The majority of patients were discharged to home (average 61.3% over 6 years). These findings show that a rural inpatient TM ID consult service can expand over time and is an effective alternative for hospitals without access to ID expertise.

Disclosures: John Mellors, MD, Abound Bio (Shareholder)Accelevir Diagnostics (Consultant)Co-Crystal Pharmaceuticals (Shareholder)Gilead (Consultant, Grant/Research Support)Merck (Consultant) Rima Abdel-Massih, MD, Infectious Disease Connect (Shareholder, Other Financial or Material Support, Chief Medical Officer)

125. Effect of Body Temperature Before Hospital Discharge on the Readmission Rate

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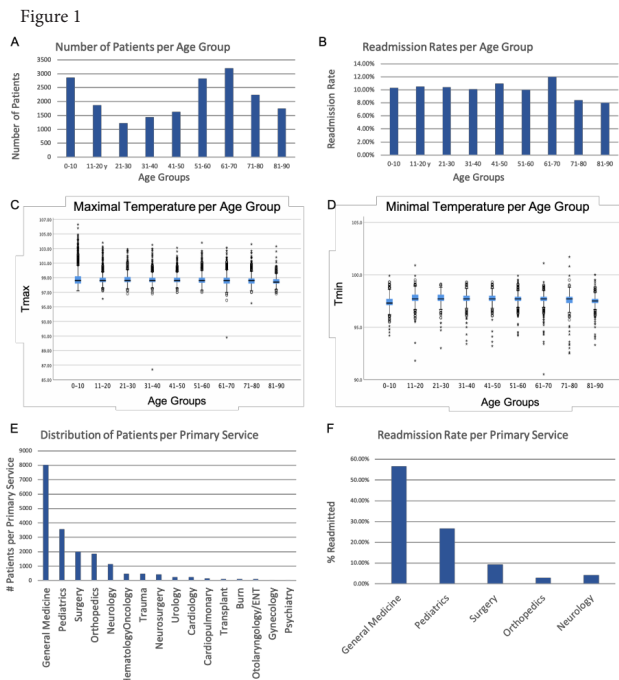
Session: O-24. Hot Issues in Clinical Practice

Background: One of the goals of the Affordable Care Act is to decrease readmission rates, which lead to wasting of resources and are associated with worse patient outcomes. While widely adhered to, there is no published research to support the practice of delaying discharge if the patient exhibits fever or hypothermia in the previous 24 hours. Our study quantifies the effect of abnormal body temperature before discharge on the readmission rate.

Methods: Retrospective analysis of the minimal (Tmin) and maximal (Tmax) body temperatures during the last 24 hrs before discharge of all patients over 1 year period from our tertiary medical center were analyzed with T-test, ANOVA, uni-and multivariate logistic regression. Fever was defined as Tmax > 100.2F(2SDs from mean Tmax), hypothermia as Tmin < 96.7F(2SDs from mean Tmin).

Results: Descriptive analysis of the data from 19,038 inpatients are featured in Table 1 and Figure 1. The overall readmission rate was 10.2% (highest for General Medicine and Pediatrics); 4.7% of patients had an abnormal temperature 24 hrs before discharge; body temperature declined with age. ANOVA showed that 1st, the average number of days to readmission was not different between those with fever, hypothermia, and normothermia (mean+/-SD: 10.6+/-8.6; 12.1+/-8.6; 12.5+/-8.1, respectively); 2nd that the rate of readmission was not different between these groups, although there was trend for higher readmission among normothermic patients (2.9%; 0.3%; 7%, respectively). Table 2 features regression analyses that model readmission. Univariate analysis revealed that higher Tmax and age are associated with lower readmission probability. Both uni- and multivariate analysis showed that the presence of fever is associated with lower readmission probability and that compared with General Medicine, the other major primary services have lower readmission probability, when correcting for all the other listed variables.

Table 1. Descriptive statistics	
Total # of patients studied	19038
% female	48.30%
Ages (mean +/- SD)	46.3+/-27.2
# readmitted (and % of total) within 30 days	1936 (10.2%)
# days between discharge and readmission (mean +/- SD)	12.5+/-8.2
Tmax (mean+/SD)	98.7+/-0.74
Tmax indicating fever at 2 SD from mean Tmax	100.2
Total # with fever using 2 SD (and % of total) from the mean Tmax	651 (3.4%)
Tmin (mean+/-SD)	97.6+/-0.49
Tmin indicating hypothermia at 2 SD from mean Tmin	96.7
Total # with hypothermia using 2 SD (and % of total) from the mean Tmin	244(1.3%)
Abbreviations: SD: standard deviation	

Figure 1

Figure 1

Table 2. Univariate and mutivariate regression analysis of readmission within 30 days after hospital discharge

	OR	p value	95% C.I.	adjusted OR	adjusted p value	95% C.I.
T max	0.936	0.049	[0.877-1.000]	1.044	0.409	[0.943-1.155]
T min	1.052	0.321	[0.952-1.163]	1.141	0.052	[0.999-1.304]
Presence of fever at 2SDs	0.683	0.006	[0.520-0.898]	0.625	0.018	[0.424-0.923]
Presence of hypothermia at 2SDs	1.134	0.56	[0.743-1.730]	0.985	0.952	[0.603-1.609]
Sex (male as reference)	1.068	0.172	[0.972-1.173]	1.075	0.172	[0.969-1.193]
Age	0.998	0.046	[0.997-1.000]	0.999	0.384	[0.996-1.002]
Primary service, compared against General Medicine						
Neurology	0.492	<0.001	[0.381-0.634]	0.486	<0.001	[0.377-0.628]
Orthopedics	0.211	<0.001	[0.158-0.283]	0.206	<0.001	[0.154-0.277]
Surgery	0.637	<0.001	[0.532-0.762]	0.623	<0.001	[0.518-0.750]
Pediatrics	1.069	0.284	[0.946-1.208]	1.029	0.772	[0.846-1.252]
Abbreviations: OR: odds ratio, C.I: confidence interval, SD: standard deviation; Highlighted cells: statistically significant data						

Conclusion: Our data clearly showed that abnormal body temperature measured within 24 hrs before discharge is not useful for predicting the chance for readmission. Therefore, delaying patients' discharge based on Tmax or Tmin alone, taken outside the specific clinical context, may lead to wasting of hospital resources.

Disclosures: All Authors: No reported disclosures

126. evaluation of Addition of Outpatient Parenteral Antimicrobial Therapy and Orthopedic ID Resources to Transitions-of-care Outcomes

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Session: O-24. Hot Issues in Clinical Practice

Background: Our large academic medical center initiated both an Outpatient Parenteral Antimicrobial Therapy (OPAT) program supported by an infectious disease trained pharmacist, along with an Orthopedic Infectious Disease (OID) consult service to assist in caring for these specialized populations. We measured the impact of these services.

Methods: Patients discharged on parenteral antimicrobial therapy were divided into two groups. The pre-OPAT cohort included all patient receiving OPAT from 4/1/18 - 10/31/18; the post-OPAT cohort included all patients who received OPAT from 4/1/19 - 10/31/19 with OPAT consult (Fig 1). The OID consult service began in September 2018 prior to initiation of the OPAT program. The primary outcome was 30-day hospital readmission. Secondary outcomes included: length of stay (LOS), 90-day readmission, clinical outcomes, and identification of predictors of hospital readmission. Clinical outcomes included: time from final OR visit to discharge for OID patients and optimal treatment (cefazolin, oxacillin, or nafcillin) for MSSA.

Figure 1: Enrollment for the pre-OPAT and post-OPAT cohort
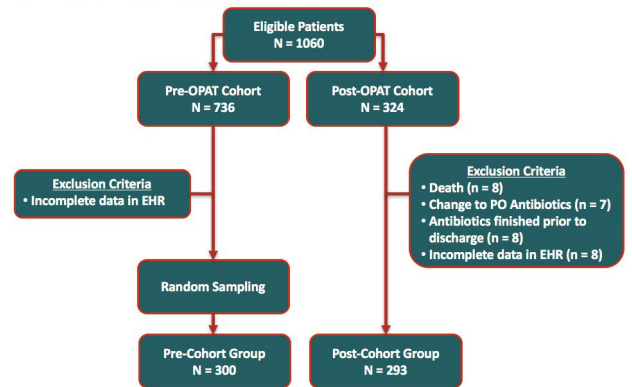
Figure 2: Enrollment for the Orthopedic Indication Subgroup
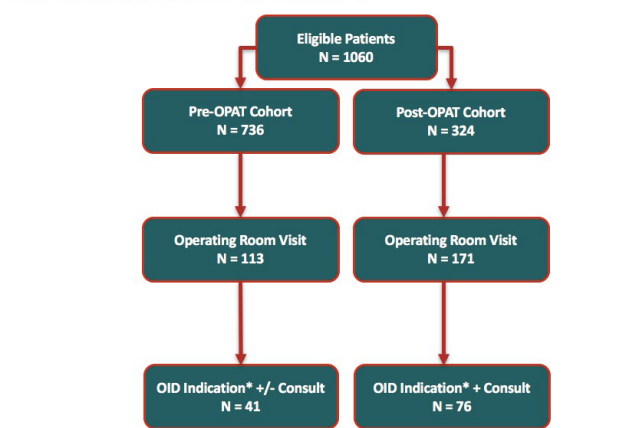
*OID Indication: Osteomyelitis, Prosthetic Joint Infection, or Septic Arthritis

Results: Introduction of these programs was associated with a reduction in all-cause 30-day readmission from 39.3% to 22.9%, and a reduction in 30-day readmission for patients on-treatment from 24.6% to 15.6% (p< 0.01 for both). No difference was seen in hospital LOS (8 days in each cohort). In a subgroup analysis (Fig 2), OID patients in the post-OPAT cohort saw a median reduction of 2 days (7 days to 5 days, p=0.002) in time from final OR visit to discharge. Use of optimal treatments for MSSA increased in the post-OPAT cohort compared to pre-OPAT (65.2% to 80.9%; p=0.06). The 90-day hospital readmission rate were higher in the post-OPAT cohort among patients who lived in metro-area zip codes (p=0.03). Having an established primary care physician was associated with lower 90-day hospital readmission in both the pre- and post-OPAT cohorts (p=0.05 and 0.01, respectively).

Conclusion: Thirty-day readmission rates among patients discharged on OPAT significantly lowered following initiation of a combination of both a pharmacist-led OPAT program and OID consult service. OPAT and OID programs accrue additional efficiencies and clinical benefits to both patients and hospitals, which can be further evaluated and used to justify such service additions.

Disclosures: **All Authors**: No reported disclosures

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127. walking to the Virtual Era. Analysis of the Telehealth Experience in the Infectious Diseases Clinic During the COVID Pandemic

Karen L. Carvajal, MD[1]; Prishanya Pillai, MD[2]; Angelina Winbush, BS[1]; Rupinder mangat, MD[1]; Ted Louie, MD[1]; [1]University of Rochester, Rochestser, New York; [2]Universitty of Rochester, ROCHESTER, New York

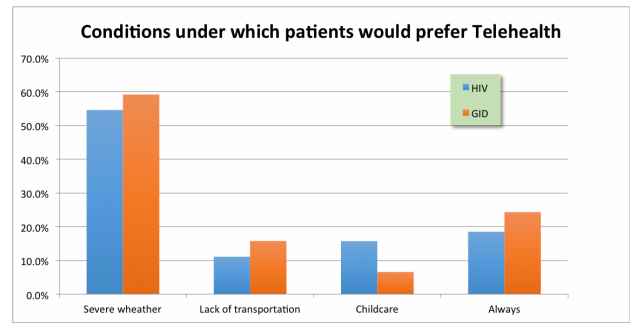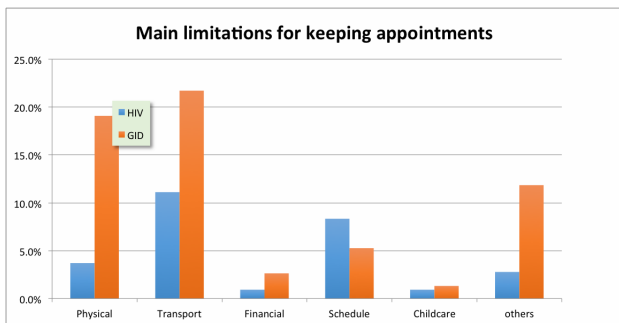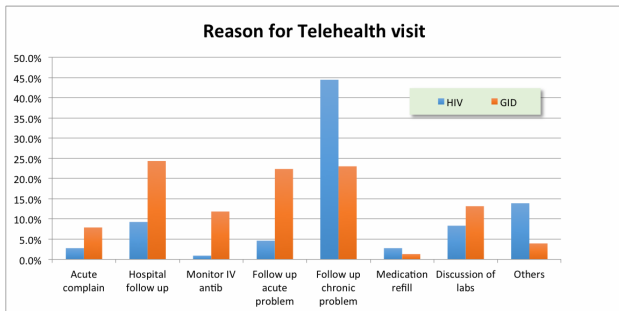**Session:** O-24. Hot Issues in Clinical Practice

Background: The COVID pandemic has changed and will continue changing the way we practice medicine. We sought to investigate the impact of telehealth (TH) in the delivery of healthcare in the general infectious diseases (GID), and HIV clinic during the COVID pandemic.

The University of Rochester Medical Center is a major tertiary care and referral center for ID in upstate New York. From March through May of 2020, the clinics were closed, and nearly all visits were conducted by TH.

Methods: We surveyed (either by telephone or online) a total of 260 patients who participated in TH visits, with a mean age of 56 years in the HIV group and 59 years in the GID group. With a predominance of 62.8 of males v/s 37.2 of females.

We collected information regarding the reason for the TH visits, access to technology, patient satisfaction, and preferences over in-person visits. We obtained the volume and no-show rate from prior years through EPIC. We evaluated compliance between in-person and TH visits using statistical analysis.

Results: We found 93.4% of GID and 84.3% of HIV patients surveyed, either strongly agreed or somewhat agreed that their TH visit was as satisfactory as a clinic visit. 67.5% of GID and 63% of HIV patients agreed that the option of TH would increase their compliance rate in the future. The no-show rate during the TH period in the HIV group decreased from 23% to 5% compared to the previous year, while the no-show rate in GID decreased from 9% to 4%. These results were statistically significant with a P-value < 0.005 in both groups.

Reason for Telehealth visit

Main limitations for keeping appointments

Conditions under which patients would prefer Telehealth

Conclusion: GID patients were more likely to have TH for hospital follow-up, follow-up of acute problems, and outpatient antibiotic therapy, compared to HIV patients, who more often had TH for chronic problems. GID patients were more likely to have the capability for televideo visits when compared to the HIV group, although this was not statistically significant. TH was statistically significant in improving patient compliance with appointments in both the HIV and ID clinics. Patients were overall highly satisfied with their TH experience and many patients also reported that continued availability of telemedicine would improve their compliance with appointments.

Comparison of the rate of non-compliance with appointments
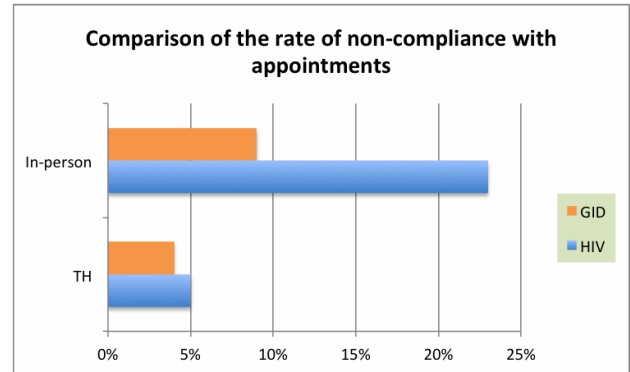
Disclosures: **All Authors**: No reported disclosures

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128. Characteristics and Outcomes of Pregnant Women Hospitalized with Influenza in the United States, Flusurv-net, 2010–2019

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Session: O-25. Hot Topics in Bacteria and Viral Infections

Background: Pregnant women are at high-risk for influenza-associated hospitalization. We used data from the U.S. Influenza Hospitalization Surveillance Network (FluSurv-NET) to characterize pregnant women hospitalized with influenza.

Methods: We included pregnant women (15–44 years) residing within a FluSurv-NET catchment area and hospitalized with laboratory-confirmed influenza between October 1 and April 30, during the 2010–19 influenza seasons. Clinical data were obtained on cases through medical chart abstraction. We examined trends in vaccination coverage and antiviral treatment using the Cochran-Armitage test for trend and characterized maternal interventions and maternal and fetal outcomes during hospitalization.

Results: Of 9,652 women aged 15–44 years hospitalized with influenza, 2,697 (28%) were pregnant. Median maternal age was 28 years and median gestational age was 32 weeks; 36% were non-Hispanic white, 29% non-Hispanic black, and 20%