

Regional Public Health *Candida auris* Prevention and Response Strategy

Introduction

Local health jurisdictions (LHJs) can use this Regional Public Health *Candida auris* Prevention and Response Strategy (“Response Phases”) document to guide prevention, response, and mitigation activities, and recommendations that depend on local or regional *C. auris* epidemiology. The “Response Phases” document is designed to complement the *C. auris* Quicksheet¹ which provides response recommendations that LHJs would implement at all levels of *C. auris* endemicity. The recommendations described in this document are the minimum set of prevention and response activities and does not preclude LHJs from providing more stringent recommendations to their healthcare facilities.

The “Response Phases” recommendations are intended to prioritize those with the highest public health impact:

- In all phases, ensure results of screening, including point prevalence surveys (PPSs), are acted upon and tied to meaningful infection prevention and control (IPC) action; screening does not prevent transmission by itself.
- For non-endemic *C. auris* LHJs (Phase 2), *C. auris* screening considerations prioritize the highest yield activities while allowing flexibility for LHJs to be more stringent.
- In long-term acute care hospitals (LTACHs) where *C. auris* has become endemic (Phase 4), we include considerations for prioritizing intensified efforts to prevent adverse clinical outcomes (e.g., central line-associated bloodstream infections) and echinocandin-resistant *C. auris*, with reduced emphasis on routine PPS.

Definitions

Screening refers to the collection of (typically) axilla/groin swabs to test for colonization in individuals exposed to or at risk of acquiring *C. auris*.

Individuals at high risk of *C. auris* acquisition include those:

- who are close healthcare contacts of a confirmed *C. auris* case, including roommates, those who shared a bathroom, those who occupy the same bedspace immediately after the index patient, and patients or residents on the same unit or in the same facility;
- mechanically ventilated or trached admitted to LTACHs or ventilator (subacute) units of skilled nursing facilities (vSNFs);
- admitted from facilities with known *C. auris* transmission;
- colonized or infected with a carbapenemase-producing organism (CPO), especially those requiring high-level care (e.g., indwelling medical devices, mechanical ventilation); and
- with international healthcare exposure in the last 12 months, especially those colonized or infected with a CPO.

Facilities at high risk of *C. auris* introduction and spread include:

- LTACHs
- vSNFs (particularly ventilator units)

- Acute care hospital (ACH) high-acuity units, e.g., intensive care, step-down, burn, and oncology units

All Phases and Facilities

1. See *C. auris* Quicksheet for response recommendations across all phases and facilities.¹
2. All confirmed *C. auris* cases must be reported to public health, and all *C. auris* isolates from sterile site specimens (e.g., blood) must be submitted to public health.²
3. Ensure laboratories can correctly identify *C. auris*,³ and healthcare facilities have access to routine *C. auris* screening resources outside of public health (e.g., polymerase chain reaction (PCR) testing through a clinical or commercial lab).⁴
 - There are a growing number of labs with PCR testing capacity.⁴ Public health can continue to engage new labs, including reference labs serving high-risk individuals to bring on *C. auris* screening testing.
 - PCR is preferred over culture-based testing due to the shorter turn-around-time which can enable more prompt response to cases.
 - Prioritize engaging facilities admitting high-risk individuals; identify successful or innovative strategies to engage facilities (especially SNFs, vSNFs) to use these resources.
4. Promote antimicrobial stewardship (AS) in all healthcare facilities.
 - Ensure appropriate use of broad-spectrum antibiotics and antifungals; e.g., do not treat organisms isolated from non-sterile sites without evidence of infection.
 - Engage facility leadership on implementation of core elements, including:
 - who is responsible for AS in the facility;
 - how the facility is tracking or monitoring antimicrobial use, and for which antimicrobials; and
 - whether the facility has a process for reassessing the indication and duration for antimicrobial prescriptions.
 - Encourage participation in CDPH AS initiatives,⁵ including the AS Program Honor Roll and multidrug-resistant organism (MDRO) prevention collaboratives.⁶
5. Ensure facility-wide implementation of Enhanced Barrier Precautions (EBP) in SNFs. *C. auris* is included in the CDC list of targeted MDROs for which EBP are indicated, in addition to indwelling devices and unhealed wounds.⁷ In units where *C. auris* transmission has been identified, recommend placing residents known to be *C. auris*-positive on Contact Precautions until containment can be demonstrated; refer to EBP: Additional Considerations for California SNFs for guidance on transitioning from Contact Precautions to EBP.⁸ LHJs may adapt EBP principles in non-healthcare congregate residential settings (e.g., assisted living facilities, group home, board and care) for known *C. auris*-positive individuals.
6. Recommend use of a List P disinfectant⁹ (List K disinfectant or bleach, if not accessible) based on response phase (for a summary, see Table 2).

Table 2. Recommendations for List P Disinfectant⁹ Use by Healthcare Facility Type and Response Phase

This table summarizes recommendations for use of a List P disinfectant (List K disinfectant or bleach, if not accessible) in healthcare settings depending on the *C. auris* Response Phase a healthcare facility or LHJ is experiencing. In general, as *C. auris* endemicity increases, the recommendations for use of a List P disinfectant become stronger both within a healthcare facility and across facility types. In facilities or units where a List P disinfectant is not indicated, ensure the use of an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant according to label instructions for facility-wide daily and terminal cleaning and disinfection. As a reminder, List P disinfectants are effective against *C. auris* as well as other MDROs including carbapenemase-producing organisms.

	ACH	LTACH	SNF	vSNF
Phase 1: No <i>C. auris</i> cases	Per routine facility protocol	Facility-wide	Per routine facility protocol	Use List P disinfectant in vent unit. Consider using List P disinfectant facility-wide.
Phase 2: Newly identified <i>C. auris</i> cases	In affected unit(s) (with cases or where transmission is suspected)		For a single <i>C. auris</i> case: in affected resident’s room When <i>C. auris</i> transmission is suspected or confirmed: in affected unit(s)	Facility-wide
Phase 3: Ongoing local transmission	In affected and high-acuity* units. Consider using List P disinfectant facility-wide.		In affected unit(s)	
Phase 4: Ongoing regional transmission	Facility-wide		Facility-wide	

* Including, but not limited to, intensive care, step-down, burn, and oncology units.

Phase 1. No *C. auris* cases in LHJ: Prevention

1. Engage LTACHs to:
 - a. conduct proactive initial and follow-up onsite infection prevention and control (IPC) assessments, education, and outreach in coordination with the HAI Program;
 - b. conduct proactive baseline PPS and consider 3-6 monthly proactive PPS;
 - c. conduct admission screening;
 - d. use List P agent⁹ (List K or bleach if not accessible) for facility-wide daily and terminal cleaning and disinfection; and
 - e. ensure clinical lab performs species identification of *Candida* isolates from normally sterile and non-sterile sites.
2. Engage vSNFs to:
 - a. conduct proactive initial and follow-up onsite IPC assessments, education, and outreach in coordination with the HAI Program;
 - b. conduct proactive baseline PPS in vent unit and consider 6-12 monthly proactive PPS; and
 - c. use List P agent⁹ (List K or bleach if not accessible) for daily and terminal cleaning and disinfection in vent unit, and consider using the disinfectant facility-wide for additional prevention.
 - d. consider screening testing in addition to ensuring EBP are implemented for residents admitted to the vent unit from LTACHs or other facilities with known *C. auris* transmission.
3. Engage ACHs to:
 - a. ensure clinical lab performs species identification of *Candida* isolates from sterile sites, and consider species identification in non-sterile sites; and
 - b. consider screening testing and placing on empiric Contact Precautions (see CDC guidance for additional recommendations¹⁰) patients admitted to high-risk units, or with indwelling devices or mechanically ventilated from SNFs, in addition to high-risk patients.
4. Engage all ACHs, SNFs, LTACHs in routine (e.g., monthly) calls.
 - a. Conduct education and outreach (may coordinate with HAI Program).
 - b. Promote interfacility communication.
 - c. Pair ACH infection preventionist (IP) (mentors) with SNF IPs in patient referral networks.
 - d. Encourage participation in CDPH MDRO prevention collaborative(s) as relevant.⁶
5. Follow up on all discharges from known outbreak facilities (intra- and inter-LHJ).
 - a. Screen and place on empiric Contact Precautions, or implement EBP empirically in SNFs in coordination with the HAI Program.
6. Consider combining *C. auris* and **carbapenemase-producing organism (CPO) prevention activities**¹¹ when feasible, including recommendations to:
 - a. in LTACHs, conduct admission screening and proactive baseline and follow-up CPO PPS facility-wide;
 - b. in vSNF vent units, conduct proactive baseline and follow-up CPO PPS; and
 - c. in ACHs, conduct CPO screening testing for patients admitted to high-risk units, or with indwelling devices or mechanically ventilated from SNFs, in addition to high-risk patients. See CDC guidance for additional recommendations on use of empiric Contact Precautions.¹⁰

Phase 2. Newly identified case(s) in LHJ: Aggressive Containment + Prevention

For Phase 2 responses, an outbreak is defined as:

1. 1+ newly identified case during PPS in response to a known case; **OR**
2. 2+ cases identified within 4 weeks of each other in the same unit or epidemiologically linked.[†]

A. Single case investigation

1. If the LHJ is responding to a single *C. auris* case (see screening decision tree on page 7):
 - a. In LTACHs and vSNFs
 - i. Conduct a PPS facility-wide in LTACHs or in vSNF vent units.
 - If initial PPS is negative, repeat PPS after two weeks. If the second PPS is negative, continue preventive PPS in vSNFs (6-monthly) and LTACHs (3-monthly).
 - If initial or repeat PPS is positive, see section B below.
 - b. In ACHs and SNFs
 - i. Screen high-risk healthcare contacts, regardless of whether the index patient was being managed with Contact Precautions, or EBP in SNFs or vSNFs.
 - ii. In high-risk ACH units consider conducting a PPS.
 - If initial PPS is negative, discontinue PPS.
 - If initial PPS is positive, see section B below.
 - c. If additional *C. auris* screening or clinical cases are identified, see section B below.
 2. Conduct initial IPC assessment, education, and outreach; coordinate with HAI Program as relevant.
 3. Recommend use of List P agent⁹ (List K or bleach if not accessible) for daily and terminal cleaning and disinfection: facility-wide in vSNFs and LTACHs; affected unit(s) in ACHs; and affected resident's room in SNFs. Consider expanding to high-acuity units or facility-wide in ACHs as resources allow.
 4. Conduct retrospective and prospective lab surveillance.
 - a. Conduct microbiologic record review to identify any *C. auris* cases that might have been unrecognized during the past 3 months.
 - b. Identify the species of all *Candida* isolates from any specimen source for at least 3 months after the initial positive *C. auris* isolate was identified.

B. Two or more cases or transmission is suspected

1. If transmission is suspected or ongoing in a healthcare facility (see screening decision tree on page 7):
 - a. Conduct a PPS. If LTACH, conduct PPS facility-wide; if vSNF, in vent unit; if ACH or SNF, in the affected unit(s).
 - b. Once the healthcare facility has 2 consecutively negative PPS at 2-week intervals **AND** no new clinical cases during the PPS screening window:

[†] Epidemiologically linked includes having previous admission at the same healthcare facility (in last year), **OR** common primary or consultative service, healthcare personnel, bathroom, procedure, or device. This outbreak facility definition excludes 2+ cases tested within 24 hours from time of admission, and not epi-linked to any other cases at the facility.

- i. In ACHs and SNFs, discontinue biweekly PPS.
 - ii. In LTACHs and vSNFs, reduce PPS frequency to monthly for 3 months; if negative, move to 3-monthly if LTACH, and 6-monthly if vSNF.
 - iii. If low-level transmission continues in LTACH or vSNF, see **Phase 3**.
- 2. For patients or residents discharged prior to PPS, at the receiving facility, implement empiric Contact Precautions, or implement EBP empirically in SNFs or vSNFs for transfers with unknown or negative *C. auris* status, including communication to outside LHJ.
 - a. Refer to Phase 2 screening decision tree (on page 7) for discharge screening and tracking considerations.
- 3. Continue follow-up IPC assessments at outbreak facility and retrospective and prospective surveillance (see A4 above).
- 4. Recommend use of List P agent⁹ (List K or bleach if not accessible) for daily and terminal cleaning and disinfection: facility-wide in vSNFs and LTACHs; affected unit(s) in ACHs and SNFs. Consider expanding to high-acuity units or facility-wide in ACHs as resources allow.
- 5. Consider disseminating weekly outbreak facility list to all healthcare facility IPs intra-jurisdictionally, and inter-jurisdictionally as applicable.
- 6. Facilities alert LHJ when transferring patients with *C. auris*.
 - a. LHJ follows up on all positive *C. auris* transfer patients to ensure implementation of appropriate Transmission-based Precautions and IPC measures.

C. Ongoing prevention activities

- 1. Engage high-risk facilities without cases, if not already done.
 - a. Prioritize LTACHs, and vSNFs by interconnectedness to *C. auris* outbreak facilities (HAI Program can support identification).
 - i. Conduct proactive PPS facility-wide in LTACHs and vent unit in vSNFs. If PPS negative, consider 3-6 monthly proactive PPS in LTACHs, 6-12 monthly proactive PPS in vSNF vent units.
 - ii. Conduct proactive onsite IPC assessments, education, and outreach in coordination with the HAI Program.
 - b. Identify other facilities (ACHs, SNFs) with highest volume of patient sharing with facilities with cases.
 - i. Prioritize for education and outreach.
 - ii. Prepare SNFs to identify and care for *C. auris*-exposed or -positive individuals, prioritizing them for initial and follow-up onsite IPC assessments.
 - iii. Encourage ACHs to implement admission screening, in addition to performing species identification of *Candida* isolates.
 - c. In vSNFs, consider routinely identifying the species of *Candida* isolates in non-sterile (e.g., from urine, respiratory, wound) in addition to sterile specimens.

Screening Decision Tree for Local Health Departments (LHDs) Conducting Phase 2 Responses^a

New Tier 2 pathogen^b case identified



Transmission suspected or ongoing in the healthcare facility, regardless of facility type
OR

Patient or resident admitted to long-term acute care hospital (LTACH) or ventilator unit in skilled nursing facility (vSNF)

NO

(No transmission suspected, and patient or resident admitted to an acute care hospital (ACH) or skilled nursing facility (SNF))^c

YES

For all ACH units and SNFs,^c screen high-risk contacts.^d
If **high-risk contacts were discharged to another healthcare facility**, screen there.

- Consider notifying the patient or resident, and flagging their chart for screening and empiric Contact Precautions or implementation of Enhanced Barrier Precautions (EBP) empirically if SNF upon readmission within 6 months.

In **ACH units with increased risk of transmission** (e.g., ICU, burn, oncology), consider broader screening such as point prevalence survey (PPS).^e

Conduct or continue PPS in the affected unit(s)

- If LTACH, conduct PPS facility-wide; if vSNF, PPS in vent unit; if ACH or SNF, PPS in the affected unit(s).
- Continue PPS every 2 weeks until 2 consecutive rounds are negative and no new clinical cases. After this:
 - For ACH and SNF, discontinue biweekly PPS.
 - For LTACH and vSNF, reduce PPS frequency to monthly for 3 months; if negative, move to quarterly PPS if LTACH, and biannual if vSNF.

For patients or residents discharged prior to PPS:

- For **all patients in LTACH and residents on affected vSNF unit/other geographic location**, and **only high-risk contacts in ACH and SNF**, if discharged before PPS, flag the chart for screening, and empiric Contact Precautions or implementation of EBP empirically if SNF/vSNF upon readmission within 6 months. If discharged to another healthcare facility, screen there.

Notes

- High-risk contact** is defined as a roommate (including patients in the same open bay unit); patient/resident who shared a bathroom with the index patient/resident; or patient/resident occupying the same bed space immediately following the index patient/resident.^f
- LHD can **consider screening additional contacts who do not meet high-risk criteria**. Prioritize contacts discharged to higher acuity settings (e.g., LTACH, vSNF vent unit, ACH).^g
- If a contact (high-risk or otherwise) is **discharged home**, screening at home is not recommended.
- In some situations, broader screening may not be indicated.^h

Screening Decision Tree Definitions and Considerations

^a Please see [Candida auris \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Cauris_Phases.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Cauris_Phases.pdf) or [Carbapenemase-producing Organism \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CPO_Phases.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CPO_Phases.pdf) Prevention and Response Strategy document to identify your LHD's phase for relevant Tier 2 antimicrobial-resistant (AR) pathogen prevention and response activities.

^b [Tier 2 AR pathogens \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/ARPathogenTiers.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/ARPathogenTiers.pdf) are those not commonly detected in California (although epidemiology can vary by region within California), for example: *Candida auris*, non-KPC-producing Enterobacterales, carbapenemase-producing *Pseudomonas* species (spp.) and *Acinetobacter* spp. (excluding OXA-23-, OXA-24/40-, and OXA-58-like carbapenemases).

^c In addition to ACHs and SNFs, this could apply to other congregate care settings including but not limited to assisted living facilities, group homes, and board & care facilities, prioritizing residents with risk factors for AR pathogen acquisition or transmission (e.g., presence of indwelling device or unhealed wound, total dependence on others for assistance with activities of daily living, or frequent healthcare exposure).

^d High-risk contacts should be screened regardless of whether the index patient or resident was being managed with Contact Precautions, or Enhanced Barrier Precautions in SNFs and regardless of the amount of time they overlapped with the index patient or resident.

^e LHD can consider PPS in ACH units with increased risk of transmission in situations including, but not limited to, healthcare settings with high-acuity patients with longer lengths of stay (e.g., 1 week); or if it will take time to identify high-risk contacts or if most high-risk contacts have been discharged from a unit/healthcare facility. This generally excludes the emergency department.

^f The highest yield is likely to be the patient exposed to Tier 2 pathogen contamination following a single terminal cleaning. Subsequent patients occupying the same bed space, including current occupant(s) may be considered for screening if feasible.

^g Considerations for pursuing screening of additional contacts who do not meet high-risk criteria can include, but are not limited to, contacts who shared a common primary or consultative service, healthcare personnel, procedure, or device; or contacts who have risk factors for AR pathogen acquisition (e.g., presence of indwelling device or unhealed wound, total dependence on others for assistance with activities of daily living receive high-level care).

^h In some situations, broader screening may not be recommended by public health. For example, if the index patient's length of stay was very short (e.g., <24 hours), screening may not be indicated. During a response to a single case in an ACH unit with a short average length of stay where patients are ambulatory and not mechanically ventilated, broader screening could be limited to situations where the index patient is currently admitted or recently discharged (<7 days prior). See [CDC Containment Strategy](http://www.cdc.gov/hai/mdro-guides/containment-strategy.html) (www.cdc.gov/hai/mdro-guides/containment-strategy.html).

Phase 3. Ongoing transmission in at least one high-risk facility for > 6 months in LHJ: Mitigation

1. Routine PPS
 - a. For LTACHs, continue monthly PPS; if <2 cases per PPS for 3 consecutive months, decrease to 3-monthly PPS.
 - b. For vSNFs, continue monthly PPS; if <2 cases per PPS for 3 consecutive months, decrease to 3-6 monthly PPS depending on *C. auris*-positive resident burden.
 - c. If PPSs are repeatedly identifying new positives and the use of resources to conduct PPSs is detracting from efforts to strengthen IPC practices, consider temporarily pausing PPSs in order to focus on broad strengthening of IPC practices.
2. Admission screening
 - a. For LTACHs, continue admission screening and empiric Contact Precautions.
 - b. For vSNF vent units, consider admission screening and rescreen residents if readmitted after >24 hours hospital admission; ensure implementation of EBP facility-wide.
 - c. For ACHs, consider admission screening for high-risk patients, if not already done.
3. Recommend use of List P agent⁹ (List K or bleach if not accessible) for daily and terminal cleaning and disinfection: facility-wide in vSNFs and LTACHs; affected unit(s) in SNFs; and affected and high-acuity units in ACHs. Consider facility-wide in ACHs as resources allow.
4. Transition from LHJ- to facility-led discharge screening and notification for *C. auris*-exposed and -positive individuals; LHJ continues notifying outside LHJ(s) of interjurisdictional transfer cases.
5. Ensure all clinical labs perform species identification of *Candida* isolates from normally sterile and non-sterile sites.
6. Implement **Phase 2** activities if:
 - a. *C. auris* case(s) identified in previously naïve facility;
 - b. new outbreak (higher-than-expected number of cases) in a non-naïve facility; or
 - c. *C. auris* case identified with echinocandin resistance or in a pediatric patient.
7. Engage facilities to mitigate morbidity and mortality from invasive *C. auris* infection (particularly bloodstream).
 - a. Prioritize individuals with lines, tubes, or drains, particularly central venous catheters (CVC).
 - i. Focus on appropriate use and care of medical devices, especially CVC insertion and maintenance practices.
 - ii. Incorporate central line-associated bloodstream infection (CLABSI) prevention and guidance¹² in LTACHs and vSNF vent units during public health onsite IPC assessments.
 - b. There are no specific recommendations for *C. auris* decolonization.

Phase 4. Ongoing transmission and very high baseline prevalence (e.g., >30%) in at least one high-risk facility for >1 year in LHJ, and in some surrounding LHJs with highly-connected patient sharing networks: Maintenance

Considerations for LTACHs

In individual LTACHs where *C. auris* has become endemic despite 1+ year of public health support to mitigate transmission, LHJ can consider shifting prioritization to intensified

efforts at preventing invasive infections and identifying and mitigating spread of echinocandin-resistant *C. auris*. This shift would occur with continued broad IPC measures and clinical isolate surveillance, but reduced emphasis on PPS. Specifically, these LTACHs should:

1. Reinforce broad IPC measures including adherence monitoring and feedback of hand hygiene and personal protective equipment (PPE) practices, and environmental cleaning and disinfection.
2. Continue admission screening + empiric Contact Precautions for all new and re-admissions to the LTACH.
3. Screening, including PPSs, should be performed if results are helping drive meaningful IPC interventions and if the use of resources to conduct PPSs is not detracting from efforts to strengthen IPC practices.
4. Intensify measures to prevent invasive *C. auris* infections (e.g., implementing adherence monitoring of central line insertion and maintenance practices to prevent CLABSI).
5. Conduct ongoing surveillance of clinical isolates to identify *C. auris* strains that are unusual in California or more resistant (e.g., non-Clade III *C. auris* isolates, isolates with echinocandin resistance, or pan-resistant strains).
 - a. Ensure species identification of all *Candida* isolates from both sterile and non-sterile sites.
 - b. Continue to obtain antifungal susceptibility testing (AFST) on all sterile site *C. auris* isolates at clinical laboratory; submit *C. auris* isolates from urine to the AR Lab Network for AFST.
6. Identify and respond to clusters of invasive or echinocandin-resistant *C. auris* e.g., by conducting a PPS and identifying opportunities for improving IPC practices.

Considerations for ACHs, vSNFs, and SNFs

Continue efforts to prevent introduction and contain spread of *C. auris* in other facilities including those in the same patient sharing network of endemic LTACHs.

1. Facilities perform screening testing in response to an increase in cases until 2 consecutive PPS at least 2 weeks apart result in ≤ 2 cases or the facility's baseline PPS percent positivity.
 - a. Once achieved in vSNFs, reduce PPS frequency to monthly for 3 months; if vSNF continues to maintain ≤ 2 cases or baseline PPS percent positivity, move to 6-monthly.
2. Perform admission screening + EBP (if SNF or vSNF) and Standard Precautions (if ACH)[‡]:
 - a. in vSNF vent units, of all new and re-admissions (after >24 hours hospital admission);
 - b. in ACHs, of high-risk new and re-admissions; and
 - c. in SNFs, of high-risk residents as resources allow.

Considerations for all healthcare facilities

1. Facilities are responsible for knowing baseline *C. auris* prevalence or incidence, conducting ongoing surveillance for sterile and non-sterile site isolates, investigating

[‡] Implement Contact Precautions if there is suspected or confirmed transmission in the unit or facility.

and reporting to public health when a new outbreak is identified, and conducting PPSs. Examples of new outbreaks can include:

- a. evidence of *C. auris* transmission in a previously naïve facility;
 - b. a cluster of cases in a distinct patient or resident population or unit;
 - c. an increase of cases above baseline occurring in a non-naïve facility;
 - d. an increase in clinical cases (e.g., bloodstream) detected within a facility;
 - e. a single case or cluster of echinocandin-resistant *C. auris* within a facility;
 - f. a single case identified in a pediatric patient.
2. For facilities identifying single *C. auris* cases in the absence of ongoing transmission, screen high-risk healthcare contacts.
 - a. Consider broader screening if there is evidence of a new outbreak (see 1a.-f. above).
 3. Public health may provide assistance depending on size and scope of the outbreak, as resources allow.
 4. LHJ may conduct or recommend routine IPC assessments or PPSs.
 5. Use of List P agent⁹ (List K or bleach if not accessible) for daily and terminal cleaning and disinfection facility-wide in SNFs, vSNFs, LTACHs, and ACHs.
 6. Facilities are responsible for all interfacility communication.
 7. LHJ supports strong IPC and AS practices in all facilities, continues engaging facilities to mitigate morbidity and mortality from invasive *C. auris* infection (particularly bloodstream), and ensures surveillance, reporting and prevention of echinocandin-resistant *C. auris*.

References

1. [CDPH *C. auris* Quicksheet \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisQuicksheet.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisQuicksheet.pdf)
2. [CDPH *C. auris* Reporting FAQ \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisReportingFAQ.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/CaurisReportingFAQ.pdf)
3. [CDC Identification of *C. auris*](http://www.cdc.gov/candida-auris/hcp/laboratories/identification-of-c-auris.html) (www.cdc.gov/candida-auris/hcp/laboratories/identification-of-c-auris.html)
4. [LACDPH List of Laboratories with *C. auris* Testing Capacity \(PDF\)](http://publichealth.lacounty.gov/acd/docs/List_C.aurisLabs.pdf) (publichealth.lacounty.gov/acd/docs/List_C.aurisLabs.pdf)
5. [CDPH AS website](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialStewardshipLandingPage.aspx) (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AntimicrobialStewardshipLandingPage.aspx)
6. [CDPH MDRO Prevention Collaboratives website](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Regional_AR_Collaboratives.aspx) (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Regional_AR_Collaboratives.aspx)
7. [CDC Enhanced Barrier Precautions \(EBP\) website](http://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html) (www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html)
8. [CDPH EBP: Additional Considerations for California SNFs \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/EBP_AdditionalConsiderationsForCA_SNF.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/EBP_AdditionalConsiderationsForCA_SNF.pdf)
9. [EPA List P Agents with Claims against *C. auris*](http://www.epa.gov/pesticide-registration/list-p-antimicrobial-products-registered-epa-claims-against-candida-auris) (www.epa.gov/pesticide-registration/list-p-antimicrobial-products-registered-epa-claims-against-candida-auris)
10. [CDC Preventing MDROs: FAQs](http://www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/preventing-mdros-faqs.html) (www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/preventing-mdros-faqs.html)
11. [CDPH Carbapenemase-producing Organisms website](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CarbapenemaseProducingOrganisms.aspx) (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CarbapenemaseProducingOrganisms.aspx)

12. [Society for Healthcare Epidemiology of America \(SHEA\) Strategies to Prevent CLABSI in Acute Care Hospitals: 2022 Update](https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/strategies-to-prevent-central-line-associated-bloodstream-infections-in-acute-care-hospitals-2022-update/01DC7C8BBEA1F496BC20C6E0EF634E3D) (www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/strategies-to-prevent-central-line-associated-bloodstream-infections-in-acute-care-hospitals-2022-update/01DC7C8BBEA1F496BC20C6E0EF634E3D)

Additional Resources

- [CDPH *C. auris* website](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris.aspx) (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/Candida-auris.aspx)
- [CDPH *C. auris* Screening Decision Tree \(PDF\)](http://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Tier2_Pathogen_Screening_Decision_Tree.pdf) (www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/Tier2_Pathogen_Screening_Decision_Tree.pdf)
- [Los Angeles County *C. auris* Mitigation Strategy \(PDF\)](http://publichealth.lacounty.gov/acd/docs/MitigatingSpreadofC.aurisLAC.pdf) (publichealth.lacounty.gov/acd/docs/MitigatingSpreadofC.aurisLAC.pdf)
- [CDC MDRO Containment Guidelines](http://www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/mdro-containment-strategy.html) (www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/mdro-containment-strategy.html)
- [CDC MDRO Prevention Strategies](http://www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/mdro-prevention-strategies.html) (www.cdc.gov/healthcare-associated-infections/php/preventing-mdros/mdro-prevention-strategies.html)