Background. The incidence of Candida spp infections in critically ill patients is increasing. Initial broad-spectrum empiric antifungal agents (e.g., echinocandins), fol-
lowed by immediate switching to fluconazole if isolates are fluconazole sensitive could be a low-cost de-escalation strategy. The aim of this study was to evaluate the budget impact of the de-escalation strategy using fungostatin in ICU patients and clinical effect.

Methods. This prospective study was conducted in a 30-bed mixed ICU, from January 2015 through January 2017. Critically ill patients with invasive candidiasis were placed on initial empiric broad-spectrum antifungal agents or either echino-
candins or liposomal amphotericin B. De-escalation to fungostatin strategy at day 3 in patients without de-escalation were compared. Clinical characteristics and the pres-
ence of clinical success by the eighth -day of treatment and 28 -day outcome were evalu-
cated. Clinical success was defined as the complete eradication of Candida spp in blood cultures. Economic outcomes included budget impact was also evaluated.

Results. Forty -seven ICU patients with documented invasive candidiasis enrolled and received empiric broad-spectrum antifungal agents with either echi-
candins or liposomal amphotericin B. Of those, 22 (47%) were eligible for de-escalation at day 3 to fungostatin based on susceptibility test for fungi. Specific Candida species isolated in the de-escalation group were C. albicans (14, 64%), and non-C. albicans (8, 36%). Interestingly 6/22 (27%) invasive candidia died -escalated cases relapsed by day 8 of initiation of the empiric therapy, vs. 2/25 (8%) of the control group (P = 0.12). Survival rates at day 28 were not statistically significant among the two groups (15/22 (68%) vs 16/19 (84%), P = 0.12). The budget impact of using de-escalation was greatest, producing cost savings of $3,200 per patient but did not translate into significant clin-
ical and mycological success.

Conclusion. Critically ill patients who have received empiric antifungal therapy for documented candidemia and underwent de-escalation from echinocandins or lipo-
somal amboise B to fungostatin had a potential economic cost -benefit but did not associate with significantly improved clinical success rates.

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746. Improved Monitoring of Outpatient Parenteral Antimicrobial Therapy (OPAT) for Solid Tumor Patients at a Comprehensive Cancer Center

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Background. Increasing rates of antimicrobial resistance require more frequent parenteral antimicrobial therapy. OPAT improves patient quality of life and is cost-effective. Although IDSA OPAT guidelines are applied to cancer patients, few studies have addressed implementation in this unique population. Through our quality improvement project, we aimed to improve monitoring of solid tumor patients recommended for OPAT by infectious diseases (ID) consultation as measured by an increased percentage of patients with physician follow-up and laboratory monitoring.

Methods. We used the plan-do-study-act methodology to guide our quality im-
provement project. To establish baseline frequencies, we retrospectively reviewed a subset of solid tumor patients for ID consultation and recommended for OPAT. We used brainstorming, fishbone analysis, and process mapping to analyze our current process. We standardized a sign-off note for inclusion with OPAT recommendations within our electronic medical record. We reminded ID providers of the new process weekly and to notify the OPAT team and outpatient clinical nursing staff of OPAT-enrolled patients.

Results. We found that clarifying recommendations addressed several identified obstacles to monitoring. After instituting our intervention, the percentage of patients who completed follow-up increased from 44% to 78% during the 6-week intervention period. Although the frequency of laboratory monitoring recommendations increased from 43% to 86%, the percentage of patients completing such monitoring did not im-
prove. Our results were sustainable during the 3-month post-intervention follow-up.

Conclusion. By standardizing ID recommendations, we increased outpatient follow-up frequency. Our inability to increase the frequency of laboratory monitor-

ing likely reflects the increased complexity of the process, which requires action from external stakeholders. We learned that a simple intervention can have a meaningful impact and that gains can be limited without involvement of all stakeholders. We plan to expand to a comprehensive OPAT clinic for all patients at our facility and further characterize challenges and opportunities for utilizing OPAT in cancer patients.

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747. Implementation of a Pharamacist-led Intervention for Infectious Diseases Patients Discharged on Antimicrobials: The Infectious Diseases Discharge Outreach and Retention (ID DOOR) Program

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Background. Hospitalized patients who require Infectious Diseases (ID) consulta-
tive services and are discharged on antimicrobials (AM) are medically complex and at high risk of readmission. Complications related to AM toxicity, suboptimal regimen completion, or lack of AM access are prevalent. Our ID clinic pharmacist contacted patients with AM prior to discharge, within 72 hours of discharge to review patient needs such as AM access and management, toxicity monitoring, AM administration teaching, and to assess discharge care progression. The goal of this intervention was to leverage the subject matter expertise of an ID-trained pharmacist to create a protocolized intervention to improve the patient-to-outpatient transition for ID patients.

Methods. During a 12 week time period, 173 patients were identified and enrolled in the ID DOOR intervention. Patients who received consultation care by an ID physician were tracked and automatically referred to ID DOOR; those discharged on antimicrobials were included in the intervention group. Phone-based assessment of discharge AM access, education, and administration was initiated by the ID pharma-
cacist within 72 hours of discharge (Table 1).
Results. Of the 173 patients, 155 (90%) were successfully contacted post-discharge. The majority of needs identified were AM education, access, and coordination of care (Table 2). In addition, discrepancies between discharge orders, summary content, and patient instructions were prevalent. Based on the medication-related assessment performed by the ID-trained pharmacists, they were able to resolve AM-related issues and identify care gaps, and link patients to appropriate multidisciplinary providers to coordinate care plans.

Conclusion. The data highlight the prevalence of immediate post-discharge needs related to antimicrobial for patients and the critical role of ID-trained pharmacists in addressing these needs. In a large public academic medical center with uninsured and underinsured patients, additional support for AM access, education, and navigation of care plans is needed. For medically and socially complex ID patients, an ID-trained pharmacist plays a critical role in reducing risk inherent in the transition from inpatient to outpatient care.

Table 1. ID DOOR Program: Pharmacist Assessment Workflow

| Task                                      | Contact + intervention | Contact + no intervention | Unable to contact |
|-------------------------------------------|------------------------|---------------------------|-------------------|
| Assess antimicrobial drug-drug interactions in antibiotic treatment | 100%                   | 100%                      | 100%              |
| Assess antimicrobial antibiotic interactions | 93%                    | 62%                       | 18%               |
| Provide teaching about antimicrobial drug interactions | 95%                    | 95%                       | 95%               |
| Review pending culture results or other studies | 94%                    | 94%                       | 94%               |
| Perform medication review and confirm antimicrobial medications | 96%                    | 96%                       | 96%               |
| Ensure appropriate follow-up (including, but not limited to, follow-up of appointments related to the hospitalization) | 97%                    | 97%                       | 97%               |
| Discuss id plan of care as outlined in discharge summary | 100%                   | 100%                      | 100%              |
| Include care team members as approver (i.e., nursing for wound care team) | 99%                    | 99%                       | 99%               |

Table 2. Summary of ID DOOR Interventions: Patient needs and content

| Intervention content                  | Contact + intervention | Contact + no intervention | Unable to contact |
|---------------------------------------|------------------------|---------------------------|-------------------|
| Education (timings, interactions, indication) | 100%                   | 100%                      | 100%              |
| Side effects                           | 100%                   | 100%                      | 100%              |
| Corrected regimen                     | 100%                   | 100%                      | 100%              |
| Other questions about non-ID needs, medication, appointments | 100%                   | 100%                      | 100%              |

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748. Does Improving Discharge Documentation Improve Post-Discharge Care for Patients on Outpatient Parenteral Antimicrobial Therapy (OPAT)?
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Background. Patients discharged on intravenous antibiotics require regular monitoring by an infectious disease (ID) specialist or other provider familiar with outpatient parenteral antibiotic therapy (OPAT). However, the lab monitoring and outpatient follow-up plan outlined prior to discharge is not always realized. We are working to understand what steps the discharging hospital can take to improve the outpatient monitoring and follow-up for patients on OPAT, who are discharged to a wide variety of institutions. We studied whether documenting the OPAT plan in a standardized note led to increased inclusion of that plan in the discharge documentation and thus to improved lab monitoring and outpatient follow-up for our patients.

Methods. We collected the pre- and post-intervention frequency of seven key OPAT elements (antibiotic, duration, end date, indication, follow-up appointment, recommend labs, fax number for labs) in the discharge documentation. Pre-intervention, this information was documented by the inpatient ID service in the Problem List (overview) section of the electronic health record. Post-intervention, OPAT plans were documented within standardized OPAT Progress Notes. Efficiency and clinical outcomes were: proportion of OPAT treatment weeks with laboratory monitoring; number of weeks the outpatient ID team had to track down missing laboratory results; number of “No Show” ID clinic visits; number of OPAT-related telephone encounters.

Results. There were 73 patients in the pre- and 68 in the post-intervention cohort. A formal OPAT Progress Note was associated with a significant increase in the number of OPAT elements included in the discharge documentation (7 vs. 5, P = 0.002). In addition, the entire OPAT note was included in the discharge documentation more frequently in the post-intervention cohort (3/73 vs. 14/68, P = 0.007). However, except for reduced telephone encounters related to OPAT (2 vs. 1 per patient, P = 0.0001), there were no significant improvements in post-discharge clinical or efficiency outcomes.

Conclusion. Creating an OPAT Progress Note improves the capture of OPAT elements into discharge documentation. Except for reducing telephone encounters, no other benefits occurred. Future interventions will focus on improving the other measured outcomes.

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750. Serious Bacterial Infections: Successful Outpatient Management by Infectious Disease Physicians in Office Infusion Centers
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Background. Patients with serious bacterial infections (SBI), identified as bone and joint infections (BJI), bacteremia/endocarditis, and central nervous system (CNS) infections are frequently discharged on outpatient parenteral antimicrobial therapy (OPAT). They account for 48% of all infections treated in our network of Infectious Disease (ID) physician office infusion centers (POICs). Care for these patients poses risks and challenges to ensure safe and successful outcomes while avoiding hospitalizations. This study examines clinical outcomes and complications of our SBI patients receiving OPAT in ID POICs.

Methods. All patients were identified with SBI receiving OPAT in 2017 from 14 POICs. A group of 250 patients were randomly selected by incidence of diagnosis and a retrospective chart review performed. Demographics, treatment regimen, clinical

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749. Wide Variation in the Use of External Cooling Blankets Among Adult Intensive Care Unit Nurses for Fever
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Background. There are limited data on whether external cooling blankets (ECBs) are beneficial in the treatment of fever that is not related to malignant hyperthermia (MH). There are no established national guidelines for the use of ECBs for fever other than for MH. Thus, there may be a wide variation in nursing practice related to their use.

Methods. We performed a cross-sectional survey of adult intensive care unit (ICU) nurses at our hospital, using SurveyMonkeyTM, to evaluate nursing practices related to the use of ECBs in febrile patients other than MH. Data collected from the survey included years of experience as an ICU nurse, type of ICU, when ECBs are used and temperature of initiation and discontinuation. Continuous variables were compared using Student’s t-test and categorical variables were described as frequency distributions. Data were analyzed using SPSS v 25.0 and a P-value of 0.05 or less was considered to indicate statistical significance.

Results. We invited 150 nurses to participate in the survey, 61 responded (40.7%). The mean number of years worked in an ICU was 8.6 ± 9.4 years (range 1–34). 14 (23%) worked in a cardiovascular ICU (CVICU), 22 (36%) worked in a medical ICU (MICU), and 25 (41%) in a surgical ICU (SICU). A total of 58 (95.1%) of nurses reported using ECBs for fever, with 50 (82%) of nurses using ECBs only when other methods failed. MICU nurses (31.8%) were more likely to report using ECBs prior to failed attempt of other anti-pyrexia methods than SICU (16%) and CVICU (0.0%) nurses. There was no association between initiation and termination of ECB use by ICU type, years of nursing experience or a given range of temperature values.

Conclusion. There was a wide variation of practice among ICU nurses as it relates to the use of ECBs in patients with fevers. Medical ICU nurses tended to use ECBs before failure of other methods compared with other ICU nurses. Standardized protocols should be developed for their use based on existing medical literature. Further studies should be performed to confirm our findings.

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