

antifungals, including echinocandins. WGS placed the isolate in the East Asian clade, indicating similarity to isolates from South Korea and Japan. Environmental cultures were negative. The asymptomatic left ear was colonized with *C. auris*; other sites were negative. As of January 29, 2020, no additional cases were detected. **Conclusions:** We identified prolonged colonization of *C. auris* in the external ear canals of a healthy patient. WGS and travel in South Korea, including ENT clinic exposure, provide strong evidence of *C. auris* acquisition in South Korea. No spread has been reported in Minnesota. Deliberate communication with clinical laboratories regarding ruling out *C. auris* was key to case discovery. Clinicians should be aware of *C. auris* epidemiology, including healthcare exposure abroad, particularly in young, healthy patients.

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Late Breaker Oral

Infection Prevention and Control for 2019 Novel Coronavirus (2019 nCoV) in Acute Healthcare Settings: The Canadian Response

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Background: Severe acute respiratory coronavirus virus 2 (SARS-CoV-2), able to cause pneumonia in humans, was discovered in Wuhan, Hubei Province, China. Investigations related to transmissibility are ongoing, but human-to-human transmission involving healthcare workers providing patient care and close contacts of infected patients have been confirmed. Infection control procedures are necessary to prevent transmission during delivery of health care in healthcare settings. Public health in Canada is a

shared responsibility among municipal, provincial, territorial, and federal governments. Significant public health events require coordination between all levels of government and a consistent approach across jurisdictions. The objective of this summary is to describe the Public Health Agency (PHAC)'s Infection Prevention and Control (IPC) guideline on SARS-CoV-2. **Methods:** The PHAC's interim guideline for infection prevention and control of 2019-nCoV in acute healthcare settings was informed by the currently limited evidence available, and adapted to the context of healthcare delivery in Canada. The guideline is based upon Canadian guidance developed for previous coronavirus outbreaks (eg, SARS and MERS), as well as the World Health Organization (WHO)'s interim guidance. Technical advice was provided by the National Advisory Committee on Infection Prevention and Control (NAC-IPC) of the Government of Canada. Interjurisdictional collaboration and decision making between multiple authorities and levels of government was facilitated using PHACs federal/provincial/territorial (FPT) Public Health Response Plan for Biological events (Fig. 1). **Results:** In the absence of effective drugs or vaccines, IPC strategies to prevent or limit SARS-CoV-2 transmission in healthcare settings include the following: prompt identification of signs, symptoms and exposure criteria, implementation of appropriate IPC measures (eg, contact and droplet precautions, patient isolation, N95 respirator plus eye protection when performing aerosol-generating medical procedures on a person under investigation), and etiologic diagnosis. Guideline recommendations are informed by collective expert interpretation of available evidence. Recommendations cover all relevant areas including screening and assessment, public health surveillance and notification, laboratory testing and reporting, respiratory hygiene, hand hygiene, patient placement and flow, management of visitors, use of personal protective equipment, environmental cleaning and discontinuation of precautions. **Conclusions:** This guideline is an ever-changing document. Changes in recommendations provided may be warranted with new evidence, changes in WHO guidelines, or other identified

Figure 1: FPT governance structure and its relation to FPT operation centres

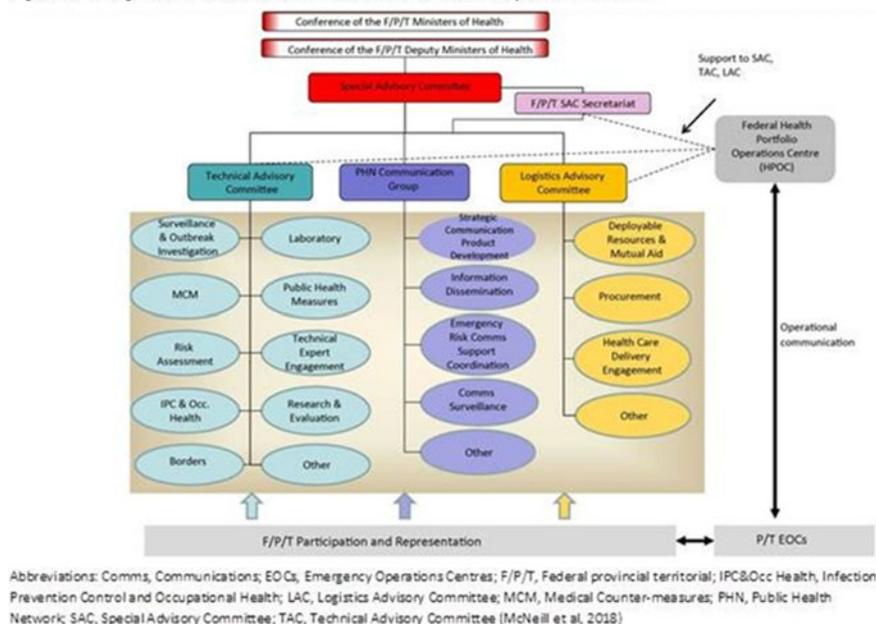


Fig. 1.

concerns. FPT governments continue to work collaboratively to ensure that Canada is ready to respond to public health events and is prepared to protect the health of Canadians. Opportunities for international collaboration on IPC products, as well as knowledge exchange and mobilization, continue to thrive.

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Making a Case for Adjusting NHSN SSI Risk Stratification Classification for Use of Enhanced Electronic Infection Surveillance

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Background: A large healthcare system in Georgia went live with an enhanced electronic infection surveillance system in August of 2018. The system was employed at its facilities using a staggered approach. Prior to the implementation of this infection surveillance platform, the healthcare system performed healthcare-associated infection (HAI) surveillance using an in-house culture-based system. The NHSN estimates that culture-based surveillance misses 50%–60% of true surgical site infections (SSIs). Due to the lack of clinical-based detection methods (eg, radiologic imaging), we were unable to appropriately detect all patient harm using the old surveillance system. **Method:** A retrospective analysis was performed to assess the change in HAI for colon (COLO), abdominal hysterectomy (HYST), hip prosthesis (HPRO), and knee prosthesis (KPRO). SSI cases that met NHSN surveillance criteria were reviewed to determine whether they would have been identified prior to launching the new enhanced electronic surveillance system. **Results:** Systemwide, 8 of 26 COLO SSIs (31%) and 9 of 18 HYST SSIs (50%) would have not been detected using our old surveillance system. HPRO SSIs and KPRO SSIs identified by our new surveillance system were detected using our old surveillance system, and no change was observed. **Conclusion:** This analysis showed an increase in COLO SSIs and HYST SSIs from enhanced

surveillance. Electronic surveillance systems are not considered a risk factor in the NHSN annual facility survey that aids in calculating a facility's standardized infection ratio (SIR). These data help support NHSN consideration of modifying the logistic regression calculation used for the complex SSI models. This revision would allow facilities to compare themselves equitably to those using electronic infection surveillance.

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Measles Exposure Investigation in a Children's Hospital Emergency Department— Denver Metropolitan Area, Colorado, 2019

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Background: On December 14, 3 unvaccinated siblings with recent international travel presented to Children's Hospital Colorado emergency department (CHCO-ED) with fever, rash, conjunctivitis, coryza, and cough. Measles was immediately suspected; respiratory masks were placed on the patients before they entered an airborne isolation room, and public health officials (PH) were promptly notified. Notably, on December 12, 1 ill sibling presented to CHCO-ED with fever only. We conducted an investigation to confirm measles, to determine susceptibility of potentially exposed ED contacts and healthcare workers (HCWs), and to implement infection prevention measures to prevent secondary cases. **Methods:** Measles was confirmed using polymerase chain reaction testing. Through medical record review and CHCO-ED unit-leader interviews, we identified patients and HCWs in overlapping ED areas with the first sibling, until 2 hours after discharge. Measles susceptibility was assessed through interviews with adults accompanying pediatric patients and HCW immunity record reviews. Potentially exposed persons were classified as immune (≥ 1 documented measles-mumps-rubella (MMR) vaccination or serologic evidence of immunity), unconfirmed immune (self-reported MMR or childhood vaccination without documentation), or susceptible (no MMR vaccine

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total COLO HAIs Identified through new System	Total COLO HAIs Since Go Live-August 2018
System	0	0	0	0	2	1	0	1	1	2	1	8	26

Fig. 1.

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total HYST HAIs Identified through new System	Total HYST HAIs Since Go Live-August 2018
System	0	0	0	0	0	0	1	3	1	2	2	9	18

Fig. 2.