

Conclusion. In summary, we found differences between faculty and trainees regarding two important aspects of medical education: setting expectations and providing feedback. While most faculty feel that conversations regarding these topics occur invariably, trainees do not always share this perception. Trainees felt less comfortable voicing concerns and giving feedback to faculty than faculty perceived them to be. Overall, the data suggest that there is room for improvement to ensure that trainees and faculty are operating from a shared mental model regarding setting team expectations and providing/receiving feedback.

Disclosures. All Authors: No reported disclosures

1130. Optimizing Use of COVID-19 Personal Protective Equipment among Resident Physicians at a Veterans Affairs Hospital

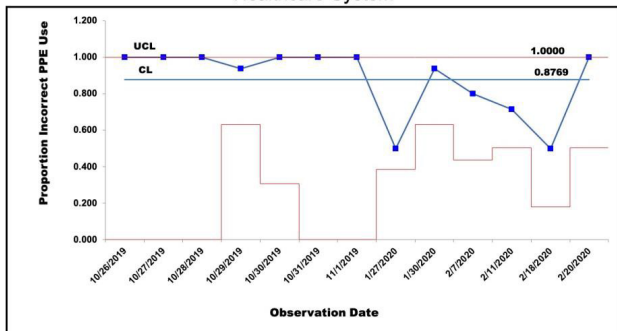
Ronald M. Beaulieu, III, MD¹; Joanna Kimball, MD¹; Samuel S. Bailin, MD¹; Michael Lowry, MD¹; Jennifer A. Werthman, PhD, MBA, RN²; Erin Gettler, MD¹; Chelsea Gorsline, MD¹; Kelly Lumpkins, MD¹; Bin Ni, MD, PhD¹; Karen Volpe, MD¹; Bryan Harris, MD¹; Todd Hulgán, MD, MPH³; Anna K. Person, MD¹; Christina Fiske, MD, MPH¹; Milner Staub, MD²; ¹Vanderbilt University Medical Center, Washington, District of Columbia; ²VA Tennessee Valley Healthcare System, Nashville, Tennessee; ³Vanderbilt University Medical Center, Nashville, Tennessee; ⁴Vanderbilt University School of Medicine, Nashville, Tennessee; ⁵VHA Tennessee Valley Healthcare System, Geriatric Research Education and Clinical Center and Vanderbilt University Medical Center, Nashville, Tennessee

Session: P-50. Infectious Diseases Medical Education

Background. Correct personal protective equipment (PPE) use is key to prevent infection. Observations on a single unit at the Veterans Affairs (VA) Tennessee Valley Healthcare System (TVHS) prior to COVID-19 (October 2019-February 2020) showed low rates of correct PPE use among healthcare workers (HCWs) (Figure 1). In response to the COVID-19 epidemic, the VA implemented new PPE protocols. Based on our initial observations, we were concerned that incorrect use of PPE may increase the risk of COVID-19 exposure among HCWs. Resident physicians, who work at many sites, may be at high-risk for incorrect PPE use due to rapid turnover and limited site-specific PPE training. We aimed to assess and improve COVID-19 PPE use among internal medicine residents rotating at the VA TVHS.

Figure 1: Pre-COVID-19 Observations of Adherence to Contact Precaution Protocols at the Veterans Affairs Tennessee Valley Healthcare System

Figure 1: Pre-COVID-19 Observations of Adherence to Contact Precaution Protocols at the Veterans Affairs Tennessee Valley Healthcare System



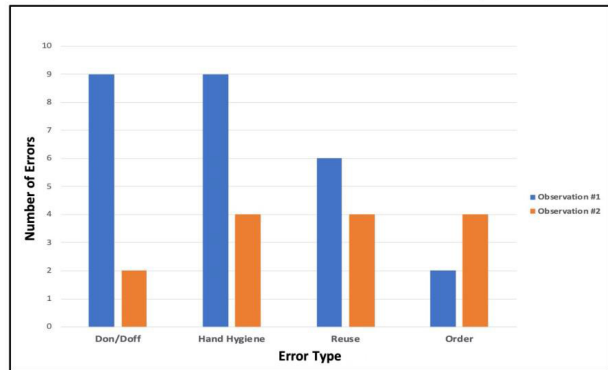
This P-Chart shows the proportion of observations in which PPE was not donned or doffed correctly. Observations were considered correct if all steps were performed in correct order and incorrect if any steps were missed or performed out of order. Upper control limit (UCL), control limit (CL), and lower control limits (LCL) were calculated by QI Macros Version 2019.01.

Methods. We used the plan, do, study, act (PDSA) model. Prior to starting VA rotations, residents were emailed PPE education to review. We implemented a 1-hour video conference PPE protocol review at rotation start followed by in-person PPE use evaluations for residents performed by infectious diseases fellows on day 2 and day 5-6 post-review to provide just-in-time educational intervention. Errors at each PPE don/doff step were tracked. Correct PPE use data from both observations were compared using McNemar's test. Baseline and post-implementation resident surveys assessed PPE use knowledge and comfort.

Results. Pre-implementation survey response rate was 72% (21/29); 19/21(91%) reported knowing which PPE to use and 16/21(76%) reported knowing how to safely don/doff PPE. Twenty of 29 (69%) residents completed both observations. Errors decreased by 55% (p=0.0045) from 17/20 (85%) to 6/20 (30%) between initial and follow up observations. Errors in hand hygiene, inclusion of all donning/doffing steps, and PPE reuse decreased, but PPE don/doff order errors increased (Figure 2). Post-project survey response rate was 16/29 (55%). All 16 reported knowing which PPE to use and how to safely don/doff PPE, and 11/16 (69%) residents felt both online and in-person interventions were helpful.

Figure 2: COVID-19 PPE Errors and Correction Types by Observation

Figure 2: COVID-19 PPE Errors and Correction Types by Observation



COVID-19 PPE procedure includes hand hygiene, donning of gown, gloves, and either N95 plus face shield or CAPR, followed by doffing of gown and gloves, hand hygiene, cleaning and storage of masks and face shields or CAPR for reuse, and terminal hand hygiene. Errors in PPE selection were considered don/doff, any missed hand hygiene step was counted as a hand hygiene error, reuse errors were counted if PPE was improperly cleaned or stored, and order errors were counted if any steps were omitted or out of sequence.

Conclusion. Correct COVID-19 PPE use is essential to protect HCWs and patients. Just-in-time education intervention for PPE training may yield higher correct use compared to pre-recorded or online training.

Disclosures. All Authors: No reported disclosures

1131. Point-of-Care Interactive Decision Support Tool Demonstrates Discordance Between Healthcare Practitioner Approaches and AASLD Guideline Recommendations in the Management of HBV Infection

Tiffany Hensley-McBain, PhD¹; Zachary Schwartz, MSC, ELS¹; Jennifer Blanchette, PhD¹; Jenny Schulz, PhD¹; Edward King, MA²; Paul Kwo, MD³; ¹Clinical Care Options, Reston, Virginia; ²Clinical Care Options, LLC, Reston, VA; ³Stanford University School of Medicine, Palo Alto, California

Session: P-50. Infectious Diseases Medical Education

Background. The AASLD HBV management guidelines were updated in 2018 to include new recommendations. Patient variables that inform HBV treatment candidacy and treatment selection are complex and interconnected. To aid healthcare practitioners (HCPs) in aligning management decisions with practice guidance, we developed a Web- and app-based decision support tool, Hep B Consult.

Methods. The tool enables users to specify a guideline (AASLD, EASL, or APASL) and prompts them to enter patient variables: HBV DNA/ALT levels, liver fibrosis, extrahepatic manifestations, family history of HCC or cirrhosis, pregnancy status, coinfection, and comorbidities. Users select their intended approach for the case, after which the tool displays guideline recommendations specific to that case. Cases entered from January 2019-April 2020 by users who specified AASLD guidance (N = 7106) were assessed.

Results. For 32.3% of cases, the user selected "unknown" for a variable necessary to reach a guideline recommendation (Fig 1). The information most often missing was the level of fibrosis/inflammation (unknown in 16.3% of cases). HCPs' intended management approach matched the guidelines in 61.3% of cases for which a guideline recommendation was possible (Fig 2; n = 3742). Cases in which the HCP chose to monitor when treatment was indicated (11.6%) and those in which the HCP was unsure (12.2%) represented the largest discrepancies. Certain types of cases demonstrated higher discordance (Fig. 2). The intended approach did not match the guidelines for 49.2% of immune-tolerant cases (n = 128). We also identified patterns important for patient health. In 20.0% of cases with compensated cirrhosis or moderate/severe inflammation or fibrosis (n = 345) and 12.5% of cases with decompensated cirrhosis (n = 72), the HCP intended to monitor although treatment was indicated.

Figure 1. Recommendation outcomes of cases entered for AASLD guidance.

Figure 1. Recommendation outcomes of cases entered for AASLD guidance.

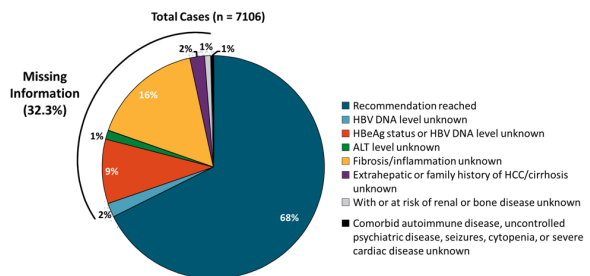


Figure 1. Total cases entered by users in which AASLD guidelines were chosen as the guideline recommendation.