electrophoresis, and whole-genome sequencing (WGS). **Results:** The isolates in this study exhibited a high level of resistance to expanded-spectrum cephalosporins and carried CTX-M or TEM β-lactamases, and all of them were classified as multidrug-resistant due to their resistance pattern to other antimicrobial drugs. The β-lactamase content did not differ among isolated *E. coli* strains from various sources (ie, hospitals, nursing homes, and the community). According to the genotyping results, the isolates were allocated into 8 clusters, which contained subclusters. Serotyping results revealed that O25 antigen was the dominant one; furthermore, isolates subjected to WGS belonged to the ST131 sequence type. The most pervasive plasmid types in the isolates from the country's capital (Zagreb) were IncFII and FIA, whereas FIA alone was a dominant plasmid type in the southern part of the country. Conversely, eastern parts were characterized by plasmids belonging to IncB/O and IncW groups. **Conclusions:** Our study demonstrated the dissemination of group 1 CTX-M–positive *E. coli* not only in different geographic regions of Croatia but also in different arms of the healthcare system (ie, hospitals, nursing homes, and the community). Our results also confirmed the switch from previously pervasive SHV-2 and SHV-5 ESBLs to the nationwide predominance of group 1 CTX-M β-lactamases; however, regional distribution was associated with different plasmid types carrying *bla*CTX-M genes. These types of nationwide studies are indispensable for informing global decision making that addresses the issue of antimicrobial resistance.

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Presentation Type:
Top Rated Posters

Financial and Mortality Modeling as a Tool to Present Infection Prevention Data: What a SIR of 1.2 Means for the Hospital

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Background: Presenting to hospital leadership is an annual requirement of many infection prevention (IP) programs. Most presentations include current statistical data of hospital-acquired infections (HAIs) and whether the hospital has met its goals according to the National Healthcare Safety Network (NHSN) criteria. We presented HAI data in a novel way, with financial and mortality modeling, to show the impact of IP interventions to leadership not attuned to NHSN metrics. **Method:** We looked at 4 HAIs, their trends, and their effect on our hospital, Santa Clara Valley Medical Center (SCVMC). To estimate the impact of specific HAIs, we used 2 metrics derived from a meta-analysis by the US Department of Health and Human Services (HHS): excess mortality and excess cost. Excess mortality is defined as the difference between the underlying population mortality and the affected population mortality expressed as deaths per 1,000 population. Excess cost is defined as the additional cost introduced per patient with a specific HAI versus a similarly admitted patient without that HAI. HHS data were multiplied by the number of HAI events at SCVMC to generate estimates. **Result:** In our presentation, we elucidated a previously unseen cost savings and decreased mortality with 2 HAIs, central-line–associated blood stream infections (CLABSIs) and catheter associated urinary tract infections (CAUTIs), which were below NHSN targets due to

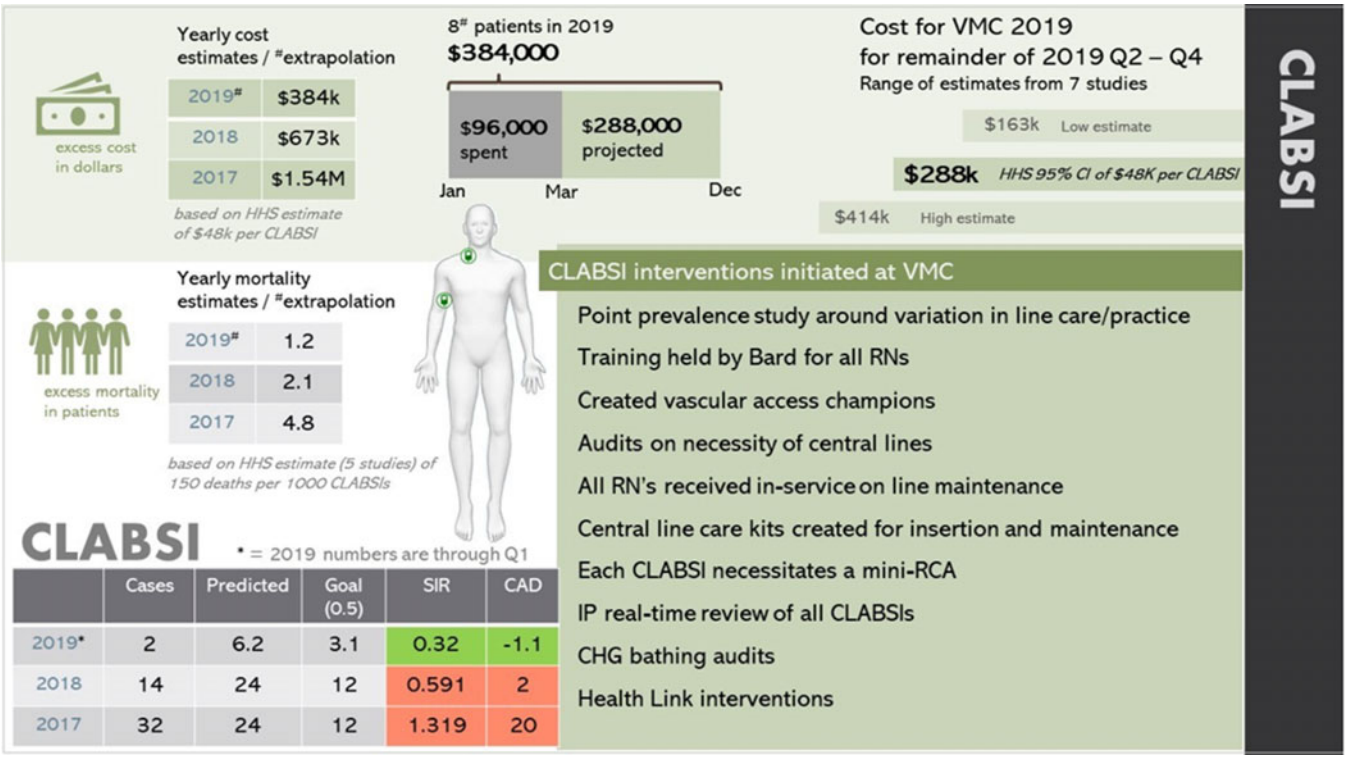

Fig. 1.

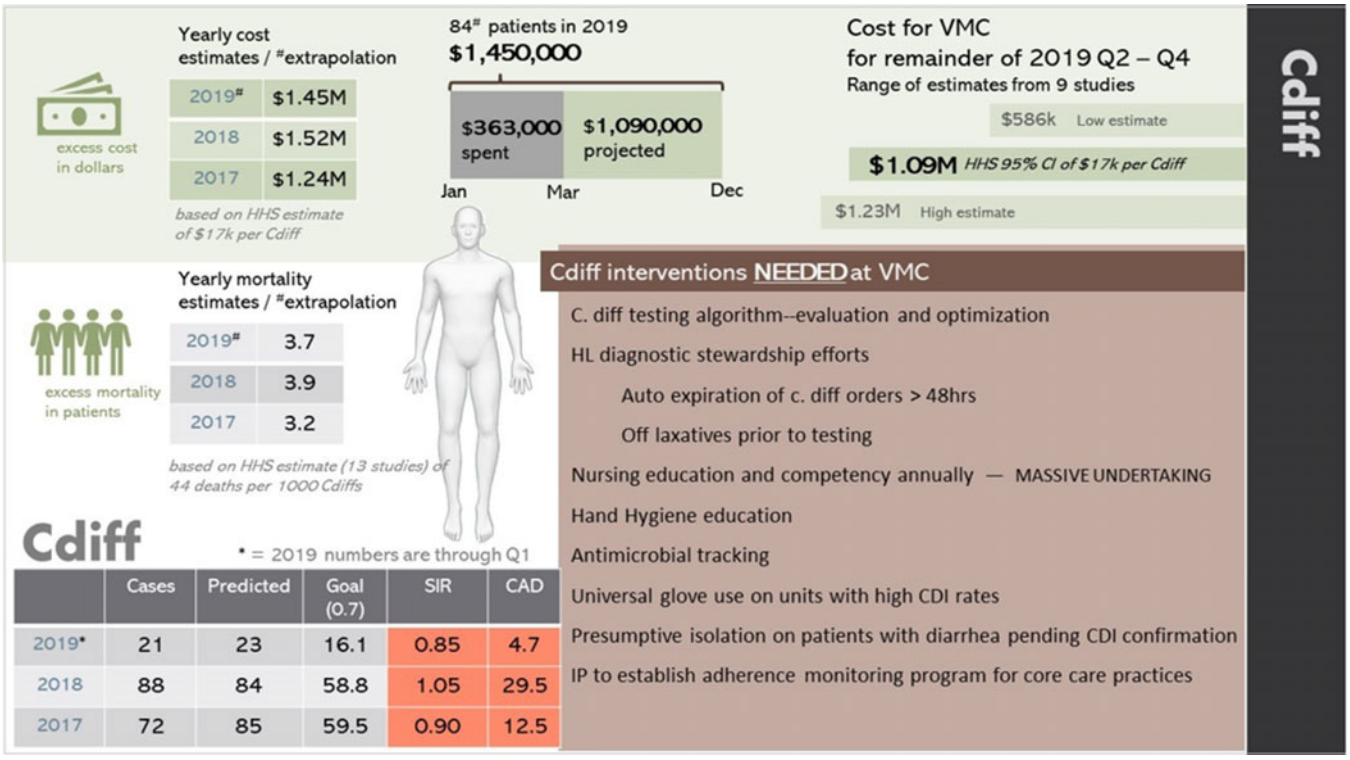

Fig. 2.

IP-led interventions. We then showed 2 other HAIs, *Clostridium difficile* infection (CDI) and surgical site infections (SSIs), which did not meet our expected NHSN and institutional goals and were estimated to increase costs and potential mortalities in the upcoming year. We argued that proactive monies directed toward expanding our IP program and HAI mitigation efforts would cost a fraction of the impending healthcare expenditures as predicted by the model. **Conclusion:** By applying financial and mortality modeling, we helped our leadership perceive the concrete effect of IP-led interventions versus presenting abstract NHSN metrics. We also emphasized that without proactive leadership investment, we would continue to overspend healthcare dollars while not meeting our goals. This format of presentation gave us critical leverage to advocate for and successfully expand our IP department. Further SHEA-led cost-analysis modeling and education are needed to help IP departments promote their efforts in an effective manner.

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Top Rated Posters

Getting the Most Out of the ICAR Visit by Using a Scoring Report to Provide Feedback

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Background: The Centers for Disease Control and Prevention developed the Infection Control Assessment and Response (ICAR) tools to assist health departments in assessing infection prevention practices and to guide quality improvement activities. ICAR tools are available for the following healthcare settings: acute care (including hospitals and long-term acute-care hospitals), outpatient, long-term care, and hemodialysis. The Virginia Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) Program developed a scoring report that provides a quantitative measure for each infection control domain and summarizes strengths and opportunities for improvement. The scoring report aims to provide feedback to facility administration in a simple, user-friendly way to increase their engagement, prioritize follow-up actions for areas in need of improvement, and to analyze statewide data systematically to identify and address major defects. **Methods:** Scoring reports were developed for acute care, long-term care, and hemodialysis facilities. Each report includes 2 tables: infection control domains for gap assessment and direct observation of facility practices. The first table has rows for infection control assessment domains, and the second table summarizes direct observations conducted during the ICAR visit such as hand hygiene, point-of-care testing, and wound dressing change. Each row is stratified by the score, which is determined by responses to the ICAR tool, for each domain or observation, interpretation of the score, strengths, and opportunities for improvement. Stoplight colors with assigned percentages are used for score interpretation. ICAR visit results from 5 long-term care facilities (LTCFs) and 3 hemodialysis centers were entered into a REDCap database and analyzed. **Results:** Data from these visits elucidated consistent gaps in Infection Prevention and Control programs and defined what practices are most lacking. The low-performance areas in LTCFs included hand hygiene, personal protective equipment (PPE), environmental cleaning and disinfection, and antimicrobial stewardship. In hemodialysis centers, respiratory hygiene and cough etiquette, injection safety, and surveillance and disease