difficulties. There are often multiple ID providers with inadequate time to properly orchestrate follow-up. There are undefined checkpoints and triaging in the department’s scheduling policies. Interventions involved reformatting the ID sign-off template and clarifying the roles of providers in the transitions-of-care process. Analysis after 6 months of implementation revealed improvement of communication among teams, decline in improper sign off by 13% and decrease in antibiotic prescription errors by 2%.

**Conclusion.** This study demonstrates that well-designed sign-off templates can help with effective communication of the final treatment plan among providers and possibly improve patient outcomes. The target goal is to reduce the number of improper sign-offs by 50% within 1 year.

### Figure 1. Current Transfer of Care

![Image](image1.png)

### Figure 2. Root Cause Analysis

![Image](image2.png)

### Table 1: Baseline Period and Study Period Comparison

|                        | Baseline Period | Study Period | P value |
|------------------------|-----------------|-------------|--------|
| Patients (n)           | 148             | 148         |        |
| Average length of stay | 6.7             | 7.1         | 0.54   |
| Case mix index         | 1.16            | 1.23        | 0.46   |
| Average days on antibiotics | 5.9          | 6.2         | 0.47   |
| Average drug cost      | $484            | $406        | 0.85   |
| Readmission %          | 22.2            | 17.8        | 0.38   |
| Deaths                 | 3               | 3           | 1      |

**Conclusion.** Tele-ID at our hospitals was noninferior to in-person ID consults. An integrated computer system, nursing support, and daily follow-up are key components of a successful Tele-ID program.

**Disclosures.** All authors: No reported disclosures.

### Session: 166. Changing Clinical Practice for Changing Times

**Friday, October 5, 2018: 2:00 PM**

**Background.** Amphotericin B for the Treatment of Murine Pulmonary Aspergillosis Caused by Azole-Resistant *Aspergillus fumigatus* Strains

**Results.** Baseline period had 148 inpatient stays and study period had 148 inpatient stays. Despite similar case mix index in both groups, there was no statistical difference between the clinical outcomes. Results are shown in Table 1.

**Disclosures.** All authors: No reported disclosures.

1669. Efficacy of Voriconazole Prophylaxis Followed by Therapeutic Liposomal Amphotericin B for the Treatment of Marine Pulmonary Aspergillosis Caused by Azole-Resistant *Aspergillus fumigatus* Strains

**Background.** Antifungal treatment for pulmonary aspergillosis is more difficult if the fungal strain causing the infection is azole resistant. To investigate this problem, we used a murine model of pulmonary aspergillosis caused by azole-resistant *Aspergillus fumigatus* strains V29 and V45, and compared treatment with voriconazole (Vr, oral 40 mg/kg, bid) or liposomal amphotericin B (L-AmB, 5 mg/kg, IV) used alone or in combination.

**Methods.** Mice (*n = 14/gp*) were immunosuppressed with 24 mg/kg triamcinolone acetonide, IP, d-3, d-1, and d+1 relative to fungal challenge (d0). For 2 groups, Vr was given prophylactically (proph) d-3, d-2, d-1 followed by L-AmB or buffer, d+1, d+2, and d+3. The other groups were given Vr, L-AmB, Vr+L-AmB, or buffer d+1, d+2, and d+3. On d0, mice were given 1.3 to 1.6 × 10⁶ *A. fumigatus* spores intranasally (Vr MIC = 64 µg/mL, V29, Vr MIC = 8 µg/mL, V45). On d3, lungs were collected from 7 mice/gp and fungal burden determined by plating for colony forming units; 7 mice/gp were then monitored for morbidity to d21.

**Results.** Optimum treatment was observed when Vr was given prophyl, followed by L-AmB post-challenge (Vr/L-AmB), with better survival (100%) for both fungal strains vs. buffer or Vr post-challenge (*P < 0.04*); for V29, significantly better survival was also seen with Vr/L-AmB vs. L-AmB or Vr+L-AmB post-challenge (*P < 0.01*). For strain V45, lung fungal burden was significantly lower for Vr/L-AmB versus all other treatments (*P < 0.04*), while for strain V29, fungal burden was lower for the Vr/L-AmB and L-AmB post-challenge groups versus the other groups, but the differences were not significant. Notably, although the lung fungal burden with Vr proph and Vr postchallenge were both similar to the buffer control, Vr proph yielded significantly better survival than Vr post-challenge (*P < 0.001*).

**Conclusion.** These preclinical observations demonstrate that combining L-AmB with Vr for the postchallenge treatment of pulmonary aspergillosis caused by azole-resistant strains is not an effective therapeutic option. However, the results do show that Vr proph, but not Vr postchallenge, can have some limited antifungal activity, and can significantly enhance the antifungal effects of post-challenge L-AmB. This regimen could be considered in areas where there is a high incidence of azole-resistant *A. fumigatus*.

**Disclosures.** All authors: No reported disclosures.