

Table 2. Adherence to Guidelines by Provider Types

	Adherence to Guidelines	Odds Ratio	95% CI	P
All Providers	48.47%			
NP	33.33%			
MD	55.62%	2.5063	1.4584, 4.3073	0.0009
ID	55.13%			
OB	59.09%	1.1757	0.4749, 2.9109	0.7264

Table 3. Adherence to Guidelines by Provider Gender

Adherence to Guidelines		Odds Ratio (95% CI)	95% CI	P
Male Providers	17.44%			
Female Providers	33.33%			
Over Screening				
Male Providers	3.59%	4.3341	1.7848, 10.5245	0.0006
Female Providers	29.74%			
Under Screening				
Male Providers	8.72%	0.4308	0.1892, 0.9781	0.0414
Female Providers	7.18%			

Table 4. Cervical Cytology by Guideline Adherence

Pathology Results	Guideline Adherence	Over Screening	Under Screening
Negative Cytology	27	29	1
Negative Cytology, HPV -	8	14	1
Negative Cytology, HPV +	4	0	0
Unsatisfactory	1	0	1
ASCUS (abnormal cells of undetermined significance)	1	0	0
LSIL (low grade dysplasia)	2	1	0
HSIL (high grade dysplasia)	1	0	0
Total	44	44	3

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2549. Variance Between Clinicians and Guidelines in Management of HIV/HCV Coinfection

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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/HCV therapy, HIV and HCV genotypes, liver histology, renal function, 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, 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 treatment guidelines for 36% of case scenarios.

Case Scenario	Treatment Choice Inconsistent With Guidelines	Clinicians Choosing Treatment Inconsistent With Guidelines, % (n/N)
Selecting ART and/or HCV Therapy		
eGFR < 60 mL/min	Tenofovir disoproxil fumarate, sofosbuvir/ledipasvir, or sofosbuvir/velpatasvir	16 (45/274)
Selecting HCV Therapy		
Receiving elvitegravir/cobicistat	Grazoprevir/elbasvir	16 (17/105)
HCV GT2,3,5,6	Grazoprevir/elbasvir	8 (12/153)
HCV GT2,3	Sofosbuvir/ledipasvir	15 (24/156)
Selecting ART		
HIV genotype unavailable	Elvitegravir or raltegravir	24 (24/99)
Receiving sofosbuvir/ledipasvir	Elvitegravir/cobicistat/lamivudine/tenofovir disoproxil fumarate	7 (3/41)
Receiving grazoprevir/elbasvir	Elvitegravir/cobicistat	9 (2/23)
HLA-B*5701 positive	Dolutegravir/abacavir/lamivudine	8 (8/38)

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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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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 care 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, and only 8/40 (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 interspecialty 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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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). When asked what time fellows should start their workday, the median response was 7:30 am from both fellows (range 6:30-8 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 respondents (100% 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 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 days on 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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