Candida auris Operational Guidance for Health Care Facilities

Background

Candida auris is a globally emerging yeast that can cause serious infection with severe outcomes. While not a clinical threat to healthy people, it is often resistant to antifungal medications commonly used to treat *Candida* species, with several strains already developing new resistance patterns. Invasive *C. auris*, primarily affecting critically ill patients, is associated with global mortality rates of 30-60%. This resistance and the possibility of severe outcomes among vulnerable people is why the CDC classifies it as an urgent threat.

Candida auris was first described in Japan in 2009 from an isolate cultured from the ear canal of a patient (thus the "auris" in the name). Once cases in clinical settings were reported, retrospective testing in South Korea identified cases as early as 1996, often previously misidentified as *C. haemolonii* or other species.

Isolates have now been identified in 40 countries. The first U.S. case of *C. auris* was identified in 2013. Patients can be colonized or infected with *C. auris*. Signs and symptoms of infection vary along with infection severity, type and location. *C. auris* dwells on the skin but can cause wound infections, bloodstream infections, and other invasive infections. *C. auris* frequently infects individuals receiving a high level of care or who have frequent interactions with the health care system. Most states in the U.S. have identified clinical or screening cases. Current data is available on the CDC's *C.* auris tracker. *C. auris* is reportable to the Vermont Department of Health.

Identification

Laboratory criteria for the detection of *C. auris* include:

- *C. auris* in a specimen obtained for the purpose of colonization screening, using either culture or validated culture-independent test (e.g., NAAT), **OR**
- *C. auris* in a clinical specimen obtained during the normal course of care for diagnostic or treatment purposes, using either culture or a validated culture-independent test (e.g., NAAT).

The CDC provides detailed algorithms for when it is appropriate to suspect *C. auris* based on given identification methods.

Common Misidentification of *Candida auris*

Identification Method	Organism *C auris* can be misidentified as
Vitek 2 YST*	*Candida haemulonii* *Candida duobushaemulonii*
API 20C	*Rhodotorula glutinis* (characteristic red color not present) *Candida sake*
API ID 32C	*Candida intermedia* *Candida sake* *Saccharomyces kluyveri*
BD Phoenix yeast identification system	*Candida haemulonii* *Candida caenulata*
MicroScan	*Candida famata* *Candida guilliermondii*** *Candida lusitaniae*** *Candida parapsilosis***
RapID Yeast Plus	*Candida parapsilosis***

*There have been reports of *C. auris* being misidentified as *C lusitaniae* and *C famata* on VITEK 2. A confirmatory test such as cornmeal agar may be warranted for these species.
**On cornmeal agar, *C. guilliermondii, C. lusitaniae,* and *C. parapsilosis* generally make pseudohyphae and *C. auris* does not make hyphae or pseudohyphae. If hyphae or pseudohyphae are not present on cornmeal agar, any of these three Candida isolates identified on MicroScan, or any *C. parapsilosis* isolates identified on RapID Yeast Plus should be submitted for further identification.

This table has been adapted using information provided by the CDC. This list is based on current knowledge about this pathogen and may be subject to change as more information emerges.

Distinguishing New Cases from Existing Cases

Patients colonized or infected with *C. auris* are currently considered to be colonized indefinitely. Therefore, the first specimen collected from an individual to result positive for *C. auris* will be considered a new case. For any subsequent positives, they will be considered an existing case.

Containment Measures

There are several strategies to mitigate the transmission of *C. auris*, whether it is one case, several cases, or an outbreak, or if no cases have yet been identified and you are working to prevent transmission in your facility with early identification.

Admission Screening

Even if you have not identified any cases in your facility, the Health Department recommends that facilities consider admission screening and proactive screening for high-risk patients such as those with a history of:

- Known exposure to *C. auris.*

- Surgery or hemodialysis in a facility outside of the US or Canada in the prior 12 months.
- Overnight stay in a health care facility outside the US or Canada in the prior 12 months.
- Inpatient/Overnight stay or Skilled Nursing Facility stay in areas of the us with documented regional transmission in the prior 12 months.
    - Information on regional transmission rates can be found on the CDC *C. auris* tracker (updated monthly).

Admission screening is not required, but strongly recommended as early identification is key to reducing transmission in health care settings, and to minimize what could be significant exposure to Vermont's patient transfer network. Identifying cases on admission will allow for infection control measures to be implemented early and may prevent the need for unit- or department-wide point prevalence surveys.

Strategies for identifying high-risk patients include adding questions to your intake screening about travel and health care stays in other areas, past exposures, and monitoring the C auris tracker for high-risk areas. Some health care facilities choose regions with documented transition that are within their patient sharing network to inquire about on intake. It is recommended that your facility set up these questions in whatever program you use for intake questions when a patient is admitted. You do not have to contact facilities that patients have stayed at previously to identify if there was transmission occurring there—the discharging facility is expected to relay exposures to the receiving facility. Admission screening is only indicated for individuals who endorse on admission that they meet the above criteria.

If you have identified a patient who meets the criteria above, place them on Transmission-Based Precautions pending laboratory results, and contact the Health Department Healthcare-Associated Infections (HAI) team who will facilitate testing.

General Infection Control Measures

As with many pathogens, the core elements of infection control measures to prevent *C. auris* transmission in health care settings are:

- Hand hygiene adherence
- Appropriate level and use of Transmission-Based Precautions
- Cleaning and disinfecting relevant areas and reusable equipment with recommended products (including shared mobile equipment such as glucometers or blood pressure cuffs)
- Communication about the patient's colonization status when transferred
- Screening contacts of newly identified cases

- Laboratory surveillance of clinical specimens

Any facility already providing care to patients with MDROs or *C. difficile* can provide care for patients with *C. auris*, and their status should not be a barrier to admission. Facilities with questions may contact the Health Department's Healthcare-Associated Infections (HAI) Team at AHS.VDHHAIProgram@vermont.gov.

Emphasize rigorous adherence to hand hygiene. Dedicate patient care equipment when possible, such as blood pressure cuffs, thermometers, stethoscopes, and blood glucose meters. If possible, single-use disposable items are recommended. See the Environmental Cleaning section below for shared or reusable equipment. It is also recommended that facilities audit infection control practices on affected unit(s). Feedback, education, and additional audits to raise compliance should be offered as needed.

Recommended Precautions

- **Hand hygiene**: standard hand hygiene practices
    - Alcohol-based hand sanitizer is the preferred hand hygiene method for this pathogen if hands are not visibly soiled.
- **Transmission-Based Precautions**:
    - **Acute Care Hospitals/Long-Term Acute Care Hospitals:** Patients who are colonized or infected with *C auris* should be placed on Contact Precautions.
    - **Long-Term Care Facilities (including Skilled Nursing Facilities):** may use either Contact Precautions or Enhanced Barrier Precautions.
- **Duration:** CDC recommends the use of Contact Precautions for the entire duration of all inpatient health care stays, indefinitely. This is because patients in facilities often remain colonized for many months to years, even after an acute infection has been treated and resolved. No intervention is known to reduce or eliminate colonization. At this time, patients are considered colonized indefinitely and reassessment of colonization is not recommended. Repeated swabbing may alternate between detection and non-detection. Many patients will have multiple negative swabs and then have another positive specimen. This may change in the future as this is still an emerging pathogen, and additional information is being collected.

Isolation of Patients with *C. auris*

Where possible, patients who are on Contact Precautions should be placed in single-patient rooms. If single-patient rooms are limited, prioritize these beds for people at higher risk of pathogen transmission to others (for example, patients with uncontained secretions/excretions, draining wounds, acute diarrhea, etc.).

Single-patient rooms are not required for these patients in nursing homes. However, if the facility has the capacity to assign these patients to single-patient rooms, they may choose to do so. Please see the CDC's FAQs about Enhanced Barrier Precautions in Nursing Homes for further information about isolation guidelines and patient placement in this setting.

Patient Placement and Cohorting

When single-patient rooms are not available, facilities may consider cohorting patients with *C. auris* in the same rooms. It is preferable that these cohorted patients have the same MDROs, but facilities may choose to assign rooms based on specific MDROs of concern, such as *C. auris* without considering co-colonization. Patient movement should only occur if there is a high level of confidence that this will not increase the risk of pathogen spreading between patients.

Facilities can consider a dedicated unit or part of a unit on which to place patients colonized or infected with *C auris* to limit movement of equipment and health care personnel from these patients to those who are not. Alternatively, facilities can dedicate health care personnel to these patients.

If rooms must be shared, strategies must be implemented to minimize transmission between patients. These are universal for shared rooms, regardless of colonization or infection status:

- Ensure at least three (3) feet of separation between beds.
- Hang privacy curtains to limit direct contact.
- Treat each bed area as though it were a different room while cleaning and disinfecting, including but not limited to:
    - Changing mopheads, cleaning cloths, and other cleaning equipment in between the bed areas.
    - Cleaning and disinfecting all shared or reusable equipment.
- Environmental surfaces should be cleaned and disinfected on a more frequent schedule.
- Health care personnel should change their PPE, including gloves, and perform hand hygiene before and after interacting with each roommate.

Environmental Cleaning and Disinfection

C auris is a very persistent pathogen. It has been cultured from multiple locations in patient areas, including both high-touch areas and surfaces that are not near the patient (i.e., windowsills), as well as mobile reusable equipment (glucometers, temperature probes, blood pressure cuffs, carts, etc.).

Important environmental cleaning and disinfection practices include:

- Reusable equipment should be cleaned and disinfected after each use.

- It should be clearly delineated which mobile and reusable equipment health care personnel are responsible for cleaning, and they should receive training on how to clean it properly.
- Ensure manufacturers' instructions are being followed for cleaning and reprocessing of medical equipment.
- Clean equipment should be labeled and stored away from dirty equipment.
- Follow all manufacturers' directions for use of surface disinfectants.
    - Personnel utilizing these disinfectants should be aware of the correct contact time.
- Use products with EPI-registered claims for *C auris*. See List P for a list of EPA-approved products. (Not to be used for the reprocessing of medical devices).
- Cleaning should be thorough and occur at least daily.
- Terminal cleaning and disinfection should be performed in patient care areas.

Environmental sampling is not recommended to assess processes and cannot confirm absence of this pathogen, or for assessing routing cleaning and disinfection practices. In certain instances, the Health Department may want to perform environmental sampling to support outbreak investigations or other activities, particularly if epidemiologic evidence implicates an environmental reservoir contributing to transmission. If your facility is considering environmental sampling, consult with the Health Department.

Outbreak Investigation

The Health Department will assist your facility with your investigation, including, but not limited to, laboratory testing, data analysis, infection control assessments (ICARs), medical record review, and other activities. This assistance can be provided on-site or remotely, depending on the needs of the investigation. Collaboration between the Health Department and the affected facility will help ensure a successful investigation and aid in limiting further transmission.

Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) Threshold Definitions

Investigation/Reporting Thresholds of Potential Outbreaks	
All Health Care Settings	
Threshold for facility to start investigation	1 *Candida auris* specimen from any source.*
Threshold for reporting to public health	1 *Candida auris* specimen from any source.*
Outbreak definition	≥ 2 cases of *Candida auris* including an epidemiologic link.+§

*Including those obtained for clinical care, screening purposes, or point prevalence surveys.

+An epidemiologic link includes but is not limited to the following examples: patients reside on the same unit (or within the same facility, if the facility is small); patients had facility staff in common; and/or patients were exposed to common medical equipment.

§ Application of the outbreak definition requires judgement and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility (informed by regional burden of *C. auris*) and other factors.

Initial Isolated Case

Case Review and Coordination

The Health Department will work with you and other facilities to identify recent health care encounters, both prior to and after the initial positive culture, including overnight stays at other health care facilities, outpatient visits, and home health visits. This lookback will include at least the three (3) months preceding identification of *C. auris*. In certain situations, such as information is made available regarding an earlier exposure, or if the initial review does not yield a likely exposure, a longer period of time may be recommended for review.

The Health Department will collaborate with the facility's infection prevention team, health care epidemiology, and clinical microbiology staff. The Health Department may also collaborate with other health departments as needed for situational awareness or to facilitate investigations.

If the patient was hospitalized outside of the U.S. in a country where the organism is known to be common, or in an area of the U.S. where it is common, this period may be considered the risk period for transmission.

Contact Screening

At a minimum, it is recommended that all roommates of the index patient in the previous month are screened, even if they were discharged from the facility. It is also recommended to consider screening patients who require higher levels of care who had overlap with the index patient on the same ward or unit for three (3) or more days. These patients are also at substantial risk for

colonization. This is also recommended if facilities that will receive these patients are at high risk for transmission if *C auris* is introduced, such as facilities that provide ventilator care.

If patients with overlapping stays have been discharged, consider flagging charts to facilitate admission screening if these individuals are readmitted to the facility in the next six months.

In order to detect ongoing transmission, the Health Department may strongly recommend broader screening. This may include point prevalence surveys (PPS). When a PPS is performed, every patient in the unit or floor where ongoing transmission is suspected should be screened. Facilities should also consider doing a PPS even if all *C. auris* patients have been discharged, especially in a long-term care facility. If new cases are identified, periodic (for example, every two weeks) PPS are recommended until transmission is controlled (two consecutive PPS with no new cases identified).

Broader screening may also be recommended if your facility is a setting with high-acuity patients and longer lengths of stay. It may also be recommended if it will take more than a few days to identify high-risk contacts or if most of the contacts have been discharged.

If the organism is believed to have been present at other facilities in the region, admission screening can be helpful to distinguish ongoing transmission within the facility from new introduction.

Absent known or suspected transmission from health care personnel or some other strong epidemiological link, it is not recommended that staff be screened. This holds for household contacts as well. Household contacts with extensive contact with the patient and frequent inpatient health care exposure could consider screening.

The Health Department may recommend admission screening and recommend that facilities retrospectively and prospectively evaluate clinical cultures at the facility for the organism. This might occur at health care facilities that your facility regularly shares patients with as well, especially those serving high-acuity patients as there is substantial risk of further amplification and poor outcomes among patients.

Coordinate with the Health Department to facilitate all screening and testing.

Communication

- Upon identification of the organism, the lab or health care facility should notify the patient's primary caregiver, patient care personnel, and health care staff promptly per their facility policies. The Health Department should also be notified.
- The Health Department and health care facilities will ensure the implementation of appropriate infection control measures.

- Patient and family should be notified of both the results and the infection prevention and control (IPC) measures that will be put into place.
- If the organism was present on admission, the transferring facility should also be notified so they can also perform appropriate review.
- Any facilities receiving exposed patients should be notified of the exposure.
- If a colonized or infected patient is discharged to another facility, that facility should be notified of the patient's status.

Additional Cases, Outbreak Response

Patient and Staff Cohorting

If additional new cases have been identified, consider cohorting patients if single rooms are not available for all cases, prioritizing room assignments based on having the same pathogens. This would also be a good time to consider dedicating health care personnel, or a unit or part of a unit.

Communication

- As with an initial isolated case, subsequent patients' primary caregivers, patient care personnel, and health care staff should be promptly notified per facility policies.
- Notify the Health Department. The health department may communicate information about initial cases and outbreaks to regional clinical providers, health care facilities, and laboratories in the area that might be affected.
- Any facilities or units receiving colonized or exposed patients should be notified.
- Consider engaging with your public affairs or communication staff, especially if this is the first case in your area or an outbreak. Be prepared to address questions from family members, the patients themselves, and health care workers regarding the risks of infection and colonization with *C. auris*. Information for patients and family members is available from the CDC.
- Guidance for making notifications regarding suspected HAI outbreaks can be found in CORHA's Framework for Healthcare-Associated Infection Outbreak Notification.

Monitoring

Once multiple cases of *C. auris* colonization or infection have been identified in a health care facility, there are some additional considerations for monitoring and follow-up until the suspected outbreak is considered resolved. The Health Department recommends the following:

- Serial point prevalence surveys (PPS) should be conducted on wards or units where transmission is suspected to have occurred. This is to assess the impact of the infection control measures put into place to interrupt transmission.
    - These should be conducted every 2-4 weeks until at least two (2) sequential PPS do not identify new cases.
    - In the event of ongoing high levels of transmission, the Health Department may recommend pausing or decreasing the frequency of PPS while infection control measures are re-evaluated and strengthened.
    - For some facilities, such as those in an area with high colonization pressure, a status of zero new cases may not be achievable. While Vermont is a low-incidence state, this may not come to pass, but it is something to consider should our cases increase.
    - Your approach may be modified in consultation with the Health Department based on need.
- The Health Department will conduct follow-up onsite infection control assessments to reinforce infection control measure adherence.
- The Health Department may recommend regional interventions, such as admission screening or proactive PPS, in facilities that share patients at which transmission has been identified or other enhanced surveillance and case finding.

Laboratory Testing

Rationale

Timely identification of patients colonized with *C. auris* is important because this pathogen can spread rapidly in health care settings. Transmission may occur when people have *C. auris* infections and when people are asymptomatically colonized with *C. auris*. Patients may be colonized for long periods of time without showing symptoms or without detection of *C. auris* from a routine clinical specimen. Identifying patients colonized with *C. auris* can also help prevent progression to serious, invasive infection. Patients who were originally found to be colonized through screening have had subsequent routine clinical specimens result positive for *C. auris*, including blood specimens. It is important to identify and track this emerging drug resistant yeast.

Screening Specimen Submission

This section will address the process of submitting specimens that are collected using screening swabs. These may be singular or multiple targeted admission specimens for high-risk patients, or part of a containment response, or part of repeated point prevalence surveys.

Criteria for Admission Screening

Consider targeted admission screening for the following high-risk patients:

- Patients with a known exposure.
- Patients who have had an overnight stay in a health care facility outside the U.S. within the past 12 months, especially if it has documented transmission.
- Patients who have had an overnight stay in a health care facility in an area of the U.S. with documented *C auris* transmission.
    - Visit CDC: Tracking *Candida auris*

Wadsworth Laboratory currently conducts admission or known exposure screenings. If you have identified a patient who meets criteria for admission screening or who has a known exposure, please reach out to AHS.VDHHAIEpiLabTeam@vermont.gov to schedule specimen submission.

Containment Screening

If a case has been identified in your facility, point prevalence surveys will likely be recommended to establish a baseline and identify if any transmission has occurred. The Health Department HAI team will work with you to identify the areas that warrant testing, as well as work with Wadsworth to coordinate access to testing supplies and to assist in scheduling your testing events.

Please contact AHS.VDHHAIEpiLabTeam@vermont.gov to arrange screening testing.

Appropriate Specimen Types

Screening Specimens - Swabs:

- Axilla/Groin swab
- Nasal/Axilla/Groin Swab
- Liquid Amies Elution Swab (ESwab) and Transport system should be used for collection of skin and mucus surface samples.

Clinical Isolate Submission

This refers to the process of submitting clinical isolates and is not part of containment screening. These isolates will be processed by the Health Department Laboratory or may be sent to Wadsworth if further testing is warranted.

Criteria for Submission

- *C. auris* is sometimes misidentified with phenotypic methods many clinical laboratories use for yeast identification. Please forward suspected or confirmed isolates.

  - One such misidentification is *Candida haemulonii*. See the section on Common Misidentification of *Candida auris* for more details on what candida isolates should be forwarded for further characterization.

- If an un-speciated *Candida* is identified from non-sterile sites, certain circumstances may warrant species-level identification as these patients may be colonized rather than infected and pose a risk for transmission. These isolates should be forwarded if:
  - A *Candida* is identified on a patient in the same facility or unit where a case of *C. auris* infection or colonization has been detected.
  - A patient has had an overnight stay in a health care facility outside the U.S. within the past 12 months, especially if the area has documented transmission.
  - A patient has had an overnight stay in a health care facility in an area of the U.S. with documented *C. auris* transmission.
    - Visit CDC: Tracking *Candida auris*
  - It is clinically indicated.
- If any antifungal susceptibility testing was performed on the isolate, results must also be sent to the Health Department.

If you have questions or are unable to speciate *Candida* at your facility, the Health Department Laboratory is available for consultation.

Appropriate Specimen Types

Clinical Isolates

- **If you are submitting an isolate (not a swab) to the Health Department Laboratory:** Send isolates on any media that supports the growth of yeast.
- Submit the following isolates to the AR Lab Network for *Candida* isolate testing:
  - All confirmed or suspected *C. auris* from any body site (invasive or non-invasive, sterile or non-sterile).
  - Candida species other than *C. albicans* from any specimen source, especially invasive sites.
  - Yeast isolates from any specimen source when unable to identify species after identification was attempted.
  - Any *Candida*/yeast from any specimen source isolated from a patient meeting high-risk criteria (see Criteria for Admission Screening).

Isolate Submission

Forms

The Health Department Laboratory and the Wadsworth Center request the following documentation be included with isolate submission:

- Antifungal susceptibility results, if any.
- A completed Clinical Test Request Form, select *Candida auris.*

Shipping to the Health Department Laboratory

- Storage prior to shipping: Specimens should be stored at 2-8°C.
- Isolates can be sent via the NECLA courier system.

Reporting Cases and Laboratory Findings

What to Report

- Clinical laboratories must submit any sterile-site *Candida* isolate from which species-level identification cannot be obtained.
- *Candida auris* must be reported to the Health Department within 24 hours of its identification.

How to Report

Phone: Call the Health Department's Infectious Disease Epidemiology Program at **802-863-7240** or **800-640-4373** (within Vermont only) from 7:45 am through 4:30 pm on business days.

Electronic Case Reporting (eCR): Providers can set up automated case reporting to the Health Department. Learn how to set up eCR at www.healthvermong.gov/ecr.

Fax: Fax paper reports to the Epidemiology Program's confidential fax machine at **802-951-4061.**

You can read more about Health's Infectious Disease and Lab Result Reporting here.

Resources

Below are some resources to support your facility:

- Information for Patients: Candida auris Testing
- Information for patients colonized with Candida auris
- CDC: Procedure for Collection of Patient Swabs for Candida auris (screening)
- Interfacility Transfer Form

- Sample Verbal Script for Colonization Screening
- Sample Patient Transfer letter: Transmission-Based Precautions
- Sample Patient Transfer Letter: Contact Precautions, Results Pending

Sample Verbal Script for Colonization Screening

Hi, my name is **[insert name]**, and I work for **[insert organization]**. I'm here to talk to you about a screening the **[insert health care facility (i.e. hospital or nursing home)]** is doing to check for a germ. Recently, we identified a germ, which is rare un the United States, in a patient who was cared for at this facility. The germ is called *Candida auris* and is a type of yeast that can be resistant to many of the drugs used to treat it. It can also spread from patient to patient in hospitals and nursing homes.

It is unlikely that you carry this germ, and fortunately, most people who do carry it never get sick from it. However, if you do carry the germ, there's a chance you can become sick with it later, and knowing you are carrying it will allow your doctors to manage your treatment better.

To make sure this germ has not spread, the Health Department would like us to screen people to make sure they don't have it. We are screening patients who might have come into contact with this germ to see if they are now also carrying it.

If you agree to be screened, the process is very simple and takes just a few seconds. We would need to swab your armpit and your groin, the area where your leg joins your body. To do that, we would gently rub the top of a soft swab, which looks like a Q-tip, across your armpit, followed by your groin. The process is not painful and there shouldn't be any side effects.

The swab will be sent to a lab to test for the germ, which will take a few days. If they find the germ, someone will contact you to discuss what to do. The results of the test will be kept confidential to the extent allowed by law.

Providing a swab is completely voluntary and you do not have to participate.

Do you have any questions? **[pause for questions]**

Is it okay if we collect the swab?

☐ Yes, I agree. ☐ No, I decline.

_____

Signature of screener Date

[Please leave a copy of "Information for Patients: Candida auris screening" with the patient or resident]

Patient Transfer Letter: Transmission-Based Precautions

NOTICE

This patient requires transmission-based precautions during all inpatient stays.

This patient has been colonized or infected with *Candida auris*—a difficult to detect yeast that can cause life-threatening infections and long-lasting outbreaks in health care facilities. It is easily spread, hard to remove from the environment, and often resistant to antifungal medications.

Transmission-Based Precautions can prevent transmission. Implement Enhanced-Barrier Precautions (CDC.gov) unless the resident meets criteria for stricter Transmission-Based Precautions.

Information on Precautions and Recommendations

- Place patient in a **private room** if possible.
- Health care personnel interacting with patients on Contact Precautions, or their environment, are required to wear a **gown and gloves**, don their PPE upon room entry, and properly discard before exiting.
- If the receiving facility is a nursing home, Enhanced-Barrier Precautions (CDC.gov) should be implemented. Health care personnel should wear gowns and gloves during high-contact, resident-care activities.
- Health care personnel should be diligent with their hand hygiene during and after contact with a patient with *C. auris* or their environment. Ensure **alcohol-based hand rub** is readily available.
- **Use disposable or dedicated patient-care equipment** whenever possible.
- **Disinfect** using an Environmental Protection Agency (EPA)-registered disinfectant effective against *C. auris*. These agents can be found on List P at EPA.gov. Thoroughly clean and disinfect:
    - Any shared equipment (such as X-ray machines, scales, stethoscopes, ventilators) after contact with this patient.
    - The patient's room daily, and terminally upon their discharge.
    - Any transport vehicles or equipment terminally after the patient's use.
- All cleaning and disinfection should follow the manufacturers' instructions for use.
- Communicate the need for Transmission-Based Precautions verbally and in writing for any intra- and inter-facility transfers, and send a copy of this letter with the patient at transfer.
- More information on *C. auris* prevention and control can be found at .

Containment of drug-resistant organisms, including *C. auris*, is a joint effort between health-care facilities and public health partners. Please coordinate containment and prevention efforts with the Health Department at AHS.VDHHAIEpi@vermont.gov.

Updated 03/2024, adapted from Pennsylvania Department of Health

Patient Transfer Letter: Contact Precautions, Results Pending

NOTICE

This patient requires **contact precautions** while lab results are **pending**.

This patient has been screened for *Candida auris* and is pending results. *C. auris* is a difficult to detect yeast that can cause life-threatening infections and has caused long-lasting outbreaks in health care facilities. It is easily spread, hard to remove from the environment, and often very resistant to antifungal medications.

This patient may have been screened in cooperation with public health because they were epidemiologically linked to a positive case or as part of surveillance testing. You will be notified by public health officials of the results of the screening and additional guidance will be provided at that time.

Information on Precautions and Recommendations

- If possible, this patient should be placed in a **private room.**
- Health care personnel interacting with patients on Contact Precautions, or their environment, are required to wear a **gown and gloves**, donning their PPE upon room entry, and properly discarding before exiting.
    - Health care personnel should be particularly diligent with their hand hygiene during and after contact with a patient positive for *C. auris* or their environment.
    - Facilities should ensure that **alcohol-based hand rub** is readily available.
    - **Disposable or dedicated patient-care equipment** should be utilized whenever possible.All **disinfection** should be completed utilizing an Environmental Protection Agency (EPA) registered disinfectant effective against *C. auris*. These agents can be found on List P at EPA.gov. If List P disinfectants are not available, products from List K may be substituted.
    - Any shared equipment (such as X-ray machines, scales, stethoscopes, ventilators) should be thoroughly cleaned and disinfected after contact with this patient.
    - The patient's room should be cleaned and disinfected daily, and terminally upon their discharge.Any transport vehicles or equipment should be terminally cleaned and disinfected after patient's use.
- All cleaning and disinfection should be performed according to the manufacturer's instructions for use.
- The need for Transmission-Based Precautions should be communicated verbally and in writing for any intra- and inter- facility transfers. We recommend sending a physical copy of this letter with the patient upon transfer.
- Additional information on C. auris infection prevention and control can be found via the CDC.

Containment of drug-resistant organisms, including *C. auris*, is a joint effort between health-care facilities and public health partners. Please coordinate containment and prevention efforts with the Health Department at AHS.VDHHAIEpi@vermont.gov.

Updated 03/2024, adapted from Pennsylvania Department of Health