



Table 1. Methicillin-resistant *Staphylococcus aureus* (MRSA) healthcare-associated infection (HAI) rates, all acute care units, all infection sites, by facility infection prevention and control policy category

Policy Category	Number of Data Months	Number of HAIs	Patient-Days	Rate*	95% CI†
AS + CPC + CPI‡	1,163	153	1,708,867	0.09	0.08 - 0.10
AS + CPI	519	106	1,075,329	0.10	0.08 - 0.12
AS alone	63	15	131,613	0.11	0.06 - 0.19
CPI only	1,015	250	2,105,012	0.12	0.10 - 0.13
No AS or CPC or CPI	142	44	294,353	0.22	0.16 - 0.29

*Number of HAIs/1,000 patient-days, †95% confidence interval, ‡AS = active surveillance for MRSA upon facility admission, CPC = contact precautions for MRSA colonized patients, CPI = contact precautions for MRSA infected patients

Table 2. Comparisons of methicillin-resistant *Staphylococcus aureus* (MRSA) healthcare-associated infection (HAI) rates by facility infection prevention and control policy category, infection site, and unit type

Policy Category	All Units			Non-ICUs			ICUs		
	HAI Rate*	95% CI†	P‡	HAI Rate	95% CI	P	HAI Rate	95% CI	P
AS + CPC + CPI	0.09	0.08-0.10		0.07	0.05-0.08		0.20	0.15-0.26	
No AS or CPC or CPI	0.22	0.16-0.29	<0.001	0.12	0.08-0.19	0.01	0.65	0.41-0.98	<0.001

Policy Category	Bloodstream Infections		
	HAI Rate*	95% CI†	P‡
AS + CPC + CPI	0.03	0.02-0.04	
No AS or CPC or CPI	0.09	0.05-0.14	<0.001

*Number of HAIs/1,000 patient-days, †95% confidence interval, ‡P values for χ^2 pairwise comparison, §AS = active surveillance for MRSA upon facility admission, CPC = contact precautions for MRSA colonized patients, CPI = contact precautions for MRSA infected patients

facilities practicing active surveillance plus CPC plus CPI compared to 0.12 (95% CI, 0.08–0.19; $P = .01$) for those not practicing any of these strategies, and in ICUs the MRSA HAI rates were 0.20 (95% CI, 0.15–0.26) and 0.65 (95% CI, 0.41–0.98; $P < .001$) for the respective policies. Similar differences were seen when the analyses were restricted to MRSA bloodstream HAIs. Accounting for monthly COVID-19 admissions to facilities over the analysis period using a negative binomial regression model did not change the relationships between facility policy and MRSA HAI rates in the ICUs or non-ICUs. There was no statistically significant difference in monthly facility urinary catheter-associated infection rates, a nonequivalent dependent variable, in the categories during the analysis period in either ICUs or non-ICUs. **Conclusions:** In Veterans Affairs medical centers, there were fewer MRSA HAIs when facilities practiced active surveillance and contact precautions for colonized or infected patients during the COVID-19 pandemic. The effect was greater in ICUs than non-ICUs.

Disclosures: None

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Subject Category: Outbreaks

Multifacility outbreak of *Candida auris* during the COVID-19 pandemic—Maricopa County, Arizona, April 2022–December 2022

Siru Prasai; JulieAnna Rivas; Bianca Munoz; Serena Bailey; Karen Zabel; Kaitlyn Chorbi; Rachana Bhattarai; Monica Hernandez-Cubias and Ariella Dale

Background: *Candida auris*, an emerging and potentially multidrug-resistant fungus, was first identified in Maricopa County, Arizona, in 2020. On April 21, 2022, an acute-care hospital reported *C. auris* in a bronchoalveolar lavage (BAL) specimen, followed by a second case reported on April 26 identified via retrospective laboratory review and species identification in yeast isolated from a clinical specimen. The Maricopa County Department of Public Health (MCDPH) investigated, and we describe the largest ongoing *C. auris* outbreak containment response in Maricopa County. **Methods:** The MCDPH conducted clinical case and contact investigations in accordance with CDC novel organism containment strategy guidelines. In Maricopa County healthcare facilities (HCFs) with suspected transmission, virtual Infection Control Assessment Responses (ICARs) were administered to identify initial infection prevention and control (IPC) gaps; subsequent regular virtual visits were also provided. HCFs with confirmed transmission completed point-prevalence surveys (PPSs) every 2 weeks until transmission halted as evidenced by 2 sequential negative PPSs. Outreach education to affected HCFs was provided to increase awareness about the public health significance of *C. auris* and the importance of implementation and sustained adherence to standardized IPC protocols. **Results:** In total, 97 HCFs received IPC outreach education, of which 22 HCFs (23%) had suspected transmission and received a virtual ICAR. Contact investigation identified 1,990 contacts, of whom 1,028 (52%) were discharged to the community, 863 (43%) were admitted to other HCFs, and 99 (5%) died. Of the 863 transferred contacts, 10 (1.2%) declined colonization screening, 853 (98.8%) were screened, and 46 (5%) tested positive for *C. auris*. Through sequential PPSs, 101 (5%) of 1,914 screened patients tested positive for *C. auris*. By December 31, 16 clinical and 147 colonized cases were epidemiologically linked to the outbreak. Their median age was 60 years (IQR, 20), and 3 pediatric cases (median age, 17 years) were identified with no pediatric unit admissions. Also, 7 colonized cases (5%) developed noninvasive infection and 3 (2%) developed candidemia. **Conclusions:** The MCDPH's established partnerships with HCFs were key to this ongoing *C. auris* outbreak response spanning 22 facilities over 8 months. Challenges included delays in specimen collection and laboratory processing, operational burden of repeated PPS, and ensuring appropriate precautions for readmitted close contacts at subsequent HCFs. The MCDPH assisted facilities in balancing public health surveillance with facility capacity to execute guidance, including repeated PPS. Consistent adherence to stringent IPC practices, interfacility communication, and proactive *C. auris* education of healthcare workers are paramount to halting transmission.

Disclosures: None

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Subject Category: Outbreaks

Investigation of the first cluster of *Candida auris* cases among pediatric patients in the United States—Nevada, May 2022

Sophie Jones; Kaitlin Forsberg; Christopher Preste; Joe Sexton; Paige Gable; Janet Glowicz; Heather Jones; Maroya Walters; Meghan Lyman; Chidinma Njoku; Kimisha Causey; Jeanne Ruff; Dallas Smith; Karen Wu; Elizabeth Misas; Teri Lynn; Chantal Lewis; Brian Min; Fathia Osman and Erin Archer

Background: *Candida auris* is a frequently drug-resistant yeast that can cause invasive disease and is easily transmitted in healthcare settings.