processes [allergy assessment (n = 2), order sets (n = 2), and implementation of rapid diagnostics (n = 1)]. Five of 16 ASPs documented full compliance with JC and CDC requirements, and 11/16 documented partial compliance (none were compliant prior to IDT implementation). Front-line pharmacists reviewed 3,593 stewardship alerts during the first 7 months, leading to 838 interventions across 16 facilities. The IDT pharmacist reviewed 1,198 alerts leading to 318 interventions.

Conclusion. We established or augmented ASPs in 16 Intermountain SCHs through local empowerment, central data sharing, and IDT mentorship. Future goals include documenting improvement in antibiotic use and patient outcomes.

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772. Volume-adjusted antimicrobial prescribing rate: An automated method for identifying antimicrobial over-prescribers in ambulatory care
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Background. A major target for outpatient antimicrobial stewardship has been the unnecessary use of antimicrobials, particularly for acute respiratory tract infections (ARTIs). The objective of this study was to determine whether data electronically extracted from the medical record (i.e., volume-adjusted antimicrobial prescribing rate) could identify outpatient providers who are more likely to prescribe unnecessary antimicrobials.

Methods. At a single VA medical center, patient visits during 2016 to primary care were prospectively reviewed to identify ARTIs. We then reviewed all ED visits and 247 primary-care visits. Antimicrobials were not indicated in 51% (324 of 633) of ED visits and 58% (144 of 247) of primary care visits. For 14 ED providers, the median antimicrobial-prescribing volume was 13.7 prescriptions per 100 patient-visits (IQR 12.5–14.8), and the median over-treatment rate was 47% (IQR 28–64%). Among 7 primary care providers, the median volume-adjusted antimicrobial prescribing rate was 8.1 prescriptions per 100 patient-visits (IQR 7.3–8.6), and the median over-treatment rate was 33% (IQR 31–59%).

Results. Manual audits to determine antimicrobial necessity were performed on 633 ED visits and 247 primary-care visits. Antimicrobials were not indicated in 51% (324 of 633) of ED visits and 58% (144 of 247) of primary care visits. For 14 ED providers, the median antimicrobial-prescribing volume was 13.7 prescriptions per 100 patient-visits (IQR 12.5–14.8), and the median over-treatment rate was 47% (IQR 28–64%). Among 7 primary care providers, the median volume-adjusted antimicrobial prescribing rate was 8.1 prescriptions per 100 patient-visits (IQR 7.3–8.6), and the median over-treatment rate was 33% (IQR 31–59%).

There was a positive correlation between a provider’s volume-adjusted antimicrobial prescribing rate and their overall rate of over-treatment in both the ED (r = 0.67, P < 0.01) and primary care (r = 0.80, P < 0.003).

Conclusion. In this small study, electronically-extracted data on a provider’s rate of volume-adjusted antimicrobial prescribing strongly correlated with the frequency at which unnecessary antimicrobials were prescribed, particularly in primary care. Comparing providers within a given outpatient setting on their volume-adjusted antimicrobial prescribing rate may be an efficient way to identify over-prescribers.

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773. Hiding in Plain Sight: Observations from a Review of Positive Urine Cultures Prior to an Antimicrobial Stewardship Program Campaign Targeting Asymptomatic Bacteriuria
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Background. Data have shown that many patients with asymptomatic bacteriuria (ASB) receive unnecessary antibiotics, increasing episodes of adverse events and resistance. Positive urine culture (PUC) and urinalysis (UA) results have been shown to prompt treatment without symptoms or compelling indication (pregnancy or prior to urologic procedure). We reviewed clinician action based on PUCs across 28 acute-care hospitals of varied size, scope, and antimicrobial stewardship program (ASP) maturity prior to an ASP educational campaign.

Methods. We conducted a retrospective sampling of inpatient PUCs collected February 1–28, 2017. Patients were excluded if pregnant, undergoing urologic procedure, <18 years, neutropenic, or were admitted on active urinary tract infection (UTI) therapy or with nephrolithiasis. A CDC UTI assessment form was adapted to collect: demographic, clinical, and laboratory data. The presence of UTI symptoms, microbiological results, antimicrobial therapy and duration, and rate of ASP interventions.

Results. Data from the First 200 included patients at 14 hospitals are shown. Most patients (84/200 (42%)) presented with only non-specific symptoms (NSS) or no symptoms (62/200 (31%)) vs. (vs) at least 1 specific urinary symptom (SUS) (54 / 200 (27%)).

Ceftriaxone was the most common empiric therapy in those with no symptoms (17/40(42.5%)) or NSS (35/74(47%)) who were treated. Interventions were documented on 18/200 (9%) patients, despite daily use of clinical decision support (CDS) at 58% of hospitals.

Conclusion. ASP presents many targets and challenges. UA and UC were often performed in patients with no symptoms or NSS. Thus, optimal ordering of UA and UC should be targeted to avoid unnecessary cost and therapy. Treatment of patients with no symptoms appeared to be more common in rural vs. urban hospitals and may help focus education. Low ASP intervention rates, despite use of CDS, may indicate challenges in identifying ASB patients. Many patients received ceftriaxone, which may not be targeted for initial review by ASP. Due to high volume at many sites, daily review of all PUCs may not be feasible.

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774. The Experience of Stewards in Using a Visual Analytic Tool to Benchmark and Track Therapy Duration for Pneumonia, Urinary Tract Infections, and Skin and Soft-tissue infections
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Figure 1. Presenting Symptoms.

Figure 2. Results by Presenting Symptoms.

Figure 3. Empiric Treatment by Urban Vs. Rural Hospital.

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Conclusion. A CPA is an innovative approach to expand the role of the dispensing and consultant pharmacist in antimicrobial stewardship initiatives in the LTC setting. Using an expert panel to develop templated resources that can be customized at the facility level may assist pharmacists and LTC providers in moving forward with this type of clinical practice change.

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776. Comparative effectiveness of Trimethoprim-Sulfamethoxazole versus Levofloxacin for Stentrophomonas maltophilia Bacteremia: Analysis of targeted therapy at 90 US Hospitals, 2000–2014
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Background. S. maltophilia is a multi-drug resistant Gram-negative opportunistic pathogen associated with discordant empiric therapy. Most S. maltophilia isolates are susceptible to trimethoprim-sulfamethoxazole (TMP-SMX) and levofloxacin (LVX) by in vitro sensitivity testing, but their relative effectiveness in S. maltophilia bacteremia remains unclear.

Methods. Clinical characteristics, in vitro activity and antibiotic therapy were examined for inpatients with S. maltophilia bacteremia in the Corner Healthfacts database. Treatment was considered targeted if administered within 5 days after S. maltophilia isolation, and empiric if administered 6–15 days prior to isolation. Excluding-resistant isolates, modified Poisson regression was used to estimate the adjusted relative risk (aRR) of therapy choice on mortality, controlling for empiric use, patient and facility-level factors.

Results. Of 171,909 patients with bacteremia from 2000–14, 660 (0.4%) at 102 hospitals had S. maltophilia; 99% of bloodstream isolates were susceptible to TMP-SMX and 97% to FQs. S. maltophilia bacteremia occurred more frequently in patients at >200 bed, urban and teaching hospitals. Nearly a third had ICU stays and over a third had central venous catheters. Of 600 evaluable patients, 122 (20%) received targeted therapy with TMP-SMX and 107 (18%) with LVX; more patients received targeted LVX in 2010–14 vs. 2005–09 and vice versa for TMP-SMX. Median age, SOFA scores, Elixhauser comorbidity index and % ICU were comparable between groups. Crude in-hospital mortality was higher in those receiving targeted TMP-SMX (23%) vs. LVX (14%). In adjusted models, mortality risk was 1.2-fold greater in recipients of targeted TMP-SMX vs. LVX (aRR = 2.9 [1.4–5.8])—and remained significant (aRR = 3.4 [1.1–10.0])—upon excluding recipients of empiric therapy with TMP-SMX or FQ.

Conclusion. In a multicenter cohort of patients with S. maltophilia bacteremia, targeted treatment with LVX was associated with a lower relative risk of mortality compared with TMP-SMX, even when these agents were initiated after identification of S. maltophilia in blood cultures.

Table 1. Baseline characteristics of patients with S. maltophilia bacteremia that received targeted Therapy with Trimethoprim-Sulfamethoxazole vs. Levofloxacin

| N (%) | Total-SMX as targeted therapy | LVX as targeted therapy |
|-------|------------------------------|------------------------|
| Patients | 600 (100.0) | 222 (36.9) |
| Age (Median[QR]) | 50 [31, 65] | 48 [22, 67] |
| Male | 301 (50.3) | 63 (36.9) |
| ICU Status | Yes | 257 (99.7) |
| Crude in-hospital mortality | 275 (45.6) | 45 (32.9) |
| No | 437 (77.6) | 86 (65.0) |
| Region | Midwest | 85 (26.4) |
| Northeast | 169 (36.0) | 31 (25.4) |
| South | 207 (82.5) | 45 (32.5) |
| West | 49 (28.2) | 17 (13.9) |
| Teaching Facility | Yes | 266 (65.6) |
| No | 132 (31.6) | 30 (24.4) |
| Facility Location Type | Rural | 204 (127.3) |
| Urban | 406 (52.9) | 54 (76.0) |
| Elixhauser Scorea (Median[QR]) | 2 (1.1) | 2 (1.1) | 1 (1.0) |
| Baseline SOFA Score (Median[QR]) | 2 (0.4) | 2 (0.4) | 2 (0.4) |
| Central Venous Catheterb | 216 (82.0) | 43 (82.8) | 38 (55.5) |
| Pulmonary Sourcec | 101 (66.8) | 16 (13.3) | 19 (27.8) |
| Home Bed Size | 500+ | 249 (60.5) |
| 200-499 | 267 (44.5) | 52 (42.6) |
| <200 | 84 (14.0) | 20 (16.4) |

**Discharge Year:**<br>2005 | 47 (7.8) | 14 (11.5) | 4 (3.7) |
2006-2010 | 43 (6.7) | 20 (17.7) | 17 (25.0) |

†Original data from 2000–04 for patients admitted to hospitals that reported to Quin Hm et al, Medical Care 2009.1907 (Cochran-Armitage trend test p-value 0.01). Based on eVital’s health record-based adaptation of the original organism-specific Pseudomonas isolated Source (SOFA) score as reported in “Quin Hm et al, Intensive Care Med 2016.” Based on eVital’s health record-based adaptation of the original organism-specific Pseudomonas isolated Source (SOFA) score as reported in “Quin Hm et al, Intensive Care Med 2016.” Based on eVital’s health record-based adaptation of the original organism-specific Pseudomonas isolated Source (SOFA) score as reported in “Quin Hm et al, Intensive Care Med 2016.”