Background: Antimicrobial resistance (AR), including Clostridioides difficile infection (CDI), can spread across the healthcare continuum when patients move between facilities. In 2015, the CDC recommended that healthcare facilities (HCFs) and local public health departments (LPHs) coordinate their efforts to prevent the spread of AR and CDI. Accordingly, the California Department of Public Health (CDPH) Healthcare-Associated Infections (HAI) Program developed a model for implementing regionally based AR/CDI prevention collaboratives within HCF networks. Methods: The CDPH HAI Program began identifying regions in California with high AR/CDI incidence or risk for AR/CDI emergence using NHSN data. During 2015–2019, we organized AR/CDI prevention collaboratives in these regions. We recruited HCFs for participation by presenting at local professional organization meetings and engaging skilled nursing facility corporate leadership. HAI Program infection preventionists conducted onsite infection prevention assessments at each participating HCF. HAI Program and LPH staff convened quarterly in-person learning and discussion sessions focused on infection prevention and antimicrobial stewardship best practices. Participating HCFs committed to facility-tailored process improvement plans and conducted self-assessments to evaluate infection prevention practice changes at the conclusion of the collaborative. For CDI-focused collaboratives, we used data reported to CDPH via NHSN to assess changes in hospital- and community-onset CDI incidence among participating hospitals before and after the collaboratives. Results: Since 2015, 205 HCFs in 15 LPH jurisdictions have participated in 6 regional AR/CDI prevention collaboratives. Participating HCFs reported improved implementation of AR/CDI prevention strategies. For CDI-focused collaboratives, hospital-onset CDI incidence decreased by ~3% per month among participating hospitals. The collaboratives created forums for communication and relationship building, which previously did not exist among LPH and the HCF networks. We used our experience and feedback from partners to develop an HAI Program AR Prevention Collaborative Tool Kit to help LPHs and healthcare organizations develop and implement regional AR/CDI prevention collaboratives in other at-risk or high AR/CDI prevalence areas in California. The tool kit includes materials developed for each of our collaboratives, which may be adapted to meet local needs. Conclusions: Regionally coordinated AR/CDI prevention initiatives among LPHs and HCFs can contribute to increased AR awareness, improved AR prevention practices, and decreased AR/CDI incidence. The effectiveness of regional AR/CDI prevention collaboratives may be the result of concurrent efforts to improve AR prevention practices both within individual HCFs and across patient sharing networks.

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