**Session:** 225. Clinical Practice Issues: HIV, Septis, QI, Diagnosis
**Sunday, October 6, 2018, 12:30 PM**

**Background.** Pneumocystis jirovecii pneumonia (PJP) is an opportunistic infection associated with high dose steroid use in non-HIV patients. Many patients on high dose steroids (>20 mg prednisone equivalents for 28 days or longer), developed PJP within a month of steroid use. This study aims to develop an electronic alert for providers to consider PJP prophylaxis for patients discharged on high-dose steroids.

**Methods.** Cases were obtained from the University of Utah Enterprise Data Warehouse between October 2014 and September 2017. A retrospective, manual chart review evaluated adults 18 years of age or older, with an inpatient PJP diagnosis made via direct fluorescent antibody or PCR. Patients with PJP due to HIV were excluded. Steroid dose and duration one month prior to diagnosis of PJP were evaluated. After retrospective analysis, via a multidisciplinary team, a best practice advisory (BPA) alert was created to flag providers to consider PJP prophylaxis at discharge, with consideration of creatinine levels and allergy profile to guide drug choices. The alert was trialed in a silent mode from January to April 2018 without provider notification so it could be modified to prevent inappropriate firing. The alert was approved for live use by the Clinical Decision Support Committee and is now active in the University of Utah Epic system as of April 10, 2018.

**Results.** In retrospective analysis, of 94 non-HIV patients diagnosed with PJP, 31/94 (33%) cases were found to be in the setting of high dose steroids. 7/31 (23%) cases were exclusively with high dose steroids, while 24/31 (77%) cases were in combination with chemotherapy or other immune modulating agents. Data from the silent BPA from February to April 2018 demonstrated 23 cases triggered the alert, all of which were determined to be appropriate by chart review. Since live use, the BPA has fired 15 times, of which 14 cases met criteria for prophylaxis for and 4/14 (29%) resulted in prophylaxis on discharge.

**Conclusion.** Chart review identified high dose steroids as a target for a quality improvement intervention, which led to development of a BPA. Data indicates room for improvement on discharge with prophylaxis. Goals include reducing morbidity, mortality and cost associated with PJP as well as educating providers regarding the need for prophylaxis.

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

---

**Disclosures.** All authors: No reported disclosures.
1911. Implementation of Diabetes Medication Management by Pharmacists in a Multidisciplinary Limb-Salvage Clinic
Molly Rockstad, PharmD, BCS, RCPAC; Tomasz Jurga, PharmD; Sophia Choi, PA; and Kayatoun Rezaei, MD1; 2; John H. Stroger, Jr., Hospital of Cook County, Chicago, Illinois, Rush University Medical Center, Chicago, Illinois

Session: 225. Clinical Practice Issues: HIV, Sepsis, QI, Diagnosis
Saturday, October 6, 2018: 12:30 PM

Background. Diabetic foot infections (DFIs) require complex medical care. At our hospital, a team of Infectious Disease (ID) specialists assess all inpatients with DFIs and transition these patients (patients) to an outpatient clinic with an ID and Podiatrist team. Clinical pharmacists have now joined to provide diabetes (DM) medication management. The goal of this project is to demonstrate the need for DM care in a multidisciplinary limb-salvage clinic.

Methods. We performed a retrospective chart review of patients seen in the ID clinic September 2014–June 2015. DM medication management was implemented in August 2017. During clinic visits, the DM care plan is assessed for medication therapy problems related to indication, efficacy, safety, and adherence for all new DFIs. All findings and interventions are documented, discussed with the team and communicated to the patient’s primary care provider. Patients are followed at each visit to assess response to the intervention.

Results. Five hundred patients were seen in ID clinic in 2014–2015. One hundred twenty-three patients had DFIs. Ninety-four patients (76%) had uncontrolled DM defined as hemoglobin A1c (HbA1c) >7%. The mean baseline HbA1c was 10.13%. Fifty patients (41%) had an amputation prior to the initial clinic visit. Sixty-nine patients (56%) were reevaluated in clinic for recurrent DFI after clinic discharge with a mean time to revisit of 210 days. 54% of these patients developed infections in the opposite foot. Post-implementation, 30 patients were seen by clinical pharmacists with a mean time to revisit of 210 days. 54% of these patients developed infections in the opposite foot. Post-implementation, 30 patients were seen by clinical pharmacists between October 12, 2017 and April 26, 2018. All patients had uncontrolled DM with a mean baseline HbA1c >7%, 20 patients (66.66%) had at least one amputation prior to the initial clinic visit. Twenty-eight patients (93%) had ≥2 medication therapy problems requiring pharmacist intervention. All patients required self-management education. There was a trend toward improved control of DM with an average HbA1c of 7.48% in the 3 patients returning for 3-month follow-up visits. Incorporating DM management into the clinic visit was feasible and well accepted. We realized that incorporating DM management in a multidisciplinary approach to limb-salvage is an effective and easy way to manage DFIs and patients may benefit from reduction in readmissions and amputations.

Disclosures. All authors: No reported disclosures.

1912. Implementation of Sepsis-3 Definition in the Emergency Department
Parsi Maharom, MD, MPH1; Thammasin Inyiva, MD, PhD2; Sorapop Pakdeeewongse, MD1; Aungsumalin Tantimongkolsuk, MD1; 2; Somdech Phra Pinklao Hospital, Naval Medical Department, Bangkok, Thailand, 1Department of Family and Preventive Medicine, Faculty of Medicine, Prince of Songkla University, Songkhla, Thailand

Session: 225. Clinical Practice Issues: HIV, Sepsis, QI, Diagnosis
Saturday, October 6, 2018: 12:30 PM

Background. Sepsis is a major public health concern. Revised definitions of sepsis in 2016 from the systemic inflammatory response syndrome (SIRS) criteria to the Sequential Organ Failure Assessment (SOFA) score made management changes in the sepsis care process. One-hour bundle proposed by the Surviving Sepsis Campaign Bundle 2018 made the process more practically challenging because of its time-constraint.

Methods. We retrospectively reviewed medical records of patients aged over 15 who visited the emergency department (ED) and got admitted to the internal medicine department from January to February 2018 in Somdech Phra Pinklao Hospital. Our study excluded pregnant women and patients who died within 48 hours after the admission. Data needed to complete SIRS, SOFA and quick SOFA (qSOFA) score was collected. Patients’ diagnosis, treatments and in-hospital mortality were also reviewed.

Results. We identified 217 cases, excluding one pregnancy and five patients who died within 48 hours. Prevalence of sepsis was 45.9% from SIRS 2, 33.9% from SOFA2, and 11.8% from qSOFA2. Because the high number of missing PaO2/FiO2 (96/188, 51.1%), we also calculated adjusted SOFA by excluding the factor. Sensitivity of SOFA2 was 0.60 (0.49–0.70), specificity was 0.94 (0.88–0.98) and AUC was 0.77 (0.70–0.82), compared to SIRS. In-hospital mortality prediction using SIRS 2 had sensitivity of 0.78 (0.58–0.91), specificity of 0.38 (0.30–0.48), and AUC of 0.58 (0.49–0.67) while applying SOFA score ≥2 had sensitivity of 0.67 (0.46–0.83), specificity of 0.62 (0.52–0.70), and AUC of 0.64 (0.79–0.92). Two-step approach by screening patients who had SIRS 2 followed by detecting who had SOFA ≥2 had sensitivity of 0.81 (0.58–0.95), specificity of 0.46 (0.34–0.58), and AUC of 0.63 (0.53–0.74). No significant difference was found between applying adjusted or completed SOFA score. By using two-step approach, about 55% decrease in number of patients needed to complete the SOFA score.

Conclusion. Although SOFA score was a better diagnostic tool to detect sepsis than SIRS, applying the method for all patients in the ED is difficult to be practically implemented. We proposed two-step approach by using SIRS ≥2 followed by SOFA score ≥2 for sepsis case identification.

Disclosures. All authors: No reported disclosures.

1913. Clinical Performance of the qSOFA Score Among Non-ICU Inpatients With Infection at a Tertiary Hospital in Jamaica From 2015 to 2016
Schadé Stanton, MBBS1; Tamarah Thompson, RN, MBBS, DM2; and Trevor Ferguson, MBBS, DM, MSc1; 2Department of Medicine, University of the West Indies, Kingston 7, Jamaica, 3Tropical Medicine Research Institute, University of the West Indies, Kingston 7, Jamaica

Session: 225. Clinical Practice Issues: HIV, Sepsis, QI, Diagnosis
Saturday, October 6, 2018: 12:30 PM

Background. Sepsis is common and catastrophic. The usefulness of the qSOFA score has been questioned. Thus far, data on the validity of the instrument have been derived from developed countries. The generalizability to developing countries is unknown. This study aimed to ascertain how ‘qSOFA’ predicted death and need for intensive care in patients at a tertiary hospital in Jamaica.

Methods. Seven hundred fifty-two patients admitted between January 2015 and December 2016 with a physician determined diagnosis of infection were randomly selected from the electronic medical database. The details of the first 48 hours of their admission were reviewed.

Results. Most patients were middle-aged females who remained in hospital for an average of 9 days and were managed by Internal Medicine. Two of the most common sites of infection (respiratory and gastrointestinal) were also the two sites associated with the highest risk of death or requiring intensive care. 126 (17%) had a qSOFA score ≥2 at presentation, 4 (0.5%) persons died, and 32 (4%) required admission to ICU. Many more patients met the SIRS criteria than qSOFA at presentation (66% vs. 17%). Meeting the SIRS criteria, however, was not significantly associated with death or needing intensive care. On the other hand, those with a positive qSOFA at presentation were three times more likely to die or need intensive care (OR 3.03; 95% CI 1.1.89, P = 0.04). The qSOFA score detected these patients, with a high degree of specificity (84%), especially when utilized at presentation (OR 3.03; 95% CI 1.03–8.92, P = 0.04) and 48 hours after (OR 2.24, 95% CI 0.94–5.37, P = 0.07). The sensitivity of the qSOFA score was poor (39%), but this was improved to 100% when combined with the SIRS score at presentation. There was a suggestion that this combined score also offered the best prognostic accuracy with an AUROC of 0.74 (95% CI 0.66–0.81) when compared with the qSOFA score (AUROC = 0.68, 95% CI 0.60–0.76) or SIRS criteria alone (AUROC = 0.71, 95% CI 0.63–0.79). However, there was significant overlap of the curves and the differences were not significant.

Conclusion. Among non-ICU inpatients with infection, the qSOFA score is useful for predicting death and the need for ICU. However, its utility is improved when scored alongside and not instead of the SIRS criteria.

Disclosures. All authors: No reported disclosures.

1914. Adherence to the Sepsis Bundle in Hospital-Onset vs. Community-Onset Sepsis
Jonathan Baghdadi, MD1; Daniel Z. Uslan, MD, MS, FIDSA, FSHEA; Douglas Bell, MD, PhD1; and Mitchell Wong, MD, PhD2; 3Division of Infectious Diseases, David Geffen School of Medicine at UCLA, Los Angeles, California, 4Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine, Los Angeles, California, 5Division of General Internal Medicine and Health Services Research, UCLA, Los Angeles, California

Session: 225. Clinical Practice Issues: HIV, Sepsis, QI, Diagnosis
Saturday, October 6, 2018: 12:30 PM

Background. Every hour of delay between onset of sepsis and administration of the sepsis bundle increases sepsis mortality. Hospital-onset sepsis is known to have higher mortality than community-onset sepsis, but the differences in care between