

**Conclusion.** Non-compliance with locally developed antimicrobial management guidelines resulted in a higher proportion of patients being transferred to the ICU and an increased length of stay in our cohort, highlighting the benefits of adherence. Future studies will assess long-term outcomes associated with compliance to infection management guidelines.

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

**112. Prescriber Perceptions on Utilization of the Antibiotic Self-Stewardship Time Out Program (SSTOP) at Veterans Affairs Medical Centers (VAMC): A Strategy for Improved Antibiotic Use**

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CARRIAGE QUERI Program

**Session:** P-07. Antimicrobial Stewardship: Program Development and Implementation

**Background.** Evidence is lacking on how to implement effective and sustainable antibiotic stewardship strategies. The Antibiotic Self-Stewardship Time Out Program (SSTOP) evaluated the implementation at VAMCs of an "Antibiotic Timeout" 3 days after the initiation of antibiotics to encourage providers to review continued use of broad-spectrum antibiotics.

**Methods.** Sites launched the SSTOP note templates in a rolling fashion from June 2019-March 2020. Clinical pharmacists largely drove the implementation. The vancomycin note template was implemented at 6 of 8 sites and the antipseudomonal note template across 4 of 8 sites. Two sites were unable to launch the note templates due to lack of resources, however they utilized SSTOP principles/guided tools. From Sept 2019-Nov 2020 we conducted post-launch qualitative interviews with Antibiotic Stewardship Program (ASP) champions involved in implementation across the 8 VAMCs. Interviews were transcribed and analyzed for thematic content.

**Results.** Feedback from ASP providers suggests prescribers had mixed reviews on the note template, but overall liked the process and deemed it to be straightforward. Many valued the algorithm, indicating it was helpful in both thinking about antibiotics prior to initiation, and identification of appropriate antibiotics. Barriers included staffing (e.g., rotating residents/turnover), surgery service, information technology (IT) support, COVID-19, and the need to remind providers to use the template. Facilitators consisted of strong stewardship, local champions (e.g., ID Fellow), medicine service, and SSTOP data feedback reports. Recommendations largely centered on improvements to the note template usability and to SSTOP feedback reports (e.g., inclusion of patient/provider-level data).

**Conclusion.** Overall, the SSTOP note templates were considered acceptable and straightforward. By guiding providers to prescribe more appropriate antibiotics, they act as influencers for practice change, and may strengthen provider/ASP relations. Plans for continued utilization of the note templates after the project concludes suggest SSTOP may serve as a way to achieve sustainable promotion of antibiotic use improvements.

**Disclosures.** Matthew B. Goetz, MD, Nothing to disclose

**113. Improving Transitions-of-Care for Patients Discharged on High-Risk Antimicrobial Therapy**

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**Session:** P-07. Antimicrobial Stewardship: Program Development and Implementation

**Background.** Providing effective transitions-of-care (TOC) services improves outcomes for patients discharged on high-risk medications. Literature has shown that successful TOC for certain antimicrobials reduces hospital readmissions, medication errors, and improves post-discharge follow-up and laboratory monitoring. Prior to this quality improvement (QI) initiative, there was no formal TOC process for patients discharged on high-risk antimicrobial therapy (HAT) at our institution. Without standardization, only 55.1% of patients discharged on HAT had successful TOC. The aim of this initiative was to develop and implement a TOC protocol in at least 90% of patients discharged on HAT.

**Methods.** This QI initiative utilized the Institute of Healthcare Improvement model for improvement. A workgroup of key stakeholders developed a protocol to identify and standardize TOC services provided to patients discharged on HAT. Successful protocol completion was achieved if the following process metrics were evaluated, obtained, and documented prior to discharge: baseline laboratory values, pharmacokinetic monitoring, appropriate intravenous access, drug-drug interactions, medication availability, discharge medication counseling, and formal pharmacist documentation in a discharge note. Outcome metrics included referral to outpatient infectious disease (ID) follow-up, 90-day readmissions, and successful TOC. Balancing metrics included pharmacist time and protocol initiation for patients not discharged on HAT.

**Results.** Between October 2020 and May 2021, 218 patients met protocol inclusion criteria. Of these, 203/218 (93.1%) were appropriately identified with the new TOC process. The protocol was successfully followed in 78.9% of patients identified. Readmission rates were 42.8%, which was unchanged from baseline. Inpatient ID

involvement increased from 80.9% to 95.7% and referral to outpatient ID follow-up from 59% to 94.8%.

**Conclusion.** This newly developed TOC protocol successfully identifies patients discharged on HAT, improves provision of TOC services to these high-risk patients, and significantly improves the rate of infectious disease involvement while inpatient and after discharge.

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

**114. Optimization of Inpatient Antibiotic Use via an Electronic Antimicrobial Stewardship Module and an Infectious Diseases Pharmacy Resident**

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**Session:** P-07. Antimicrobial Stewardship: Program Development and Implementation

**Background.** Antibiotic resistance is a public health crisis and antimicrobial stewardship (AMS) pharmacists serve a crucial role in preventing inappropriate use. At Montefiore Medical Center (1,500-bed hospital), a new electronic medical record AMS module was implemented with assistance from an infectious diseases (ID) pharmacy resident in October 2020. The module utilizes a dynamic scoring system to assist in prioritizing interventions, including bug-drug mismatches, insufficient coverage, or de-escalation. The AMS module is operationalized by ID pharmacists during the week and an ID pharmacy resident every other weekend. The objective of this study was to assess the impact of an ID pharmacy resident performing AMS module interventions on broad spectrum antibiotic use.

**Methods.** An observational study of AMS module interventions on antibiotic use (AU) in days of therapy per 1,000 days present and standardized antimicrobial administration ratio (SAAR) was performed. AU data for piperacillin-tazobactam (P/T) and SAAR prior to (October 2019- December 2019) and after (October 2020 - December 2020) the integration of an ID pharmacy resident and the AMS module was compared. Additional data collected included total number and type of interventions.

**Results.** A total of 539 interventions were made by AMS pharmacists and 36.5% of these were completed by the ID pharmacy resident. Across 6 different units, there was a statistically significant decrease in the SAAR for broad spectrum antibacterial agents (Figure 1), and a decrease of at least 10% in P/T use during the two different time periods (Table 1). An estimated P/T cost reduction of 26% of (\$48,708 to \$36,235.80) was observed. AMS pharmacists made 63 interventions in respective units. The top three intervention types were dose/frequency/duration recommendations, pharmacokinetic vancomycin dosing/monitoring, and de-escalation. The acceptance rate of interventions was 99% (534 accepted interventions/539 total interventions).

Figure 1. SAAR Comparison of Broad-Spectrum Agents

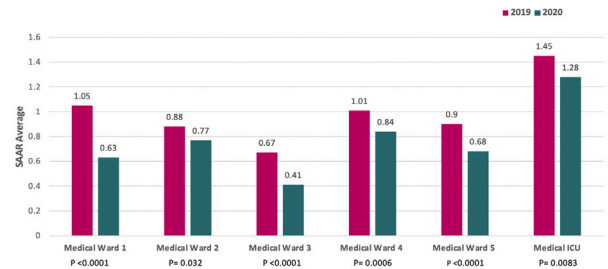


Table 1. AU Rate of Piperacillin-tazobactam

	Location	2019	2020	Change	% Change
Piperacillin-tazobactam AU Rate (DOT/1000 days Present)	Medical Ward 1	70.4	50.3	-20.1	-29%
	Medical Ward 2	61	51.1	-9.9	-16%
	Medical Ward 3	42	32.9	-9.1	-22%
	Medical Ward 4	89.1	75.9	-13.2	-15%
	Medical Ward 5	62.9	51.3	-11.6	-18%
	Medical ICU	233.4	195.1	-38.3	-16%

**Conclusion.** Overall, there was a statistically significant impact on SAARs and a >10% change in P/T AU rate with an estimated cost reduction >25% on select units after implementation of the AMS module with an ID pharmacy resident.

**Disclosures.** Kelsie Cowman, MPH, Merck (Research Grant or Support) Priya Nori, MD, Merck (Grant/Research Support) Priya Nori, MD, Nothing to disclose Yi Guo, PharmD, BCIDP, Merck (Research Grant or Support)

**115. Variable Use of Diagnostic Codes for Acute Respiratory Infections Across Emergency Departments and Urgent Care Clinics in an Integrated Healthcare System: Implications for Accuracy of Antibiotic Stewardship Metrics**

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