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. 81 survey respondents (32%) were in 4 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. TH usage increased during the pandemic with the most gain in provider-patient communications with 65.6% increase for synchronous and 22.1% for asynchronous TH (Figure 1). Gains in provider-provider TH were less than 20%. Respondents reported a 6-fold gain in comfort with TH usage versus pre-pandemic level (Figure 2). Most respondents report being satisfied with their current platform and modality. Once the COVID-19 waivers expire, 70% of respondents plan to continue using TH. The most common TH modality used was an EHR-integrated TH platform (Figure 3). The main perceived barriers to TH adoption were lack of complete physical examination (73.7%), dealing with new technology (21.5%), and insufficient reimbursement (20.8%) (Figure 4).

Conclusion. The COVID-19 pandemic has resulted in a significant increase in the use of TH by PID specialists versus pre-pandemic usage. Respondents gained comfort with use of different telehealth modalities during the pandemic. This data can help clinicians and organizations in planning and resource allocation for telehealth programs in a post-pandemic environment.

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606. Implementation of a Telehealth-based OPAT Early Post-Discharge Clinic May Reduce Hospital Readmission
Nicolas W. Cortes-Penfield, MD 1; Nicolas W. Cortes-Penfield, MD 1; Melissa LeMaster, RN, BSN 2; Bryan Alexander, PharmD 1; University of Nebraska Medical Center, Omaha, NE; Nebraska 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 re-admission 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). Clinic 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. Categorical variables were compared using a Chi-square test at the α=0.05 level of significance.

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.

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preventive care, however, recommended health maintenance items unique patients with HIV (PWH) are not always accomplished. We aimed to improve health maintenance by implementing a SmartPhrase and a Care Gap package in the EPIC Electronic Medical Record (EMR).

Methods. We developed a HIV health maintenance SmartPhrase in EPIC that included the last screening dates for syphilis, gonorrhea, chlamydia, hepatitis A, hepatitis B, hepatitis C, latent tuberculosis, hyperlipidemia, diabetes and human papilloma virus and the dates of receipt of hepatitis A vaccines, hepatitis B vaccines, pneumococcal conjugate vaccines, pneumococcal polysaccharide vaccines and influenza vaccines (Figure 1). Providers can select their plan for each health maintenance item based on these data and their plans are documented in the encounter notes. Providers were educated to use the SmartPhrase in each office visit. An HIV registry was built after choosing 509 HIV related medical conditions. The health maintenance topics were displayed in a “Care Gaps” summary using the data in the HIV registry (Figure 2). Completion rates for the health maintenance items were compared before and after implementation. The health maintenance package was implemented on 3/1/2020.

Results. Of the 380 patients in the registry, 162 had office visits with the ID clinic from 1/1/20 to 6/5/20. Chart review of 100 patients who had office visits after implementation was performed and compared to the 62 patients prior to implementation (Table 1). The rates of hepatitis A vaccination (P= 0.001), hepatitis B vaccination (P= 0.05) and influenza vaccination (P=0.035) were increased significantly. The rates of hepatitis A vaccination (P= 0.001), hepatitis B vaccination (P= 0.05) and influenza vaccination (P=0.035) were increased significantly.

Conclusion. A health maintenance package consisting of a SmartPhrase and summary display in the EMR with provider education likely helps improve health maintenance in PWH.

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688. Continuous Infusion Vancomycin Is Not Associated with Improved Safety in an Outpatient Parenteral Antimicrobial Therapy Program

Rosemarie D. Tagare, PharmD1; Joshua A. McDonald, PharmD2; Brandon Tritle, PharmD, BCIDP2; Karen Fong, PharmD, BCIDP1; Michael G. Newman, MS1; Laura Certain, MD, PhD3; Russell J. Benefield, PharmD1; 1University of Utah Health, Salt Lake City, Utah; 2Intermountain Healthcare, Salt Lake City, Utah; 3University of Utah, Salt Lake City, Utah

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Background. Continuous infusion (CI) vancomycin has been reported to be associated with improved safety outcomes compared to intermittent infusion (II) in the outpatient parenteral antimicrobial therapy (OPAT) setting. Based on this our institution implemented a quality improvement intervention to discharge more patients on CI vancomycin aiming to improve vancomycin safety in our OPAT program.

Methods. This single-center, pre-/post-intervention, quasi-experimental study evaluated adult patients who received vancomycin for a minimum 7-day intended duration of therapy after discharge, were discharged to home health or a skilled nursing facility, and had a follow-up visit with an infectious diseases provider. Outcomes included discontinuation due to acute kidney injury (AKI) or due to any adverse drug event (ADE), time to AKI or ADE, and unplanned 30-day readmissions and were compared between the pre-intervention (11/25/2018 to 7/5/2020) and post-intervention (7/6/2020 to 3/31/2021) periods. Adverse events were defined as premature discontinuation of vancomycin with documentation of a suspected adverse event.

Results. Of the 445 patients included, 102 patients received CI vancomycin. Demographic characteristics were generally similar between time periods, although more patients discharged to home health were included during the post-intervention period. CI vancomycin use was higher after the intervention (42% vs 11%, P = 0.0001). Discontinuation due to AKI (7% vs 8%, P = 0.68) or any ADE (16% vs 18%, P = 0.65) occurred just as frequently post-implementation. Unplanned 30-day readmission was higher post-intervention (21% vs 12%, P = 0.02). When comparing patients receiving CI and II vancomycin, discontinuation rates due to AKI (10% with CI vs 7% with II, P = 0.35) and any ADE (17% with CI vs 17% with II; P = 0.85) were similar. Time to AKI (median 21 days with CI vs 16 days with II, P = 0.26) and any ADE (median 22 days vs 22 days, P = 0.55) were also similar. There was a trend toward a significantly higher unplanned 30-day readmission rate with use of CI compared to II (22% vs 14%, P = 0.07).

Conclusion. We found no safety advantages when using CI instead of II vancomycin in the outpatient setting. The potentially higher readmission rate observed with CI vancomycin will be investigated further.

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