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).

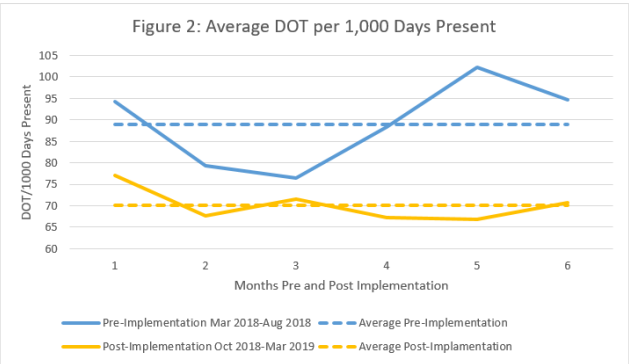
Results. During the post-implementation period, the average DOT per 1,000 DP for T3 and T4 agents decreased by 21.3% (89 vs. 70, P = 0.001) compared with the pre-implementation period (Figure 2). Average T3 and T4 antimicrobial costs decreased by 26% during the post-implementation period ($9.83 vs. $7.27,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

Tier 3 Antimicrobials	Tier 4 Antimicrobials
Ceftaroline	Bezlotoxumab
Colistin	Ceftazidime-avibactam
Ciprofloxacin	Ceftolozane-tazobactam
Daptomycin	Dalbavancin
Ertapenem	Delafloxacin
Fidaxomicin	Doripenem
Imipenem-cilastatin	Meropenem-vaborbactam
Levofloxacin	Oritavancin
Linezolid	Tedizolid
Meropenem	Telavancin
Polymyxin B	Tigecycline

Figure 2:



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1072. The Role of an On-site Infectious Disease Specialist in Hospital-Based Antimicrobial Stewardship Programs

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

Background. Antimicrobial stewardship programs (ASPs) are now a requirement for many hospitals, but a large proportion of US hospitals lack an on-site Infectious Disease (ID) specialist. We sought to compare the processes and outcomes of ASPs at Veterans Health Administration (VHA) hospitals with and without an on-site ID specialist.

Methods. This retrospective cohort included all acute-care patients in VHA hospitals admitted during 2016, or 2 years after a VHA mandate for hospital-based ASPs. Data from a mandatory nationwide survey were used to identify hospitals that self-reported the absence of an on-site ID specialist, including an ID physician or ID pharmacist, in 2016. Antimicrobial use was quantified at the hospital-level as days-of-therapy (DOTs) per 1,000 days present and categorized based on National Healthcare Safety Network definitions. A facility-level negative binomial regression model with risk adjustments made for aggregated case-mix and facility-level factors was used to determine the association between the presence of an on-site ID specialist and antimicrobial use.

Results. Eighteen of 122 (14.8%) hospitals lacked an on-site ID specialist. Non-ID hospitals had fewer admissions per month than ID sites (mean 107.3 vs. 425.4, $P < 0.01$). An ASP policy and an ASP pharmacy champion were present at ≥90% of hospitals with and without an ID specialist. Core ASP strategies were frequently used in both ID and non-ID sites, including prior authorization (90.4% vs. 83.3%, $P = 0.41$) and prospective audit-and-feedback (76.9% vs. 66.7%, $P = 0.38$). Broad-spectrum antibacterial use (263.9 vs. 317.6 DOTs per 1,000 days-present, $P = 0.01$) but not total antimicrobial use (600.8 vs. 634.3 DOTs per 1,000 days-present, $P = 0.34$) was lower at ID vs. non-ID hospitals. After facility-level risk-adjustment, broad-spectrum antibacterial use (OR = 0.81, 95% CI 0.69–0.94) but not total antimicrobial use (OR = 0.92, 95% CI 0.70–1.21) was lower at ID hospitals.

Conclusion. An on-site ID specialist was not associated with greater use of core ASP strategies, but the presence of an on-site ID specialist was associated with less frequent prescribing of broad-spectrum antibacterial agents. An on-site ID specialist may be an important part of an effective hospital-based ASP.

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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. Antibiotic 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 prior to 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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1074. Evaluation of a Pharmacist-led Antimicrobial and Anticoagulant Monitoring Initiative

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

Background. Adverse drug events are associated with an increase in hospital stay and cost. Risks from these events are minimized by adjusting a medication's dose or frequency, and changes in renal function may necessitate adjustments. Currently, there is no formal procedure for a prospective audit of renal function over the weekend at our institution. This pharmacist-driven initiative will evaluate if a prospective review