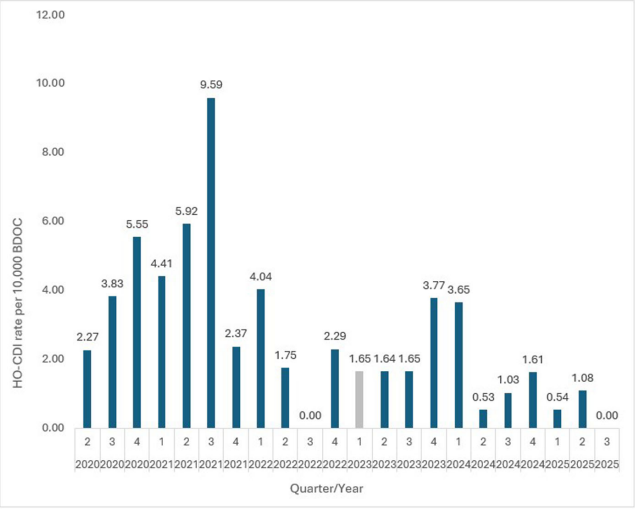
Figure 1 Hospital-Onset Healthcare Facility-Associated *Clostridioides difficile* Infections (HO-HCFA CDI) per 10,000 bed days of care between April 1, 2020, to September 30, 2025



Institutional antimicrobial guidelines were developed for common infections, and educational presentations were delivered to providers, using illustrative cases to highlight key stewardship principles. ASP team members audited 2,282 patient charts from April 1, 2023, through September 30, 2025. Interventions were made for 1,215 (53%) patients, and prescribers accepted 972 (80%) recommendations. Common interventions consisted of either antibiotic discontinuation or de-escalation in 74% of patients. Mean quarterly high-risk CDI antibiotic use declined from 95 to 71 per 1,000 BDOC (25%, p<0.01), and HO-CDI rates declined 59% from 3.81 (pre) to 1.55 (post) infections per 10,000 BDOC. **Conclusion:** A multi-pronged approach of reinforcing IPC practices, 2-step testing, and targeted feedback for antibiotics use led to significant decreases in HO-CDI rates.

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Presentation Type:
Poster Presentation
Subject Category: C. difficile
Physician Approach to Indeterminate Clostridioides difficile Test Results‡

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Background: Clostridioides difficile infection (CDI) has been diagnosed with a variety of test methods that vary in their sensitivity and specificity. Because of concerns over potential overdiagnosis of clinical CDI, a single step method was adopted in May 2023 with glutamate dehydrogenase (GDH) and toxin enzyme immunoassay (EIA) with nucleic acid amplification test (NAAT) only to be ordered by clinicians who had ongoing clinical suspicion of CDI despite indeterminate test results. We aimed to describe the physician response to indeterminate test results, evaluate the percentage of people who had re-admission within 90 days for all-cause mortality and those with re-admission for diarrhea Methods: A multicenter historical cohort study was conducted among patients who were found to have GDH+/toxin- C. difficile results from 6/1/2023 to 12/31/24. Data were collected by retrospective chart review on the initial hospitalization and subsequent episodes of CDI in the following 90 days based on receipt of treatment for the initial episode of GDH+/toxin-. Data were analyzed using Student's t-test, the Mann-Whitney U test, and the chi-squared test, using SPSS v. 31.0. **Results:** Of 382 patients, 380 had complete information on treatment history. Of these patients, 25% were treated (95/380). Among 285 patients with indeterminate C.difficile tests who were untreated and had re-admission in 90 days for diarrhea, only 2.1% were diagnosed with C.difficile colitis on the follow up admission. Patients who received vancomycin alone had the highest percentage of re-admission among other treatment options. Patients with chronic steroid use (p=0.05), other immunosuppressive agents (p=0.02) and with inflammatory bowel disease (IBD) (p=0.002) were significantly more likely to be readmitted for diarrhea within 90 days. **Conclusion:** A physician-based approach reduces overtreatment of indeterminate C. difficile results using a single step reporting method with only a small number of patients readmitted with CDI within 90 days.

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Presentation Type:
Poster Presentation
Subject Category: C. difficile
Patient and Provider Differences between Treated and Untreated Cases of PCR ( )/Toxin EIA (−) clostridioides difficile Infections‡

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Background: Patients with NAAT positive/toxin EIA-negative C. difficile infections (TNCDI) represent a spectrum from fulminant infection to asymptomatic colonization. We assessed differences in patient and provider factors associated with TNCDI treatment. **Methods:** A retrospective review was performed of all hospitalized patients ≥ 18 years with TNCDI from Jan 1st 2018 to Dec 31st 2024. Patients who received anti-CDI

Table – Characteristics and predictors of treatment in NAAT positive/toxin EIA-negative CDI (TNCDI)

Variable	Total N=550	Treated TNCDIN= 488, 88.7 %	Untreated TNCDIN= 62, 11.3%	p-value	Multivariable Odds Ratio for treatment (95% C.I.)
Age median [IQR]	63.00 [50.00, 74.00]	63.00 [50.00, 74.00]	64.00 [49.00, 78.75]	0.343	
Gender					
Female	281 (51.1)	242 (49.6)	39 (63.9)	0.066	0.62 (0.35-1.06)
Ethnicity					
Hispanic or Latino	69 (12.5)	61 (12.5)	8 (12.9)	1.000	
Race					
White	237 (43.1)	211 (43.2)	26 (41.9)	0.953	
BMI median [IQR]*	25.08 [21.64, 30.01]	25.09 [21.66, 30.09]	24.18 [21.19, 28.68]	0.435	
Selected Comorbid Conditions					
Charlson Comorbidity Index median (IQR)	3.00 [1.00, 6.00]	3.00 [1.00, 6.00]	2.00 [0.00, 6.00]	0.145	1.02 (0.94-1.12)
Charlson Comorbidity Index >= 3	295 (53.6)	266 (54.5)	29 (46.8)	0.310	
Solid Organ or Bone Marrow Transplant	78 (14.2)	74 (15.2)	4 (6.5)	0.097	2.32 (0.90-7.92)
SOT	40 (7.3)	38 (7.8)	2 (3.2)		
BMT	38 (6.9)	36 (7.4)	2 (3.2)		
Metastatic Solid Tumor	83 (15.1)	71 (14.5)	12 (19.4)	0.419	
Community-acquired CDI	368 (66.9)	319 (65.4)	49 (79.0)	0.044	0.50 (0.26-0.93)
Provider Service				0.551	
Internal Medicine	274 (49.8)	244 (50.0)	30 (48.4)		
Oncology/BMT	112 (20.4)	103 (21.1)	9 (14.5)		
Surgery	57 (10.4)	48 (9.8)	9 (14.5)		
ICU	68 (12.4)	60 (12.3)	8 (12.9)		
Therapy					
Vancomycin	411 (74.7)	411 (84.2)	0 (0)		
Fidaxomicin	182 (33.1)	182 (37.3)	0 (0)		
Metronidazole	63 (11.5)	63 (12.9)	0 (0)		
Outcomes					
LOS after *C. difficile* diagnosis median days (IQR)	5.87 [2.70, 12.09]	6.12 [2.80, 12.77]	4.34 [1.77, 7.86]	0.006	
Any *C. difficile* Reoccurrence	63 (11.5)	58 (11.9)	5 (8.1)	0.498	
Multiple *C. difficile* Reoccurrences	15 (2.7)	14 (2.9)	1 (1.6)	0.874	
Diarrhea within 90 days following SOC ABX initiation	27 (4.9)	27 (5.5)	0 (0.0)	0.112	
Mortality within 90 days following SOC ABX initiation	44 (8.0)	44 (9.0)	0 (0.0)	0.027	

*For BMI, total N=329, Treated TNCDI N=284, Untreated TNCDI N=45

For C difficile to first reoccurrence, total N=63, Treated TNCDI N=58, Untreated TNCDI N=5

‡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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