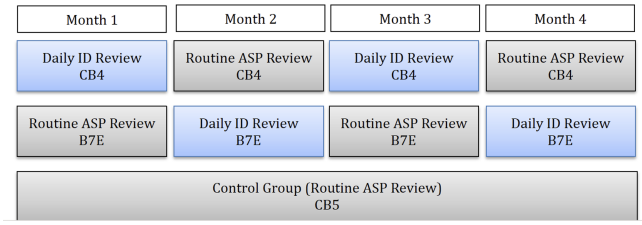
Figure 1. Study schematic



and optimizes antibiotic utilization in terms of deescalation, duration of treatment and targeted antibiotic selection. Limitations include low availability of ID physicians for daily rounds, limited number of ID pharmacists for dailys ASP review and occasional disregard of recommendations by medicine teams.

Antimicrobial Stewardship & Healthcare Epidemiology 2026;6(Suppl. S1):s70–s71

doi:10.1017/ash.2026.10534

Presentation Type:
Poster Presentation
Subject Category: Antibiotic Stewardship
Inter-Rater Agreement of Real-World Electronic Health Record-Based Antimicrobial Stewardship Assessments‡

Nathan Radakovich[1], Allison Bond[1], Natasha Spottiswoode, Ritika Prasad[1], Daniel Escobar[1], Emily Kaip[2], Will Simmons[1] and Sarah Doernberg[3]
[1]UCSF; [2]UCSF Health and [3]University of California, San Francisco

Background: Prospective audit and feedback (PAF), a cornerstone of antimicrobial stewardship programs (ASP), relies on infectious disease (ID) clinicians' direct review of electronic health records (EHR). We assessed the consistency of ID clinicians' EHR-based assessments on real-world patient data. **Methods:** Antibiotic orders were randomly selected from a list of hospitalized adults at UCSF medical center. ID specialists (physicians and pharmacists) independently reviewed orders in real time using data from the EHR. Reviewers assessed the stated need for antibiotics, their agreement with necessity and choice, and overall appropriateness as defined by the National Antimicrobial Prescribing Survey (NAPS) tool. We measured agreement with either Cohen's kappa or weighted Cohen's kappa for ordinal observations. **Results: Conclusion:** We observed only modest agreement between independent ID clinicians' reviews of antibiotic orders in a real-world assessment of inter-rater agreement. Discrepancies in assessments likely reflect a mixture of practice pattern variation, the intrinsic difficulty of assessing antibiotic choice without directly evaluating the patient, and variation due to the instruments used to collect information. Reference: Khanina A, Douglas AP, Yeoh DK, et al. Validation of the Antifungal National Antimicrobial Prescribing Survey (AF-NAPS) quality assessment tool. J Antimicrob Chemother. 2023;78(6):1367-1377. doi:10.1093/jac/dkad085

Antimicrobial Stewardship & Healthcare Epidemiology 2026;6(Suppl. S1):s71

doi:10.1017/ash.2026.10535

	Overall	BSCA	BSHO	Gram Positive	NSBL	Other
Consult needed	0.68	0.76	0.66	0.62	0.61	0.77
Indication	0.76	0.96	0.61	0.73	0.75	0.92
NAPS	0.42	0.40	0.31	0.55	0.29	0.32
Reason not indicated	0.33	0.23	0.35	0.25	0.25	0.56
Spectrum	0.40	0.25	0.21	0.55	0.39	0.38

Table 1: Inter-rater agreement by spectrum of coverage (Cohen's Kappa). BSCA: broad-spectrum community-acquired; BSHO: broad-spectrum hospital acquired; NSBL: narrow-spectrum beta-lactam

Presentation Type:
Poster Presentation
Subject Category: C. difficile
Motivations for Clostridioides difficile testing algorithms among Veterans Affairs Medical Centers‡

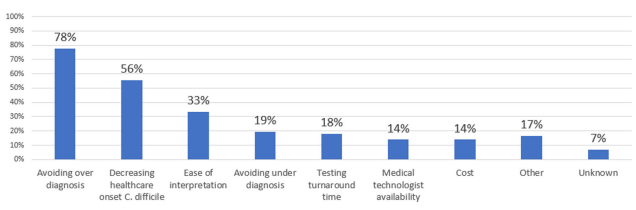
Elise Martin[1], Robin Jump[1], Dimitri Drekonja[2] and University of MN Medical School
[1]VA Pittsburgh Healthcare System and [2]Minneapolis VA Health Care System

Background: There is no gold standard approach to Clostridioides difficile (C. difficile) testing clinically. The National Healthcare Safety Network (NHSN) uses the last test in a series to determine if positive testing will be considered a healthcare associated infection (HAI) and there is concern that this may impact testing choice. Increasingly, healthcare facilities are considering 2-step testing algorithms, but limited data exists on clinical or surveillance motivations for algorithm choice. **Methods:** In October and November 2023, we distributed electronic surveys to Veterans Affairs Medical Center (VAMC) infection preventionists and infectious diseases physicians asking about current facility C. difficile testing practices, motivations for their current strategy, and considerations for change. Only one response was included per facility. Duplicate responses from the same facility were combined. Data were analyzed using Chi-squared tests. **Results:** Among 126 VAMCs, 72 (57%) completed the survey. The most common testing strategies were polymerase chain reaction (PCR) with reflex to toxin (n=31, 43%) and PCR with reflex to glutamate dehydrogenase (GDH)/toxin (n=20, 28%) when PCR is positive. Less common strategies included PCR alone (n=9, 13%), GDH/toxin with reflex to PCR when discordant (either GDH or toxin positive) (n=5, 7%), GDH/toxin alone (n=1, 1%), and other (n=6, 8%). Factors associated with testing strategy selection were avoidance of overdiagnosis (78%), to decrease rate of C. difficile HAIs (56%), and ease of interpretation (33%) (Figure 1). When comparing 2-step testing algorithms, avoiding overdiagnosis was a motivation for positive PCR with reflex to toxin or GDH/toxin (84%) as well as GDH/toxin with reflex to PCR (80%) (p=0.8). When compared to PCR with reflex to toxin or GDH/toxin, sites using GDH/toxin with reflex to PCR more frequently reported test turn-around-time (80% vs 14%, p≤0.001) and cost (60% vs 8%, p≤0.001) as motivating factors. Sites using PCR with reflex to toxin or GDH/toxin were more motivated by decreasing HAIs than GDH/toxin with reflex to PCR (63% vs 40%), although not statistically significant. Notably, 40% of facilities reported switching their testing strategy within 2 years of survey and 24% were actively considering a change. **Conclusion:** The most common testing strategy among VAMCs is a 2-step algorithm starting with PCR, then reflex to either toxin or GDH/toxin when PCR positive, driven by desire to avoid overdiagnosis and decrease HAI rates. It is unclear how this actually impacts rates or if this will change if facilities move to healthcare facility-onset, treated C. difficile infection metrics.

Antimicrobial Stewardship & Healthcare Epidemiology 2026;6(Suppl. S1):s71

doi:10.1017/ash.2026.10536

Figure 1: Motivations for selecting *C. difficile* testing strategies amoung VA Medical Centers



‡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.

https://doi.org/10.1017/ash.2026.10536 Published online by Cambridge University Press