CDPH recommends a coordinated approach among healthcare facilities and public health to contain *Candida auris* (*C. auris*) in California. Local health departments (LHD) should be aware of *C. auris* incidence in healthcare facilities and communities in their regions, understand prevention measures, and provide guidance to healthcare facilities when responding to *C. auris* reports.

**Background and Epidemiology**

- *C. auris* is an emerging, often multidrug-resistant fungus. Some are resistant to all three available classes of antifungals.
- *C. auris* was first identified in 2009 in Japan, and has since been reported from over 35 countries, including the United States.¹
- In California as in the U.S., *C. auris* has mainly been identified among patients with exposure to ventilator units at skilled nursing facilities (vSNF) and long-term acute care hospitals (LTACH).²

**C. auris** Cases in California by Specimen Collection Facility and Case Type through June, 2020 (N=312)

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Clinical Case</th>
<th>Screening/Screening Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>180</td>
<td>0</td>
</tr>
<tr>
<td>vSNF</td>
<td>160</td>
<td>10</td>
</tr>
<tr>
<td>ACH</td>
<td>140</td>
<td>20</td>
</tr>
<tr>
<td>SNF</td>
<td>120</td>
<td>30</td>
</tr>
<tr>
<td>Dialysis</td>
<td>100</td>
<td>40</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80</td>
<td>60</td>
</tr>
</tbody>
</table>

- Other risk factors include presence of indwelling medical devices, recent surgery, diabetes, recent antimicrobial use, and overnight healthcare exposure in a country with documented *C. auris* transmission.¹
- *C. auris* can cause serious infections, including in blood and wounds. Mortality rates for invasive infections are as high as 60%.¹
  - In California, the reported 90-day mortality rate among *C. auris* cases through June, 2020 ranged from 21% among colonization/screening cases (specimens from swabs) to 35% among clinical cases (specimens obtained during the course of patient care).
- Standard laboratory methods can misidentify *C. auris* as other yeasts (especially *C. haemulonii*).
  - The Centers for Disease Control and Prevention (CDC) provide guidance for when to suspect *C. auris*.³
- *C. auris* can persist in the healthcare environment for weeks, where it can spread through contact with contaminated surfaces or equipment. Person-to-person spread can also occur; infected and colonized patients can serve as sources of transmission.
- Identifying and containing *C. auris* is a public health priority. Early detection, infection control, and interfacility communication can limit the spread of *C. auris*.²

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³ CDC Identification of *C. auris* (https://www.cdc.gov/fungal/candida-auris/recommendations.html#suspect)
C. auris Clinical Isolates by Specimen Type (n=44)

Facility Actions
1. Routine Surveillance and Identification of C. auris
   • Ensure clinical labs can identify C. auris. If not, know when to suspect it, and send those isolates to public health for further testing.
   • Identify all Candida isolates from normally sterile sites to the species level.
   • For Candida isolated from non-sterile sites, consider species-level identification:
     ▪ when clinically indicated for patient care
     ▪ when C. auris has been detected in the facility as part of prospective surveillance for additional case detection
     ▪ at high-risk facilities such as LTACH or vSNF
     ▪ when a patient meets criteria for active surveillance (see below).
   • C. auris testing is available at some local public health labs and the CDPH Microbial Diseases Laboratory (MDL).
   • Clinical labs immediately notify clinicians and infection prevention staff whenever C. auris is identified.
2. Active Surveillance
   • Healthcare facilities screen for C. auris and implement preemptive Contact precautions, and ensure use of appropriate disinfectant for patients at risk for C. auris, including those:
     ▪ who have received care at LTACH or vSNF
     ▪ admitted from facilities known to have ongoing C. auris transmission
     ▪ who are close healthcare contacts of a newly-identified C. auris case
     ▪ colonized or infected with another multidrug-resistant organism (MDRO), especially carbapenemase-producing organisms
     ▪ who had an overnight healthcare exposure outside the U.S. in the past 12 months, especially if in a country with documented C. auris cases.
3. Investigation and Reporting
   • A single, confirmed case of C. auris from any body site is cause for investigation and notification to public health.
   • Report unusual infectious disease occurrences and outbreaks to public health under Title 17 and CDPH Licensing & Certification if in licensed healthcare facility per All Facilities Letter 19-18.

Public Health Response to C. auris Reports
1. Initial Response and Recommendations
   LHD makes recommendations to the facility for information gathering, surveillance, and infection control measures.
   • Collect relevant case information in line list format, including:
     ▪ Previous/subsequent healthcare facilities
     ▪ Dates of admission, discharge, initiation of Contact precautions
     ▪ Locations (e.g., units, wings)
     ▪ Indwelling devices/mechanical ventilation
     ▪ Healthcare exposures outside the U.S. in the previous 12 months

4 C. auris Testing at CDPH MDL: (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TestOrderFungallIDYeastMALDI.aspx)
5 LHD may choose to reduce or expand the time period for history of overnight healthcare exposure abroad depending on whether C. auris has previously been identified in the region, and as resources allow.
6 CDPH Reportable Diseases and Conditions: (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx)
8 Licensing and Certification District Offices Directory: (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx)
Recommend placing patient in a single-bed room on Contact precautions, and using an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant effective against C. auris for daily and terminal cleaning and disinfection of patient care environment.9

Ensure transferring facilities inform receiving facilities of patient’s C. auris status and recommended infection control measures at time of transfer.

2. LHD consults with CDPH HAI Program to determine need for an on-site infection control assessment

3. Retrospective and Prospective Lab Surveillance
   • Conduct retrospective surveillance to identify additional confirmed or suspected cases during the past six months, or as far back as 2015 in regions where C. auris has not previously been identified.
   • Identify the species of all Candida isolates from any specimen source for at least three months, until there is no evidence of transmission.
   • In high-risk facilities such as LTACH or vSNF, consider routinely identifying the species of non-sterile (i.e., urine, respiratory or both) in addition to sterile Candida isolates if not already done.

4. Contact Investigation or Point Prevalence Survey
   • In consultation with CDPH HAI Program, recommend C. auris colonization testing of close healthcare contacts not previously identified with C. auris, including those:
     ▪ who shared a bathroom and roommates
     ▪ who require high levels of care (e.g., ventilator-dependent) and overlapped on the same ward or unit as the index
     ▪ with shared primary HCP, or exposed to the same device
     ▪ residing on unit(s) where transmission is suspected (point prevalence survey (PPS))
   • Facilities flag the medical record of patients identified as contacts, but who were discharged prior to screening; if discharged to another facility, consider screening contacts there.
   • If one or more additional patients are identified with C. auris, conduct serial PPS at two-week intervals until two consecutive PPS are completely negative.
     ▪ For patients testing negative during PPS and discharged to another facility, screen and place on preemptive Contact precautions at receiving facility.
   • In long-term care facilities, consider following up with less frequent PPS if one or more C. auris-positive patients are in residence.
   • C. auris colonization testing of axilla-groin swab specimens is available at no cost to facilities via the CDC Antibiotic Resistance Laboratory Network.10

5. Infection Control Recommendations for Facilities Room Placement
   • Place patients infected or colonized with C. auris in a single-bed room whenever possible, and implement Contact precautions.
   • In facilities with multi-bed rooms, patients with C. auris may be placed in the same room. Ideally, only place patients co-colonized with other MDRO in multi-bed rooms with other patients co-colonized with the same MDRO.
   • In multi-bed rooms, treat each bed space as a separate room. HCP must change gown and gloves and perform hand hygiene between contact with patients in the same room.

Hand Hygiene
   • Follow and audit standard hand hygiene practices, including the use of alcohol-based hand sanitizer as the preferred method for cleaning hands if not visibly soiled. If hands are visibly soiled, wash with soap and water.

Transmission-based Precautions
   • Contact precautions consist of HCP use of gowns and gloves upon entry to the patient room;

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9 CDC C. auris Environmental Disinfection: (https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html#disinfection)

10 CDC Screening for C. auris Colonization: (https://www.cdc.gov/fungal/candida-auris/c-auris-screening.html)
patients may only leave room when medically necessary.

- Continue Contact precautions for the duration of admission in acute care hospitals, including LTACH.
- In SNF, if there is no evidence of transmission, implement Enhanced Standard Precautions for residents with risk factors for transmission.\(^{11}\)
- Do not perform repeated cultures or \emph{C. auris} screening to demonstrate \emph{C. auris} “clearance”, as patients may remain colonized for many months, possibly indefinitely.

**Dedicated Staff and Equipment**

- Dedicate daily care equipment as much as possible, and consider using single-use, disposable, non-critical devices. If multiple \emph{C. auris}-infected or -colonized patients are present in a healthcare facility:
  - Place them in rooms in the same geographic area of the facility whenever possible.
  - Dedicate primary HCP (e.g., nursing) without responsibility to care for non-\emph{C. auris} patients.
    - HCP who cannot be dedicated to \emph{C. auris} patients should care for non-\emph{C. auris} patients before \emph{C. auris} patients, whenever feasible.

**Environmental Cleaning**

- Conduct and audit daily and terminal cleaning and disinfection of patient care environment including high-touch surfaces, and non-dedicated equipment after use, with an EPA-registered hospital-grade disinfectant effective against \emph{C. auris}.\(^ {9}\)
- Consider extending use of appropriate disinfectant to entire unit or facility where patients with \emph{C. auris} are located.

**Adherence Monitoring**

- Evaluate implementation of infection control measures using adherence monitoring tools and provide feedback to HCP.\(^ {12}\)

**6. Communication and Follow-up for Facilities**

- When transferring a \emph{C. auris}-infected or -colonized patient to another healthcare facility, the transferring facility must communicate the patient’s \emph{C. auris} status, including recommended infection control measures to the receiving facility at time of transfer.\(^ {13}\)
- When receiving transferred patients, facilities may consider actively seeking information on MDRO status.
- Facilities with ongoing \emph{C. auris} outbreaks should inform facilities to which they transfer patients. Receiving facilities may screen such patients for \emph{C. auris} and place them on preemptive Contact precautions pending the test result.
  - LTACH or vSNF known to regularly share patients with the index facility may also consider admission screening of transfer patients, or PPS of high-risk patients or units.
- If patient has had previous healthcare exposure, and date of collection is within three days of admission, notify previous facility of \emph{C. auris} status. The previous facility may also consider conducting a contact investigation or PPS.
- Facilities also alert LHD when transferring patients with \emph{C. auris}.
- Flag the medical record of patients with \emph{C. auris} to ensure infection control precautions are implemented upon readmission.
- Provide education materials to patients, their families, and HCP as needed.\(^ {14}\)

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\(^{12}\) \textit{CDPH Tools for Monitoring Adherence to Health Care Practices that Prevent Infection}: (https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPPracticesThatPreventInfection.aspx)

\(^{13}\) \textit{Infection Control Transfer Form} (PDF): (https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Interfacility%20Transfer%20Form%20061417.pdf)

\(^{14}\) \textit{CDPH \emph{C. auris} Website}: (https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris.aspx)