

in-hospital mortality ($P = 0.36$) between the short and long groups (Table 2). There were 7 adverse drug outcomes, 2 in the short group and 5 in the long group (Table 3).

Conclusion. Antibiotic de-escalation in AML patients with neutropenic fever with no identifiable infectious source was associated with a lower rate of recurrent fever without affecting ICU transfer, adverse drug events, and death. Physicians should consider de-escalation prior to ANC recovery in the appropriate setting.

Table 1- Demographics

Variable	Cohort 1 early de-escalation N=38	Cohort 2 until engraftment N=39	Combined N=77	P-value
Female, n (%)	17 (45%)	19 (49%)	36(47%)	0.7263
Age, Median [Q1-Q3]	55 [47-64]	60 [44-68]	57 [44-66]	0.2924
Min, Max	20, 82	22, 82	20, 82	
Race, n (%)				
Asian	3 (8%)	8 (21%)	11 (14%)	0.3918
Black	9 (24%)	5 (13%)	14 (18%)	
White	13 (34%)	16 (41%)	29 (38%)	
Other	9 (24%)	7 (18%)	16 (21%)	
Unknown	4 (11%)	3 (8%)	7 (9%)	
Chronic Kidney Disease ¹ , n (%)	0 (0%)	3 (8%)	3 (4%)	0.2403
Chronic Liver Disease ² , n (%)	1 (3%)	3 (8%)	4 (5%)	0.6151
Cardiac Disease ³ , n (%)	7 (18%)	12 (31%)	19 (25%)	0.2089
Rheumatologic Disease ⁴ , n (%)	0 (0%)	3 (8%)	3 (4%)	0.2403
Performance Score, n (%)				
0	10 (26%)	11 (28%)	21 (27%)	0.3739
1	12 (32%)	6 (15%)	18 (23%)	
2	2 (5%)	0 (0%)	2 (3%)	
Unknown	14 (37%)	22 (56%)	36 (47%)	
Antimicrobial prophylaxis prior to neutropenic fever, n (%)	22 (58%)	25 (64%)	47 (61%)	
Duration of Neutropenia				
ANC Recovery, n (%)	24 (63%)	36 (92%)	60 (78%)	
Discharge before Recovery, n (%)	14 (37%)	3 (8%)	17 (22%)	
Median Days to Recovery ⁵ [95% CI]	30 [25-44]	17 [15-21]	23 [20-27]	

CI, Confidence Interval; ¹chronic kidney disease, end-stage renal disease, renal transplant, other; ²cirrhosis, chronic hepatitis, other; ³arrhythmia, coronary artery disease, cerebrovascular disease, hypertension, other; ⁴lupus, rheumatoid arthritis, other; ⁵patients discharged prior to ANC recovery were censored

Table 2- Treatment and Outcomes

Variable	Cohort 1 early de-escalation N=38	Cohort 2 until engraftment N=39	Combined N=77	P-value
Initial gram negative treatment, n (%)				
Cefepime	35 (92%)	35 (90%)	70 (91%)	1.0000
Piperacillin-tazobactam	3 (8%)	0 (0%)	3 (4%)	0.1153
Aztreonam	0 (0%)	3 (8%)	3 (4%)	0.2403
Metronidazole	2 (5%)	3 (8%)	5 (6%)	1.0000
Other	0 (0%)	1 (3%)	1 (1%)	1.0000
Initial gram positive treatment, n (%)				
Vancomycin	30 (79%)	34 (87%)	64 (83%)	0.3350
None	6 (16%)	4 (10%)	10 (13%)	0.5170
Days of antibiotics for first neutropenic fever	9 [6-13]	15 [11-20]	12 [7-17]	0.0008
Median [Q1-Q3]	3, 55	5, 55	3, 55	
Min, Max				
Infectious Disease consult obtained, n (%)	28 (74%)	29 (74%)	57 (74%)	1.0000
ICU transfer, n (%)	1 (3%)	6 (15%)	7 (9%)	0.1080
In-hospital mortality, n (%)	1 (3%)	4 (10%)	5 (6%)	0.3584

Table 3- Adverse Events

Variable	Cohort 1 early de-escalation N=38	Cohort 2 until engraftment N=39	Combined N=77	P-value
Colonization with MDR organism, n (%)	4 (11%)	2 (5%)	6 (8%)	0.6745
<i>Clostridium difficile</i> infection within 90 days of induction chemotherapy, n (%)	2 (5%)	2 (5%)	4 (5%)	1.0000
Adverse Events ¹ from antibiotics, n (%)	2 (5%)	5 (13%)	7 (9%)	0.4309
Need to change to different antibiotic class due to adverse event, n (%)	2 (100%)	5 (100%)	7 (100%)	

¹All adverse events were drug rash; MDR, multi-drug resistant

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1091. An Ethnographic Approach to Interrogating Antimicrobial Stewardship at US Teaching Hospitals

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Background. Hospital antimicrobial stewardship programs (ASPs) deploy variably evidence-based interventions aimed at improving antimicrobial use and reducing antimicrobial resistance. Little is known about how ASPs are perceived by hospital clinicians or how such data might inform ASP improvement. We conducted an ethnographic study of hospital ASPs and infectious diseases (ID), surgical intensive care unit (SICU) and medical intensive care unit (MICU) practitioners to identify how ASPs are understood and integrated into everyday practice by hospital staff.

Methods. A medical anthropologist performed direct observation of patient care and semi-structured interviews with ID ($N = 29$), SICU ($N = 10$), and MICU ($N = 19$) practitioners at two affiliated teaching hospitals in Chicago, IL, between July 2017 and September 2018, accruing >576 hours of direct observations and 48 hours of semi-structured interview data. Data collection and analysis centered on explicating the understandings and interpretations of ASPs present in diverse practice groups.

Transcriptions of the data were analyzed using thematic coding aided by MAXQDA qualitative analysis software.

Results. Understandings and interpretations of ASPs varied greatly between the practice groups. ID practitioners commonly focused on “changing prescribing behavior” and “restricting inappropriate usage,” while MICU and SICU practitioners more often emphasized “following guidelines” and maintaining clinical “balance.” Additionally, direct observation data demonstrate that MICU and SICU practitioners are bounded by social and institutional determinants of antimicrobial prescribing (Table 1) that affect the pursuit of “appropriate antimicrobial use.”

Conclusion. Ethnographic interrogation found that practice groups understand and integrate ASPs differently according to everyday encounters with the social and institutional determinants of antimicrobial prescribing. ASP effectiveness might be enhanced by adopting a more mindful approach to accounting for and addressing the distinct understandings and interpretations of ASPs among diverse practice groups operating within the same institution.

Table 1. Key Factors Influencing Antimicrobial Prescribing

Key Factors	Examples of Context
Practitioner role in patient care	Consultant (ID, SICU) Primary service (MICU)
Communication	Attending-attending, attending-fellow Face-to-face vs. chart, formal vs. informal
Resources	Lab result availability and timeliness Personnel (e.g. resident number)
Time Pressures	Patient discharge Patient diagnosis
Interpersonal dynamics	Professional rank and standing Visibility of pharmacist(s)
Expert cultures (e.g. ID, surgery, critical care)	Interpreting test results Understanding recommendations

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1092. Impact of Relieving Infectious Diseases Fellows from Off-Hour/Weekend Antimicrobial Stewardship Coverage

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Background. Antimicrobial stewardship programs (ASPs) often utilize Infectious Diseases fellows (IDFs) to cover pre-authorization processes during evening and weekend hours. IDFs often provide ASP coverage in addition to their inpatient consult roles. In response to increasing consult volume, we worked with our fellowship program to relieve IDFs of evening and weekend coverage (a decrease in fellow coverage by 26 hours per week) starting in October 2017. Members of the ASP assumed the majority of these evening and weekend hours. Additional post-prescriptive activities and a rotation in Infection Control and Antimicrobial Stewardship were implemented in response. We sought to analyze the impact of this intervention.

Methods. Intervention and medication data were extracted from the electronic medical record during 1 July 2017 through 30 September of 2017 (IDF Coverage) and the same 3 months of 2018 (ASP Coverage). Comparisons between the two periods were performed using descriptive statistics of the number of interventions, number of weekend interventions, types of interventions, and days of therapy (DOT; per 1000 patient-days).

Results. Comparing July-September of 2017 and 2018, total ASP interventions increased 16% (1192 to 1391); weekend ASP interventions increased 75% (139 to 243). The most common interventions were “Choice of Therapy” (41% in both years), “De-escalation” (17% in 2017, 16% in 2018), and “Dose/Interval Optimization” (10% in both years). The most intervened agents were piperacillin-tazobactam, cefepime, vancomycin, meropenem, and ceftazidime.

Comparing the same time periods, total antibiotic DOT decreased 4% (714.1 to 684.9). There was a 28% decrease in piperacillin-tazobactam (41.47 to 29.85), 19% decrease in meropenem (28.08 to 22.61), and 7% decrease in vancomycin (125.09 to 116.17) use. Ceftazidime was unchanged (18.13 to 18.08). Cefepime increased by 9% (56.78 to 61.97).

Conclusion. Relieving IDFs of evening and weekend ASP coverage during busy inpatient consult rotations may help decrease burnout. The assumption of these hours by dedicated members of ASP led to an increase in documented total and weekend ASP interventions. In addition, the change was associated with a relative decrease in piperacillin-tazobactam, meropenem, and vancomycin use.

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1093. Evaluation of an Antimicrobial Stewardship Elective Rotation for Medicine Residents

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Background. In 2017, an Antibiotic Stewardship (ASP) elective was established for the medicine residents to engage directly in stewardship practice, learn how to