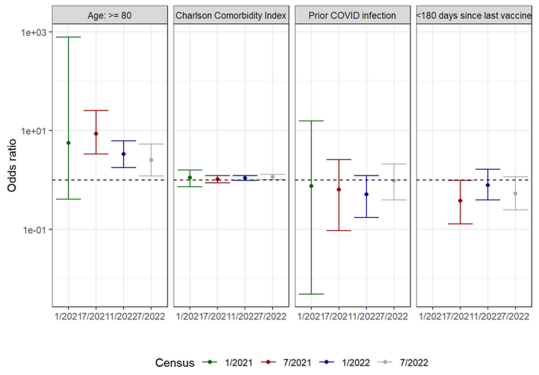
Figure 2: Forest plot predicting 30-day mortality following breakthrough infection by era



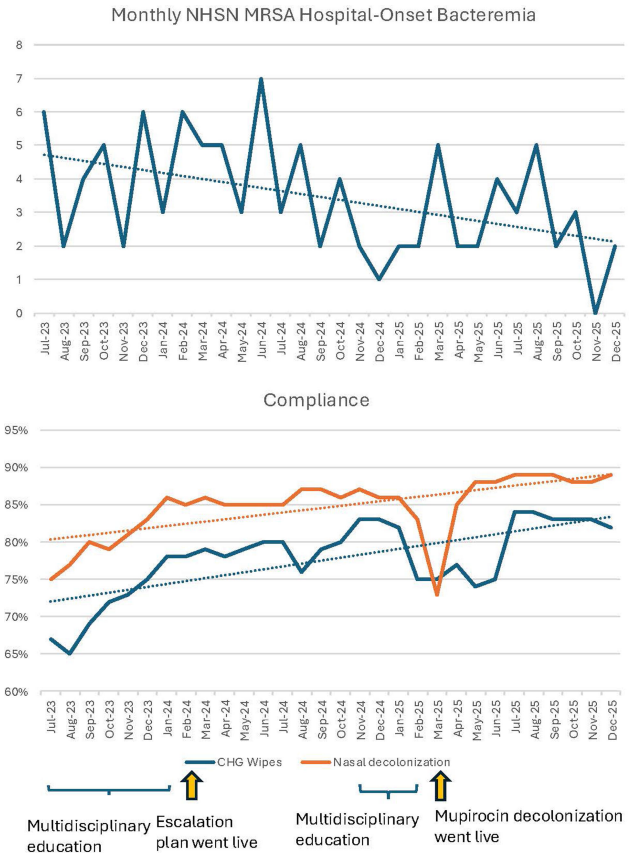
Presentation Type:
Oral Presentation
Subject Category: MRSA/VRE

Focused Contact Precautions and Data-Driven Dashboards to Improve MRSA Hospital Acquired Infection Rates at the University of Kentucky‡

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Background: Following the COVID-19 pandemic, the University of Kentucky (UKY) experienced elevated rates of methicillin-resistant Staphylococcus aureus (MRSA). To drive rapid improvement, an MRSA escalation program was developed incorporating targeted contact precautions for units not meeting decolonization thresholds, enhanced MRSA surveillance testing, and data-driven reports to support unit leadership. **Methods:** The UKY Infection Prevention and Control Program (IPAC) implemented a data-driven MRSA escalation strategy. At baseline, all patients in intensive care units, patients with indwelling lines or tubes, and patients testing positive for MRSA were expected to undergo daily chlorhexidine bathing and intranasal povidone iodine decolonization. Upon review, gaps were identified in decolonization performance and screening of at-risk populations. The intervention addressed these gaps by including electronic health record (EHR)–prompted MRSA screening for at-risk patients, development of aggregate decolonization compliance dashboards, and real-time performance dashboards for unit supervisors. A monthly decolonization performance threshold of 70 percent was established. Units with persistent compliance below 70 percent were placed on contact precautions with an "MRSA Escalation" designation in the EHR. IPAC met with identified units to provide toolkits and education on dashboard utilization and integration of MRSA metrics into routine huddles and sprints. In March 2025, intranasal decolonization was transitioned from povidone iodine to mupirocin. Monthly hospital-onset MRSA bacteremia counts, chlorhexidine bathing compliance, and nasal decolonization compliance from July 2023 through December 2025 were analyzed using simple linear regression with time in months as the independent variable. **Results:** Multidisciplinary education was conducted across nursing, physician, and leadership groups from August 2023 through January 2024, with program go-live in February 2024. Chlorhexidine bathing compliance increased significantly over time, with an average improvement of 0.39 percentage points per month (95% CI 0.24–0.55, $p < 0.001$, $R^2 = 0.48$, Figure 1). Nasal decolonization compliance also increased significantly, with an average improvement of 0.30 percentage points per month (95% CI 0.16–0.44, $p < 0.001$, $R^2 = 0.40$). Hospital-onset MRSA bacteremia demonstrated a significant downward trend (slope –0.089 cases per month, $p = 0.012$, $R^2 = 0.20$), corresponding to an average reduction of approximately one case every 11 months. Quarterly SIR decreased from 1.10 in Q3 2023 to 0.54 in Q4 2025. **Conclusions:** Implementation of an MRSA escalation program incorporating decolonization performance thresholds, targeted contact precautions, enhanced education, real-time data reporting, and transition to mupirocin for nasal decolonization was associated with significant improvements in decolonization compliance and a sustained reduction in hospital-onset MRSA bacteremia.

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Presentation Type:
Oral Presentation
Subject Category: Outbreaks

'Can'tida auris': When Candida auris can't be controlled ‡

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Background: Candida auris (CA) poses an urgent public health threat due to its multidrug-resistance, associated mortality, and ability to persist in the inanimate healthcare environment. We sought to ascertain factors associated with a prolonged multi-facility outbreak that was not amenable to previously successful containment measures involving Clade 1. **Methods:** Contact tracing and testing, environmental sampling, cleaning observations with intensified cleaning, and whole genome sequencing were performed. Additionally, dry hydrogen peroxide units (Synexis DHP® Overland Park, KS) were installed, damaged furniture was replaced, and availability of dedicated equipment was increased. Standard urine culturing protocols were changed to better detect and identify yeast. Exposed patients that remained uncolonized were compared to exposed colonized patients in a nested case control exploratory analysis using multivariable logistic regression with excess antibiotic days as the primary exposure in

‡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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Table 1 Patient Characteristics and Variables

	0 (N=40)	1 (N=44)	Total (N=84)	p value
Age				0.005
Mean (SD)	70.325 (14.945)	61.205 (14.337)	65.548 (15.246)	
Range	37.000 - 100.000	30.000 - 89.000	30.000 - 100.000	
Sex				0.647
F	22 (55.0%)	22 (50.0%)	44 (52.4%)	
M	18 (45.0%)	22 (50.0%)	40 (47.6%)	
Charlson Comorbidity Score				0.008
Mean (SD)	6.950 (3.202)	5.250 (2.516)	6.060 (2.971)	
Range	2.000 - 14.000	1.000 - 12.000	1.000 - 14.000	
Simplified Acute Physiology Score				0.274
Mean (SD)	46.425 (11.003)	49.432 (13.692)	48.000 (12.502)	
Range	21.000 - 92.000	7.000 - 84.000	7.000 - 92.000	
Dialysis				0.368
No	34 (85.0%)	34 (77.3%)	68 (81.0%)	
Yes	6 (15.0%)	10 (22.7%)	16 (19.0%)	
Invasive Vent				0.261
No	30 (75.0%)	28 (63.6%)	58 (69.0%)	
Yes	10 (25.0%)	16 (36.4%)	26 (31.0%)	
Recent Past Antibacterial and Antifungal Exposure				0.004
No	7 (17.5%)	0 (0.0%)	7 (8.3%)	
Yes	33 (82.5%)	44 (100.0%)	77 (91.7%)	
Indwelling Device				< 0.001
No	25 (62.5%)	6 (13.6%)	31 (36.9%)	
Unknown	0 (0.0%)	1 (2.3%)	1 (1.2%)	
Yes	15 (37.5%)	37 (84.1%)	52 (61.9%)	
Number of Prior Admissions				0.753
Unknown	0	4	4	
Mean (SD)	3.200 (2.301)	3.375 (2.648)	3.288 (2.466)	
Range	1.000 - 11.000	1.000 - 13.000	1.000 - 13.000	
Number of Rooms Before Culture				< 0.001
Unknown	0	6	6	
Mean (SD)	4.325 (2.454)	10.816 (6.689)	7.487 (5.934)	
Range	1.000 - 13.000	2.000 - 38.000	1.000 - 38.000	
CVC				0.008
No	32 (80.0%)	23 (52.3%)	55 (65.5%)	
Yes	8 (20.0%)	21 (47.7%)	29 (34.5%)	
SNF/LTC				0.234
Unknown	0 (0.0%)	2 (4.5%)	2 (2.4%)	
No	29 (72.5%)	26 (59.1%)	55 (65.5%)	
Yes	11 (27.5%)	16 (36.4%)	27 (32.1%)	
Days of Antibiotics Prior to Culture				< 0.001
Mean (SD)	8.050 (16.785)	28.000 (24.234)	18.500 (23.176)	
Range	0.000 - 105.000	0.000 - 101.000	0.000 - 105.000	
Days of Excess Antibiotics				< 0.001
Mean (SD)	0.875 (2.278)	8.114 (8.992)	4.667 (7.586)	
Range	0.000 - 10.000	0.000 - 41.000	0.000 - 41.000	

the adjusted model. Covariates were selected based on prior understanding of the pathogen, biological plausibility, and univariable analyses to explore crude associations. We created one primary adjusted model, with additional sensitivity analyses conducted to avoid overfitting due to the small sample size and potential confounding. Model discrimination was evaluated using the area under the curve. **Results:** All isolates in the initial clusters were Clade III and highly genetically related to each other. Later a small cluster of highly related Clade 1 emerged. Patient variables and descriptive statistics appear in Table 1. After adjusting for age, sex, number of rooms the patient occupied, and Charlson comorbidity score, each additional day of unjustified antibiotics prior to culture was associated with a 63% increase in the odds of CA positivity (OR=1.63 per day, 95% CI: 1.22-2.53, p=0.007). Number of patient rooms occupied prior to culture was also strongly associated with positivity (OR=1.83 per additional room, 95% CI 1.37-2.82, p=0.0007). Discussion We applied the same containment measures that had previously succeeded, along with those described above, but were unable to control this outbreak. At the time of this submission, CA continued to be detected sporadically in clinical cultures, supporting our hypothesis that clade III is more difficult to contain than Clade I. This report is notable because it confirms our earlier findings of CA emergence linked solely to excess antibiotic exposure, using a more robust study design. As excess antibiotic days was independently associated with CA positivity, it underscores the importance of aggressive antimicrobial stewardship to prevent emergence. Once CA establishes itself, containment may be impossible.

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Oral Presentation
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Getting Ready for the Storm: A Taskforce Approach to Measles Readiness‡

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Background: The U.S. is on track to lose measles elimination status after experiencing the highest number of cases in <30 years. With ongoing transmission and falling vaccination rates, health systems must prepare for measles, focusing on minimizing secondary cases and maximizing prevention. We describe a taskforce approach for comprehensive measles (with a lens towards all-hazard)preparedness across our enterprise. **Methods:** Our mitigation and preparedness taskforce included four workstreams (Figure 1): Early MMR vaccination for children with international travel: Consistently offer and administer initial or second MMR vaccine, as appropriate, for infants and children travelling abroad. Optimize exposure and testing management: Develop tools to expedite the identification of exposed non-immune patients and optimize processes for high volume testing

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