may be an important antimicrobial stewardship tool. For LC, there was a significant decrease in ID consults and echocardiograms after changing to PCR for CRR indicating PCR CRR may be an important tool for healthcare resource utilization.

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Antifungal use following Candida Growth in Bile Cultures Collected during Endoscopic Retrograde Cholangiopancreatography

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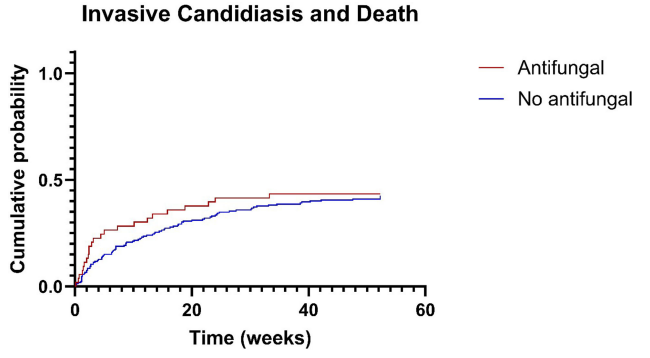
Background: Candida species are increasingly causing infections and are considered high priority fungal pathogens. Despite this, published data describing the clinical importance of Candida growth in the bile tract is limited to case reports and small cohorts. Our goal is to characterize treatment outcomes of patients who had Candida spp isolated from bile cultures obtained via Endoscopic Retrograde Cholangiopancreatography (ERCP) to determine the value of antifungal use in these cases. **Methods:** We performed a single-center retrospective cohort study of patients with bile cultures positive for Candida spp collected during ERCPs from January 2010 to December 2023. Patients were identified by cross-matching databases of patients who underwent ERCP and patients with Candida-positive bile cultures. The treatment cohort included patients who received antifungals within seven days of the first ERCP with Candida growth in bile cultures (principal ERCP) compared to a control cohort who did not. Patients with candidemia or deep-seated candida infection prior to the principal ERCP or insufficient chart data were excluded. The primary outcome was a composite of death and/or development of invasive candida infection within one year of the principal ERCP date. Kaplan Meier plots and log-rank tests were used to analyze the primary outcome. **Results:** A total of 266 patients were included out of 285 with 8 being excluded for insufficient records and 11 being excluded for invasive candidiasis within one year prior. The included patient population was 60.2% male, 79.7% white, 7.9% black, and 12.4% other/unknown race and had a mean age of 63.6 +/- 15.8 years. The most common species of Candida identified were C albicans (65.9%), C glabrata (17.4%), and C tropicalis (7.2%) with 27 patients (9.2%) having 2 isolates in their culture. There were 52 patients (19.5%) who received antifungals—46 fluconazole and 6 micafungin. At one year the primary endpoint occurred in 23 out of 53 patients (43.3%) in the antifungal group and 93 out of 213 patients (43.6%) in the control group. The primary outcome was plotted on a Kaplan Meier curve. The hazard ratio was 1.14 (0.71 to 1.85, 95% CI; p=0.574) which did not reach statistical significance. Additionally, antifungal initiation had no statistically significant impact on rehospitalization rates (p=0.602), relapse of bacterial cholangitis (p=0.230), or recurrent Candida-positive bile cultures (p=0.441) within one year. **Conclusions:** This retrospective study of the use of antifungals in patients with Candida growing from bile cultures following ERCP found no benefit in starting antifungal treatment.



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Results of a Statewide Survey of the Antibiotic Tracking and Reporting Inventory (ATARI) in Wisconsin Nursing Homes

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Background: Antibiotic tracking and reporting are core components of nursing home (NH) antibiotic stewardship programs. Nevertheless, how NHs conduct these essential activities remains poorly understood. The objectives of this study were to understand how NHs capture information on antibiotic use (AU) and characterize how AU is reported in Wisconsin NHs. **Methods:** The Antibiotic Tracking and Reporting Inventory (ATARI), a survey instrument designed to characterize the structure and process of antibiotic tracking and reporting in NHs was developed and piloted through a mixed methods approach. The instrument is organized into three sections: facility demographics, structure and process of AU data collection, and types of AU measures reported and methods of generation. After coding into REDCap, the ATARI instrument was distributed to Wisconsin NHs (n = 328) in partnership with the Wisconsin Department of Health Services. Descriptive statistics were utilized to summarize information regarding antibiotic data collection, AU reporting, and NH characteristics. **Results:** One hundred and thirty-two responses were

Figure 1 Nursing Home Characteristic

Region	Count [n/(%)]
Southern	22 (22.4%)
Southeastern	15 (15.3%)
Northeastern	29 (29.6%)
Northwestern	32 (32.7%)
Ownership	
For profit	35 (35.7%)
Not for profit	49 (50.0%)
Government	14 (14.3%)
Electronic health record (EHR) vendor	
American Data/ECS	21 (21.4%)
Matrix Care	17 (17.3%)
Point Click Care	53 (54.1%)
Other	7 (7.1%)
Utilization of infection prevention software or tools in addition to EHR	
Electronic Health Record Integrated Infection Control Solution	32 (32.7%)
Stand-alone infection control solution	16 (16.3%
Does not use additional Infection Prevention Software or Tool	53 (54.1%)
Bed group	
Less than 50 beds	18 (18.4%)
50 to 60 beds	32 (32.7%)
61 to 100 beds	27 (27.6%)
Greater than 100 beds	21 (21.4%)

Figure 2: Structure and Process of Antibiotic Case Finding

Line listing tools used	Count [n/(%)]
Facility-developed Excel line list	58 (59.2%)
Externally developed Excel line list	10 (10.2%)
EHR-embedded line list	23 (23.5%)
Stand-alone infection control software line list	6 (6.1%)
Paper line list	38 (38.8%)
Other	2 (2.0%)
Average hours per week NH devoted to collecting information on antibiotic events by bed size	**Mean (SE of mean)**
All facilities	9.82 (0.79)
Facility size < 50 beds	6.72 (1.47)
Facility size 50 - 60 beds	8.56 (1.44)
Facility size 61 - 100 beds	8.96 (1.08)
Facility size > 100 beds	15.47 (1.90)
Average hours per month NH spent developing and disseminating antibiotic reports by bed size	**Mean (SE of mean)**
All facilities	17.99 (3.62)
Less than 50 beds	12.27 (2.73)
50 to 60 beds	17.44 (5.52)
61 to 100 beds	16.00 (3.64)
Greater than 100 beds	26.29 (13.86)

Figure 3: Antibiotic Utilization Measure Reporting

Tools used for generating antibiotic reports	Count [n/(%)]
Facility-develop Excel spreadsheet	59 (60.2%)
Externally-developed Excel spreadsheet	10 (10.2%)
EHR-embedded reporting tool	25 (25.5%)
Stand-alone infection control software tool	4 (4.1%)
Another tool	2 (2.0%)
None of the above	16 (16.3%)
Antibiotic initiation	
Facilities reporting at least one initiation measure	82 (83.7%)
Facilities that rate adjust reported initiation measure(s)	75 (76.5%)
Facilities that stratify reported initiation measure(s) by indication	82 (83.7%)
Facilities that stratify reported initiation measure(s) by appropriateness	79 (80.6%)
Types of initiation measures reported	
Antibiotic starts: A measure that counts each unique antibiotic prescription as a new start, regardless of whether that antibiotic was prescribed for a single infection.	49 (50.0%)
Antibiotic treatments: A measure that counts the number of infections that were treated with an antibiotic regardless of the number of antibiotics used either at the same time or consecutively to treat a single infection.	21 (21.4%)
Antibiotic courses: A measure that counts the number of distinct antibiotics that were utilized for a single infection regardless of changes in dose, duration, or start.	13 (13.3%)
Other	1 (1.0%)
None	13 (13.3%)
Antibiotic duration	
Facilities reporting at least one antibiotic duration measure	38 (38.8%)

received, of which 98 completed the instrument in its entirety for a final response rate of approximately 30%. Figure 1 details NH characteristics, including size and information system employed by responding facilities. Responding NHs reported devoting approximately 10 hours per week doing line listing activities and 18 hours per month in developing and disseminating reports (Figure 2). Paper and facility-developed Excel-based tools were used to conduct line listing activities in a majority of NHs, and 32 NHs employed more than one tool for this purpose (Figure 2). A majority, approximately 84%, of NHs reported at least one measure of antibiotic initiation although there was variation in whether facilities employed starts, courses, and treatment measures (Figure 3). Nineteen NHs utilize one or more report tools. A majority of NHs employed rate adjustment and stratification of their initiation measure by indication as well as appropriateness in their reports (Figure 3). In contrast a minority, 39%, of NHs reported a treatment duration measure (Figure 3). **Conclusions:** Wisconsin NHs devote a considerable amount of time to tracking and reporting of AU and employ a variety of low-tech tools for this purpose. There is considerable variability in the types of AU measures monitored in NHs with a majority focused on antibiotic initiation measures and lesser focus on measuring duration of therapy. These results suggest a need for standardization of AU measures in NHs as well as information systems that improve the efficiency of their collection and reporting.

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Impact of Infectious Diseases Consultation for Patients with Enterococcal Bacteremia: a Retrospective Cohort Study

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Background: Gram-positive bacteremia is a challenging cause of morbidity and mortality. Past publications have shown improved patient outcomes and increased adherence to recommended standards of care with infectious disease consultation (IDC) for Staphylococcus aureus bacteremia1. Enterococcus species are another common cause of gram-positive bacteremia with significant morbidity and mortality. This study aims to assess the impact of IDC on the care of patients with Enterococcal bacteremia. **Methods:** A retrospective chart review was performed on 227 inpatients with at least one blood culture growing an Enterococcus species between June 2022 and November 2023. Patient characteristics collected included age, Charlson Comorbidity index, presence of endocarditis, source of bacteremia, and consultation of the inpatient ID service. Outcomes assessed included in-hospital and 30-day mortality, 30-day re-admission rate, acquisition of repeat blood cultures to document clearance of bacteremia, transthoracic (TTE) and/or transesophageal echocardiography (TEE), and anti-Enterococcal antibiotic duration. Categorical variables were compared with Chi-square or Fisher's exact tests. Continuous variables were compared with independent t-tests or Mann-Whitney U nonparametric tests. **Results:** Of 227 patients, 195 (85.8%) received IDC while 32 (14.2%) did not. Patients in both groups had similar Charlson comorbidity indices. 23 (11.7%) patients had Enterococcal endocarditis, all of whom received IDC (Table 1). Patients with IDC had a significantly higher rate of acquisition of clearance blood cultures (98.96% vs. 83.87%, p 76.80% vs. 56.25%, p = .014), and TEE (20.21% vs 0.0%, P = .005)

Table 1. Patient Characteristics

	No ID Consult (N=32)	ID Consult (N=195)	All Patients (N=227)	p-value
Median age, years (range)	70 (28-95)	65 (18-94)	66.00 (18-95)	0.072
Ampicillin resistance	4 (12.50%)	49 (25.13%)	53 (23.35%)	0.118
Vancomycin resistance	6 (18.75%)	46 (23.59%)	52 (22.91%)	0.546
Endocarditis	0	23 (11.7%)	23 (10.1%)	0.052
Median Charlson comorbidity index (range)	5.72 (0-12)	5.18 (0-13)	5.26 (0-13)	0.410
Source				0.254
Intraabdominal	10 (41.67%)	63 (38.18%)	73 (38.62%)	
Urinary	9 (37.50%)	35 (21.21%)	44 (23.28%)	
Vascular Device	2 (8.33%)	37 (22.42%)	39 (20.63%)	
Musculoskeletal	1 (4.17%)	7 (4.24%)	8 (4.23%)	
Pulmonary	1 (4.17%)	4 (2.42%)	5 (2.65%)	
Skin/Soft Tissue	1 (4.17%)	19 (11.52%)	20 (10.58%)	