Table 3. Summary of Outcomes, n =63

		All 4 interventions	<4 interventions	p-value
Clinical cure	Yes	14 (54%)	12 (46%)	P=0.03
	No	10 (27%)	27 (73%)	
OPAT Completion	Yes	15 (48%)	16 (52%)	P=0.098
	No	9 (28%)	23 (72%)	
Retention in MOUD treatment at 30 days	Yes	19 (54%)	16 (46%)	P=0.003
	No	5 (18%)	23 (82%)	

Conclusion: Patients discharged to medical respite who received the combination of ID consult, Addiction consult, case management and/or mental health, and MOUD had higher rates of clinical cure compared to those who did not receive all four interventions. Developing a patient-centered comprehensive care plan, including ongoing support and access to MOUD should be a priority to ensure successful treatment of infections.

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617. Physician Perspective: Utilization of Advanced Practice Providers (APPs) in the ID Workforce

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Background: Applicants entering Infectious Disease (ID) fellowships are declining and shortages of ID physicians is a challenge recognized by the clinical workforce and Infectious Diseases Society of America (IDSA). There is increased awareness of more Advanced Practice Providers (APPs) being used within ID to expand and extend existing practices. However, little is known about APP utilization, APP clinical scope of practice, specific roles, and opportunities for education.

Methods: To evaluate physician perspectives on APP utilization in ID, we created an anonymous and voluntary survey using the REDCap data tool that was distributed by social media, key stakeholder emails, and IDSA online community forum between 12/1/2019-1/31/2020. In addition to collecting geographic information and the type of ID practice, participants were also surveyed about the use of APPs and any perceived barriers that may limit their use.

Results: 218 practicing ID physicians responded to the survey (Figure 1). 155 (71%) physicians work with APPs in their current practice (Figure 2); specifically, 56 (27%) with 1 APP, 62 (30%) with 2-4 APPs, 28 (13%) with 5-9 APPs, and 11 (5%) with > 10 APPs. Of respondents, 104 (48%) practiced at University/Medical schools, 80 (37%) in hospitals/clinics, and 28 (13%) in private practice (Table 1); most work in adult inpatient/outpatient ID. The main reasons selected by respondents for not using APPs in their practice included concerns around a lack of formal ID training 22 (15%), lack of time/lack of ability to assist with APP training 29 (20%), practice is already sufficiently staffed 19 (13%), and concern for physician revenue loss 16 (11%) (Table 1).

Figure 1. Physician Responses by Region, n = 218

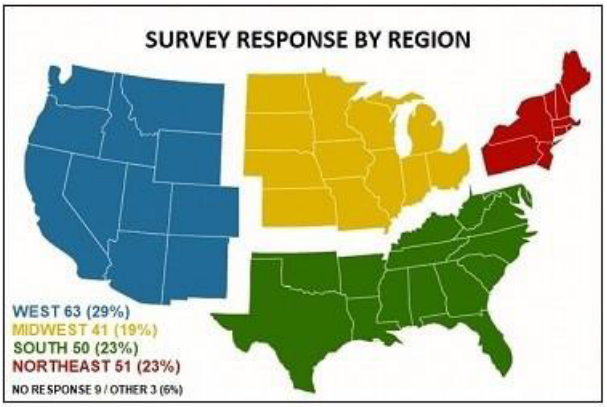

Figure 2. Physicians Utilizing APPs in Practice, n = 210 (*no response, 8)

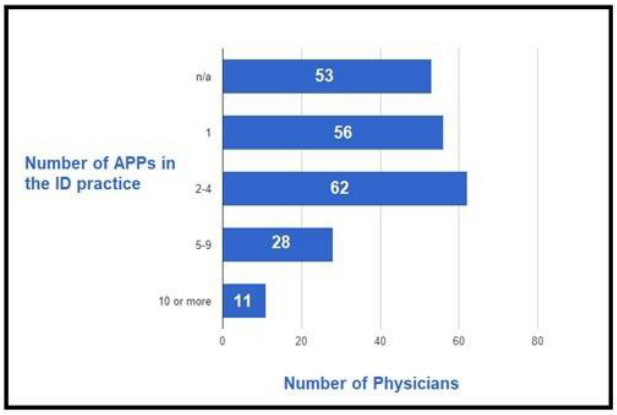

Table 1. Physician ID Practice Type, Setting, and Concerns

Physician Care Provided	**n = 218 (%)**
Inpatient Adult ID	185 (85%)
Outpatient Adult ID	162 (74%)
HIV Outpatient care	152 (70%)
HIV Inpatient care	137 (63%)
Clinical Education	132 (61%)
Antimicrobial Stewardship	131 (60%)
OPAT	128 (59%)
Clinical Research	111 (51%)
Infection Control	104 (48%)
Transplant ID	83 (38%)
Travel Medicine	79 (36%)
Infusion Center	38 (17%)
Pediatric ID	26 (12%)
Other	4 (2%)
Type of ID practice setting	**n = 218 (%)**
University/Medical school	104 (48%)
Hospital/Clinic	80 (37%)
Private Practice	28 (13%)
Federal Government	5 (2%)
Prefer not to answer	1 (.5%)
Reported reasons/concerns for not having APPs in a practice	**n = 142 (%)**
No concerns	81 (57%)
No standardized ID specific training	22 (15%)
Practice has sufficient staffing	19 (13%)
Amount of time training would take	17 (12%)
Loss of physician revenue	16 (11%)
Not comfortable providing job training	12 (8%)
Legal (malpractice) ramifications	11 (8%)
Concerned about proper billing	10 (7%)
Do not feel equipped to provide oversight	7 (5%)
Other reasons (Open End Responses)	
Knowledge gaps	6 (4%)
Lack of funding	5 (4%)
Lack of weekend/call coverage	4 (3%)
Decision made by other administration	3 (2%)
In process of hiring APP	2 (1%)

Conclusion: Results suggest that while collaboration between ID physicians and APPs exists to meet current needs, a lack of ID training is a limiting factor. Our findings demonstrate there is an opportunity for formal ID education and resource development both to enhance APPs clinical skills and address perceived knowledge gaps. Inclusion of APPs in the ID workforce may allow physicians to expand ID care into more resource limited areas to continue to provide high quality patient care.

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