

Presentation Type:

Poster Presentation

Subject Category: COVID-19**Barriers and Facilitators to COVID-19 Vaccination Access Among Older Adults: A Comprehensive Needs Assessment for Vaccination Strategies**Jiye (Cecilia) Lee¹, Jamie Trumpler², Scott Roberts³, Lauren Pischel⁴ and Richard Martinello⁵¹Yale University; ²Yale University; ³Yale and ⁴Yale University

Objectives: Multiple barriers exist for COVID-19 vaccination in high-risk individuals especially adults over the age of 65. Each healthcare visit represents a critical opportunity for vaccination, yet many patients who do seek vaccination receive their vaccines in locations other than their routine health care providers and healthcare sites often lack the capacity for vaccine administration. Here-in we conducted a needs assessment to identify hospital system specific barriers and facilitators to COVID-19 vaccine access in individuals 65 and older in 2024. **Methods:** We conducted six semi-structured interviews (June-July 2024) with seven healthcare leaders in Yale New Haven Enterprise. We transcribed and analyzed interviews to develop a larger-scale survey targeting healthcare professionals including vaccine leadership of individual clinics across the healthcare systems. The survey was distributed to 42 healthcare leaders (physicians, administrators, and practice supervisors) across 52 ambulatory locations. **Results:** The survey received twenty responses (47% response rate). Four primary challenges to COVID-19 vaccination among older adults were identified: (1) Patient Hesitancy, driven by misinformation about vaccine contents, concerns about side effects, polarized attitudes, and waning interest in booster doses; (2) Challenges Related to Staff, including distrust in vaccine motives, mandates, and efficacy, as well as a shortage of personnel available to administer vaccinations; (3) Operational and Logistical Barriers, including complex vaccine schedules, vaccine storage, and reliance on retail pharmacies, which led to lower vaccination rates at primary care sites; and (4) Policy and Financial Constraints, such as insufficient financial incentives for on-site vaccinations, Medicare coverage limitations, and high administrative costs. The main proposed actions to address vaccination hesitancy and challenges include enhancing education sessions for patients and staffs, modifying streamlining administration by simplifying the workflows including on-site vaccination process for employees, and centralizing vaccine delivery in primary care or hubs, improving accessibility via routine (home) visits and flexible hours, and partnering with pharmacy department to ensure greater access to vaccination. **Conclusion:** Through semi-structured interviews and surveys, we identified targets for future quality improvement efforts. Multiple overlapping barriers to COVID-19 vaccination in older adults exist within one U.S. based health care system. Some of these barriers, such as improving vaccine administration workflows or enhancing patient education, can be more readily addressed, while others involve larger structural issues that would require larger societal change. We are seeking a subspecialty clinic partnership to pilot an implementation project, using high-impact intervention tailored to clinic needs and iterative Plan-Do-Study-Act (PDSA) cycles to refine and optimize outcomes.

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Subject Category: Decolonization Strategies**Tackling Staph: Reducing Staphylococcus aureus Colonization in a College Football Team**Jessica Seidelman¹, Erin Gettler², Aaron Barrett³, Bobby Warren⁴, Hap Zarzour⁵, Connor Warren⁶, Jeffrey Bytomski⁷, Nicholas Potter⁸, Becky Smith⁸ and Deverick Anderson⁹¹Duke University; ²Duke University Medical Center; ³Duke Center for Antimicrobial Stewardship and Infection Prevention; ⁴Duke Center forAntimicrobial Stewardship and Infection Prevention; ⁵Athletic Medicine; ⁶Duke University Athletic Medicine; ⁷Jeffrey Bytomski, Duke University; ⁸Duke University Medical Center and ⁹Duke Center for Antimicrobial Stewardship and Infection Prevention

Introduction: Athletes in contact sports have a higher rate of Staphylococcus aureus nasal carriage than the general population, leading to an increased risk of skin and soft tissue infections (SSTIs). These infections can have a significant impact on individual players and teams. This study aimed to assess the effectiveness of adding a nasal decolonization protocol in reducing S. aureus colonization among a Division I (D1) college football team to chlorhexidine gluconate body wash. **Methods:** A total of 113 athletes were screened for S. aureus nasal carriage at two time points during intensive summer training. During the first screening, athletes were universally prescribed intranasal mupirocin twice daily using clean Q-tips for five consecutive days. Players were also educated on proper hygiene and adherence to the decolonization protocol. Four weeks later, all players were screened again for S. aureus nasal carriage. Protocol success was defined as either detection of Staph aureus in the first round of screening but not in the second (elimination) or a persistently negative result (lack of acquisition). Protocol failure was defined as either the isolation of the same organism in the first and second rounds (lack of elimination) or a positive second-round culture following a negative first-round culture (acquisition). Select S. aureus isolates were submitted for multilocus sequence typing (MLST). **Results:** At the initial screening, 2 players (1.8%) were colonized with methicillin-resistant Staphylococcus aureus (MRSA), 23 players (20.4%) with methicillin-susceptible Staphylococcus aureus (MSSA), and 4 players (3.5%) with both MRSA and MSSA. After decolonization, follow-up screening identified 0 players with MRSA and 12 players (10.6%) with MSSA, representing a 58.6% reduction in overall S. aureus nasal carriage. Based on study definitions, the decolonization protocol was successful in 101 (89%) players (Figure 1). MLST was performed on 11 of the 27 initial MSSA-positive isolates and 6 of the 12 second-round MSSA-positive isolates. Based on limited molecular typing data, at least 1 player may have acquired MSSA from another team member within the athletic environment. **Discussion:** Our findings suggest that implementing a nasal decolonization protocol in a D1 college football team is feasible and effective, resulting in a significant reduction of S. aureus nasal carriage. While initial screening effectively identified carriers, a small subset of athletes acquired MSSA colonization, indicating potential re-exposure or incomplete protocol adherence. Further research should explore decolonization adherence strategies and expand decolonization efforts across contact sports programs to reduce S. aureus-related SSTIs among athletes.

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