurrence rate in patients who are adherent and non-adherent to our institutional CDI treatment protocol.

Methods. Patients with CDI between September–December 2018 were identified using electronic health record (EHR) reports. A retrospective chart review was conducted to collect the following information: baseline demographics, white blood cell count, CDI severity, and risk factors, etc. Outcome measures included clinical cure rate, 30-day recurrence rate, and global cure rate, stratified by whether treatment was adherent or non-adherent to institutional protocol. Student’s t-test was used for continuous variables. Fisher exact test or Chi-square test was used for categorical variables.

Results. A total of 188 patients (adherent group n = 100; non-adherent group n = 88) were included. Patient demographics and baseline risk factors did not differ between groups. Clinical cure rate performed by pharmacist (23/33, 71.4%). Only half of ASPs (51.3%) create guidelines for IPI management, to promote access to laboratory-based tests for rapid and accurate IPI diagnosis, and to perform surveillance for antifungal utilization with data reporting to NHSN.