oncology status), diagnostic testing, TB identification, airborne precaution duration, and costs. EPTB evaluation was defined by initiation of the institutional pathway (e.g., airborne precautions and PTB rule-out orders). Laboratory and PPE costs were estimated using institutional unit costs. PPE utilization was estimated using a workflow-based assumption of 14 room entries per day. Sensitivity analyses used 10 and 18 daily room entry assumptions. Environmental impact was assessed descriptively via estimated PPE encounters. Results Thirty-eight patients undergoing evaluation for EPTB were included (133 airborne precaution days). Twenty-five (65%) had no identified epidemiologic TB risk factors; many had nonspecific pulmonary findings. Two (5%) had hematologic malignancies. Estimated laboratory cost was $4,640.38 ($122.12/patient). Estimated PPE cost was $2,197.16 ($57.82/patient), with sensitivity estimates ranging from $1,510–$2,719. The combined estimated direct cost was $6,837.54 ($179.94/patient). Under base-case assumptions, airborne precautions generated 1,862 PPE encounters. Among this 38-patient EPTB evaluation cohort, 1 case of EPTB and 0 cases of PTB were identified. Conclusions In this cohort, routine PTB rule-out and airborne precautions were applied during evaluation for possible EPTB, yet no patients were diagnosed with PTB. Although direct laboratory and PPE costs were modest, this practice generated substantial airborne precaution days and imposed unmeasured burdens, including delays in care/procedures, reduced quality of care, and additional staff/provider time. Environmental impacts beyond estimated PPE utilization were not captured. These findings suggest the current universal approach overestimates risk in this population. A targeted, risk-stratified approach aligned with epidemiologic risk, clinical suspicion, and guideline-based recommendations may reduce unnecessary precautions and testing while maintaining patient and staff safety.

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Poster Presentation
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Effect of a Diagnostic Order Set on Sexually-Transmitted Infection Co-Testing ‡

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Background: National guidelines recommend that anyone diagnosed with a sexually transmitted infection (STI) be tested for other STIs. However, in the majority of cases, appropriate STI co-testing is not performed. Additionally, STI diagnosis is often a missed opportunity for referral for HIV pre-exposure prophylaxis (PrEP). Order sets can be an effective tool within electronic medical records (EMR) to standardize diagnostic and therapeutic pathways. We sought to improve STI co-testing, PrEP referrals, and antimicrobial management through the implementation of a diagnostic and treatment order set within the Durham VA Health Care System (DVAHCS). **Methods:** An STI order set prompting co-testing was implemented in September of 2024 across DVAHCS. STI co-testing rates were analyzed one year pre- and post-implementation. Interrupted time series (ITS) analysis was performed using Gaussian regression to evaluate the effect of order set implementation for both co-testing of gonorrhea, chlamydia and syphilis (GCS) and additional cotesting for HIV (total STI). New starts and overall administration of HIV PrEP and order set utilization for therapeutics were analyzed using incidence rate ratios (IRRs) comparing incidence rates pre- and post-implementation. **Result:** The GCS cotesting IRR was 0.991 (p p p p p p p p p = 0.582). (Figure 3) The treatment order set was used on average 24.6% of the time after implementation. (Figure 4) **Conclusion:** The implementation of a STI co-testing order set did not change the rate of co-testing for chlamydia, gonorrhea, syphilis and HIV. An accompanying treatment order set was used to a significant degree, although in a minority of cases. There was no significant change in the initiation of PrEP after implementation of the order set as compared to prior. Our study was limited by small numbers of incident STI diagnoses. Further research is warranted to understand the optimal ways towards increasing recommended testing patterns and how tools within EMRs can assist with this goal.

Quarter	Incident diagnoses	STI cotesting	STI cotesting percentage	HIV cotesting	STI and HIV cotesting	Full cotesting percentage
2023q3	16	10	62.50	12	10	62.50
2023q4	43	32	74.42	33	31	72.09
2024q1	32	22	68.75	25	21	65.63
2024q2	22	15	68.18	19	15	68.18
2024q3	35	25	71.43	27	23	65.71
2024q4	36	28	77.78	31	28	77.78
2025q1	31	23	74.19	24	22	70.97
2025q2	38	26	68.42	30	25	65.79
2025q3	33	22	66.67	23	20	60.61

Quarter	Ceftriaxone	Moxifloxacin	Penicillin G	Order set	Total	% Order set
2023q3	18	1	2	0	21	0.00%
2023q4	32	3	5	0	40	0.00%
2024q1	43	4	9	0	56	0.00%
2024q2	38	10	7	0	55	0.00%
2024q3	30	16	10	7	56	12.50%
2024q4	27	15	7	11	49	22.45%
2025q1	27	27	6	23	60	38.33%
2025q2	39	14	14	17	67	25.37%
2025q3	36	14	3	12	53	22.64%

Quarter	Unique starts	Total eligible	On PrEP	Not on PrEP	On PrEP %
2023q3	11	761	196	576	27.20%
2023q4	5	804	209	600	26.62%
2024q1	1	795	212	584	26.79%
2024q2	2	795	208	589	26.42%
2024q3	4	810	215	599	27.04%
2024q4	5	883	245	643	28.31%
2025q1	3	914	258	659	28.56%
2025q2	6	889	248	647	28.57%
2025q3 (Aug)	1	606	165	442	27.39%

Cotesting	Control Dates	Intervention Dates	Control STI diagnoses	Intervention STI diagnoses	Control cotesting (%)	Intervention cotesting (%)	Pre-intervention Slope (95% CI, p-value)	Intervention Change (95% CI, p-value)	Post-intervention Slope (95% CI, p-value)	Cotesting IRR (95% CI, p-value)
Chlamydia, gonorrhea and syphilis cotesting	9/2023-8/2024	9/2024 - 9/2025	136	150	71.32	70.67	0.005 (95% CI -0.015, 0.025, P = 0.60)	-0.014 (95% CI -0.20, 0.18, P = 0.89)	-0.008 (95% CI -0.034, 0.018, P = 0.56)	0.99 (95% CI 0.75, 1.30, P = 0.95)
Total STI cotesting	9/2023-8/2024	9/2024 - 9/2025	136	150	69.12	67.33	0.002 (95% CI -0.018, 0.022, P = 0.84)	0.023 (95% CI -0.16, 0.21, P = 0.81)	-0.009 (95% CI -0.035, 0.017, P = 0.52)	0.97 (95% CI 0.74, 1.29, P = 0.86)

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Colonizer or Culprit? Significance of Stenotrophomonas maltophilia in Urine Cultures‡

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Background: Stenotrophomonas maltophilia isolated from urine cultures often reflects colonization, however true urinary tract infection (UTI) can occur. At Massachusetts General Hospital, antimicrobial susceptibility testing (AST) is routinely performed on urinary S. maltophilia isolates when present in at least moderate amounts or is the predominating organism from a non-sterile culture source. We evaluated patients with S. maltophilia urinary isolates to characterize treatment practices, determine the proportion of isolates representing definitive UTI, and assess recurrence by treatment status to evaluate whether limiting routine AST could reduce laboratory workload and avoid unnecessary antibiotic prescribing. **Methods:** We performed a retrospective cohort study of patients with positive urine cultures containing S. maltophilia between May 1, 2021 and

‡The abstract titles in this supplement have been corrected since original publication. A notice detailing the changes has been published at https://doi.org/10.1017/ash.2026.10802.

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