standardization, a lookback manual detailing of investigation procedures was created in 2009 and was updated subsequently. The contents of this manual include identifying and notifying patients; providing services to veterans responding to notifications; laboratory testing algorithms; disclosure and documentation of test results and clinical follow-up; and epidemiologic investigation of patients with newly identified infection. (3) Prompt patient notification and obtaining adequate samples for initial and follow-up pathogen genetic testing is critical. Determination of genetic linkages was greatly limited because specimens were unavailable for supplemental testing. (4) Ethics and legal counsel staff are key partners in providing guidance on appropriate disclosure procedures and documentation. (5) Designating a single mechanism for reporting results ensures consistent communication among stakeholders. (6) Education of dental staff on importance of following the manufacturers' cleaning recommendations, not using outside equipment and reporting instances of concern promptly can help prevent future infection control breaches.

Presentation Type:
Poster Presentation
Leveraging Electronic Health Record Clinical Decision Support to Identify *Clostridium difficile* Infection in Clinically Appropriate Patient Populations

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Background: In 2017, the IDSA and the SHEA released updated *Clostridium difficile* practice guidelines. Implementing institutionally accepted criteria for identifying clinically appropriate patients for testing was endorsed. When utilizing NAAT as the sole laboratory testing methodology, testing clinically symptomatic patients is important to reduce inappropriate treatment of *C. difficile* colonization. *C. difficile* rates at a regional community health system were higher than expected, and patient case reviews identified inappropriate patient testing as an issue. Therefore, the infection prevention team sought to optimize and standardize protocols surrounding appropriate patient selection for *C. difficile* testing. **Methods:** Current recommendations were evaluated, and processes formulated to implement an innovative process to support our clinicians in identifying clinically appropriate patients to test for *C. difficile* infection. The electronic decision support is summarized as a bundled approach with 4 best practice alerts that incorporate algorithms that warn providers of potentially inappropriate testing scenarios. These alerts include the following criteria: (1) a laxative having been administered within 48 hours of attempted order, (2) a negative test resulted within 7 days, (3) a positive test resulted within 14 days, and (4) identification of patients at high risk for *C. difficile* infection (based on recent long-term care facility exposure, recent inpatient hospital visits, recent antimicrobial therapy).

Outcomes of our acute-care hospitals were monitored by real-time evaluation of each hospital's quarterly *C. difficile* LabID standardized infection ratio (SIR) as defined by the NHSN. For statistical analyses, the cumulative second and third quarters of 2018 (before the intervention) were compared to the cumulative second and third quarters of 2019 to account for seasonality of *C. difficile* infections. **Results:** Utilizing the NHSN statistical calculator to compare 2 SIRs, there was a statistically significant decrease ($P = .0026$) in the largest hospital's *C. difficile* LabID SIR when comparing representative preintervention cumulative quarters to the postintervention cumulative quarters. Although the other hospitals did not see a statistically significant decrease in their *C. difficile* LabID SIR, a clinically significant decrease was appreciated for 2 of our hospitals. **Conclusions:** Electronic health record–based decision support helps clinicians identify clinically appropriate patients to test by NAAT alone for *C. difficile* infection. By limiting the number of patients tested without clinical signs or symptoms of infection and/or after receiving laxatives, hospitals more accurately capture their true *C. difficile* rates and maximize reimbursement based on this measure within the CMS Safety of Care Measure.

Presentation Type:
Poster Presentation
Leveraging Local Expertise in Stewardship, Hospital Epidemiology and Public Health to Enrich Postgraduate Training in NYC

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Background: New York City is a gateway for emerging pathogens and global threats. In 2013, faculty from Montefiore Medical Center and Memorial Sloan Kettering developed a free half-day workshop for postgraduate trainees in antimicrobial stewardship (AS), infection prevention (IP), hospital epidemiology, and public health. This annual workshop, sponsored by the Infectious Diseases Society of New York (IDSNY), incorporates case studies and expert panel discussions on timely topics such as Ebola, *Candida auris*, *Clostridioides difficile*, measles, nosocomial influenza, drug shortages, and AS/IP "big data." **Methods:** From 2013 through 2017, the workshop involved 10–15 interactive AS/IP cases with audience response questions and panel discussions. In 2018–2019, based on feedback, the format was revised to emphasize breakout sessions in which participants actively practiced AS/IP tools, (eg, medication utilization evaluations, epidemiologic curves, and performance improvement devices). Examples of 2018–2019 cases

NHSN CLDI LABID SIR							
Facility		2018 Quarter 2 & Q3			2019 Quarter 2 & Q3		
	Beds	Observed	Expected	NHSN SIR	Observed	Expected	NHSN SIR	Two-tailed P value
York Hospital	585	59	55.883	1.056	30	55.03	0.545	0.0026
Ephrata Hospital	159	4	6.22	0.643	2	6.137	0.326	0.4626
Gettysburg Hospital	76	3	3.997	0.751	3	5.071	0.592	0.7800

Table. 1.