Table 2. Patient Characteristics, Stratified by Perianal Specimen Collection Status During Eligible Study Visits.

Characteristic	All Patients (N=641)[a]	Patients With Perianal Cultures (N =533)	Patients Without Perianal Cultures (N=108)	P value[b]
Age, y, mean (SD)	74.7 (12.2)	74.5 (12.1)	75.8 (12.7)	0.32
Male Gender, No. (%)	270 (42.1)	227 (42.6)	43 (39.8)	0.59
Non-Hispanic White, No. (%)	397 (61.9)	324 (60.8)	73 (67.6)	0.18
Charlson Comorbidity Index Score, mean (SD)	2.6 (2.1)	2.5 (2.0)	3.0 (2.2)	**0.04**
Cognitive Function Score (BIMS), mean (SD)[c]	12.8 (3.5)	13.0 (3.3)	12.2 (4.2)	0.07
Physical Self-Maintenance Score, mean (SD)	14.4 (4.6)	14.0 (4.5)	16.7 (4.6)	**<0.001**
Antibiotic Usage in Past 30 Days, No. (%)	384 (59.9)	319 (59.9)	65 (60.2)	0.95
Device Usage (Baseline), No. (%)	66 (10.3)	52 (9.8)	14 (13.0)	0.32
Wounds (Baseline), No. (%)	281 (43.8)	221 (41.5)	60 (55.6)	**0.007**
Previous Hospitalization, No. (%)	608 (94.9)	507 (95.1)	101 (93.5)	0.49
Hospital Stay > 2 Weeks, No. (%)	59 (9.2)	52 (9.8)	7 (6.5)	0.28
Length of Stay, mean (SD)	45.0 (46.4)	47.7 (47.7)	31.5 (37.1)	**<0.001**

[a] Patients were included in this analysis if they had a study visit where all three body site specimens were collected: hands, nares, and groin. Eligible patients were then stratified by whether a perianal area specimen was collected during any of their eligible study visits.

[b] Chi-square test of associated was used to assess significance for categorical variables while Student's t-test was used to assess significance for continuous variables.

[c] Cognitive function was evaluated using the Brief Interview for Mental Status (BIMS). Nineteen patients had missing or incomplete BIMS assessments on study enrollment.

Abbreviations: BIMS, Brief Interview for Mental Status; SD, standard deviation.

characteristics associated with the acquisition of perianal cultures (eg, selection bias), we compared clinical characteristics, overall patient colonization, and room environment contamination of patients in whom all body sites were sampled during a study visit (533 patients; 1,026 visits) to patients with all body sites except the perianal culture sampled during a study visit (108 patients; 168 visits). **Results:** Of 651 patients, 533 met the inclusion criteria; average age was 74.5 years, 42.6% were male, and 60.8% were white. Of 1,026 eligible visits, 620 visits detected MDRO colonized patients; 155 MRSA, 363 VRE, and 386 RGNB (Table 1). If perianal cultures were not collected, nonperianal surveillance misses 7.7%, 41.3%, and 45.1% of MRSA, VRE, and RGNB colonized visits, respectively. The addition of environmental surveillance to non-perianal screening detected 95.5%, 82.9%, and 67.9% of MRSA, VRE, and RGNB colonized visits, respectively. The specificity of environmental screening was 85.3%, 72.7%, and 73.4% for MRSA, VRE, and RGNB, respectively. Patients without attainable perianal cultures had significantly more comorbidities, worse functional status, shorter length of stay, and higher baseline presence of wounds than patients with attainable perianal cultures; introducing potential selection bias to surveillance efforts (Table 2). No significant differences in overall patient colonization and room contamination were noted between patients with and without attainable perianal cultures. **Conclusion:** Perianal screening is important for the detection of VRE and RGNB colonization. Infection prevention must be cognizant of the tradeoff between reducing type 2 error and the selection bias that occurs with required attainment of perianal cultures. In the absence of perianal cultures, environmental surveillance improves MDRO detection while introducing type 1 error.

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Late Breaker Oral

Case of *Candida auris* Identified From the External Ear Canal of a Healthy Minnesota Outpatient With Travel to South Korea

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Background: *Candida auris* is a globally emerging, multidrug-resistant fungal pathogen that causes healthcare-associated outbreaks and can be misidentified in clinical laboratories. Most US *C. auris* cases occur in hospitalized or long-term care patients with underlying medical conditions. Also, 4 global phylogenetic *C. auris* clades largely cluster geographically. Receiving health care abroad is a risk factor for US *C. auris* cases. In December 2019, the Minnesota Department of Health (MDH) confirmed Minnesota's first *C. auris* case, isolated from the external ear canal of a healthy young adult outpatient with right-sided otitis externa. We describe the investigation and response for this uncommon US presentation of *C. auris*. **Methods:** The MDH initiated mandatory reporting and submission of confirmed or possible *C. auris* isolates in August 2019. The MDH Public Health Laboratory (MDH-PHL) confirmed *C. auris* by MALDI-TOF (Bruker) from an isolate submitted by a hospital laboratory as *C. duobushaemulonii* to rule out *C. auris*. The MDH-PHL performed broth microdilution antifungal susceptibility testing (AFST). The CDC Mycotics Diseases Branch laboratory performed whole-genome sequencing (WGS). The MDH epidemiologists obtained a patient history through interviews with healthcare staff and the patient, and they collected environmental samples from otoscopes. The MDH-PHL tested environmental samples by *C. auris* RT-PCR and culture. The MDH recommended disinfection of examination rooms and otoscopes and 3 months of *C. auris* surveillance for patients evaluated with otoscopes who later returned with otic inflammation. Swabs from the patient's axilla, groin, and external ear canals were tested for *C. auris* by PCR at the MDH-PHL. **Results:** The patient reported recurrent right ear infections in 2016 during a 16-month visit to South Korea, with treatment in multiple ENT clinics. December 2019 otitis resolved after treatment with oral amoxicillin/clavulanate and otic ciprofloxacin/dexamethasone. AFST showed resistance to fluconozale and susceptibility to 8

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 January29, 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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Infection Prevention and Control for 2019 Novel Coronavirus (2019 nCoV) in Acute Healthcare Settings: The Canadian Response

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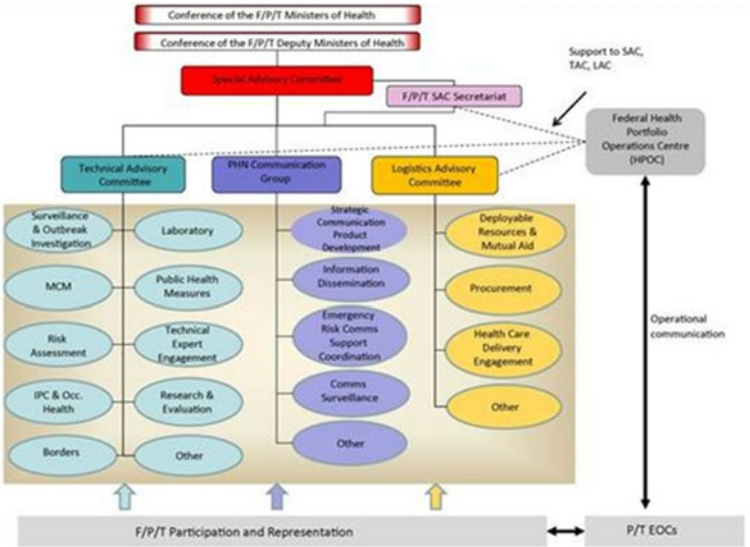
Background: Severe acute respiratory coronavirus virus 2 (SARS-CoV-2), able to cause pneumonia in humans, was discovered in Wuhan, Hubei Province, China. Investigations related to transmissibility are ongoing, but human-to-human transmission involving healthcare workers providing patient care and close 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



Abbreviations: Comms, Communications; EOCs, Emergency Operations Centres; F/P/T, Federal provincial territorial; IPC&Occ Health, Infection Prevention Control and Occupational Health; LAC, Logistics Advisory Committee; MCM, Medical Counter-measures; PHN, Public Health Network; SAC, Special Advisory Committee; TAC, Technical Advisory Committee (McNeill et al, 2018)

Fig. 1.