

changes to estimate IP-derived denominators. We compared rates generated by different numerators and denominators (EMR and IP) using Fisher's exact test.

Results: We identified 176 SSIs during the study period. Of the 82 changes made by IPs, 37 (45%) were meaningful. The proportion of meaningful changes ranged from 0-60% across all months. Out of 34 months, 21 (62%) showed a higher rate when using EMR class vs. IP class with the largest difference of 2.33 vs. 0.47 ($p = 0.22$). When comparing the alternative rate to IP class rate across all months, the rate was 1.14 vs. 0.91 ($p = 0.17$). For both comparisons, September 2019 showed the largest monthly rate difference.

Conclusions: This study found that using EMR wound class for numerator and denominator increases the SSI rate, although not significantly different from IP class rate, even when adjusting the denominator for meaningful changes. Rates using IP class numerator and EMR class denominators are likely accurate.

Leadership Development and Program Management

LDPM-17

A Whole New World: Changes in the Nursing Home Infection Preventionist Role in Response to the COVID-19 Pandemic

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Background: Nursing home (NH) infection prevention and control (IPC) programs struggled before the COVID-19 pandemic. As the pandemic began, NHs were challenged with frequently changing directives including isolation, testing, visitation, and reporting. Within a larger research project, we compared changes in the infection preventionist (IP) role pre-COVID (before March 2020) and during the pandemic.

Methods: 78 Michigan NHs participated in a 12-month program to reduce healthcare-associated infections from 2018-2021. A 36-question survey on IPC characteristics was sent before starting each of four cohorts. Surveys were completed by IPs, nursing directors, or NH administrators. We compared IPC characteristics pre- and intra-COVID using Fisher's exact test and Wilcoxon Rank Sum to assess significance in categorical and continuous descriptors, respectively.

Results: 74 (94.8%) NHs completed the survey, 56 pre-COVID (before March 2020) and 18 during COVID (> one year after COVID was identified in Michigan). Full-time equivalent (FTE) for the IP role was similar between the two groups, but hours worked per week increased significantly from an average 20 to 38 hours per week ($p < 0.001$). Half of respondents in 2021 reported working 40 hours or more on IPC activities. Despite the additional workload, the IP did not have a significant decrease in their non-IP responsibilities (e.g., staff educator, employee health). Pre-COVID, 21.8% of NHs were enrolled in CDC's National Health Safety Network (NHSN). As mandatory COVID reporting into NHSN began mid-2021, its use contributed to an average of five additional hours per week. Inter-facility notification of resident infections was done by a variety of methods, with facility-to-facility telephone calls increasing during COVID.

Conclusions: COVID-19 has dramatically added to the IP workload in NH settings with no reduction in their other non-IP responsibilities. With reporting requirements unlikely to decrease soon, investment

into staffing is needed to reduce staff burnout, maintain quality of care, and resident safety.

LDPM-18

The Role of Infection Prevention Department Structure in Maintaining Program Resiliency

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Background: Infection Prevention (IP) department structures vary in how responsibilities are assigned. During the COVID-19 pandemic IP program workload significantly increased and healthcare-associated infections (HAI) performance declined. This study assessed whether department structures that reassign administrative tasks away from hospital-based IPs are able to recover quickly from the effects of increased program demand and hospital surge.

Methods: The IP department structure of a 13-hospital system was modified in March 2020 with the creation of a centralized surveillance (CS) team. The CS team was assigned responsibility for communicable disease reporting, healthcare associated infection (HAI) surveillance, and maintenance of HAI-specific line listings. Line listing data entry included electronic health record review for potential performance improvement (PI) opportunities. Hospital-based IPs remained responsible for site-based functions. PI efforts were initiated during 2020 targeting abdominal hysterectomy (HYST), Clostridoides difficile (CDI) and catheter-associated urinary tract infection (CAUTI) using data gathered by the CS team both during and between surges of COVID-19.

Results: The standardized infection ratio (SIR) of HAIs where PI efforts were initiated were compared from 2019 to 2021 to assess department resilience during periods of increased program demand. The CAUTI SIR decreased from 1.02 in 2019 to 0.485 in 2021. ($p = 0.001$). The CDI SIR decreased from 0.683 in 2019 to 0.457 in 2021. ($p = 0.003$). The HYST SIR decreased from 1.483 in 2019 to 0.00 in 2021. ($p = 0.005$). There was no statistical difference in central line-associated bloodstream infection (CLABSI) or methicillin-resistant Staphylococcus aureus (MRSA) performance from 2019 to 2021.

Conclusions: IP program structure can create resiliency during periods of increased IP program demand. Decoupling surveillance and administrative tasks from hospital-based IPs is one approach hospitals and healthcare systems can consider helping ensure critical performance improvement activities continue regardless of demands within hospitals.

LDPM-19

Who You Gonna Call? A Novel Approach to Supporting Infection Prevention On-Call

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