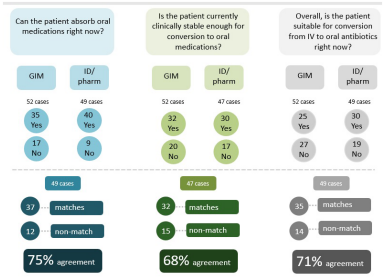
cases of non-agreement and obtaining GIM consensus for tool utility are important for our next step, assessing INFORMER implementation on realtime IV to PO conversion rates.




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

**2073. Apples and Oranges: Comparing Toolkits to Track Antimicrobial Prescribing in Ambulatory Care Settings**

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**Session:** 238. Antibiotic stewardship: Non-Inpatient Settings
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***Background.*** Between 15–50% of patients seen in ambulatory settings are prescribed an antibiotic. At least one-third of this usage is considered unnecessary. Multiple tools have emerged to evaluate antibiotic prescribing in ambulatory settings. The toolkits, MITIGATE and Choosing Wisely, have been funded by the Centers for Disease Control and Prevention and promoted by the American Board of Internal Medicine, respectively, but use different reporting criteria. Notably, the target rate of antibiotic prescribing in the MITIGATE framework is zero, whereas the target rate for Choosing Wisely is not zero because it includes diagnoses for which an antibiotic may be appropriate. We compared both to evaluate prescribing in primary care and specialty clinics, urgent care, and the emergency department.

***Methods.*** This was a single-center observational study. Electronic medical record data were accessed to determine antibiotic prescribing and diagnosis codes. The primary outcome was rate of inappropriate antibiotic prescribing overall and in each of the individual settings.

***Results.*** Between March 2018 and April 2019, 42,650 patient visits met MITIGATE inclusion criteria and 11% received an antibiotic unnecessarily. In the same time-period, 23,366 patient visits met Choosing Wisely inclusion criteria and 17% received an antibiotic unnecessarily. Within the MITIGATE framework, inappropriate prescribing was highest in the ED (17%), followed by primary care (12%), urgent care (10%), and specialty care (5%). Choosing Wisely, inappropriate prescribing was highest in primary care (23%), followed by urgent care (15%), and specialty care (8%). The ED was not included in the Choosing Wisely technical specifications. The top coded diagnosis in both frameworks was acute respiratory infection, unspecified.

***Conclusion.*** Rates of inappropriate antibiotic prescribing varied widely depending upon the toolkit used. Inappropriate antibiotic prescribing in primary care by Choosing Wisely framework was double that of MITIGATE. Careful consideration of the differences and goals of using these toolkits is needed both on the local level for individual provider feedback and more broadly, when comparing prescribing rates between institutions.

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

**2074. A Successful Acute Respiratory Tract Infection Campaign to Improve Antibiotic Prescribing in Outpatient Clinics and an Emergency Department**

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***Background.*** Acute Respiratory tract infections (ARI) are infections involving the upper respiratory tract. Most ARIs are viral in nature and self-limited in which most of the times antibiotic treatment is unnecessary. A recent VA medication utilization evaluation conducted in 28 medical centers identified high rates of unnecessary antibiotic prescribing for ARI. Based on these analyses the VA National Academic Detailing Service (VANADS) created the ARI campaign, providing materials for VA systems to employ as the seek to improve ARI management. Our project consists of implementation of the ARI Campaign in a South Florida Veteran Affairs HealthCare System (Miami VAHS).

***Methods.*** We utilized VANADS resources for our campaign. Activities included assessing ARI prescribing patterns, garnering stakeholder support, identifying pharmacist and physician champions, providing targeted academic detailing, handing out provider ARI guidance documents (in paper and electronically), disseminating provider-specific feedback with peer comparison, order-set development with advertisement, promoting appropriate coding, and reporting to the Miami VAHS antimicrobial stewardship program (ASP) subcommittee. Campaign activities were initiated in October 2017. The ARI Campaign was selected as the priority item for FY-2019, from our annual ASP risk assessment with a goal of reducing antibiotic prescribing for ARI diagnosis to below 40%. We present the data up to March 2019.

***Results.*** Baseline data from October 2015 through September 2017 revealed an antibiotic was prescribed to 1,651 of 2,843 (58%) encounters in which an ARI diagnosis was made in our system. In the months following ARI Campaign initiation, a decline in antibiotic prescribing for ARI diagnosis was found. In the most recent quarter (January–March 2019), the prescribing rate was 39%. Figure 1 shows system-wide vs. Florida region prescribing rates. Table 1 provides data by major site and for the top 10 priority providers we identified.

***Conclusion.*** Implementation of a multifaceted ARI Campaign at a single-center resulted in a substantial reduction in antibiotic prescriptions. Future work is warranted investigating which activities are most impactful for reducing unnecessary antibiotic prescribing for ARI.

**Figure 1.** Antibiotic prescribed for acute respiratory tract infection diagnosis

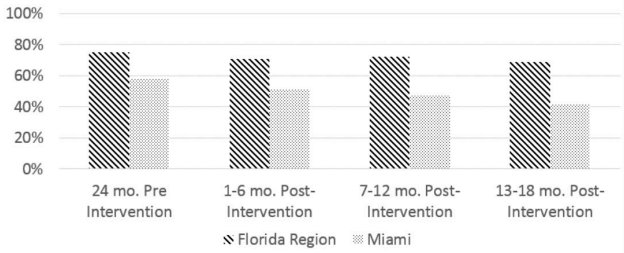


**Table 2.** Site-specific and top 10 priority provider antibiotic prescribing rates for acute respiratory tract infection diagnosis

| Provider | Practice Location | 24 mo. Pre-Intervention | 1-6 mo. Post-Intervention | 7-12 mo. Post-Intervention | 13-18 mo. Post-Intervention |
|---|---|---|---|---|---|
| All Providers | Emergency Department | 1199 of 1670 (72%) | 345 of 526 (66%) | 196 of 339 (58%) | 249 of 493 (51%) |
| All Providers | Medical Center Clinics | 439 of 1076 (41%) | 95 of 332 (29%) | 69 of 221 (31%) | 81 of 306 (26%) |
| All Providers | Major Satellite Clinic | 1004 of 1321 (76%) | 379 of 500 (76%) | 185 of 306 (60%) | 235 of 385 (61%) |
| Provider #1 | Major Satellite Clinic | 165 of 211 (78%) | 52 of 67 (78%) | 21 of 30 (70%) | 25 of 40 (63%) |
| Provider #2 | Emergency Department | 160 of 254 (63%) | 42 of 80 (53%) | 10 of 32 (31%) | 26 of 73 (36%) |
| Provider #3 | Emergency Department | 136 of 160 (85%) | 53 of 69 (77%) | 34 of 57 (60%) | 26 of 57 (46%) |
| Provider #4 | Major Satellite Clinic | 133 of 159 (84%) | 53 of 58 (91%) | 12 of 23 (52%) | 17 of 28 (61%) |
| Provider #5 | Emergency Department | 114 of 166 (69%) | 36 of 57 (63%) | 21 of 37 (57) | 17 of 46 (40%) |
| Provider #6 | Emergency Department | 107 of 128 (84%) | 42 of 46 (91%) | 19 of 24 (79%) | 28 of 30 (93%) |
| Provider #7 | Major Satellite Clinic | 80 of 86 (93%) | 30 of 31 (97%) | 8 of 12 (67%) | 4 of 5 (80%) |
| Provider #8 | Emergency Department | 69 of 73 (95%) | 6 of 10 (60%) | 5 of 8 (63%) | No data |
| Provider #9 | Emergency Department | 68 of 91 (75%) | 24 of 33 (73%) | 16 of 24 (67%) | 2 of 16 (13%) |
| Provider #10 | Medical Center Clinic | 55 of 110 (50%) | 10 of 23 (43%) | 5 of 11 (45%) | No data |

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

**2075. Transforming Outpatient Antimicrobial Stewardship Through a Clinical Surveillance System**

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**Session:** 238. Antibiotic stewardship: Non-Inpatient Settings
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***Background.*** Multiple studies have highlighted the predominance of inappropriate antibiotic prescribing in the outpatient setting, thus making an area ripe for antimicrobial stewardship interventions. One way to identify intervention opportunities and monitor performance metrics is through utilization of a clinical surveillance system (CSS).

***Methods.*** In October 2017, TheraDoc (DSS Inc.) was obtained which serves as a CSS. Upon installation, the antimicrobial stewardship committee designed the alerts found in Figure 1 that would be utilized to identify potential interventions. Alerts that were deemed to be of high value or time sensitive were