Table 1. Framework for classifying consults into 7 types

| Consult Type       | Description                                                                 |
|--------------------|-----------------------------------------------------------------------------|
| Ideal Consult      | Concerns a clinically significant illness that undoubtedly falls within the expertise of the consultant |
| Obligatory Consult | Consult obligated by hospital policy                                         |
| Procedural Consult | Consult for procedural assistance                                           |
| SOS Consult        | Primary team requests assistance with diagnosis or management of a complicated or sick patient in the absence of clear question |
| Confirmatory Consult | Caller seeks to confirm the existing clinical plan                          |
| Inappropriate Consult | Consults that may inappropriately affect the patient or not contribute meaningfully to care |
| Curbside Consult   | Clinical question without expectation to see the patient, document recommendations, or submit a bill |

Methods. A randomly selected sample of 100 de-identified infectious diseases (ID) consult requests from a single academic center were independently coded as 1 of the 7 consultation types by 3 ID specialists and 3 hospitalists. Perfect concordance (6/6 coders) and partial concordance (4/6 or 5/6 coders) was calculated. Total (3/3 coders) and partial (2/3 coders) concordance based on consult subtype and provider specialty was also calculated. We compared proportions between groups using a chi square test.

Results. Perfect concordance was 30%, and partial concordance was 60% (Figure 1). Total concordance among ID specialists was 44% and among hospitalists was 54% (Table 2). In cases without perfect concordance (n=70), ID specialists had 20% total concordance and 70% partial concordance, while hospitalists had 34% total concordance and 59% partial concordance. ID specialists were less likely than hospitalists to have perfect concordance for ideal consults (52% vs 73%, P=0.001). ID specialists and hospitalists were similarly likely to classify a consult as ideal (65% vs 69%, P=0.34), but ID specialists were less likely than hospitalists to classify a consult as S.O.S (25% vs 17%, P=0.02), and hospitalists were similarly likely to classify a consult as ideal (65% vs 69%, P=0.34), but have perfect concordance for ideal consults (52% vs 73%, P=0.01). ID specialists and hospitalists had 34% total concordance and 70% partial concordance, while hospitalists had 34% total concordance and 70% partial concordance, while hospitalists had 34% total concordance and 70% partial concordance. ID specialists were less likely than hospitalists to have perfect concordance for ideal consults (52% vs 73%, P=0.001). ID specialists and hospitalists were similarly likely to classify a consult as ideal (65% vs 69%, P=0.34), but ID specialists were more likely to classify a consult as S.O.S (25% vs 17%, P=0.02), and less likely to classify a consult as S.O.S. (5% vs 7%, P=0.02) (Table 3).

Table 2. Concurrency by consult type stratified among infectious disease specialists and hospitalists

| Consult Type       | Perfect concordance | Partial concordance | Discordant |
|--------------------|---------------------|---------------------|------------|
| Overall (n=100)    | ID                  | Hos                  | ID         |
| Ideal (n=17)       | 18 (70)             | 11 (33)             | 3 (11)     |
| S.O.S (n=32)       | 25 (78)             | 13 (41)             | 2 (6.3)    |
| Obligatory (n=10)  | 12 (60)             | 9 (45)              | 2 (10)     |
| Confirmatory (n=2) | 2 (100)             | 0 (0)               | 0 (0)      |
| Procedural (n=4)   | 4 (100)             | 0 (0)               | 0 (0)      |
| Curbside (n=10)    | 1 (100)             | 0 (0)               | 0 (0)      |
| Inappropriate (n=1) | 1 (100)             | 0 (0)               | 0 (0)      |

Results. To the date, the 9 activities have reached over 24,000 physicians. Selected improvements in knowledge and competence measured as relative % change in correct responses pre/post education across the learning themes are reported here. (i) 45% improvement in PCPs and a 31% improvement in ID specialists’ knowledge/competence in identifying patients who would benefit from mAbs (P < .01). (ii) 83% improvement in PCPs and a 42% improvement in ID specialists’ confidence in identifying patients who would benefit from mAbs (P < .01). (iii) 15% improvement in ID specialists’ knowledge/competence on the clinical data on mAbs for COVID-19 (P < .01). (iv) 32% improvement in PCPs’ knowledge/competence in understanding the mechanism of action (MOA) of mAbs for COVID-19 (P < .001).

Conclusion. This series of online, CME-certified educational activities delivered in multiple formats resulted in significant improvements in knowledge and competence regarding the management of patients with mild to moderate COVID-19. This analysis also uncovered remaining educational gaps; 55% of content related to identifying patients who would benefit from mAbs was not retained post-education.

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Table 3. Consult type by physician subspecialty, among infectious disease specialists and hospitalists

| Consult type       | Infectious disease n=300 | Hospitalists n=300 |
|--------------------|--------------------------|--------------------|
| Ideal              | 196 (65.3)               | 207 (69.0)          |
| S.O.S              | 74 (24.7)                | 51 (17.0)           |
| Obligatory         | 19 (6.3)                 | 18 (6.0)            |
| Confirmatory       | 10 (3.3)                 | 23 (7.7)            |
| Procedural         | --                       | --                 |
| Curbside           | --                       | --                 |
| Inappropriate      | 1 (0.3)                  | 1 (0.3)             |

Data are shown as n (%) concordant within consult subtype.

Conclusion. ID consults can be classified into a novel rubric of 7 subtypes. Overall, partial or perfect concordance between hospitalists and ID consultants was 90%. ID specialists were more likely to classify consult requests as S.O.S than hospitalists, and hospitalists were more likely to classify consults as confirmatory. Opportunities exist to utilize the rubric to improve provider communication and interprofessional education.

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954. Resources Needed by Critical Access Hospitals to Address Identified Infection Prevention and Control Program Gaps

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Background. Critical Access Hospitals (CAH) may face challenges with limited resources in their infection prevention and control (IPC) program. As part of the Project Firstline collaborative, the University of Nebraska Medical Center and its clinical partner Nebraska Medicine sought to identify needs and develop resources to strengthen IPC program gaps in small and rural hospitals, including CAHs. Since, little is known about the resources needed by CAHs to strengthen their IPC program, a needs assessment survey was deployed to Federal Emergency Management Agency Region VII CAHs.

Methods. A 49-question Research Electronic Data Capture (REDCap) survey was distributed via email to infection preventionists in Region VII CAHs. The survey had 4 sections with questions focused on IPC program infrastructure, competency-based training, audit and feedback, and identification and isolation of high-risk pathogens/serious communicable diseases. An IPC practice score was assigned to each CAH based on the responses pre/post education across the learning themes are reported here. (i) 45% improvement in PCPs and a 31% improvement in ID specialists’ knowledge/competence in identifying patients who would benefit from mAbs (P < .01). (ii) 83% improvement in PCPs and a 42% improvement in ID specialists’ confidence in identifying patients who would benefit from mAbs (P < .01). (iii) 15% improvement in ID specialists’ knowledge/competence on the clinical data on mAbs for COVID-19 (P < .01). (iv) 32% improvement in PCPs’ knowledge/competence in understanding the mechanism of action (MOA) of mAbs for COVID-19 (P < .001).

Conclusion. This series of online, CME-certified educational activities delivered in multiple formats resulted in significant improvements in knowledge and competence regarding the management of patients with mild to moderate COVID-19. This analysis also uncovered remaining educational gaps; 55% of content related to identifying patients who would benefit from mAbs was not retained post-education.

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953. Online Medical Education Improves Knowledge of Monoclonal Antibody Treatment for COVID-19 Among Physicians

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Methods. The educational series consisted of 9 online, CME activities in multiple formats. At the individual activity level, educational effect was assessed with a repeated paired pre-/post-assessment study including a 3-item, multiple choice, knowledge/competence questionnaire and one confidence assessment question, with each participant serving as his/her own control. To assess changes in knowledge, competence, and confidence data from all clinicians who completed both pre- and post-questions were aggregated across activities and strata grouped by learning themes. McNemar’s test (P < .05) assessed educational effect. Data were collected from 12/20 to 5/21.

Results. To the date, the 9 activities have reached over 24,000 physicians. Selected improvements in knowledge and competence measured as relative % change in correct responses pre/post education across the learning themes are reported here. (i) 45% improvement in PCPs and a 31% improvement in ID specialists’ knowledge/competence in identifying patients who would benefit from mAbs (P < .01). (ii) 83% improvement in PCPs and a 42% improvement in ID specialists’ confidence in identifying patients who would benefit from mAbs (P < .01). (iii) 15% improvement in ID specialists’ knowledge/competence on the clinical data on mAbs for COVID-19 (P < .01). (iv) 32% improvement in PCPs’ knowledge/competence in understanding the mechanism of action (MOA) of mAbs for COVID-19 (P < .001).

Conclusion. The series of online, CME-certified educational activities delivered in multiple formats resulted in significant improvements in knowledge and competence regarding the management of patients with mild to moderate COVID-19. This analysis also uncovered remaining educational gaps; 55% of content related to identifying patients who would benefit from mAbs was not retained post-education.

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