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.

Presentation Type:
Late Breaker Oral
Making a Case for Adjusting NHSN SSI Risk Stratification Classification for Use of Enhanced Electronic Infection Surveillance

Meri Pearson, Piedmont Healthcare; Krista Doline, Piedmont Healthcare

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 as 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.

Presentation Type:
Late Breaker Oral
Measles Exposure Investigation in a Children's Hospital Emergency Department— Denver Metropolitan Area, Colorado, 2019

Ashley Richter, Tri-County Health Department

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
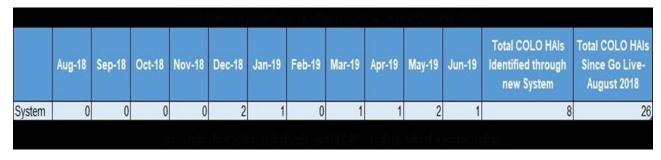

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total COLO HAIs Identified through new System	Total COLO HAIs Since Go Live- August 2018
System	0	0	0	0	2	1	0	1	1	2	1	8	26

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.

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