outcomes, adverse drug reactions (ADRs) and unplanned hospitalizations during OPAT were collected. Clinical success was defined as clinical cure or improvement at completion of OPAT. Patients were included who were hospitalized for <7 days and subsequently completed OPAT. ADRs leading to hospitalization or discontinuation of OPAT were deemed serious. Descriptive statistics were used for distribution of variables.

**Results.** SBI patients included BJI (n = 175), bacteremia/endocarditis (n = 60) and CNS infections (n = 15) as described in Table 1. Successful clinical outcomes were reported in 224 patients (89.6%) after a mean duration of OPAT of 323.20 days. Of these, 12 patients (6.7%) were hospitalized during OPAT and returned to the ICU with a successful clinical outcome. Clinical success rates for BJI, bacteremia/endocarditis and CNS infections were 89.1%, 91.6% and 86.7%, respectively. The primary reason for nonfavorable outcomes was worsening of infection (15/26, 58%). Serious ADRs were reported in 12 patients (4.8%) with (2.4%) leading to hospitalization. Unplanned hospitalizations during OPAT occurred in 33 patients (13.2%) with the majority (21/33, 64%) related to disease. ADRs and hospitalizations compare favorably to data previously reported. (Schmidt et al. OFID 16, 4, 2017).

**Conclusion.** Patients with serious bacterial infections had high success rates when treated by an ID physician in infusion centers. Adverse events and unplanned hospitalization rates were low.

**Table 1. Characteristics of OPAT for Serious Bacterial Infections Managed in ID Physician Office Infusion Centers**

| Type of Infection | No. of Pts. | Age (mean years SD) | OPAT Duration (mean days SD) | Clinical Success | Serious ADRs during OPAT | Hospitalizations during OPAT | OPAT duration during OPAT |
|-------------------|-------------|---------------------|-------------------------------|-----------------|-------------------------|-----------------------------|--------------------------|
| Bacterial infection | 175         | 58.3 (10.5)         | 13.4 (6.5)                    | 95.9%           | 4.1%                    | 3.1%                        | 9.1%                     |
| CNS infection     | 60          | 66.2 (10.7)         | 11.0 (6.1)                    | 91.1%           | 8.9%                    | 5.0%                        | 14.1%                    |

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**751. Study on Daptomycin Prescription Suitability as a First Step Towards an Antimicrobial Stewardship Program**

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**Background.** Daptomycin use has increased since its approval and has often been used empirically. The main reasons for this are high success rates in patients with severe bacteremia and low hospitalization rates. In a recent study (Schmidt et al. OFID 16.4, 2017), infection-related mortality was 64% related to disease. ADRs and hospitalizations compare favorably to data previously reported. (Schmidt et al. OFID 16, 4, 2017).

**Methods.** Observational, retrospective study including all patients treated with daptomycin during 2017 in a tertiary hospital. Clinical variables were collected in a pre-established protocol including demographics, comorbidities, infection type, microbiological results, adverse events (AE), outcomes, and treatment adequacy (selection, dosage, microbiological adjustment and duration). Daptomycin prescription is not restricted at our institution. The dosages were considered adequate according to clinical guidelines.

**Results.** Overall 176 patients (62% men, median age: 70 years) started treatment with daptomycin, 58% of them on empirical bases. Main uses were: skin and soft tissue infections (37.5%), fever without obvious source (17.6%) and osteoarticular infection (12.5%). Fifty-three patients (35.8%) had concomitant bacteremia. An etiological diagnosis was reached in 89.2% of patients and S. aureus was the most frequently isolated microorganism (n = 58, and 10 MRSA), followed by CoNS (n = 35). Overall, 77.7% of patients evolved satisfactorily. Five patients discontinued treatment due to AE (urticaria, cholestasis, increased CPK and rhabdomyolysis). Infection-related mortality was 7.4%. Daptomycin was correctly selected in 94.3% patients, length of therapy was adequate in 87.4%. However, only 47.1% of patients received adequate dosage (under-dosing in 27.8%) and in 9.8% of patients, the treatment was not adjusted according to microbiological results. The prevalence of daptomycin use was 3.7 patients/1,000 admissions.

**Conclusion.** Daptomycin is often prescribed empirically, using nonadequate dosages and duration of therapy needs an improvement. The follow-up of patients treated with daptomycin should be considered a priority intervention within an Antimicrobial Stewardship Program.

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**752. Timing of Antibiotics Administration in Emergency Department and Mortality in Sepsis by Sepsis-3 Definition**

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**Background.** Even after the introduction of the Sepsis-3 definition, there is still debate on the ideal antibiotic administration time in patients with sepsis. This study was performed to evaluate the association between the timing of antibiotic administration and mortality in sepsis patients who visited the emergency room.

**Methods.** A prospective cohort study was conducted on patients who were diagnosed as sepsis with Sepsis-3 definition among patients who visited the emergency department (ED) of Korea University Ansan Hospital from September 2017 to January 2019. The timing of antibiotic administration was defined as the time in hours from ED arrival until the first antibiotic administration. Cox logistic regression analysis was used to estimate the association between time to antibiotics and 7-, 14-, and 28-day mortality.

**Results.** During the study period, a total of 251 patients were enrolled with a 7-, 14-, and 28-day mortality of 16.7%, 36.3%, and 57.4%, respectively. The median time to antibiotic administration was 247 minutes (interquartile range 72 – 202 minutes). The mean age was 72 ± 15 years old and 122 patients (48.6%) were female. The most common site of infection was respiratory infection. The timing of antibiotic administration was not associated with 7-, 14-, and 28-day mortality. Female (adjusted hazard ratio [HR] 2.06 [95% confidence interval (CI) 1.21 – 3.53]; P value = 0.008), SOFA score (aHR 1.17 [95% CI 1.05 – 1.31]; P = 0.005), and initial lactate level (aHR 1.13 [95% CI 1.05 – 1.22]; P = 0.001) increased the risk of 7-day mortality. Female (aHR 2.07 [95% CI 1.48 – 2.89]; P = 0.001), Charlson comorbidity index (aHR 1.12 [95% CI 1.02 – 1.24]; P = 0.025), and initial lactate level (aHR 1.19 [95% CI 1.02 – 1.16]; P = 0.011) increased the risk of 14-day mortality. Female (aHR 1.95 [95% CI 1.50 – 2.54]; P = 0.001) increased the risk of 28-day mortality in patients with sepsis.

**Conclusion.** The timing of antibiotic administration did not increase the risk of mortality in the treatment of sepsis patients who visited ED. Rather, the SOFA score, lactate, female, and comorbidity increased the mortality associated with sepsis.
753. Outpatient Parenteral Antibiotic Therapy (OPAT) in a Large Urban Safety Net Hospital Setting: Therapy for Vulnerable Populations at Home

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Background. Adoption of outpatient parenteral antibiotic therapy (OPAT) is accelerating due to proven safety and value, but experience in safety-net settings remains limited, especially in those with history of illicit drug use. Emerging reports from safety-net settings have featured OPAT delivered in nursing facilities, respite care centers, and infusion centers (including some persons who inject drugs [PWID]), but literature is sparse on home-based OPAT for vulnerable patients. In a new home anti-

Methods. We conducted a cohort study of patients discharged from a large urban medical center and enrolled in an outpatient IV antibiotics program from September 2017 to January 2019. We collected demographic and clinical data and computed outcomes of safety (30- and 90-day readmission for infection, vascular access complications, and death) and efficacy (completion of antibiotic therapy).

Results. Overall, 47 courses of antibiotics were given to 45 patients. Of these, 39/47 (83%) of antibiotic courses were administered in a residential setting, and 8/47 (17%) via the hospital outpatient infusion center. Comorbid conditions were common, including 9/45 (20%) with hepatitis B/C and 8/45 (18%) with HIV (Table 1). Most common indications for antibiotics were osteomyelitis and bacteremia (Table 2). Efficacy in the OPAT program was high: overall, 44/47 (94%) courses were completed, and the 30-day and 90-day readmission rates were 13% and 20% respectively, with zero 30-day readmissions related to OPAT (Table 3).

Conclusion. An OPAT program embedded within a safety net hospital system delivering care in patients’ homes has high completion rate and low readmission rate, despite patients’ high prevalence of underlying comorbid conditions and noninjection illicit drug use. Home-based OPAT should be considered for broader adoption in safety-net hospital systems.

Table 1. Demographics & Clinical Description of Adults Participating in Safety Net Hospital OPAT Program

| Variable | Unadjusted OR | p-value | Adjusted OR | p-value |
|----------|---------------|---------|-------------|---------|
| Age      |               |         |             |         |
| CSS      |               |         |             |         |
| SFOA     |               |         |             |         |
| Inpatient days | |         |             |         |
| CRP      |               |         |             |         |
| Readmission |             |         |             |         |
| Antibiotics |             |         |             |         |
| Time to antibiotics administration | |         |             |         |

Table 2. Prevalence of Infectious Disease Indications Among N=47 Outpatient Parenteral Antibiotic Therapy Courses

| Disease                          | Occurrence |
|----------------------------------|------------|
| Osteomyelitis/hardware-associated infection | 15 (32%) |
| Bacteremia                        | 11 (23%)   |
| Abscess                           | 9 (19%)    |
| Urinary tract infection           | 5 (11%)    |
| Endocarditis                      | 3 (6%)     |

Notes: A: Certain patients had ≥1 indication for antibiotics; B: Septic arthritis (n=4); sepsis (n=2); endocarditis (n=1), sinusitis (n=1), eczular syphilis (n=1).

Table 3. Antibiotic Therapy Completion and Hospital Readmission Rates among N=47 Antibiotic Treatment Courses

| Outcome                          | Occurrence |
|----------------------------------|------------|
| 30-day readmission to ZSFG        | 6 (13%)    |
| 30-day readmission related to OPAT| 0 (0%)     |
| 90-day readmission to ZSFG        | 9 (20%)    |

Notes: N=47 readmission; n=1 readmitted to hospital for non-OPAT related problem and completed antibiotics in hospital, n=1 patient currently completing therapy, B: OPAT-readmission defined as due to antibiotic complication/adverse effect or vascular access device complication.

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754. Evaluation of Standardized Dalbavancin Use to Facilitate Early Hospital Discharge for Patients Inappropriate for Outpatient Parenteral Antibiotic Therapy

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Background. Patients frequently remain in the hospital for prolonged intravenous (IV) antibiotic therapy for serious infections when outpatient IV antibiotic therapy is unsafe or unfeasible. A protocol was developed to facilitate early discharge by administering one dose of dalbavancin 7–10 days prior to the planned end of treatment, allowing patient discharge the same day as the infusion. The purpose of this analysis was to describe the effectiveness, safety, and financial impact by using dalbavancin to facilitate early discharge.

Methods. This is a retrospective observational analysis of all inpatients who received dalbavancin at Denver Health Medical Center from April 2018 to April 2019. One dose of dalbavancin 1,500 mg was administered over 30 minutes to each patient. The medical record was reviewed 30 days after discharge to determine safety (adverse reaction to dalbavancin) and effectiveness (readmission or receipt of additional antibiotics). The estimated cost of one hospital day was $1,800; one dose of dalbavancin costs $3,000.

Results. Sixteen patients (69% male; average age 45 years) received dalbavancin. The majority of patients were homeless (91%), injection drug users (75%), and infected with HCV (56%). One patient was infected with HIV (6%) and none had diabetes, kidney disease, or cirrhosis. Antibiotics administered prior to dalbavancin were vancomycin or cefazolin, based on organism, for a median duration of 25 days (IQR 11–34). Patients were infected with methicillin-resistant S. aureus (n = 8), methicillin-susceptible S. aureus (n = 7), and one co-infection with S. epidermidis and S. pyogenes. The infections included complicated bacteremia (n = 6), uncomplicated bacteremia (n = 4), osteomyelitis (n = 2), right-sided endocarditis (n = 2), and osteomyelitis with bacteremia (n = 2). No adverse reactions were noted. Readmission 30 days from discharge occurred for two patients for reasons unrelated to the infection or dalbavancin. None received additional antibiotics. 115 hospital days were averted (average of 7 days per patient). Cost savings to the hospital were estimated to be $159,000.

Conclusion. A standardized approach to use dalbavancin for serious infections to facilitate early hospital discharge appears to be safe and effective and led to substantial cost savings.

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