Background. Our infectious disease fellows rarely see follow-up patients. Yet longitudinal patient care teaches the fellow how to approach chronic illnesses, continued clinical decline, and adverse effects of antimicrobial therapy. Fellows at our institution typically rotate with a different faculty member every 1–2 weeks. Follow-up visits are scheduled with the faculty member. While this model exposes the fellow to a variety of cases and management styles, it limits fellow follow-up opportunities. We developed a model to solve this problem.

Methods. The Mentor Model involves 12-week blocks during which the fellow and a faculty member share the same schedule, facilitating fellow participation in post-discharge visits, re-consultations, and repeat outpatient appointments. We queried our electronic medical record for a list of all consult notes written by fellows during both Mentor Model and traditional (non-Mentor Model) blocks. The number of repeat encounters, or evaluations of an established patient, were tallied and divided by the number of total encounters to determine each fellow’s follow-up rate. This value was compared between Mentor Model and non-Mentor Model blocks.

Results. Historically, our fellows have reported 1–2 follow-ups each over the course of his or her training. Four first-year fellows rotated through two Mentor Model blocks totaling 23 weeks and several non-Mentor Model blocks totaling 14 weeks within the study period. Fellow follow-up rates ranged from 5–12% during non-Mentor Model blocks. One fellow demonstrated increased rates during the first Mentor Model block (5% vs. 9%) and three demonstrated increased rates during the second Mentor Model block (5–11% vs. 9–18%). The most encounters noted for a single patient was five. The majority of repeat encounters occurred in the outpatient setting.

Conclusion. We describe a rotation model designed to improve continuity of patient care among first-year Infectious Disease fellows at our institution. Compared with our previous rotation schedule, the Mentor Model increased fellow follow-ups. Structural changes to promote longitudinal patient care experiences are described in outpatient-heavy training programs. Further interventions to improve fellow follow-up rates in all training programs are merited.

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Table 1: List of 12 Objectives Meeting Consensus Criteria for Inclusion

| Objective | Mean Rating | % Rating ≥4 |
|-----------|-------------|-------------|
| Background | 4.23 | 86 |
| Intervet local epidemiologic data or antibiograms to determine local rates of AMR infections | 4.33 | 86 |
| List key risk factors for drug-resistant infection | 4.19 | 86 |
| Describe factors that may lead to unnecessary antibiotic prescribing by healthcare providers | 4.00 | 86 |
| Describe the types of precautions needed/infection control measures for AMR organisms | 3.76 | 50 |
| Diagonsis | 3.66 | 50 |
| Treatment | 3.30 | 50 |
| Identify infections that do not require antibiotic therapy | 4.60 | 70 |
| Recognize that treatment of infections may require both antibiotic therapy and source control | 4.86 | 70 |
| Recognize the concept of using the narrowest spectrum antibiotic for the shortest period of time | 4.86 | 70 |
| Utilize the local (and regional, if available) microbiology lab to help interpret patient test results | 4.38 | 50 |
| List resources that can be useful in the treatment of patients with AMR infections | 3.41 | 50 |

2548. Provider Adherence to Cervical Cancer Screening in HIV Patient Populations

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Session: 266. Medical Education: Medical School to Practice

Saturday, October 5, 2019: 12:15 PM

Background. Antiretroviral therapy has nearly normalized the life expectancy of people living with HIV (PLWH). However, malignancies still remain a major cause of morbidity and mortality in PLWH, and thus an important part of the clinical visit is age appropriate screening and referral to care, from Lancet 2019 for the poster. Most cases of cervical cancer occur in women who were either never screened or were screened inadequately. Over-screening for cervical cancer, on the other hand, leads to unnecessary stress and procedures, adding increased costs to the patient and to the healthcare system. The central aim of this project is to evaluate provider adherence at the Immunology Center (IC) to cervical cancer screening guidelines and to identify factors associated with over and underscreening.

Methods. A retrospective chart review from January 1, 2015, to December 31, 2017 was performed. Study included HIV-seropositive women seen at the IC between April 2014 and June 2018. Exclusion criteria includes prior hysterectomy, abnormal cytology, cervical excision procedures, or other causes of immunosuppression.

Results. Of the 803 HIV-positive women identified, n = 262 met criteria for inclusion in the study. Overall adherence was 48%, with statistical significance found in cervical cancer screening between MDs and NPs, with an OR = 2.51 (P < 0.01). In regard to gender of provider, statistical significance in over screening was found between male and female providers, with an OR = 4.3 (P < 0.01), and in under screening between male and female providers, with an OR = 0.43 (P < 0.05). Over screening led to 44 excess pap smears over a 2-year period, yielding an excess cost of $6461. HPV co-testing was underutilized, with only one-third of encounters having HPV testing performed.

Conclusion. This project gives us the opportunity to reeducate and retrain the clinical staff and practitioners providing cervical cancer screening at the Immunology Center. This is an ongoing quality improvement project, where adherence will be reassessed on a continuous basis at one-year intervals to ensure compliance with guidelines-based cervical cancer screening among female HIV seropositive patients at the Immunology Center.

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266. Medical Education: Medical School to Practice

Saturday, October 5, 2019: 12:15 PM

Background. Antimicrobial resistance (AMR) is a global public health problem, but the learning needs of the medical profession on this topic are not well understood. The World Health Organization has called for better educational resources on AMR. Thus, we aimed to identify AMR learning objectives for physicians and medical trainees.

Methods. We designed a modified, two-round Delphi process to build consensus around these objectives, recruiting attendees at a one-day, multidisciplinary, international AMR symposium. Through review of the literature and discussion with experts in AMR, we generated an initial list of 17 objectives. We asked participants to rate the importance of including each objective in an AMR curriculum for physicians and medical trainees.

Results. The first round was completed by 30 participants, and the second by 21. Nobody declined to participate, but several people had to leave between rounds. Participants included physicians, researchers, graduate students, and a pharmacist, foundation manager, patient advocate, leader of an international financial institution, health administrator, and biomedical scientist. After the first round, 16 objectives met the consensus criteria, and participants suggested five additional topics. After the second round, 12 objectives met the consensus criteria (see Table 1). Objectives related to treatment of AMR most frequently met consensus criteria. Specific objectives with the highest consensus ratings were related to identifying infections not requiring antibiotics and recognizing the importance of using the narrowest spectrum antibiotic for the shortest period of time.

Conclusion. We successfully employed a modified, one-day Delphi process at an international, multidisciplinary AMR symposium to build consensus among experts and stakeholders regarding key learning objectives for AMR. This technique may be useful for guideline committees and other task forces in the Infectious Diseases community. Our generated list may be useful for those developing AMR training materials for medical students and physicians.

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2549. Variance Between Clinicians and Guidelines in Management of HIV/HCV Coinfection
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Session: 266. Medical Education: Medical School to Practice Saturday, October 5, 2019: 12:15 PM

Background. Clinicians often encounter patients requiring simultaneous treatment for both HIV and HCV. Although several resources help clinicians identify potential drug interactions, these resources do not account for other factors that should be considered when selecting HIV and HCV regimens, such as renal function, HLA-B*5701 status, and HCV genotype. We developed an online decision support tool based on HIV and HCV guideline recommendations. We report data comparing guideline recommendations with the initial treatment plans of clinicians using the tool.

Methods. In May 2018, American Association for the Study of Liver Diseases (AASLD)/IDSA and DHHS treatment recommendations were applied to 304 unique HIV/HCV coinfection case scenarios based on a simplified set of patient variables: current ART status, HIV/HCV genotypes, liver histology, renal function, and HLA-B*5701 status. We then developed an online decision support tool that enables clinicians to specify a patient scenario using these variables. After clinicians select their currently intended HIV and HCV treatment from among the guideline-recommended first-line options, guideline recommendations for that specific patient case are shown, and clinicians are asked if this information changed their treatment plan.

Results. From August 2018 to March 2019, 505 participants (n = 303 ID/HIV, n = 68 hepatology/GI, n = 58 IM/FP/GP/addiction, n = 76 other; n = 229 North America, n = 118 Europe) entered 694 patient case scenarios in the HIV/HCV coinfection tool. In 36% of patient case scenarios (248/694), clinicians were unsure or were planning a treatment not recommended by guidelines. All treatment choices that were inconsistent with guidelines are shown in the table. Not all clinicians self-identified the impact of the tool, but in the subset of 174 patient case scenarios where they did, 47 identified their initial treatment plan as different from the guidelines. Of these, 32% (15/47) changed their treatment plan based on the recommendations, 40% (19/47) had barriers to implementing the recommendations, and clinicians were still undecided, 23% (11/47) were still undecided, 4% (2/47) disagreed with the recommendations.

Conclusion. This online treatment decision support tool shows substantial variability between clinicians’ treatment plans and HIV and HCV guideline recommendations for 36% of case scenarios.

2550. A Meeting of the Minds Over Matters of the Heart: Using Interdisciplinary Education to Build Consensus in Managing Cardiac Implantable Electronic Device (CIED) Infections
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Session: 266. Medical Education: Medical School to Practice Saturday, October 5, 2019: 12:15 PM

Background. CIED infections carry significant morbidity and mortality. Guidelines differ in management recommendations for CIED infections, which can result in a lack of consensus amongst Infectious Disease (ID) and Cardiology providers caring for these patients. We sought to identify areas of disagreement and consensus in the management of CIED infections amongst ID and Cardiology providers at an academic medical center. We used these data as a needs assessment to develop an interdisciplinary educational intervention focused on standardizing our institutional approach toward CIED infections, to create an internal guideline and to develop a new multidisciplinary team (MDT) for assistance managing complex patients hospitalized with CIED infections.

Methods. A pre-intervention survey was delivered to advanced practitioner providers, fellows and faculty of the divisions of Cardiology, Electrophysiology (EP) and ID to assess content knowledge in the diagnosis and management of CIED infections, attitudes toward the formation of a MDT, and perception of the degree of consensus amongst these specialty providers.

Results. The survey was sent to 206 providers, 40 (19.4%) participated. Only 16/40 (40%) agreed that there was consensus within the ID division in managing patients with CIED infections, 7/40 (20%) agreed that there was consensus amongst Cardiology and EP providers. 37/40 (92.5%) agreed that a MDT approach would be beneficial. Some survey responses diverged significantly from guideline recommended management strategies, including only 50% of respondents recommending CIED extraction for devices eroding through the skin. For patients with CIED-related endocarditis, 35% recommended delaying reimplantation of a new CIED until completion of a full course of antibiotics, despite guideline recommendations of significantly shorter delays.

Conclusion. Our survey revealed a striking lack of consensus amongst ID and Cardiology providers in the appropriate diagnosis and management of CIED infections, along with divergence from guideline recommendations in key areas. An interdisciplinary educational intervention to update provider content knowledge and unify interprofessional approaches could improve collaborative efforts and, ultimately, care of patients with CIED infections.

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2551. Optimizing Rounding Efficiency on the Infectious Diseases Inpatient Service: A Multi-Generational Conversation
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Session: 266. Medical Education: Medical School to Practice Saturday, October 5, 2019: 12:15 PM

Background. To optimize faculty and trainee wellness without compromising patient care and trainee education, it is important to develop efficient team rounding strategies. This quality improvement project describes rounding practices and suggestions for optimizing rounding efficiency on Infectious Diseases (ID) inpatient consult services at a large academic institution.

Methods. An anonymous survey on rounding strategies was distributed to the ID Section at Baylor College of Medicine in February 2019 as part of a facilitated discussion on optimizing clinical education for fellows.

Results. Twenty-seven members of the ID section completed the survey (17 faculty, 10 fellows). Fellows reported rounding for a median of 4 hours per day (range 3–5), while faculty reported 4.5 hours (range 2.5–5.5). When asked what time rounds should start their workday, the median response was 7:30 am from both fellows (range 7–8 am) and faculty (range 7–8 am). When asked what time fellows should end their work day, the median response was 5:30 pm from both fellows (range 5–6 pm) and faculty (range 5–7 pm). Fellows reported signing their last note at 5:30 pm (range 5–9 pm), vs. 9 pm for faculty (range 6–11 pm). Regarding rounding method, most fellows (80% of fellows and 77% of faculty) preferred a combination of traditional rounding at patient bedside and “table” rounds. Regarding teaching method, most faculty (64%) preferred bedside teaching, while most fellows (60%) preferred additional rounding at patient bedside and “table” rounds. Regarding teaching method, most faculty (64%) preferred bedside teaching, while most fellows (60%) preferred teaching presentations in the work room (P = 0.011, Fisher’s exact). Both fellows and faculty had many suggestions for optimizing rounding efficiency; the most common was to avoid having fellows see all patients twice daily (“double rounding,” suggested by 80% of fellows and 30% of faculty).

Conclusion. Overall, the reported behaviors of fellows regarding the structure of their daily inpatient ID services coincided with faculty expectations, although preferences differed between fellows and faculty regarding teaching methods. Avoiding “double rounding” was the most common suggestion to optimize efficiency. Larger studies are needed to better understand rounding behavior and strategies that will optimize the efficiency and effectiveness of inpatient ID consult teams.

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