concept using an antimicrobial tier structure, in addition to historical PAAF. The purpose was to assess the impact of the tier structure, along with PAAF performed by the pharmacists and TMDs, compared with PAAF alone.

**Methods.** This retrospective pre (March–August 2018)- and post (October 2018–March 2019) implementation study was conducted at AHO. The ASAP team developed a hospital-wide policy listing antimicrobials based on a tier system (Figure 1), with higher priority agents falling in tiers 3 (T3) and 4 (T4). Education was completed in September 2018 and the process was implemented in October 2018. Criteria for use was evaluated at the point of order entry, followed by PAAF by the pharmacist and TMD. The primary outcome was impact on T3 and T4 antimicrobial utilization, measured in days of therapy (DOT) per 1,000 days present (DP). Secondary outcomes included T3 and T4 antimicrobial cost/adjusted patient-days and rates of hospital-acquired *C. difficile* infections (CDI).

**Results.** During the post-implementation period, the average DOT per 1,000 DP for T3 and T4 agents decreased by 21.3% (89 vs. 70, \(P = 0.001\)) compared with the pre-implementation period (Figure 2). Average T3 and T4 antimicrobial costs decreased by 26% during the post-implementation period (\$9.83 vs. \$7.27, \(P < 0.001\)). Additionally, rates of hospital-acquired CDI decreased by 14% (\(P = 0.41\)) during the post-implementation period.

**Conclusion.** The tier concept, along with PAAF collaborations between the pharmacists and TMD, allowed for a greater impact on antimicrobial utilization, compared with pharmacist-led PAAF alone. In addition to significant decrease in antimicrobial utilization, substantial cost-savings were demonstrated. A nonsignificant declining trend in the incidence of hospital-acquired CDI was also noted during the post-implementation period.

**Figure 1:**

![Image](https://example.com/image1.png)

**Figure 2:**

![Image](https://example.com/image2.png)

**Disclosures.** All authors: no reported disclosures.

1073. Analysis of the Antimicrobial Stewardship Program Recommendation Process in the Intensive Care Units at a Large Tertiary Community Hospital

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**Session:** 132. Antimicrobial Stewardship: Program Evaluation
Friday, October 4, 2019: 12:15 PM

**Background.** Studies suggest up to 60% of antibiotics prescribed in the intensive care units (ICUs) may not be optimized. The antimicrobial stewardship team (AST) at Abbott Northwestern consists of infectious diseases trained pharmacists, pharmacy residents, and/or advanced pharmacy practice experience (APPE) pharmacy students and provides prospective audits and feedback on all inpatients not being seen by infectious diseases specialists and currently receiving any anti-infectives. Comprehensive daily profile reviews are performed and recommendations are communicated via a physician sticky note in the electronic medical record (EMR) and/or via a direct page.

Beginning January 2018, the AST started reviewing patients in the two ICU units earlier to ensure recommendations were completed prior to multidisciplinary rounds. The AST also initiated sending a message within the EMR alerting the decentral pharmacists and TMDs to ensure recommendations were completed prior to multidisciplinary rounds.

**Methods.** A retrospective chart review was conducted on recommendations made by the AST between February and April 2017 (control group) and February and April 2018 (intervention group) for patients on two ICU units (ICU 1 and ICU 2). Time to acceptance and acceptance rates were calculated for the control and intervention period. A one-tailed \(t\)-test was performed for the time to acceptance analysis and a Chi-squared test was performed to compare acceptance rates. Results were deemed statistically significant when \(P < 0.05\).

**Results.** Time to acceptance for the recommendations showed a significant decrease from 25.9 to 13.7 hours with the new process in ICU 1 (\(P = 0.038\)). Provider acceptance rate increased significantly from 77.8% to 88.4% in ICU 2 (\(P = 0.037\)).

**Conclusion.** Changing the workflow of the prospective audit and feedback process by the AST had a meaningful impact by decreasing the response time (time to acceptance) and increasing acceptance rates of the recommendations in the ICUs. The revised process improved communication between the AST, decentral pharmacist, and attending provider, which in turn may have contributed to the positive outcomes.

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identified by real-time clinical decision support alerts over the weekend will reduce the time from change in renal function to dose adjustment of select antimicrobials and/or anticoagulants.

**Methods.** This monitoring initiative is comprised of a pre- and post-cohort population. The pre-cohort population included patients admitted to Penn Presbyterian Medical Center (PPMC) from January to March of 2018 on select antimicrobials and/or anticoagulants, who were identified to have a change in renal function (serum creatinine change of 0.3 mg/dL or greater) over the weekend. The post-cohort population was identified with a clinical decision support system (ILÚM Health Solutions, Kenilworth, NJ) and included patients admitted to PPMC from January to March of 2019. A pharmacy resident reviewed alerts in the clinical decision support system over the weekend and contacted providers with dose adjustment recommendations. The Mann–Whitney U test was used to analyze the primary endpoint while descriptive statistics were used for the secondary endpoints.

**Results.** Eighteen interventions were completed within the 3-month post-cohort intervention period, with a time to dose adjustment between the pre/post-cohort being reduced by 50 hours (P = 0.0001) resulting in a median time to change of 11 hours in the post-cohort. All pharmacy recommendations were accepted by the provider, and 94% of medication adjustments were antimicrobials.

**Conclusion.** The application of this prospective weekend initiative utilizing a clinical decision support system demonstrates a clinically and statistically significant reduction in the time to dose adjustments for antimicrobials and/or anticoagulants. Implementation of this initiative will further establish a role for pharmacist-led evaluations and could potentially be expanded to other clinical areas.

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1075. The Impact of Physician Peer Comparison of a Novel Inpatient Antimicrobial Stewardship Metric: the Start-Stop Ratio (SSR)
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**Session:** 132. Antibiotic Stewardship: Program Evaluation
Friday, October 4, 2019: 12:15 PM

**Background.** The 48-hour “Antibiotic Timeout” (ATO), one of the CDC’s interventions defined in the Core Elements of Antimicrobial Stewardship Programs (ASP), has not reliably proven to impact inpatient antibiotic use. Given the reported history of utilizing peer-comparison data to change prescribing behavior, it was hypothesized that open disclosure of individual inpatient antibiotic start-stop ratios (SSR) would be an effective tool to increase prescribers’ tendency to (1) observe patients off antibiotics upon admission while pursuing treatments perceived more likely to provide systemic resolution and (2) discontinue antibiotics in the setting of diagnostic uncertainty at 48 hours, or possibly even earlier, without introducing harm.

**Methods.** In a community, nonteaching hospital, all adult systemic antibiotic orders initiated by an inpatient hospitalist with at least one administration during the baseline period of January - March of 2018 were retrieved. A prescriber-specific count of all antibiotic orders (“starts”) and discontinuations (“stops”) was collected. Each provider received a document with their baseline SSR compared with the group SSR and was assigned a visual cue that corresponded to the quartile in which they performed at baseline. The same antibiotic data were then collected and evaluated for the post-intervention period of February–April 2019 to determine whether open disclosure of inpatient SSRs impacted antibiotic prescribing.

**Results.** Of 19 providers that were included in both study periods, there was no significant difference in the pre- and post-intervention SSR (1.93 to 2.09, P = 0.19). However, in the pre-intervention high-ratio target group (n = 10) for whom we felt open SSR reporting would impact the most, the SSR decreased from 2.41 to 2.26 (P = 0.24). In the entire study population, 68% of providers had a reduction or no change in their SSR. Overall facility-wide antibiotic utilization decreased from 561 to 478 days of therapy per 1,000 days present (P < 0.05).

**Conclusion.** Open reporting of antibiotic SSRs to an inpatient provider group may be utilized as an ASP tool to reduce overall inpatient antibiotic consumption, especially by providers that are found to be high-ratio prescribers at baseline.

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1076. Antimicrobial Stewardship Program Achieves Marked Decrease in the use of Vancomycin in a Veterans Hospital
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**Session:** 132. Antibiotic Stewardship: Program Evaluation
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**Background.** Methicillin-resistant *Staphylococcus aureus* (MRSA) is the most common nosocomial infection worldwide. Infection control measures using molecular tests (polymerase chain reaction (PCR) on nares swabs) aid to prevent hospital transmission of MRSA. Nares screening for MRSA has proven to be a valuable tool for antimicrobial stewardship programs (ASP) to de-escalate empiric anti-MRSA therapy in patients with pneumonia (community/nosocomial acquired) not nasally colonized with MRSA. In January 2016, an ASP was initiated at our institution with emphasis on rational use of antibiotics, decrease antibiotic duration and timely de-escalation of all empiric antibiotics, including IV vancomycin using nares PCR for MRSA.

**Methods.** We compared the vancomycin use at the Northport Veterans Affairs Medical center by days of therapy/1,000 patient-days from 2011–2015 to 2016–2019. Screening for MRSA is by DNA PCR (Cepheid GeneXpert Infinity). ASP reviewed all restricted antibiotic

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