972. Antimicrobial Stewardship Educational Needs of Residents in an Internal Medicine Program

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Session: P-54. Infectious Diseases Medical Education

Background. Antibiotic stewardship continues to be a health concern that physicians often acknowledge, but whose real-life practices do not reflect that awareness. There is a wide range of opinions on the efficacy of the type of modality that is most effective for each stewardship. Our project addresses resident needs specifically, with coverage in four topics—proper antibiotic dosing, IV to PO transitioning, duplicate coverage, and antibiotic time outs.

Methods. Categorical Internal Medicine residents in PGY 1-3 were sent an optional 48-question Likert survey querying needs in the above four topics.

Results. General Demographics. Resident response was 35%, with equal representation from all PGY years. Over half reported no ID or stewardship elective exposure and 74% agreed they could benefit from further education on stewardship (Figure 1). Proper Dosing Educational Needs. Of residents, 68% reported feeling confident about where to find information on dosing antibiotics for a given condition/organism (Figure 2a), but only 37% were comfortable with establishing an initial dose. When a range was suggested, 55% of respondents admitted to at least “sometimes, often, or always” choosing the highest suggested dose by default. IV to PO transition. Residents preferred (76%) and used (89%) IV antibiotics by default in an inpatient setting. Nearly 45% of respondents reported “sometimes or rarely” feeling comfortable in making an IV to PO transition, and 40% “often or always” avoid PO transition until discharge (Figure 2b). Duplicate Coverage. Over 70% of residents reported they “sometimes, rarely, or never” felt confident in stopping double coverage themselves when started by the primary team (Figure 3a). Antibiotic Time Out. Only 17% of respondents had heard of an antibiotic timeout, and only 8% have ever used one (Fig.3b). 80% of residents had no structured way to review usage and 53% reported “sometimes or often” forgetting about assessing for de-escalation daily.

Figure 1. Resident Demographics

Our anonymous, optional survey attracted a 35% response rate from the categorical residents at our suburban program spread over two tertiary hospitals with >1200 beds total. Most had not received prior training in infectious disease or stewardship, yet most recognized antibiotic overuse and resistance as a major, ongoing problem.

Figure 2. Resident responses on proper dosing and IV to PO questions.

(A) Residents appear most uncomfortable with initial antibiotic dosing and seeking additional sources for best dosage when commonly used sources suggest a range of possible doses. (B) Majority of residents preferred and used IV antibiotics, and commonly transitioned to PO only at patient discharge. Some residents reported discomfort with establishing equivalent IV to PO transition dosages.

Figure 3. Resident responses to questions regarding duplication of therapy and antibiotic time outs.

(A) Though many could and had recognized duplication of therapy on the wards, several participants reported at least some discomfort in independently stopping double coverage. (B) Most residents had not heard of or utilized an antibiotic time-out or any other structured method to re-assess their antibiotic use on daily rounds. As such, 41% of respondents admitted they would likely just continue initial, broad-spectrum therapy.

Conclusion. Our analysis aimed to establish resident educational needs in four major topics in stewardship. Gaps in knowledge include timing transition from IV to PO, initial antibiotic dosing, stopping double-coverage, and lack of awareness of time outs. This needs assessment will be used to build an antibiotic stewardship curriculum for IM residents.

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973. Utilization of Project ECHO for COVID-19 Medical Knowledge and Best Practices for Health Professionals serving an Underserved Population

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Background. During the global COVID-19 pandemic, the release of research and data particularly to guide clinical care evolved rapidly and highlights the critical need for timely, and equitable access to medical knowledge and best practices. Specialized medical knowledge has historically been confined to specialists in academic medical centers and disconnected from healthcare professionals in underserved areas. It is important to bridge this gap and democratize knowledge through a model that supports rapid dissemination of best practices to build capacity in areas of need.

Methods. A Project ECHO partnership was implemented between academic infectious diseases specialists and local healthcare professionals involved in COVID-19 screening, diagnosis and management serving an underserved population. BCM COVID-19 ECHO supported the Access2Health SmartPod COVID-19 clinical operations staffed by a charitable community organization. The SmartPod clinical team were engaged in weekly one-hour ECHO sessions with didactic presentations and case discussions on diverse COVID-19 topics. The program was evaluated at 6 months.

COVID-19 ECHO Model

Utilization of Project ECHO for COVID-19 Medical Knowledge and Best Practices for Health Professionals serving an Underserved Population

Methods: Figure 1

BCM COVID-19 ECHO Telementoring Program with the United Health Partners in the community

BCM COVID-19 ECHO Telementoring Session Topics