

collected healthcare worker (HCW) demographics, including department of service, age, sex, pregnancy, and breastfeeding status in those who were at risk of exposure. We interviewed HCWs at 2 time points and collected information related to infestation, allergies to treatment, acceptance of empiric treatment, and whether employee was furloughed. **Results:** On initial screening, 20 of 124 at-risk HCWs had symptoms (Fig.). Most had a “new onset raised red rash or new pimple like rash (not on face), or linear rash” and 4 had “new onset uncontrollable itching.” All 124 HCWs were contacted 28 days later. One HCW that had not been compliant with prophylaxis became symptomatic and was diagnosed with scabies by dermatology. Of the remaining 20 HCWs, 3 were still having symptoms (2 had itching and 1 had a rash and a scrape performed by dermatology with confirmation of mites). All 3 were retreated with ivermectin. Overall, 21 of 124 exposed HCWs were ultimately symptomatic. **Conclusions:** During a 22-day admission of an undiagnosed and unisolated elderly patient with crusted scabies, the scabies mite was transmitted to 21 HCWs for an acquisition rate of 17%. Persistence of symptoms after treatment with permethrin occurred in 14%. The infectivity of this disease necessitates early recognition and infection control measures.

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Poster Presentation

Adjustments to an Existing Colorectal Surgical Site Infection Prevention Bundle Lead to Fewer Infections

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Background: Surgical site infections (SSI) related to colorectal procedures are detrimental to patients and publicly reportable events. Our institution implemented a successful bundle of interventions to decrease SSI rates in 2014. In 2018, compliance started to wane, with a concurrent increase in infections. In an effort to enhance compliance and incorporate up-to-date information, we convened a multidisciplinary team to streamline this process.

Methods: Our team evaluated published studies on successful bundle components and updates to professional guidelines for SSI prevention to determine adjustments. Modifications included allowing surgeon preference for (rather than mandating) wound protector use and simplification of clean closure protocol (determined by intraoperative contamination, leading to more efficient closure time). In addition, measures were added to achieve perioperative patient optimization (maintenance of normothermia, prevention of intraoperative hypoxia, tighter glucose control and postoperative bathing). The bundle was implemented in stages starting January 2019. SSI rates were monitored throughout the

process using NHSN definitions, and rates were compared using χ^2 analysis (Epi Info, CDC). **Results:** From 2015 to 2017, bundle compliance was 90%, and 8 SSIs (rate, 3.8 per 100 procedures) were detected (Table 1). In 2018, compliance was 82%, with 4 SSIs (rate, 6.6 per 100 procedures). From January through September 2019, SSI rates decreased to a rate of 4.8 per 100 procedures, with notable increase in superficial SSI, with zero cases of deep or organ-space infections. Feedback from operating-room personnel indicated their commitment to bundle compliance and perceived intraoperative time savings. **Conclusions:** Revamping an existing colorectal SSI bundle, including relaxation of time-intensive and expensive intraoperative measures and increased focus on evidence-based guidelines, resulted in decreased deep-organ space SSI rates, as well as increased satisfaction from procedural team members. Successful implementation of care pathways to prevent infections is an iterative process and requires the engagement of practitioners.

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Administrative Coding Methods Impact Surgical Site Infection Rates

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Background: Surveillance for surgical site infections (SSI) is recommended by the CDC. Currently, colon and abdominal hysterectomy SSI rates are publicly available and impact hospital reimbursement. However, the CDC NHSN allows surgical procedures to be abstracted based on *International Classification of Diseases, Tenth Revision* (ICD-10) or current procedural terminology (CPT) codes. We assessed the impact of using ICD and/or CPT codes on the number of cases abstracted and SSI rates. **Methods:** We retrieved administrative codes (ICD and/or CPT) for procedures performed at the University of Iowa Hospitals & Clinics over 1 year: October 2018–September 2019. We included 10 procedure types: colon, hysterectomy, cesarean section, breast, cardiac, craniotomy, spinal fusion, laminectomy, hip prosthesis, and knee prosthesis surgeries. We then calculated the number of procedures that would be abstracted if we used different permutations in administration codes: (1) ICD codes only, (2) CPT codes only, (3) both ICD and CPT codes, and (4) at least 1 code from either ICD or CPT. We then calculated the impact on SSI rates based on any of the 4 coding permutations. **Results:** In total, 9,583 surgical procedures and 180 SSIs were detected during the study period using the fourth method (ICD or CPT codes). Denominators varied according to procedure type and coding method used. The number of procedures abstracted for breast surgery had a >10-fold difference if reported based on ICD only versus ICD or CPT codes (104 vs 1,109). Hip prosthesis had the lowest variation (638 vs 767). For SSI rates, cesarean section showed almost a 3-fold increment (2.6% when using ICD only to 7.32% with both ICD & CPT),

Table 1.

	Deep/Organ Space		Superficial		Overall	
	# SSI	Rate	# SSI	Rate	Rate	Procedures
2015-2017	8	2.4	5	1.5	3.8	339
2018	5	4.1	3	2.5	6.6	122
YTD 2019	0	0.0	5	4.8	4.8	105
p value (old bundle compared to new)	0.06		0.24		0.84	

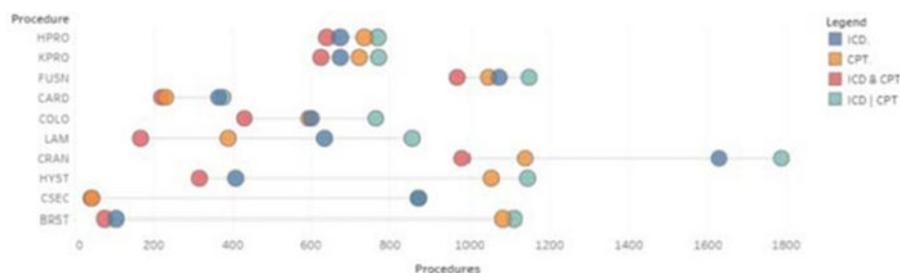


Figure 1: Abstracted procedures performed at the University of Iowa Hospitals & Clinics during one year: October 2018–September 2019. Abbreviations: COLO, colon; HYST, hysterectomy; CSEC, cesarean section; BRST, breast; CARD, cardiac; CRAN, craniotomy; FUSN, spinal fusion; LAM, laminectomy; HPRO, hip prosthesis; ICD, International Classification of Diseases; CPT, Current procedural Terminology codes.

Fig. 1.

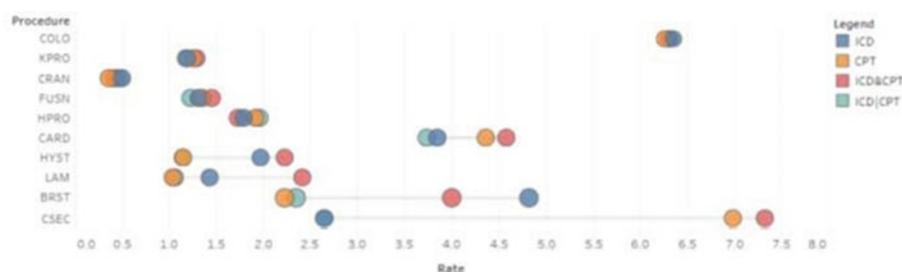


Figure 2: Surgical site infection rate variation by procedure type and coding method used. The University of Iowa Hospitals & Clinics, 2018–2019. Abbreviations: COLO, colon; HYST, hysterectomy; CSEC, cesarean section; BRST, breast; CARD, cardiac; CRAN, craniotomy; FUSN, spinal fusion; LAM, laminectomy; HPRO, hip prosthesis; KPRO, knee prosthesis; ICD, International Classification of Diseases; CPT, Current procedural Terminology codes.

Fig. 2.

whereas abdominal hysterectomy showed nearly a 2-fold increase (1.14% when using CPT only to 2.22% with both ICD & CPT codes). However, SSI rates remained fairly similar for craniotomy (0.14% absolute difference), hip prosthesis (0.24% absolute difference), and colon (0.09% absolute difference) despite differences in the number of abstracted procedures and coding methods. **Conclusions:** Denominators and SSI rates vary depending on the coding method used. Variations in the number of procedures abstracted and their subsequent impact on SSI rates were not predictable. Variations in coding methods used by hospitals could impact interhospital comparisons and benchmarking, potentially leading to disparities in public reporting and hospital penalties.

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Admission Screening for *Candida auris* Among High-Risk Patient Populations

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Background: *Candida auris* is a highly transmissible healthcare-associated pathogen that can cause severe infection as well as long-lasting colonization. *C. auris* is often resistant to the antifungals that are commonly used to treat *Candida* infections, which may lead to clinical failure. Therefore, healthcare facilities must identify the organism quickly and implement strict precautions to prevent its spread. In 2019, the NIH Clinical Center instituted *C. auris* admission screening among its high-risk patient populations. **Methods:** Patients admitted to the NIH Clinical Center, a 200-bed research hospital, were identified on admission as having been hospitalized outside the United States in the prior 6 months. Admission screening began in August 2019. In September 2019, due to evolving regional epidemiology, we expanded surveillance criteria to include patients housed in any healthcare facility in the District of Columbia, Maryland, and Virginia metro area in the previous 6 months. Screening was performed as routine clinical care, and therefore did not require written informed consent.