understanding OPAT processes within key domains of decision-making, patient education, care coordination, and post-discharge management. We used rapid analysis and a summary matrix to compare practices across sites within each domain. **Result:** Our findings highlight significant variability among VHA medical centers that provide OPAT to Veteran patients. Three of the 6 medical centers had dedicated OPAT programs as evidenced by a multidisciplinary team with clearly delineated roles and responsibilities, and processes that may help mitigate adverse outcomes and improve communication between providers at all OPAT care points. These processes map to the key elements outlined in the Infectious Diseases Society of America (IDSA) practice guidelines for OPAT programs, and include determination of appropriate therapy, patient education, lab monitoring, and discontinuation of treatment. (Figure 1) Conversely, at the three VHA sites without evidence of a multidisciplinary OPAT team or program, most participants described poor communication and coordination, lack of support, and uncertainty among providers about who is responsible for OPAT care. This confusion extends to follow-up and discontinuation of treatment. OPAT key elements were lacking or poorly defined. A process map helps visualize the contrasts in care between sites with and without defined OPAT programs. (Figure 1) **Conclusion:** Despite its centralized healthcare system, VHA medical centers demonstrate highly variable processes with respect to OPAT care. In the absence of a clear OPAT policy or program, uncertainty among providers about roles and responsibilities may be greater. The presence of a dedicated multidisciplinary OPAT team may help improve communication and care coordination, thereby minimizing quality and safety concerns.

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Poster Presentation
Subject Category: Antibiotic Stewardship
Bridging the Knowledge Gap: Enhancing RN Engagement in Antimicrobial Stewardship at MEDVAMC
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Background: Antimicrobial resistance (AMR) poses a critical threat to global health, with healthcare-associated infections (HAIs) such as Clostridioides difficile and multidrug-resistant organisms (MDROs) exacerbated by antibiotic misuse. Up to 50% of inpatients receive antibiotics during their hospital stay, nearly 1/3 of which is inappropriate. The Standardized Antimicrobial Administration Ratio (SAAR) at Michael E DeBakey VA Medical Center (MEDVAMC) exceeded 1 from 2023–2024, signaling higher-than-expected antibiotic use. Nurses, as pivotal frontline healthcare providers, are often underutilized in antimicrobial stewardship program (ASP) efforts due to a lack of formal ASP education. Addressing this gap aligns with The Joint Commission standards, CDC guidelines, and ANA recommendations for improving ASP engagement and reducing HAIs. **Methods:** This quality improvement project utilized the Plan-Do-Study-Act (PDSA) framework to develop, implement, and refine an educational intervention aimed at enhancing RN knowledge and engagement in ASP. Baseline data, including a survey assessing RN ASP knowledge, informed the creation of a tailored training program. The program emphasized the 5D approach (Diagnosis, Drug, Dose, Duration, De-escalation), the role of nurses in ASP, and interdisciplinary collaboration. The initiative was endorsed by leadership and delivered through interactive workshops and case-based learning. Post-intervention surveys and infection rate analyses were conducted to evaluate outcomes. **Results:** The intervention led to a 92% increase in RN knowledge, with a mean post-intervention scores of 92 out of 100 among 67 participating nurses, compared to preintervention score of 48 out of 100. Improved RN competency in ASP facilitated stronger interdisciplinary communication and adherence to stewardship protocols, such as performing antibiotic time outs. Feedback from participants highlighted increased confidence in ASP roles and improved patient safety practices. Some examples of patient safety practices that improved, included more consistent documentation of allergy checks, antibiotic indications, and treatment plans within the electronic health record. Post-intervention, nurses felt more comfortable providing patient education on the importance of completing antibiotics, recognizing side effects, and infection prevention. **Conclusions:** Empowering nurses through targeted ASP education not only bridges critical knowledge gaps but also fosters a culture of safety and accountability in antibiotic use. Sustaining these outcomes requires integrating ASP education into routine RN training, continuous monitoring of infection rates, and leveraging interdisciplinary collaboration to maintain compliance with evidence-based stewardship practices. These findings underscore the transformative potential of nurse-led initiatives in combating AMR and improving healthcare outcomes.

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Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship
Developing a Desirability of Outcome Ranking for Adults with Non-severe Community-acquired Pneumonia: physician and patient preferences
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Background: Dichotomous outcomes rarely capture the range of potential outcomes important to patients and clinicians. To address this limitation, the Desirability of Outcome Ranking (DOOR) score was created to rank potential outcomes from least to most desirable. Currently, there is no standardized method to develop a DOOR score and data are limited on whether patients and their clinicians rank outcomes similarly. We aimed: (a) to develop a novel DOOR score for adults hospitalized with community-acquired pneumonia (CAP) by surveying patients and clinicians on their preferred outcome ranking and (b) to compare their relative DOOR rankings. **Methods:** We created nine clinical scenarios describing the spectrum of potential outcomes of patients with CAP two weeks after initial emergency department visit. To ascertain clinician DOOR score, we used a snowball sampling method to recruit a target of 25 clinicians in specialties that regularly treat CAP. For the patient DOOR score, we recruited patients hospitalized with CAP by reviewing electronic patient lists for adults hospitalized with pneumonia. Respondents were asked to rank the 9 cases from most to least desirable in REDCap. To create the final DOOR score, we used Friedman rank sum tests to combine/collapse DOOR outcomes with scores that did not significantly differ. We used the Mann Whitney U test to compare DOOR rankings between physicians and patients. Final study results were presented to a national hospital medicine patient and family advisory committee (PFAC) for their impressions. **Results:** 22 patients (71% response rate) and 25 clinicians responded to our DOOR survey. Their ranked order of DOOR outcomes is shown in Table 1. Combining non-significantly different DOOR outcomes resulted in collapsing of 6 cases into 2 categories for 5 overall DOOR scores that significantly differed from each other (Table 1 for final ranking). Patients and clinicians had significantly different preferred ranking for 6 DOOR cases. Our PFAC had several hypotheses as to why rankings differed (Table 2). **Conclusion:** We present a novel DOOR score derived from patient and clinician reported preferences for outcomes of hospitalized adult patients with CAP. Clinicians and patients differed in their perception of certain outcomes with patients ranking symptoms that were uncomfortable but

Table1. Desirability of Outcome Ranking (DOOR) Combining Physician and Patient Survey Results[a]

Final Ranking	Clinician ranking (median (IQR))	Patient ranking (median (IQR))	p value*	Description of clinical outcome 2 weeks after initial emergency department visit
1	1.0 (1.0 to 1.0)	1.0 (1.0 to 1.0)	0.183	Not hospitalized, no PNA symptoms, no anitibiotic AE
2	3.0 (2.0 to 3.0)	4.0 (3.0 to 4.5)	*0.002*	Not hospitalized, no PNA symptoms, nausea and vomiting requiring antiemetic during hospitalization
2	3.0 (2.0 to 4.0)	2.0 (2.0 to 3.0)	*0.04*	Not hospitalized, non-limiting residual PNA symptoms, no antibiotic AE
2	3.0 (2.0 to 4.0)	4.0 (3.0 to 6.0)	*0.02*	Not hospitalized, no PNA symptoms, non-limiting nausea and diarrhea after hospitalization
3	5.0 (5.0 to 6.0)	5.0 (3.0 to 7.0)	0.200	Not hospitalized, limiting residual PNA symptoms, no antibiotic AE
3	6.0 (5.0 to 6.0)	7.0 (6.0 to 7.5)	0.053	Not hospitalized, no residual PNA symptoms, C difficile infection requiring visit and treatment
3	7.0 (6.0 to 7.0)	5.0 (4.5 to 6.0)	*<0.001*	Not hospitalized, no residual PNA symptoms, MDRO UTI requiring IV antibiotics
4	8.0 (8.0 to 8.0)	8.0 (7.0 to 8.0)	*0.03*	Hospitalized, any or none PNA symptoms, any or none antibiotic AE
5	9.0 (9.0 to 9.0)	9.0 (9.0 to 9.0)	*0.04*	Patient has died

*Comparisons made using Mann Whitney U test, p<0.05 considered significant. [a]Rankings ordered based on physician median and IQR, similar rankings color coded. Abbreviations: PNA, pneumonia; AE, adverse event; MDRO UTI, multi-drug resistance organism urinary tract infection.

Table 2. Selected quotes from PFAC meeting paired with clinical outcome cases

Clinical Outcome Case	Physician and patient ranking difference	PFAC patient or family exemplar quote
Patient has died.	Patient ranked more desirable	"Sometimes, when very ill, patients might feel like they've had enough. Chronic discomfort can make death seem like a relief. The severity of symptoms can be very subjective."
Not hospitalized, no PNA symptoms, nausea and vomiting requiring antiemetic during hospitalization. AND Not hospitalized, no PNA symptoms, non-limiting nausea and diarrhea after hospitalization.	Patient ranked more undesirable	"There's a difference in perspective between doctors and patients. Doctors might not prioritize what patients have to live with in terms of symptoms. Patients are focused on what's bad for them personally."
Not hospitalized, no residual PNA symptoms, C difficile infection requiring visit and treatment.	Patients ranked more undesirable (p=0.053)	"I agree that C. diff is the worst. It's a significant risk throughout a patient's life once infected. I rate it very high on the severity scale."
Requiring readmission, any or none PNA symptoms, any or none AE.	Patients ranked more desirable	"As someone that works in a health system, when I see what the docs think are worse, those are things that in a health system you're conditioned to think are worse."

Abbreviations: PFAC, patient and family advisory committee; PNA, pneumonia; AE, adverse event.

not potentially life-threatening as less desirable than physicians. Physicians tended to rank quality linked metrics such as readmission as worse than patients. When designing future trials using DOOR scores, researchers should consider including patients in DOOR score design as their perspectives may differ from clinicians.

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Effect of UTI treatment guideline implementation on antibiotic duration and selection

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Background: Clinicians have variable prescribing practices for treating urinary tract infections (UTI), resulting in broader and longer treatment durations than necessary. In March 2023, guidelines for UTI treatment were developed and disseminated across our hospital system. **Methods:** We evaluated inpatients at Emory University Hospital (EUH) who received antibiotics with an indication of UTI between November 2022 and March 2024 to investigate implementation effect on treatment duration and choice. We characterized days of therapy (DOT) by performing interrupted time series analysis, adjusting for demographic and clinical variables. Additionally, we looked at percent use of guideline concordant antibiotics chosen before and after implementation. **Results:** A total of 978

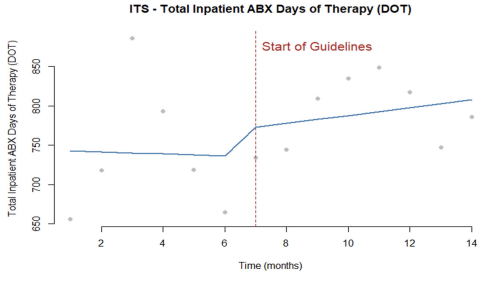

Figure 1: Inpatient DOT
Following implementation, increase by 31.5 DOT/month with a sustained increase by 6.25 DOT/month with no statistically significant change

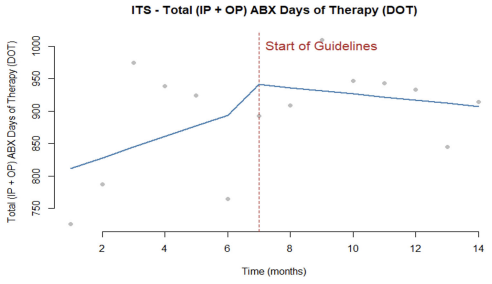

Figure 2: Total DOT (Inpatient + Outpatient)
Following implementation, sustained decrease by 21.1 DOT/month with no overall statistical significance

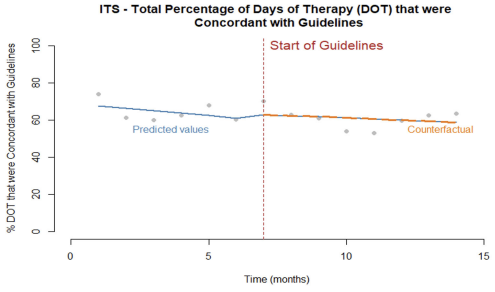

Figure 3: Inpatient Guideline Concordance Prescribing
Following implementation, increase by 2.5% per month with a sustained increase by 0.7% per month with no statistically significant change

Clinical Outcome	Pre-Guidelines (n = 978)	Post-Guidelines (n = 1420)	Estimate or OR (95% CI)	*P* value	Adjusted Estimate or OR (95% CI)[a]	*P* value
LOS, mean (SD)	12.4 (20.4)	11.0 (16.2)	-1.4 (-2.9, 0.07)	0.06	-1.2 (-2.6, 0.13)	0.08
Positive *C.difficile* test w/in 90 Days, n (%)	9 (0.9%)	17 (1.2%)	1.3 (0.59, 3.1)	0.52	1.3 (0.60, 3.1)	0.51

Table 1: Crude and Risk-Adjusted Secondary Outcomes
LOS (length of stay) and rates of C. diff were not statistically significant