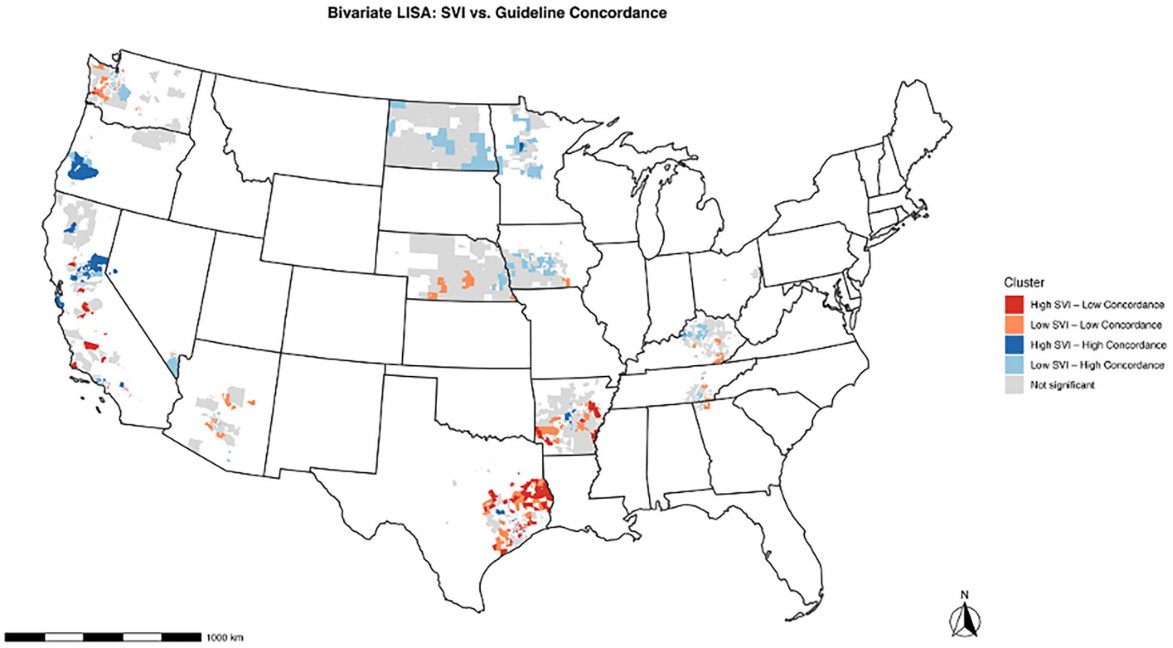
**Figure 1.** Bivariate LISA map of IV-predicted SVI and guideline-concordant antibiotic selection across US census tracts




***Notes:*** Global Moran's test showed spatial dependence between predicted SVI and guideline concordance (I = -0.04, P = 0.0003), indicating a modest negative spatial association. The distribution included 625 high-SVI/ high-concordance, 725 low-SVI / low-concordance, 636 low-SVI / high-concordance, 801 high-SVI/ low-concordance, and 3338 non-significant clusters. High-SVI/ low-concordance clusters were largely located in the South, and low-SVI/ high-concordance clusters were mainly seen in the Midwest. Predicted SVI values were obtained from the instrument value model using maximum EITC. The adjusted values were then obtained after regressing on other variables. LISA: Local Indicators of Spatial Association; SVI: Social Vulnerability Index

to longer travel time, higher tract non-employment, household crowding, and lack of vehicle access. Regions of high deprivation and lower concordance clustered predominantly in the South, whereas higher-concordance areas were concentrated in the Midwest (Figure 1). **Conclusions:** Community disadvantage was associated with lower guideline-concordant antibiotic prescribing for older adults, mainly through increased underuse and modest reductions in overuse. Stewardship programs should monitor both phenomena separately and target high-deprivation areas with enhanced diagnostics, follow-up, and locally tailored implementation to improve equity.

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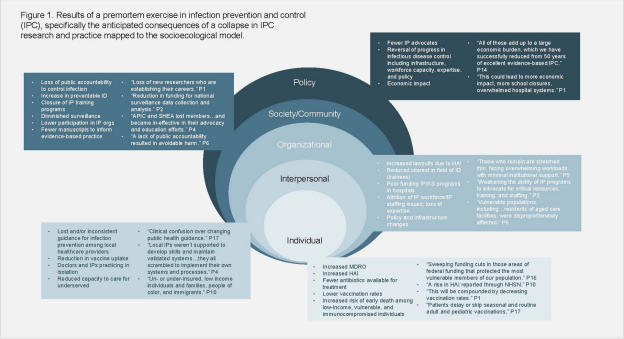
**Forecasting the Consequences of Collapse in Infection Prevention and Control: A Premortem Analysis Using the Socioecological Model**‡

Stephanie Stroever[1], Elizabeth Monsees[2], Lisa Hall[3], Monika Pogorzelska-Maziarz, Shelley Kon[4] and Heather Gilmartin[5]
[1]Texas Tech University Health Sciences Center; [2]Children's Mercy Hospital; [3]The University of Queensland; [4]Rocky Mountain Regional Veterans Affairs Hospital and [5]Denver/Seattle Center of Innovation

‡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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**Background:** Since January 2025, critical structural and funding changes have altered the global healthcare landscape. To respond effectively, we performed a situation premortem. Premortem methods are commonly used within the field of implementation science to identify risk factors and early warning signs for failure of complex systems. Recognizing the systems-oriented nature of participant responses, we applied the socioecological model (SEM) to organize emergent themes. Methods In April 2025, a cross-sectional electronic premortem survey was distributed to IPC thought leaders. Participants were asked to imagine the year 2029 in which IPC research and practice had collapsed and to identify contributing factors, early warning signs, barriers, populations most affected, and missed opportunities for prevention or mitigation. Responses were analyzed using thematic content analysis. Themes were organized using the socioecological model to map findings across policy, community/professional, organizational, interpersonal, and individual levels. Results Nineteen of twenty-nine people agreed to participate (66.83% response rate) from the U.S., Australia, and Singapore. The majority (n = 13) were researchers with representation from clinical practice (n = 3), policy and regulation (n = 1), or in public health or professional capacity building (n = 2). Participants anticipated widespread consequences across all SEM levels (Figure 1). At the policy level, they described diminished IPC advocacy, global reversal of progress in infectious disease control, and increased economic burden. At the community and professional level, anticipated impacts included loss of public accountability, closure of training programs, reduced surveillance capacity, and fewer scholarly outputs to inform practice. Organizational consequences included inadequate funding of infection prevention/antimicrobial stewardship programs in healthcare facilities, workforce attrition, and increased legal risk. Interpersonally, participants anticipated inconsistent guidance and confusion, reduced support for frontline clinicians, decreased vaccine uptake, and diminished capacity to serve underserved populations. At the individual level, consequences included increased multidrug-resistant and healthcare-associated infections, fewer treatment options, lower vaccination rates, and increased morbidity and mortality among vulnerable, low-income, and immunocompromised individuals. Conclusion This premortem exercise highlights the potential impacts of a collapse of IPC research and practice. Participants anticipated cascading harms across multiple levels. These results identify areas for proactive, creative strategies tailored to specific socioecological domains of impact. Reliance on traditional federal funding models and the expectation for national data collection and reporting standards may be insufficient. The field must collaborate and develop alternative approaches to sustain IPC research, training, and practice to prevent negative downstream consequences and uphold professional values.

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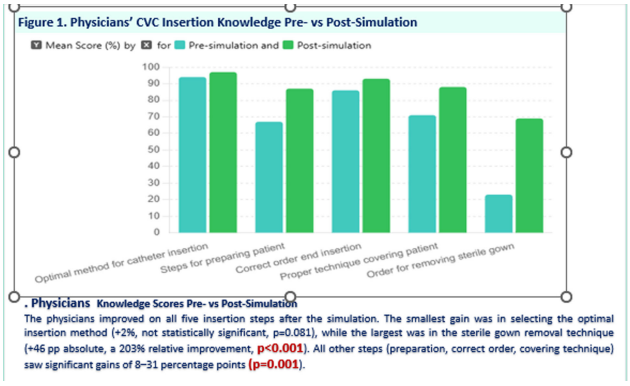
**National Simulation-Based Training Improves Central Venous Catheter Insertion and Maintenance Knowledge Across Israeli Hospitals‡**

Dafna Chen[1], Yehuda Carmeli[2] and Debby Ben David[3]
[1]National Center for Infection Prevention and Antimicrobial Resistance, Israeli Ministry of Health; [2]Tel Aviv Sourasky Medical Center and [3]Wolfson Medical Center

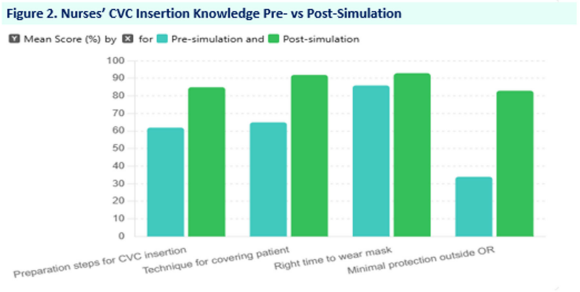
**Background:** central line–associated bloodstream infections (clabsis) remain a leading cause of preventable morbidity and mortality in hospitalized patients. although evidence-based guidelines for central venous catheter (cvc) insertion and maintenance are well established, variability in knowledge, procedural practice, and access to essential equipment persists across hospitals and clinical settings. **Methods:** between january 2019 and march 2020, a mobile classroom simulation-based training (sbt) program was implemented in 26 of 30 public acute-care hospitals in israel,

Table 1. Pre- vs Post-Simulation Knowledge Scores for CVC Insertion & Maintenance

| Intervention | Participants (N) | Pre-training mean (%) | Post-training mean (%) | Δ (%) | p-Value |
|---|---|---|---|---|---|
| CVC insertion – physicians | 432 | 68.2 | 86.8 | 18.6 | <0.001 |
| CVC insertion – nurses | 374 | 61.8 | 88.3 | 26.5 | <0.001 |
| CVC maintenance – nurses | 619 | 78.2 | 94.6 | 16.4 | <0.001 |




**. Physicians Knowledge Scores Pre- vs Post-Simulation**
The physicians improved on all five insertion steps after the simulation. The smallest gain was in selecting the optimal insertion method (+2%, not statistically significant, p=0.081), while the largest was in the sterile gown removal technique (+46 pp absolute, a 203% relative improvement, **p<0.001**). All other steps (preparation, correct order, covering technique) saw significant gains of 8–31 percentage points **(p=0.001)**.




**Nurses: Knowledge Scores Pre- vs Post-Simulation**
Nurses demonstrated highly significant improvements across all four items **(p<0.001)**. The greatest increase was in minimal protection measures (+49 pp, +144%), followed by steps for patient preparation (+23 pp, +37%), covering technique (+27 pp, +42%), and mask-wearing timing (+7 pp, +8%). These results confirm the effectiveness of the SBT program in boosting CVC knowledge.



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