possible horizontal transmission in a high-risk patient population. Ongoing monitoring and evaluation will inform our screening practices and enhance our ability to respond to outbreaks. As the prevalence of C. auris continues to grow, our screening program will continue to provide a proactive approach to managing this growing threat to our highly vulnerable patient population.

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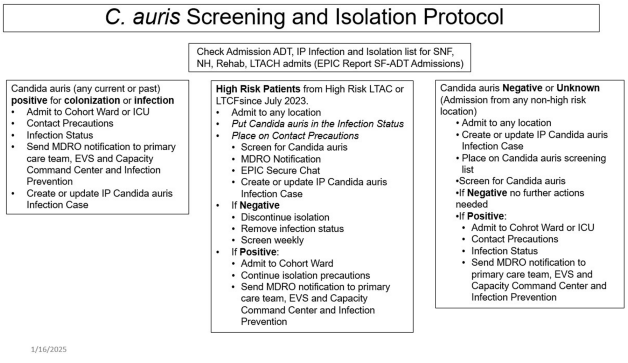
Presentation Type:
Poster Presentation
Subject Category: Surveillance
Candida auris Screening and Isolation in a Tertiary Medical Center, 2019-2024
Risa Webb[1], Sheila Fletcher[2] and Melinda Grubb[3]
[1]University of Mississippi Medical Center; [2]University of Mississippi Medical Center and [3]The University of Mississippi Medical Center

Background: Candida auris(CA) first recognized in the US in 2013, can be resistant to all major antifungal agents limiting treatment options. To decrease its spread, guidelines indicate patients with CA, if admitted to hospital, should be placed in isolation and considered positive indefinitely. Screening around newly identified patients is recommended. **Methods:** We review CA history in our facility, including colonizations, infections and screening/isolation protocols from 2019-2024. **Results:** In late 2019,a patient with a CA infection was transferred to our hospital. It was late 2022, before two additional patients with CA were admitted to our facility from a long-term acute care facility (LTAC) that had a newly recognized CA cluster of cases/colonizations. Screening in our facility did not identify additional cases/colonizations (n =49) at that time. Patients with known infection or colonization were placed in contact isolation. Additional LTAC/LTCFs were recognized from which patients with CA were routinely identified and admitted to our facility Patients from these facilities were deemed high risk (HRP) and were preemptively placed in isolation and screened for CA. From March, 2023 through August 2024,patients with CA or HRPs were placed on a cohorted ward in contact isolation. Cohorted isolation was continued on high risk but screening negative patients until three screening tests were negative and they were no longer at the high risk LTAC/LTCF. Providers were notified by email or through electronic record of patients status and reminded of infection control measures to follow. Any patient with CA had their electronic record flagged for contact isolation in the event of readmission. Screening specimens for colonization were sent to an outside laboratory until August, 2024 when in-house testing became available. With in-house testing, screening results became available in 1-2 days rather than 3-4 days. A new protocol was started and only placed patients with known positive cultures in the cohorted ward. (see image) HRPs are placed in isolation wherever in the hospital they are admitted until screening results are known. If results are positive for CA they are transferred to the cohorted ward. Additionally rooms are cleaned with appropriate disinfectants for surfaces and floors.



From December, 2022, through August, 2024 we identified 22 unique patients with cultures from clinical isolates. Specimens included nine cultures from blood, including three of hospital onset. Three cultures were from wounds, one was hospital onset. Other cultures were 1 from bone, 1 from pleural fluid and 9 from urine. 106 patients were identified as colonized with screening. **Conclusion:** Screening, isolation and cohorting have all been tools for managing CA in our facility. Only three hospital onset CA bacteremias have been identified with those protocols.

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Presentation Type:
Poster Presentation
Subject Category: Technology
The Effectiveness of Virtual Reality-Based Multidrug-Resistant Organisms Infection Control Education for Nursing Students
Kyungmi Kim and Jeong Sil Choi

Purpose: This study aimed to verify the effectiveness of a virtual reality (VR)-based multidrug-resistant organisms (MDROs) infection control education program for nursing students. **Methods:** This study is quasi-experimental with a nonequivalent control group pretest-posttest design. The subjects were 56 nursing students (28 in the experimental and 28 in the control group). A VR education program on infection control for MDROs was applied to the experimental group. The effectiveness of the education was assessed using a questionnaire. **Results:** The experimental and control groups had no statistically significant difference in the knowledge of MDROs infection control, performance confidence, and self-efficacy before and after the VR-based education. The difference in the knowledge of MDROs infection control between the experimental group before and after the VR education was 9.08±7.50, and the control group was 6.12 ±16.69. The difference value between the two groups was statistically significant (p = .036). The difference in performance confidence was 0.32

±0.38 points in the experimental group and 0.27±0.52 points in the control group, and there was no statistically significant difference between the two groups (p = .073). The difference value of self-efficacy was 0.43±0.39 points in the experimental group and -0.23±0.71 points in the control group, and there was a statistically significant difference between the two groups **Conclusion:** This study found that This study found that VR-based infection control education can help acquire knowledge and self-efficacy in MDROs infection control.

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Presentation Type:
Poster Presentation
Subject Category: Vaccination
The Impact of Low Influenza Immunization Rates on U.S. Hospital System Resources: A Dynamic Model Estimation
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Background: Increasing influenza vaccination rates can significantly reduce the onset of severe symptoms and the risk of complications, thereby alleviating the burden on hospitals during flu seasons. However, the overall vaccine uptake has been decreasing in the United States, which is expected to increase the burden of disease. This study aims to estimate the impact of low influenza vaccination rates on disease burden and U.S. hospital system resources. **Methods:** The impact of reduced flu immunization rates was estimated using a dynamic age-stratified transmission model. Two U.S. flu seasons (2011-2012 for low incidence and 2017-2018 for high incidence) were analyzed to simulate flu epidemic variations. This study assessed four different flu vaccination rates: 25%, 30%, 35%, and 40%. Outcome measures included the number of infections, outpatient visits, hospitalizations, intensive care unit (ICU) stays, and deaths. The flu vaccine effectiveness (VE) rate was taken from CDC reports, estimating an average VE of 42% for all ages over the last 10 seasons. Vaccination rates by age group were also estimated using CDC reports, assuming immunization with quadrivalent flu vaccines for all ages. The total number of acute hospital and ICU beds available for influenza in the U.S. was assumed to be 300,000 and 30,000, respectively. **Results:** Using the U.S. flu immunization rate from the 2023-2024 season (approximately 35%), a high flu incidence season is expected to result in 71 million symptomatic infections, 29 million office visits, 0.94 million hospitalizations, and 133,670 deaths. Any scenario with an immunization rate below 45% will generate significant pressure on the U.S. hospital system and saturate the number of ICU beds during high incidence seasons. Only increasing the flu immunization rate to 50% or higher may prevent the saturation of acute hospital or ICU beds, regardless of the flu season's incidence. **Conclusions:** The analysis shows the critical need to increase U.S. flu immunization rates to at least 50% to improve health outcomes and avoid the saturation of hospital system resources, especially ICU beds.

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Presentation Type:
Poster Presentation
Subject Category: Vaccination
A Survey of Healthcare Worker Attitudes and Perceptions Toward the Ebola Vaccine, Ervebo
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[1]New York University, Langone Health; [2]NYU Langone Health; [3]Denver Health & Hospital Authority; [4]University of Texas Medical Branch and [5]NYU Grossman School of Medicine

Background: Outbreaks of Zaire ebolavirus are an ongoing public health threat associated with high case fatality rates. The US Advisory Committee on Immunization Practices (ACIP) recommends preexposure vaccination with rVSVΔG-ZEBOV-GP Ebola vaccine (Brand name: Ervebo), which is effective in preventing disease caused by Zaire ebolavirus, to people at high risk for occupational exposure. We describe the perceptions and desire to be vaccinated with Ervebo among a subset of eligible US healthcare workers (HCWs). **Methods:** We conducted a cross-sectional online anonymous survey during March-October 2024, distributed to eligible HCWs at three Regional Emerging Special Pathogen Treatment Centers (RESPTCs): NYC Health + Hospitals/Bellevue, University of Texas Medical Branch, and Denver Health & Hospital Authority. **Results:** There were 66 responses (40% response rate), with the majority aged 30-49 years (63%), female (65%), and either a physician (42%) or nurse (27%). The majority (56%) had received some form of education on Ebola vaccines, most commonly through informational sheets or pamphlets (60%). Thirty-four (51%) were interested in (n=30) or already vaccinated with (n=4) Ervebo. Among those interested or already vaccinated, 44% would choose to receive the vaccine immediately, while 24% would get vaccinated if there were a case of Ebola virus disease (EVD) in the US. Among those not interested or unsure (n=32), most were concerned about risks of spreading the vaccine viral vector (44%), insufficient knowledge about the vaccine (31%), and unacceptable side effects (31%). Among all respondents, the most common concerns about adverse events included potential for a serious

Figure 1a. If you were eligible to receive the Ebola virus vaccine, Ervebo, would you choose to be vaccinated? N=66

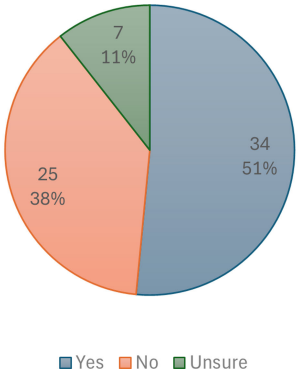

Figure 1b: When would you choose to receive the Ebola virus vaccine, Ervebo? n=34