considered. OPAT-related ED visits, and separately OPAT-related readmissions, were compared across the two groups in subdistribution proportional hazards competing risks regression models. Adverse drug events were compared using logistic regression.

**Results.** Thirty nonagenarians and 87 control subjects were identified for patients discharged on OPAT between January 1, 2013 and May 21, 2014. Mean (SD) of age for nonagenarians and controls were 92 (3) and 61 (16), respectively, and 67 (57%) were males. Cardiovascular and osteoarticular infections accounted for more than 50% of infections treated in each group, and the majority of patients received their OPAT in skilled nursing facilities. The cumulative incidences of OPAT-related ED visits and readmissions for nonagenarians and control patients with death and non-OPAT-related readmissions accounted for as competing events, are shown in the figure. Compared with matched patients below 90 years of age, nonagenarians were not at increased risk of OPAT-related ED visits (HR 1.32, 95% CI 0.55–3.18, P = 0.54), OPAT-related readmissions (HR 1.2, 95% CI 0.23–6.19, P = 0.83), or adverse drug events from OPAT medications (OR 1.22, 95% CI 0.28–8.55, P = 0.81).

**Conclusion.** OPAT can be accomplished in nonagenarians as safely as in younger patients.

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

1936. Implementation of IV Push Antibiotics for OPAT in a Safety Net Hospital Following a National Fluid Shortage

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**Session:** 226. Clinical Practice Issues: OPAT Saturday, October 6, 2018: 12:30 PM

**Background.** In the wake of Hurricane Maria, hospitals nationwide have faced a shortage of IV fluids sourced from Puerto Rico. Out of necessity to conserve IV fluids, Parkland Memorial Hospital shifted IV antibiotic administration from traditional fluid suspension via pump/gravity to “IV push” administration. The safety and potential cost savings of short infusion administration of antibiotics have been previously described; however, implementation of IV push administration among patients receiving long-term IV antibiotics has yet to be described.

**Methods.** Starting November 2017, patients requiring long-term IV antimicrobial treatment with were transitioned to receive IV push administration from infusion. Per the Parkland self-administered Outpatient Parenteral Antimicrobial Therapy (5–OPAT), patients were screened and trained to self-administer IV antibiotics prior to hospital discharge and followed in the Parkland OPAT clinic.

**Results.** Since implementation November 2017, 200 patients completed anti-microbial therapy with IV push method with 100% success rate and no reported complications. The following supplies were estimated to be saved: 3,000 less IV fluid bags, 1,000 IV tubing, and 50 fewer gloves and alcohol swabs, amounting to approximately $22,000 of cost savings for a patient going home on once a day antibiotic therapy. Teaching time for the nursing team was reduced on average by 50% per patient. Preliminary patient satisfaction surveys indicate greater satisfaction due to decreased infusion time from an average of 45 minutes to 3–5 minutes with the IV push method. Patient’s reported satisfaction with the new IV Push method due to greater convenience for both storing the medication and a faster preparation time.

**Conclusion.** Parkland Memorial Hospital was able to implement IV push as a safe and cost-effective alternative to traditional IV antibiotic administration in fluid suspension. Use of IV push antibiotics resulted in $22,000 of cost savings and reduced utilization of a critical resource currently facing a nationwide shortage. Though implemented at our institution in response to a national crisis, IV push is a favorable alternative to administration via a pump or gravity due to time savings, cost reduction, and convenience.

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

1937. A Dedicated OPAT Program Reduces Readmission and Complications Rates

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**Session:** 226. Clinical Practice Issues: OPAT Saturday, October 6, 2018: 12:30 PM

**Background.** Outpatient Parenteral Antibiotic Therapy (OPAT) programs provide improved patient outcomes by reducing the rate of complications and readmissions. Despite the benefits of decreased hospital lengths of stay (LOS), risks related to central venous catheter (CVC)-related complications and medication toxicities remain. We implemented intensive monitoring with our antimicrobial stewardship program (ASP) aimed at decreasing the frequency of complications and readmissions.

**Methods.** A retrospective study was conducted including all patients discharged from the Birmingham Veterans Affairs (VA) Medical Center on OPAT from January 1, 2014 to December 31, 2014 (Period 1) and January 1, 2015 to December 31, 2016 (Period 2). Prior to January 1, 2015 OPAT was managed by individual infectious diseases physicians. Starting with Period 2, OPAT was monitored by a dedicated ASP physician and pharmacist. Episodes that eclipsed both periods were excluded. Data collection included demographics, antibiotic indication, treatment received, and clinical outcomes (frequency and types of drug related complications, acute kidney injury [AKI] defined as a rise in serum creatinine requiring a change in antibiotic dosing, CVC complications, hospital readmission, and planned OPAT duration [difference between discharge and planned stop dates]).

**Results.** Period 1 included 120 patients, period 2 included 299 patients. The mean planned OPAT duration was 30.3 days in Period 1 vs. 28.3 days in Period 2 (P = 0.21). Demographics and OPAT indications for each period are in Table 1. Fewer patients had complications in Period 2 compared with Period 1 (50 [42%] vs. 77 [26%], P = 0.001). Complications for each period are detailed in Table 2. Readmission rates were lower in Period 2 compared with Period 1 (27.5% of patients vs. 10%, P < 0.001). Year is significantly negatively associated with complications (P < 0.0001) and hospitalization (P < 0.0001, Figure 3).

**Conclusion.** The establishment of an OPAT-ASP tasked with close monitoring of therapy improved patient outcomes with reductions in the rate of complications and readmissions in our VA population. Our data support the center’s efforts to dedicate centralized resources to improving the outcomes of OPAT patients.

**Table 1**

| Period 1 | Period 2 |
| --- | --- |
| **Relevant Demographics** |  |
| **Age** | 61 (29) vs. 64 years |
| **Age, African American** | 57 (29) vs. 29 (26)% |
| **Vital signs** |  |
| **Temperature** | 101 (8) |
| **Hypertension** | 101 (5) |
| **Mobility** | 101 (5) |

**Indications**

| Reactional indications |  |
| --- | --- |
| **Otitis media** | 3.04 (3) vs. 10.36 (3) |
| **Skin and soft tissue infections** | 10 (10) vs. 45 (19) |
| **Bacteremia** | 13(13) vs. 19 (9) |
| **Catheter colonization** | 11 (11) vs. 20 (17) |
| **Joint infection (prosthetic/native)** | 11 (11) vs. 35 (11) |
| ** внутриабдоминальное** | 11 (11) vs. 21 (11) |
| **Pneumonia** | 11 (11) vs. 21 (11) |
| **Infective endocarditis** | 1 (1) vs. 4 (1) |
| **Neutropenic eosinophilia/measuring eosinophils** | 1 (1) vs. 3 (1) |
| **Urinary tract infection** | 1(1) vs. 21 (11) |
| **Sepsis/Septic shock** | 1(1) vs. 21 (11) |

**Table 2**

| Period 1 | Period 2 |
| --- | --- |
| **Complication Type** | **Number of Episodes (%)** | **Number Requiring Hospitalizations (%)** | **Number of Episodes (%)** | **Number Requiring Hospitalizations (%)** |
| **Acute Kidney Injury** | 20 (17) | 1 (1) vs. 3 (1) | 3 (3) | 3 (3) |
| **Catheter Related** | 8 (7) | 4 (4) | 11 (11) | 2 (2) |
| **Supra/Infrahepatic (Liver) Drug Largens** | 4 (4) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Rash** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Ototoxicity** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Vaginitis** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Gastroenteritis** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Dextrose** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Iskemia** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Hypertension** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Hypothermia** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Mental Status** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Volume Overload** | 1 (1) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |
| **Infused IVs** | 3 (3) | 1 (1) vs. 3 (3) | 1 (1) | 1 (1) |