304. Impact of COVID-19 Pandemic on Telehealth Practices in Pediatric Infectious Diseases
Sindhu Mohandas, MD; Daniel Olson, MD; Sergio Fanella, MD, FRCP(C), DTM&H; Amin Hakim, MD, FIDSA, CPE, FACPE; Sabah Kavousi, D.O.; Claudia Gaviria-Agudelo, MD, MS; Belinda Lynch, MD, FACP; Rachel Alexander, Medical Degree; Carla Silk, RN, BSN, MPH; Mia Lynch, Pharmacy Degree; Adrian Jones-Dove, Pharmacy Degree; Carla Alexander, Medical Degree; University of Maryland, Baltimore, Maryland

Session: P-27. Clinical Practice Issues

Background. The COVID-19 pandemic has led to changes in clinical practice, including a significant increase in the use of telehealth (TH). We sought to assess the impact of the pandemic on the use and perceptions of TH by pediatric infectious disease (PIDD) clinicians.

Methods. The PIDS Telehealth Working Group developed a 26-question online survey to assess telehealth practices among PID clinicians. The survey was available via SurveyMonkey from 12/6/2020-2/26/2021 to members of PIDS, PICNIC*, AAMI, and AAP*. Clinicians in active practice in North America were included in the analysis.

Results. Data was collected on reasons for use of TH, and is the preferred method of administration among nursing and pharmacy staff.

Disclosures. All Authors: No reported disclosures

603. Misdiagnosis of Lyme Disease in Patients Referred to an Academic Lyme Center
Kalpana D. Shere-Wolfe, Medical Degree; Rachel Silk, RN, BSN, MPH; Mia Lynch, Pharmacy Degree; Adrian Jones-Dove, Pharmacy Degree; Carla Alexander, Medical Degree; University of Maryland, Baltimore, Maryland

Session: P-27. Clinical Practice Issues

Background. Confusion and controversy surround various aspects of Lyme Disease (LD) including diagnosis. Typically, the diagnosis of LD is based on tick exposure, clinical history, exam, and laboratory testing. Laboratory testing and interpretation can be confusing, difficult, and a source of misdiagnosis.

Methods. One hundred and fifteen records of patients referred to the Integrated Lyme Program at University of Maryland for evaluation of LD were analyzed. All patients underwent initial evaluation by Infectious Disease (ID) physician who made a determination regarding Lyme diagnosis based on history, exam, epidemiologic risk factors and laboratory test results. Pt were determined to have one of the following diagnoses: 1) Acute LD 2) Past LD 3) Post Treatment Lyme Disease Syndrome (PTLDS) 4) Misdiagnosed LD. Data was also collected on reasons for misdiagnosis based on record review, referral information and patient reported information.

Results. We evaluated 115 patient records from our Lyme Program Registry. There were 78 female (66%) and 37 males (32%). The mean age was 46 years (range 19 to 83). Of the 115 records analyzed, there were 8 (7%) patients with acute Lyme disease; 38 (33%) patients with past Lyme disease, 3 (2.6%) patients with PTLDS and 93 (81%) of patients who were misdiagnosed with LD. Patients were misdiagnosed for multiple reasons and by different people. Twenty three percent (21/93) were misdiagnosed based on false positive IGM Western Blot; 16% (15/93) were misdiagnosed based on misread IGG Western Blot and 14% (13/93) were misdiagnosed based on un-conventional Lyme test. The remainder were misdiagnosed based on symptoms. Forty two percent (36/93) were misdiagnosed by PCP; 43% (39/93) were misdiagnosed by Urgent/Emergent care physician and 31% (29/93) were misdiagnosed by physicians self-referred as Lyme Literate Medical Doctor. The remainder were incorrectly self-diagnosed by patients based on symptoms.

Conclusion. Misdiagnosis of patients referred to Lyme Center is common and due to various reasons including misinterpretation of laboratory Lyme testing by healthcare providers and misinterpretation of symptoms by patients.

Disclosures. All Authors: No reported disclosures

604. Impact of COVID-19 Pandemic on Telehealth Practices in Pediatric Infectious Diseases
Sindhu Mohandas, MD; Daniel Olson, MD; Sergio Fanella, MD, FRCP(C), DTM&H; Amin Hakim, MD, FIDSA, CPE, FACPE; Sabah Kavousi, D.O.; Children Hospital Los Angeles, Los Angeles, CA; 7University of Colorado, Denver, CO; 8University of Manitoba, Winnipeg, MB, Canada; 9Emro Solutions, New York, NY; 10University of South Florida Morsani College of Medicine, Tampa, FL; 11The Children’s Hospital at Saint Peter’s University Hospital, Clinical Assistant Professor at Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ
PIDS Telehealth Working Group and *PIDS: Pediatric Infectious Diseases Society; PICNIC: Pediatric Investigators Collaborative Network on Infections in Canada; AMMI: Association of Medical Microbiology and Infectious Disease Canada; AAP: American Academy of Pediatrics-Section of Infectious Diseases

Session: P-27. Clinical Practice Issues

Background. Telehealth can be as safe as IVPB while reducing time-to-first dose vancomycin in the ED and cost, and is the preferred method of administration among nursing and pharmacy staff.

Methods. The PIDS Telehealth Working Group developed a 26-question online survey to assess telehealth practices among PID clinicians. The survey was available via SurveyMonkey from 12/6/2020-2/26/2021 to members of PIDS, PICNIC*, AAMI and AAP*. Clinicians in active practice in North America were included in the analysis.

Results. 366 treatment episodes were evaluated for 355 unique patients. Results. 366 treatment episodes were evaluated for 355 unique patients. Complications occurred in 13 out of 183 (7.1%) treatment episodes in the IV group compared to 18 out of 183 (9.8%) treatment episodes in the IVPB group (P = 0.35). The median time to complications was 2 days for both groups. IV ceftriaxone and ceftriaxone reduced the median time to first-dose vancomycin in the ED by 25 minutes. The use of cefazolin, ceftriaxone, and cefepime as IVPB yielded a quarterly cost savings of $38,890.04. 55% of nursing staff and 85% of pharmacy staff prefer IVPB administration for cefazolin, ceftriaxone, and cefepime.

Conclusion. Cefazolin, ceftriaxone, and cefepime given as IVPB were observed to be as safe as IVPB while reducing time-to-first dose vancomycin in the ED and cost, and is the preferred method of administration among nursing and pharmacy staff.

Disclosures. All Authors: No reported disclosures

Figure 1. Modalities

Figure 2. Comfort

Figure 3. Platforms
Results. The response rate was 10% (n=253) of 2,550 PID clinicians. Physicians accounted for 98.4% of the cohort. The remaining 1.6% were allied health professionals. In the survey respondents (32%) were in US states (CA, TX, OH and NY) and the province of Quebec. 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care. The mean age was 64.31 (SD=14.78), 54.99% were 65+ years old, and 62.8% of respondents were women. 37% of respondents were 36–45 years old, with 42.7% devoting about 50–99% of their time to direct patient care.

Conclusion. Analysis of each survey question shows the 65+ patients are less satisfied than younger patients on the following: being informed of side effects, explanation of financial responsibilities, and the helpfulness of the billing staff. Even though the scores are high for both age groups, additional research needs to be conducted to determine why scores for the 65+ age group are lower, and changes needed for improvement. Knowing the level of OPAT patient satisfaction will benefit infectious disease physicians, providers, prescribers, payers, and regulators as they evaluate how to expand home-based services.

Disclosures. All Authors: No reported disclosures

606. Implementation of a Telehealth-based OPAT Early Post-Discharge Clinic May Reduce Hospital Readmission
Nicolas W. Cortes-Penfield, MD, Nicolas W. Cortes-Penfield, MD, Melissa LeMaster, RN, BS; Bryan Alexander, PharmD,1 University of Nebraska Medical Center, Omaha, NE; 2Nebraska Medicine, Omaha, Nebraska
Session: P-27. Clinical Practice Issues

Background. Recent studies suggest that early post-discharge follow-up for patients receiving outpatient parenteral antimicrobial therapy (OPAT) reduces readmission rates. We report our experience implementing a telehealth-based clinic to facilitate early (1-2 week) follow-up for selected OPAT patients perceived to be at high risk for readmission.

Methods. We identified patients who met criteria for and completed a supplemental OPAT telehealth visit following the initial seven months after implementation of this clinic (11/1/20 – 5/31/21). Clinical criteria triggering intake of patients for these visits included: endovascular or cardiac device-related infection; treatment with vancomycin, oxacillin/nafcillin, or aminoglycosides; ≥2 prior hospitalizations within past 1 year; treating Infectious Disease or OPAT team's subjective assessment of high readmission risk. Patients planned for < 14 days of OPAT therapy were excluded.

Results. A total of 49 patients completed a telehealth visit; mean time from discharge to telehealth visit was 12.1 days (SD +/- 3.9). An intervention was made in 27% of these visits (13 of 49 patients), most commonly involving attempted mitigation of an adverse event or line-related complication (7 cases). The all-cause, 30-day readmission rate for this cohort was 6.1% (3 of 49 patients), while the rate for OPAT patients who did not receive an early telehealth visit during the same period was 22.7% (52 of 229 patients) which was statistically significant (p=0.008). This association of benefit was also found when comparing infection-related, 30-day readmission rates (0% vs 7.4%, p=0.049).

Conclusion. Implementation of OPAT telehealth encounters for high-risk patients resulted in a high rate of intervention to mitigate adverse events of OPAT therapy. Readmission occurred less than one-third as frequently in the telehealth group compared to patients with no early follow-up visit. Telehealth-based encounters appear comparable in effectiveness to those previously reported utilizing in-person visits, introducing efficiencies that may allow for broader implementation of this intervention.

Disclosures. Nicolas W. Cortes-Penfield, MD, Nothing to disclose Bryan Alexander, PharmD

1Astellas Pharma (Advisor or Review Panel member)

607. Improving Health Maintenance Among Patients with HIV by Implementing a SmartPhrase and a Care Gap in the EPIC Electronic Medical Record
Yuriko Fukuta, MD, PhD; Thomas P. Giordano, MD, MPH; Baylor College of Medicine, Bellaire, Texas
Session: P-27. Clinical Practice Issues

Background. Most deaths in HIV-infected patients receiving antiretroviral therapy are now related to conditions other than AIDS. HIV infection appears to increase the risk of many non-AIDS-related conditions, highlighting the importance of

Abstracts • OFID 2021:8 (Suppl 1) • S405