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.

![Example of Documentation in Epic (introduced)](Image)

...) Description and note documentation

Information relevant to health maintenance and providers’ plan for each health maintenance are documented in the encounter notes.

![CareGaps® 2021 Epic Systems Corporation](Image)

**Figure 2. CareGaps® 2021 Epic Systems Corporation**

CD4 every 6 months is displayed as a part of the health maintenance in a “Care Gaps” summary using the data in the HIV registry, whether their HIV is well controlled or not.

**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. Pneumonia vaccine administrations and anal pap smear performance compliance remained suboptimal. Providers reported that the time they spent searching for lab results and immunizations records and documenting were shortened.

![Table 1 Comparison of Health Maintenance Compliance Between Pre and Post Implementation Groups](Image)

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

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**Session: P-27. Clinical Practice Issues**

**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 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 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).

**Control Charts**

These control charts show the variation over time of the proportion of patients A. utilizing CI vancomycin, B. experiencing any adverse drug reaction, C. experiencing acute kidney injury, and D. being readmitted within 30 days. Upper and lower control limits are depicted by red lines, and the mean is depicted by a green line.

**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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