384. Findings From a *Candida auris* Admission Screening Pilot in New York State

Elizabeth M. Dufort, MD[1]; Richard Erazo, BS[2]; Monica Quinn, RN, MS[3]; Sudha Chaturvedi, PhD[4]; Snigdha Vallabhaneni, MD, MPH[5]; Valerie B. Haley, PhD[6]; Emily Lutterloh, MD, MPH[6]; Jiankun Kuang, MS[7]; Carolyn Stover, BA[8]; Coralie Bucher, MPH[8]; Robert McDonald, MD, MPH[1]; Eleanor H. Adams, MD, MPH[2] and Debra S. Blog, MD, MPH[1]; [1]Division of Epidemiology, New York State Department of Health, Albany, New York, [2]Healthcare Epidemiology and Infection Control, New York State Department of Health, New Rochelle, New York, [3]Health Care Epidemiology and Infection Control, New York State Department of Health, Albany, New York, [4]Wadsworth Center, New York State Department of Health, Albany, New York, [5]Mycotic Diseases Branch, Centers for Disease Control and Prevention, Atlanta, Georgia, [6]Bureau of Healthcare-Associated Infections, New York State Department of Health, Albany, New York, [7]New York State Department of Health, Albany, New York, [8]University at Albany School of Public Health, State University of New York, Albany, New York

Session: 56. Fungal Disease: Management and Outcomes
Thursday, October 4, 2018: 12:30 PM

Background. *Candida auris* is an emerging multidrug-resistant yeast which can spread within healthcare facilities and is associated with significant morbidity. Over 160 clinical cases have been reported in NYS. This pilot aims to assess the feasibility of *C. auris* admission screening and to better understand its role in controlling spread of *C. auris* in an area where it has emerged.

Methods. One hospital and two nursing homes (NHs) with known prior cases participated (one NH and hospital are closely associated and are reported together). Patients were screened on admission to any of three hospital intensive care units (medical, cardiac, pulmonary) or to a ventilator unit in the NHs from November 2017 to April 2018. Screening consisted of bilateral nares and axilla/groin swabs sent to the NYS Department of Health Wadsworth Center (WC) for a WC-developed *C. auris* real-time polymerase chain reaction (rt-PCR) test. Specimens with detection of *C. auris* on rt-PCR underwent fungal culture. Facilities were alerted of positive results and infection control precautions were promptly initiated.

Results. To date, 575 patients (1,371 samples) were screened. Of patients not previously known to be colonized, 39 had *C. auris* detected on rt-PCR; 34 confirmed by *C. auris* culture at either site and one culture pending. Of these, 30 (88%) were detected and confirmed from the axilla/groin specimen (Figure 1). Mean age was 76 years and 59% were females. Patients had significant healthcare facility exposure (Figure 2). Eleven (32%) were from NH-A and 23 (68%) from the hospital/NH-B combined. Rates of positivity were 16.2% (11/68) for NH-A and 4.6% (23/498) for the hospital/NH-B.

Conclusion. *C. auris* rt-PCR is a useful tool within an admission screening program; however, more accessible and affordable rapid laboratory diagnostics are urgently needed. The axilla/groin site detected the majority of colonized individuals. Admission screening was feasible and increased facility knowledge of colonization status, which led to earlier implementation of infection control precautions potentially limiting spread. However, further study is needed to assess transmission dynamics and potential impact of admission screening on control of *C. auris* within an outbreak or endemic setting.

Figure 1.

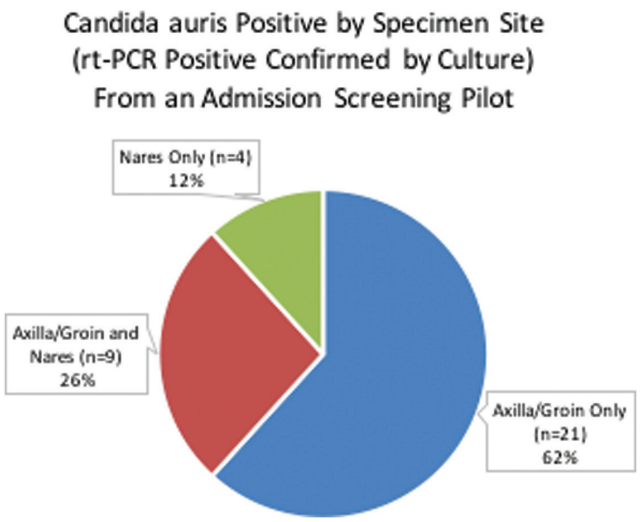
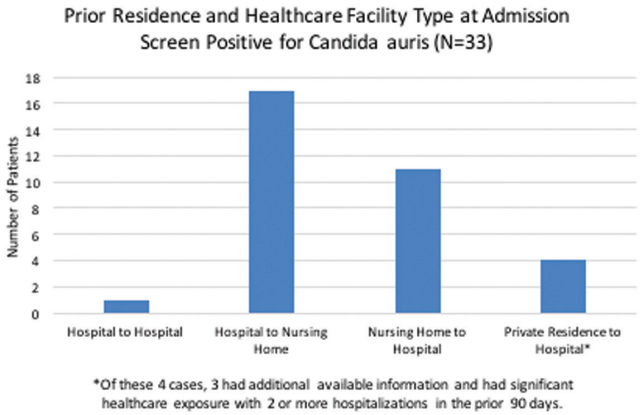


Figure 2.



Disclosures. **All authors:** No reported disclosures.

385. The Value Added From *Candida auris* Point Prevalence and Environmental Studies in New York State

Eleanor H. Adams, MD, MPH[1]; Monica Quinn, RN, MS, CIC[2]; Belinda Ostrowsky, MD, MPH[3]; Karen Southwick, MD[4]; Jane Greenko, RN, MPH, CIC[5]; Rafael Fernandez, MPH[6]; Rutvik Patel, MSW[1]; Ronald Jean Denis, BS[1]; Richard Erazo, BS[1]; Sudha Chaturvedi, PhD[7]; Lynn Leach, MS[7]; Yan Chun Zhu, MS[7]; Valerie B. Haley, PhD[2]; Sharon Tsay, MD[8]; Snigdha Vallabhaneni, MD, MPH[9]; Emily C. Lutterloh, MD, MPH[2]; Debra S. Blog, MD, MPH[10] and Elizabeth M. Dufort, MD[10]; [1]Healthcare Epidemiology and Infection Control, New York State Department of Health, New Rochelle, New York, [2]Bureau of Healthcare-Associated Infections, New York State Department of Health, Albany, New York, [3]Dhqp, Centers for Disease Control and Prevention, New York, New York, [4]New York State Department of Health, Albany, New York, [5]Healthcare Epidemiology and Infection Control, New York State Department of Health, Central Islip, New York, [6]Healthcare Epidemiology and Infection Control, New York State Department of Health, New York, New York, [7]Wadsworth Center, New York State Department of Health, Albany, New York, [8]Epidemic Intelligence Service, Centers for Disease Control and Prevention, Atlanta, Georgia, [9]Mycotic Diseases Branch, Centers for Disease Control and Prevention, Atlanta, Georgia, [10]Division of Epidemiology, New York State Department of Health, Albany, New York

Session: 56. Fungal Disease: Management and Outcomes
Thursday, October 4, 2018: 12:30 PM

Background. As of March 25 2018, 151 clinical cases of *C. auris* were diagnosed in NYS. We conducted point prevalence surveys (PPS) and environmental surveys (ES) to detect surveillance cases and assess the burden of environmental contamination in NYS healthcare facilities from September 12, 2016.

Methods. A PPS was defined as culturing ≥2 individuals at a healthcare facility that diagnosed, cared for, or was near a facility with a *C. auris* case. ES involved environmental swabbing in facilities where cases resided or were admitted. Cultures and polymerase chain reaction (PCR) were performed at the NYS Wadsworth Center.

Results. As of March 25, 2018, 81 PPS or ES had been conducted at 55 facilities. From these PPS, a total of 144 (6.1%) individuals were positive for *C. auris* by culture; 125 were PCR positive. The rates of culture positive *C. auris* identified patients varied by facility type: hospitals (38/767, 5.0%), long-term care facilities (LTCF) (88/1,404, 6.3%), long-term acute care (1/35, 2.9%), and co-located hospital and LTCF (17/138, 12.3%). The majority of the LTCF *C. auris* culture-positive cases (80/82) were identified in facilities that cared for ventilated patients. Rates in LTCF caring for ventilated patients were nearly 10 times as high as other LTCF [86/1,121 (7.7%) vs. 2/284 (0.7%)]. ES identified 86 (3.0%) samples positive by culture and 257 (8.9%) by PCR. Thirty-seven (67%) of the 55 facilities had at least one positive environmental sample by PCR or culture; many of these positive samples were from surfaces or equipment deemed to be "clean." Over 1,900 person-hours were needed to conduct onsite PPS and ES that collected >4,200 human and >2,800 environmental samples and identified opportunities for improving basic infection prevention and environmental cleaning. Ten facilities, including the co-located hospital and LTCF, had multiple positive PPS or ES.

Conclusion. PPS conducted over 17 months detected many colonized individuals and *C. auris* in facility environments, likely indicating a silent reservoir for this organism beyond clinical cases, especially in LTCFs. Serial PPS and ES can help improve *C. auris* detection and inform subsequent infection prevention and control interventions. However, these efforts are resource intensive and can divert resources from other activities.

Disclosures. **All authors:** No reported disclosures.