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.

Fellow	Year	Mentor Model		Non-Mentor Model	
1	2018	10/139	7%	9/75	12%
	2019	**10/164**	**6%**		
2	2018	15/191	8%	3/62	5%
	2019	**10/108**	**9%**		
3	2018	13/151	9%	7/71	10%
	2019	**14/122**	**11%**		
4	2018	12/192	6%	10/92	11%
	2019	**24/134**	**18%**		

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

2547. Prioritizing Antimicrobial Resistance Learning Objectives Through a Modified, Two-Round, One-Day Delphi at a Multidisciplinary Conference

Jehan Budak, MD[1]; Eneyi E. Kpokiri, PhD[2]; Emily Abdoler, MD[3]; Joseph Tucker, MD, PhD[4]; Brian Schwartz, MD[1]; Brian Schwartz, MD[1]; [1]University of California - San Francisco, San Francisco, California; [2]London School of Hygiene and Tropical Medicine, London, UK; [3]University of Michigan, San Francisco, California; [4]University of North Carolina - Chapel Hill, Chapel Hill, North Carolina

Session: 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 on a 5-point Likert scale, which ranged from "do not include" (1) to "very important to include" (5). Consensus for inclusion was predefined as ≥ 80% of participants rating the objective ≥ 4.

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 taskforces in the Infectious Diseases community. Our generated list may be useful for those developing AMR training materials for medical students and physicians.

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

Objective	Mean Rating	% Rating ≥ 4
Background		
Interpret local epidemiologic data or antibiograms to determine local rates of AMR infections	4.23	86
List key risk factors for drug-resistant infection	4.33	86
Prevention		
Describe factors that may lead to unnecessary antibiotic prescribing by healthcare providers	4.19	86
Describe the types of precautions needed/infection control measures for AMR organisms	4.00	86
Diagnosis		
Interpret susceptibility testing results to select the most appropriate antibiotic regimen	4.48	95
Utilize the local (and regional, if available) microbiology lab to help interpret patient test results	4.38	95
Treatment		
Identify infections that do not require antibiotic therapy	4.76	100
Recognize that treatment of infections may require both antibiotic therapy and source control	4.48	90
Recognize the concept of using the narrowest spectrum antibiotic for the shortest period of time	4.76	100
Utilize a multidisciplinary healthcare approach when managing AMR organisms	4.14	86
List resources that can be useful in the treatment of patients with AMR infections	4.10	81
Describe the incidence of and the spectrum of antibiotic effects	4.24	95

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

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

Catherine Brett, MD, MPH[1]; Hannah Puckett[2]; Devin Potter[3]; Divya Ahuja, MD[4]; Olabisis Badmus, MD, MPH[5]
[1]Prisma Health, Columbia, South Carolina; [2]University of South Carolina School of Medicine, Columbia, South Carolina; [3]University of South Carolina School of Medicine, Columbia, South Carolina; [4]Univeristy of South Carolina, Columbia, South Carolina; [5]PH-USC Med. Group, University of South Carolina School of Medicine, Columbia, South Carolina

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.