| | No Consultation (n = 47) | Tele-ID Consultation (n = 75) | Total (n = 122) | P value |
|--|-----------------------------|-------------------------------------|-----------------|---------|
| Standard of Care | | | | |
| With appropriate antibiotics | 7 (15%) | 68 (91%) | 75 (61%) | < .01 |
| With first-line antibiotics | 1 (2%) | 65 (87%) | 66 (54%) | <.01 |
| Clearance documented | | | | < .01 |
| Not performed | 11 (23%) | 1 (1%) | 12 (10%) | |
| No – died or hospice | 5 (11%) | 4 (5%) | 9 (7%) | |
| Yes | 31 (66%) | 70 (93%) | 101 (83%) | |
| Echocardiogram | | | | < .01 |
| TTE | 24 (50%) | 72 (99%) | 96 (79%) | |
| TEE | 5 (11%) | 25 (33%) | 30 (25%) | |
| Appropriate Antibiotics | | | | |
| Overall | 16 (35%) | 74 (99%) | 90 (74%) | < .01 |
| Dose | 27 (100%) | 74 (100%) | 101 (100%) | 1 |
| Duration | 15 (36%) | 71 (100%) | 86 (76%) | <.01 |
| First-line Antibiotic Used | 16 (34%) | 71 (95%) | 87 (71%) | <.01 |
| Additional <u>Cross</u> Sectional Imaging | 22 (63%) | 56 (76%) | 78 (72%) | .17 |
| Source Control Procedure | 9 (60%) | 32 (73%) | 41 (69%) | .36 |

| | No Consultation (n = 47) | Tele-ID Consultation (n = 75) | Total (n = 122) | P Value |
|--------------------------------|-----------------------------|-------------------------------------|-----------------|---------|
| 30-day SAB-related mortality | 11 (24%) | 5 (7%) | 16 (14%) | <.01 |
| 90-day SAB-related mortality | 11 (25%) | 6 (8%) | 17 (15%) | <.01 |
| 30-day SAB-related readmission | 7 (15%) | 8 (11%) | 15 (12%) | .49 |
| 90-day SAB-related readmission | 7 (15%) | 14 (19%) | 21 (17%) | .59 |
| 30-day relapsed SAB | 4 (9%) | 5 (7%) | 9 (7%) | .72 |
| 90-day relapsed SAB | 5 (11%) | 9 (12%) | 14 (11%) | .82 |

| | In-Person (n = 35) | Tele-ID (n = 93) | Total (n = 128) | P value |
|--|---------------------|-------------------------|-------------------------|---------|
| Initial Vanderbilt Campus | | | | .02 |
| Tullahoma | 14 (40%) | 17 (18%) | 31 (24%) | |
| Bedford | 1 (3%) | 11 (12%) | 12 (9%) | |
| Wilson County | 20 (57%) | 65 (70%) | 85 (66%) | |
| Age – Median (Q1, Q3) | 53 (41, 72) | 66 (56, 74) | 64 (52, 74) | .01 |
| BMI – Median (Q1, Q3) | 27.89 (24.9, 34.92) | 26.02 (22.43, 32.64) | 26.44 (23.04, 33.08) | .12 |
| Non-white Race | 3 (9%) | 8 (9%) | 11 (9%) | 1 |
| Uninsured | 7 (20%) | 10 (11%) | 17 (13%) | .18 |
| Charlson Comorbidity Index – Median (Q1, Q3) | 2 (1, 3) | 3 (2, 4) | 3 (2, 4) | .01 |
| IVDU | 6 (18%) | 3 (3%) | 9 (7%) | < .01 |
| ESRD on RRT | 3 (9%) | 16 (17%) | 19 (15%) | .22 |
| Indwelling Hardware | 13 (37%) | 50 (54%) | 63 (49%) | .09 |

SAB (91% vs 15%, p < .01). This finding was consistent across all hospitals and among the individual components of the primary outcome. In addition, Tele-ID consultation was associated with significantly decreased SAB-related 30-day mortality (7 vs 24%, p < .01) and SAB-related 90-day mortality (8 vs 25%, p < .01). No significant difference was observed in rates of readmission or relapsed bacteremia. **Conclusion:** In this retrospective cohort study of 122 patients with SAB cared for in rural, academic affiliated hospitals, Tele-ID consultation was associated with a significantly increased likelihood of receiving standard of care and decreased mortality.

| | In Person (n = 35) | Tele-ID (n = 93) | Total (n = 128) | P value |
|---|--------------------|------------------|-----------------|---------|
| Length of Stay – Median days (Q1, Q3) | 13 (7.5, 19.5) | 9 (6, 16) | 10 (6, 16) | .14 |
| MRSA | 13 (37%) | 57 (61%) | 70 (55%) | .01 |
| Bacteremia Duration – Median Days (Q1, Q3) | 4 (2.5, 5.5) | 3 (2, 5) | 3 (2, 5) | .15 |
| Persistent Bacteremia | 18 (51%) | 36 (41%) | 54 (44%) | .29 |
| Uncomplicated SAB | 5 (14%) | 21 (23%) | 26 (20%) | .30 |
| Location of Acquisition | | | | .25 |
| Community | 30 (86%) | 78 (84%) | 108 (84%) | |
| Care Facility | 5 (14%) | 9 (10%) | 14 (11%) | |
| Hospital | 0 (0%) | 6 (6%) | 6 (5%) | |
| Time to ID Consultation – Median Days (Q1, Q3) | 1 (1, 2) | 3 (2, 5) | 3 (2, 5) | <.01 |
| Time to First Source Control Procedure | 1.5 (1, 3.75) | 2 (1, 3) | 2 (1, 3.25) | .79 |
| ICU Transfer | 2 (9%) | 9 (14%) | 11 (13%) | .49 |
| Initially Admitted to ICU | 11 (32%) | 28 (31%) | 39 (31%) | .86 |
| Salvage Therapy | 10 (29%) | 12 (13%) | 22 (17%) | .01 |
| Antibiotic Adverse Event | 5 (14%) | 5 (5%) | 10 (8%) | .09 |
| | | | | |

| | In-Person (n = 35) | Tele-ID (n = 93) | Total (n = 128) | P- value |
|--|--------------------|------------------|-----------------|----------|
| Standard of Care | | | | |
| With appropriate antibiotics | 33 (94%) | 86 (92%) | 119 (93%) | .72 |
| With first-line antibiotics | 31 (89%) | 79 (85%) | 110 (86%) | .60 |
| Clearance Documented | | | | |
| Not performed | 0 (0%) | 1 (1%) | 1 (1%) | |
| No – died or hospice | 0 (0%) | 4 (4%) | 4 (3%) | |
| Yes | 35 (100%) | 88 (95%) | 123 (96%) | |
| Echocardiogram | | | | |
| TTE | 35 (100%) | 90 (96%) | 125 (99%) | |
| TEE | 16 (46%) | 35 (38%) | 51 (40%) | |
| Appropriate Antibiotics | | | | |
| Overall | 33 (94%) | 92 (99%) | 125 (98%) | .12 |
| Dose | 34 (97%) | 92 (100%) | 126 (99% | .10 |
| Duration | 34 (97%) | 88 (100%) | 122 (99%) | .11 |
| First-line Antibiotic Used | 33 (94%) | 86 (92%) | 119 (93%) | .72 |
| Additional <u>Cross</u> Sectional Imaging | 34 (97%) | 72 (78%) | 106 (83%) | .01 |
| Source Control Procedure | 18 (67%) | 42 (71%) | 60 (70%) | .67 |

This data will inform policy at regional hospitals, such as supporting a mandatory ID consult for SAB and implementation of a SAB bundle.

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Presentation Type:

Oral Presentation

Subject Category: Quality Improvement

Using Culture and Whole Genome Sequencing to Assess Sterilization to Reduce Bacterial Contamination of Ventilator Heater Wires

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Ventilator-associated events (VAEs), including ventilator-associated pneumonia (VAP), are important among hospitalized patients due to their

high morbidity, mortality, and associated costs. These infections are freby multidrug-resistant ESKAPE caused (Enterococcus, Staphylococcus, Klebsiella, Acinetobacter, Pseudomonas, and Enterobacter), which are known for their antibiotic resistance.

Heater wires used in mechanical ventilators regulate air humidity and temperature which prevents complications when the upper airway is bypassed. However, because these are in direct contact with the air supplied to patients, they can become sources of infection and reservoirs for antimicrobial-resistant organisms.

At a hospital in New Mexico, we transitioned from using low-level disinfectant wipes to sterile processing for heater wires. The dry climate in New Mexico accelerates the evaporation of disinfectants, reducing their effectiveness by shortening their contact time. Additionally, achieving full surface coverage with disinfectant wipes is difficult, compromising sterilization effectiveness.

To address these challenges, we implemented a protocol to send heater wire probes to sterile processing for sterilization. We evaluated the impact of this change by comparing the prescence of bacteria on the probes before and after sterilization. Swabs from heater wire prongs were cultured and sequenced using Oxford Nanopore Technology. Metagenomic sequencing and analysis was also performed.

Before the new protocol, we swabbed 19 clean probes and 11 used probes. Bacterial DNA was detected on all clean probes and bacterial growth found on 42% of clean probe cultures. Of these, 63% were positive for ESKAPE pathogens, with five out of eight probes showing all ESKAPE species, and three probes lacking only Enterobacter. Additionally, all of the clean probe cultures were positive for Stenotrophomonas, another well known multi-drug resistant pathogen. After the autoclaving protocol was implemented, no bacterial growth was observed cultures (72 hours) of freshly sterilized probes. In conclusion, sterilization significantly improved the cleanliness of heater wires over use of disinfectant wipes. This improved sterilization protocol is expected to reduce the risk of infection transmission and the incidence of VAEs, thereby improving patient safety and outcomes.

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Presentation Type:

Oral Presentation

Subject Category: SSI

Results From The AHRQ Safety Program for MRSA Prevention: Targeting SSI in High-Risk Surgical Services- Process Measures and Outcomes

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¹Johns Hopkins University School of Medicine; ²Agency for Healthcare Research and Quality; ³Johns Hopkins Armstrong Institute for Patient Safety and Quality; ⁴NORC at the University of Chicago; ⁵JHU School of Medicine and ⁶Armstrong Institute for Patient Safety & Quality

Background: The Agency for Healthcare Research and Quality Safety Program for MRSA Prevention Surgical Services cohort aimed to reduce surgical site infections (SSIs) and prevent methicillin-resistant Staphylococcus aureus (MRSA) in teams performing surgeries at high risk for infection with and high morbidity due to MRSA (cardiac, knee or hip replacement, and spinal fusion) using evidence-based infection prevention interventions and the Comprehensive Unit-based Safety Program (CUSP) framework. We report process and outcome measures associated with program participation. Methods: The Surgical Services Safety Program for MRSA Prevention was implemented from January 2023 to June 2024. The aim was to increase teamwork and collaboration, reinforce safety culture, implement evidence-based infection prevention practices, and decrease SSIs and MRSA. The project team provided 22 live webinars, supporting materials, and other tools to assist surgical teams (Table 1). Teams were also assigned an implementation advisor who provided support through monthly coaching calls.

Table 1. Educational Toolkit Content for the AHRQ Safety Program for MRSA and SSI Prevention

| Introduction to the ANRO, Safety Program for MRSA Prevention: Targeting SSI Omboarding Webiner Inter Compenhancia Webiner Inter Compenhancia Unite Based Safety Program (CUSP) Importance of MRSA and SSI Prevention CUSP: Learning from Defects Importance of MRSA and SSI Prevention CUSP-Learning from Defects Decolonization Stratagies Decolonization Implementation Decolonization Implementation Use of Pre-Operation Chemberdina MRSA Surveillance Review of SSI Program Tools Decolonization Implementation. A Pear-to-Pear Perspective Antimicrobial Prophylaxis: Part 2 Beyond the Basics Hartimicrobial Prophylaxis: Part 3 Beyond the Basics Hartimicrobial Prophylaxis: Part 2 Beyond the Basics Hartimicrobial Prophylaxis: Part 2 Beyond the Basics Hartimicrobial Prophylaxis: Part 3 Beyond the Basics Hartimicrobial Prophylaxis and Normania Anti-Part 2 Beyond the Basics Hartimicrobial Prophylaxis and Normania Anti-Part 2 Beyond the Basics Hartimicrobial Prophylaxis Duration Departure from Control for Infection Control Hartimicrobial Prophylaxis Duration Departure from Control for Infection Control Hartimicrobial Prophylaxis Duration Departure from Decolonization Agent Hartimicrobial Prophylaxis Duration USP Landing Protocolonization Agent Hartimicrobial Prophylaxis Duration USP Landing Formania (Leaning Machas and Step Prevention USP Landing Formania (Leaning Machas and Step Prevention USP Landing Formania | Table 1. Educational Toolkit Content for the AHRQ Safety Program for MRSA and SSI Prevention |
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| Hospital Survey on Patient Safety Culture and Instructions | Service-Level Clinical Data Collection Templates and Instructions |
| | Hospital Survey on Patient Safety Culture and Instructions |
| | *Each webinar has an associated recording, slide set, and script |

Teams submitted baseline and endline information on patient safety culture and on infrastructure at the team- and hospital-level, as well as monthly data regarding process measures and SSIs. Teams submitted SSI data from 12 months prior to the start of the program and for 18 months after program implementation. Changes were assessed using