NJHealth New Jersey Department of Health
Communicable Disease Service

Candida (Candidozyma) auris

(Including Colonization & Clinical Infection)

DISEASE REPORTABLE WITHIN 24 HOURS OF DIAGNOSIS

Cases should be reported to the local health department where the patient resides. If patient residence is unknown, report to your own local health department. Contact information is available at: localhealth.nj.gov.

If the individual does not live in New Jersey, report the case to the New Jersey Department of Health at: (609) 826-5964 or DOH.CDS.HAIAR.EPI@doh.nj.gov.

In cases of immediately reportable diseases or other emergencies – if the local health department cannot be reached – the New Jersey Department of Health maintains an emergency after-hours phone number at: (609) 392-2020.

Table of Contents

Disclaimer

This document provides general guidance of the investigation of *Candida (Candidozyma) auris* (*C. auris*) cases and outbreaks. However, *C. auris* outbreaks should be evaluated on an individual basis with the consultation of local and state public health professionals to determine the appropriate steps for prevention and control.

The content is based on available information from The Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiology of America (SHEA), the Council for Outbreak Response: Healthcare Associated Infections and Antimicrobial Resistant Pathogens (CORHA), and other organizations.

The materials in this toolkit were prepared and are updated as of August 2026. These organizations continue to release updated recommendations and guidance regarding *C. auris*. Please contact the New Jersey Department of Health (NJDOH) if you have questions about updated resources or guidance.

NJDOH welcomes feedback regarding this guidance (DOH.CDS.HAIAR.EPI@doh.nj.gov).

I. THE PATHOGEN AND ITS EPIDEMIOLOGY

The following section provides definitions for terminology commonly used in *Candida (Candidozyma) auris (C. auris)* resources, information on the etiology, reservoirs, modes of transmission, pathogenesis, clinical description, risk factors, incubation period, diagnosis, and treatment.

Etiologic Agent

Candida auris (C. auris), more recently known as *Candidozyma auris* (*C. auris*), is a fungal pathogen that has inherent antimicrobial resistance and can cause serious, hard-to-treat infections. *C. auris* can cause infections of the bloodstream, urinary tract, respiratory tract and wound. Invasive infections caused by *C. auris* are known to have high attributable mortality rates (30-60%). Patients can also be colonized by *C. auris* and show no clinical signs or symptoms of disease. Colonized patients can still spread *C. auris* to other patients, to medical equipment/devices and to the care environment. Additionally, colonized individuals may become infected with *C. auris* over time.

Modes of Transmission

C. auris is primarily healthcare-associated and can easily spread and cause outbreaks in healthcare settings. *C. auris* spreads through direct and indirect contact with patients infected or colonized with *C. auris* or contaminated environmental surfaces and equipment. It is often transmitted from person to person, via the hands of healthcare personnel, or transmitted from environmental contamination such as by touching contaminated shared medical equipment, like IV poles and blood pressure machines.

Clinical Description

There are no general signs or symptoms specific to *C. auris* colonization or infection. Individuals colonized with *C. auris* lack visible signs and symptoms of illness. Individuals infected with *C. auris* can have nonspecific symptoms (e.g., fever) that range in severity. Symptoms and clinical presentation depend on the site and type of infection (e.g., intra-abdominal, bloodstream, wound, respiratory tract, urinary tract).

Incubation Period

The incubation period, or time from exposure to onset of disease, for *C. auris* is currently unknown.

Pathogenesis and Reservoirs

C. auris is an environmentally hardy pathogen that can survive both moist and dry conditions for long durations. Research has shown it to be capable of persisting in the healthcare environment and on medical equipment for months unless appropriately cleaned and disinfected with a product effective against *C. auris* (i.e., EPA List P). Shared mobile medical equipment and devices, such as vitals machines, stethoscopes, glucometers, ultrasound machines, and workstations on wheels, used from patient to patient, can become contaminated and act as a reservoir, enabling silent transmission within healthcare facilities.

C. auris can form biofilms, a collection of microorganisms that stick to each other and adhere to surfaces, which helps the pathogen survive on moist and dry surfaces. *C. auris* can form biofilms on the surface of the skin, making colonized and infected patients one of the most significant reservoirs for *C. auris*.

Individuals often become colonized with *C. auris* prior to developing a clinical infection. Colonized individuals have *C. auris* growth and replication on their skin and inside the body, and can shed the pathogen from their skin to the environment. *C. auris* can then enter the body and infect the bloodstream and other clinical sites through wounds and other openings in the body created by

indwelling medical devices, such as mechanical ventilators, tracheostomies, urinary catheters and central lines. Once inside indwelling device tubing, *C. auris* can rapidly proliferate and grow biofilms.

Period of Communicability or Infectious Period

C. auris colonization lasts for an unknown period, perhaps indefinitely, even following treatment of a clinical infection caused by *C. auris*. Long-term follow up of *C. auris* case patients suggests that colonization persists for a long time (e.g., years) and the results of repeat testing may alternate between positive and negative results. Consequently, individuals identified as colonized or infected with *C. auris* are currently considered to be indefinitely infectious. **Negative results for an individual with any prior history of *C. auris* should not be used to discontinue implementation of Transmission-Based Precautions.**

Risk Factors

C. auris tends to affect patients who require complex medical care and those that have invasive indwelling medical devices (e.g., mechanical ventilation, tracheostomy, central lines, urinary catheters). Risk factors for *C. auris* acquisition are listed below; having multiple factors increases risk:

- Mechanical ventilation or tracheostomy
- Invasive indwelling medical devices (e.g., central lines, urinary catheters)
- History of frequent or prolonged healthcare stays, particularly in ventilator-capable skilled nursing facilities, long-term acute care hospitals, and intensive care units
- History of colonization or infection with other multidrug-resistant organisms
- History of broad-spectrum antimicrobial use
- Epidemiologic link to a laboratory-confirmed case of *C. auris*
- Overnight stay in a healthcare facility abroad within the past 12 months
- Prior healthcare receipt in highly endemic states as determined by CDC

Treatment

There is currently no known effective decolonization methods for patients colonized with *C. auris* and re-testing previously positive patients for *C. auris* is not recommended. CDC and NJDOH do **NOT** recommend antifungal treatment for patients colonized with *C. auris* who do not have signs or symptoms of infection.

C. auris clinical infections may require antifungal therapy; echinocandins are typically the first-line treatment in adult patients. Consultation with an infectious disease specialist is recommended to determine appropriate treatment for clinical *C. auris* infections.

II. SURVEILLANCE AND CASE INVESTIGATIONS

Strong surveillance helps to quickly identify new cases, epidemiological links between cases, and the need for outbreak investigations. Outbreak investigations are critical for detecting potential sources of transmission and implementing control measures.

The following section includes the case definitions for *Candida (Candidozyma) auris*, guidance on investigating and counting cases, and tools to conduct a case investigation.

Reporting

Healthcare providers and administrators, as well as testing laboratories, are required to report cases of *C. auris* (colonization [i.e., screening] and clinical infections) to the local health department where the patient resides within one business day of identification (N.J.A.C. 8:57 – 1.4). If the patient's residence is out of state, report to NJDOH; NJDOH will coordinate with other states to determine case status, and if further investigation of case-associated healthcare facilities within NJ is indicated, the case will be assigned to the local health department with jurisdiction over the involved healthcare facility. If the patient's residence is unknown, report to the local health department with jurisdiction over the identifying healthcare facility. Contact information is available at: localhealth.nj.gov.

If possible, include the following data elements in the initial report:

- **Medical Information**: Positive specimen source, positive specimen collection date, facility of positive specimen collection, reason for specimen collection (e.g., diagnostic work up, admission screening), history of *C. auris*.
- **Exposure Information:** Healthcare facilities where the patient was admitted in the 30 days prior to positive specimen collection, status of Transmission-Based Precautions during prior healthcare admissions, roommate history during prior healthcare admissions, current admission status/discharge disposition.

Case Definitions and Criteria for Case Classification

The following are descriptions of case definitions and laboratory criteria needed to determine how a case of *C. auris* should be classified (e.g., confirmed screening, confirmed clinical).

Case Definitions and Subtypes

Confirmed *C. auris* screening case: Person with confirmatory laboratory evidence from a swab collected for the purpose of screening for *C. auris* colonization regardless of site swabbed.*

*Typical screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. **Refer to Section IV Table 5 as necessary.**

Confirmed *C. auris* clinical case: Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care.**

This includes specimens from normally sterile sites (e.g., blood, cerebrospinal fluid) and specimens or swabs from non-sterile sites (e.g., wounds, urine, respiratory tract, swabs from a wound or draining ear) collected as part of clinical care. This does not include swabs collected for screening purposes. **Refer to Section IV Table 5 as necessary.

Laboratory Criteria for Confirmation

Laboratory evidence confirming a *C. auris* diagnosis includes one of the below:

- Detection of *C. auris* in a specimen from a swab obtained for the purpose of colonization screening using either culture or validated culture-independent test (e.g., real-time polymerase chain reaction [PCR]), **OR**
- Detection of *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., real-time PCR)

Case Classification

- **Confirmed**: A screening or clinical case with confirmatory laboratory evidence for *Candida (Candidozyma) auris*.
- **Probable and Suspect**: Not applicable

Note: For CDRSS case classification instructions, see "Conducting a *C. auris* Case Investigation" section below.

Multiple Case Reporting

Since *C. auris* can cause both colonization and infection, there is the potential for multiple cases to be reported for the same individual. If a person initially identified as a screening case later develops an infection meeting clinical case criteria, create a separate clinical case for the person in NJDOH's Communicable Disease Reporting and Surveillance System (CDRSS). In this situation, the person is counted as both a screening case and a clinical case. However, a person initially identified as a clinical case should *not* have a screening case created in CDRSS if *C. auris* colonization is later identified. Screening cases should only be counted once per person, regardless of the interval between colonization testing. Clinical cases should only be counted once, even if a person has a new clinical infection or colonization identified in the future. There is no minimum or maximum timeframe between lab detections that triggers creation of a new case. See Table 1 for further clarification:

Table 1. Enumerating *C. auris* Cases by Initial and Subsequent Laboratory-Confirmed Specimen Types

Initial Laboratory-Confirmed *C. auris* Specimen	Additional Laboratory-Confirmed *C. auris* Specimen(s)	Number of Times Counted as a Confirmed Case	Count of Distinct Case Records to Create in CDRSS
Screening swab (colonization)	Clinical specimen (infection)	Twice: once as screening, once as clinical	Two (i.e., one screening, one clinical)
Clinical specimen (infection)	Screening swab (colonization)	Once: clinical at time of first positive specimen	One (i.e., clinical)
Screening swab (colonization)	Screening swab (colonization)	Once: screening at time of first positive specimen	One (i.e., screening)
Clinical specimen (infection)	Clinical specimen (infection)	Once: clinical at time of first positive specimen	One (i.e., clinical)

Case Designations for Surveillance Purposes

- **Presumptive Healthcare-Associated:** A *C. auris* screening or clinical case that has a positive specimen collected >24 hours from admission or presentation (whichever occurs first) to the identifying healthcare facility.
- **Present on Admission:** A *C. auris* screening or clinical case that has a positive specimen collected within 24 hours of admission or presentation (whichever occurs first) to the identifying healthcare facility.

Single Case Investigations

Since *C. auris* is primarily healthcare-associated, most aspects of the investigation focus on:

- the healthcare facility where a case patient (either screening or clinical) was identified, and
- healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and
- any healthcare facility where the patient received care from the earliest positive specimen collection date until appropriate precautions were implemented.

The 30-day traceback and investigation period may need to be further expanded if:

- Epidemiologic evidence indicates the case patient likely acquired the organism earlier, or
- Epidemiologic links to other known cases or outbreaks are identified that occurred >30 days prior to positive specimen collection

New Jersey (NJ) local health departments (LHDs) are responsible for investigating:

1. *C. auris* cases identified in NJ among NJ residents, and
2. Healthcare facility exposures at NJ healthcare facilities where *C. auris* cases are identified or received care, regardless of the case patient's state of residence.

Investigations should be initiated by contacting the healthcare facilities involved. In most situations, *C. auris* case patients reside in long-term care facilities or are admitted to high acuity healthcare facilities and are unable to provide information needed for public health investigation. As a result, the LHD should initiate case investigations directly with the healthcare facility's Infection Preventionist (IP), Director of Nursing (DON), Assistant Director of Nursing (ADON) or similar role. **The case patient should not be contacted by public health as part of the case investigation or healthcare facility exposure investigation process unless absolutely necessary**. If the LHD is unable to determine the facility or location where a patient had their positive specimen collected or successfully get in contact with the facility, consult with NJDOH.

Table 2: Entities Responsible for Leading Various Aspects of *C. auris* Investigations when a Single Case is Reported

Investigation Type	Patient's State of Residency	Responsible Entity	Facilities to Contact
Case Patient Investigation	NJ	LHD with jurisdiction over the patient's primary address	• Facility of positive specimen collection, and • Healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and • Healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented
Case Patient Investigation	Out-of-state	NJDOH	• Facility of positive specimen collection, and • In-state healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and • In-state healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented, and • State Health Department with jurisdiction over out-of-state healthcare facilities where the case patient previously received care
Healthcare Facility Exposure Investigation	NJ	LHD with jurisdiction over the healthcare facility where exposure(s) to the case patient are being assessed	• In-state healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and • In-state healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented
Healthcare Facility Exposure Investigation	Out-of-state	LHD with jurisdiction over the healthcare facility where exposure(s) to the case patient are being assessed	• In-state healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and • In-state healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented

C. auris Epidemiologic Assessment

The *C. auris* Epidemiologic Assessment is a standardized data collection tool that helps public health investigators obtain the most pertinent information needed to identify healthcare facility exposures, determine next steps, and assess epidemiologic links between case patients. This tool facilitates information collection and documentation that would otherwise be obtained verbally from each involved healthcare facility. LHDs should instruct healthcare facilities in their jurisdiction to use the *C. auris* Epidemiologic Assessment to document healthcare facility exposures and risk factor information for all confirmed cases of *C. auris*. The *C. auris* Epidemiological Assessment must be digitally completed using Adobe Acrobat to ensure data can be extracted from the fillable PDF by NJDOH. Additional investigation tools, such as the Case Patient Investigation Checklist and the Healthcare

Facility Exposure Investigation Checklist, may also be used to assist LHDs in collecting and documenting required information. LHDs should provide the *C. auris* Epidemiologic Assessment to the following healthcare facilities within their respective jurisdictions and instruct them to digitally complete and return the document within two business days:

- the healthcare facility where a case patient was identified,
- healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection, and
- healthcare facilities that were unaware of the patient's *C. auris* status (or did not implement appropriate precautions) and cared for the patient following their positive specimen collection.

LHDs are responsible for following up with each healthcare facility in their jurisdiction to ensure completion and receipt of the document in a timely manner. LHDs must provide the digitally completed fillable PDF to NJDOH via secure email within 1 business day of completion. Information obtained from each involved healthcare facility using the *C. auris* Epidemiological Assessment must be entered into the appropriate fields in CDRSS **within 5 business days**.

Case Patient Investigation Overview

The case patient investigation will be led by the LHD with jurisdiction over the patient's primary address. The case patient investigation involves confirming and categorizing the case appropriately, determining the case patient's place of residence, determining the healthcare facility where the case patient had their positive specimen collected for testing, identifying any/all healthcare facilities where the case patient received healthcare services in the 30 days prior to positive specimen collection, and identifying any healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented. The LHD leading the case patient investigation is responsible for ensuring timely completion of the required fields in CDRSS, confirming laboratory submission of clinical isolates, adding/updating investigation addresses associated with the case patient, and notifying other LHDs with jurisdiction over impacted healthcare facilities that require a healthcare facility exposure investigation. **All components of the case patient investigation are to be completed within 5 business days (Priority 3).**

Conducting a *C. auris* Case Patient Investigation

NJDOH recommends the following investigation steps at the LHD level:

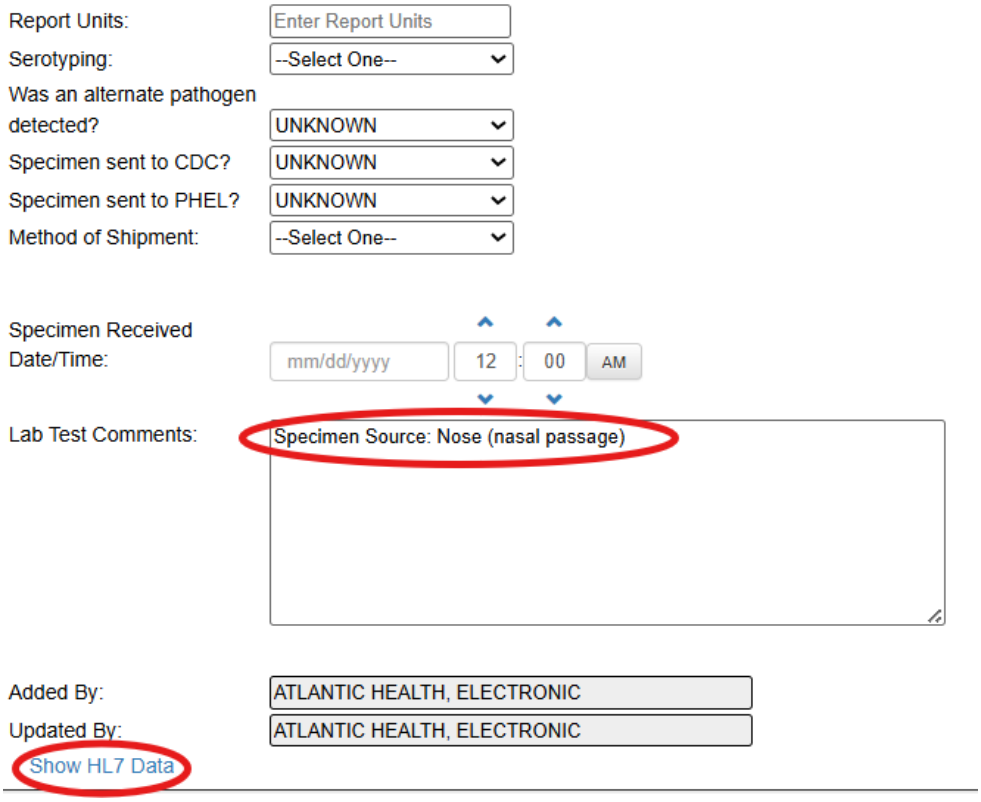
1. **Search the patient information within CDRSS to check for any prior *C. auris* case record(s) associated with the person. Enter the case into NJDOH's Communicable Disease Reporting and Surveillance System (CDRSS)** if not already entered by the provider or laboratory. Instructions for creating a case in CDRSS can be found here.

2. **Determine specimen source: Review the specimen source information within the laboratory test section of CDRSS to determine the specific body site identified to be positive and appropriately classify the case subtype as either "clinical" or "screening".** The positive specimen source information may be included in the Lab Test Comments field; otherwise, specimen source details for cases created through ELR can be found in the specimen segment (SPM) of the HL7 laboratory data. If the positive specimen source

information cannot be found within CDRSS, contact the testing laboratory or the identifying facility's IP to obtain this information, and other relevant details.

a. Enter the positive specimen source(s) into the Test Result Data text box.

b. Where to find Lab Test Comments and HL7 data within the Laboratory Test section:



c. HL7 data example:

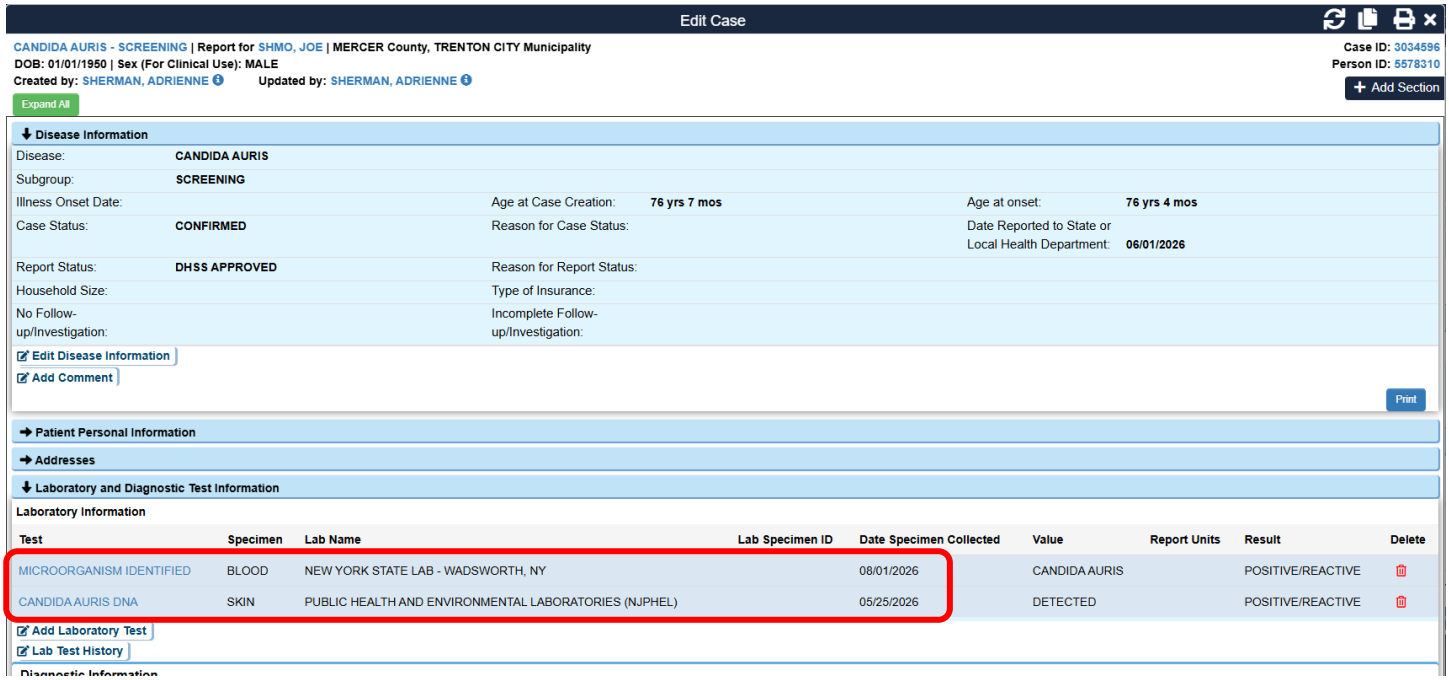
MSH|^~\&|NYSDOH ECLRS|WADSWORTH^33D0654341^CLIA|NJ-ELR|NJDOH|20241408000656||ORU^R01|202414080220|P|2.5.1|||||USA||||PHLabReport-Batch^^2.16.840.1.113883.9.11^ISO
PID|1||10694819^^^^PI^WADSWORTH&33D0654341&CLIA||MOUSE^MIKE||19350101000000|F|||^124 NEW YORK ST^^NY^10001^USA||||||||||U^MALE^HL70189
ORC|RE||||||||||||||||||MONTEFIORE MEDICAL CENTER LABORATORIES|111 EAST 210TH STREET^^BRONX^NY^10467|^^PH^^^718^9204523|111 EAST 210TH STREET^^BRONX^NY^10467
OBR|1|MVL333250035|IDR2500086127-01|^^^YEAST_ID^Yeast Identification^L|||202429072700|||||OUTBREAK HEIC-Cauris16;|Nares/Axilla/Groin Swab|FFI2465-LABDIR^DIRECTOR^LABORATORY|^^PH^^^718^9204523|||||202429072700|||F
OBX|2|CWE|97936-9^C auris DNA Spec QI NAA+probe^LN^C_AUR_DNA^Candida auris DNA^L|243391237|DETECTED|||A|||F|||202429072700|33D2005937^Wadsworth Center - David Axelrod Institute^CLIA|||||||Wadsworth Center - David Axelrod Institute^^^^^^CLIA^^^33D2005937|
SPM|1|^IDR2400086127-01|^Nares/Axilla/Groin Swab||||^Nares/Axilla/Groin Swab|||||||202429072700|0000

3. **Confirm that the laboratory results meet the confirmatory laboratory criteria of the *C. auris* case definition.**

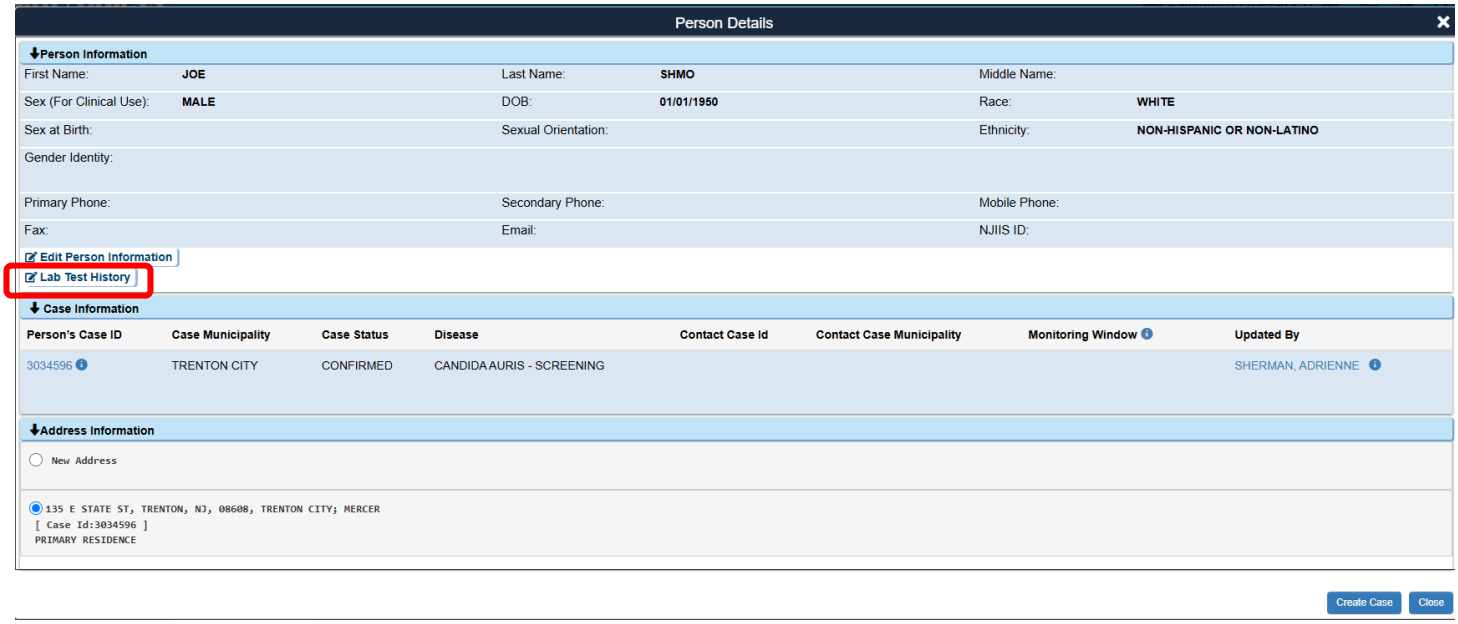
    a. **Review any prior positive *C. auris* laboratory results for the case patient** within the laboratory section. Cross-reference Table 1 to determine if a new case needs to be created or laboratory results need to be moved to a different case record.

    b. **PLEASE NOTE:** Known *C. auris* case patients with previous positive laboratory results may not require a full case patient investigation and healthcare facility exposure investigation if the involved healthcare facility/facilities was/were aware of the case patient's prior positive laboratory result, have been using an effective disinfectant product from EPA List P or EPA List K and have had appropriate Transmission-Based Precautions implemented (i.e., Contact Precautions or Enhanced Barrier Precautions) since admission.

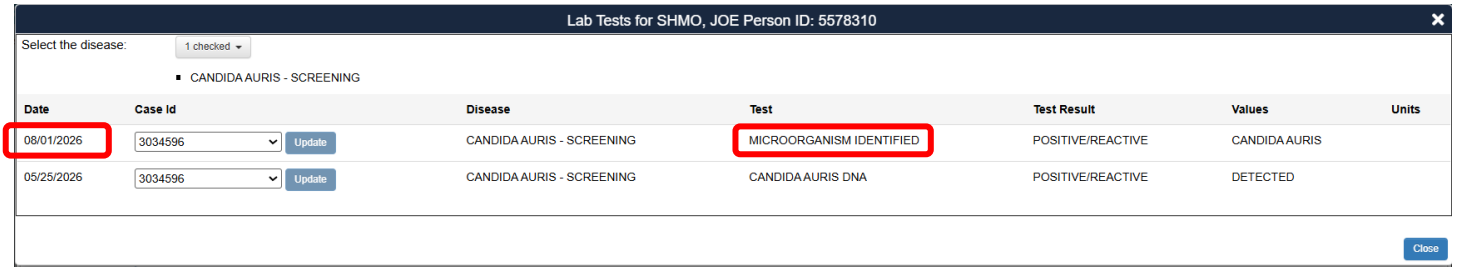
    c. **SCENARIO 1:** If the case patient was **previously identified as a screening case** and **is now reported to have a positive clinical specimen that was added into the patient's existing screening case record**, move the new positive lab result for the clinical specimen into a new case record and categorize the case as "clinical". See the example provided below:



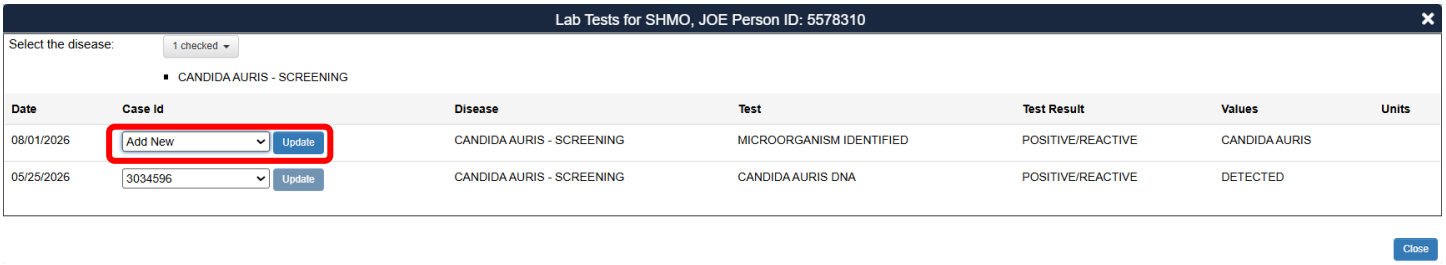
    i. Individual laboratory results can be moved to a new case record by searching the person ID, opening the person details, and selecting "Lab Test History". A new window will display all lab tests associated with that person record.

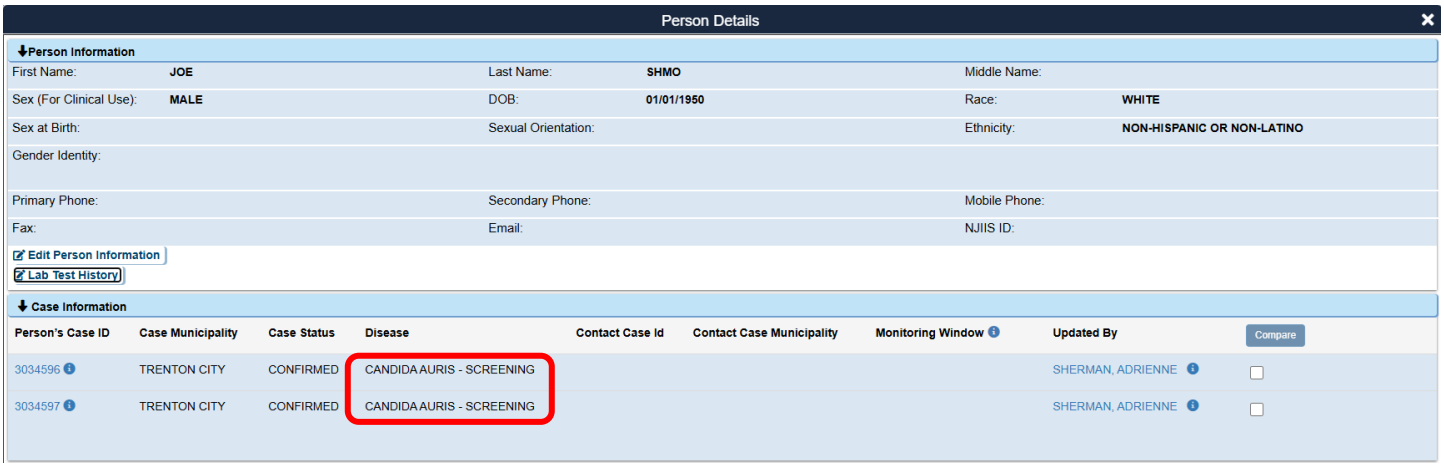


ii. Identify the specific laboratory test result that needs to be moved to a new case record and select the drop-down for Case ID next to that specific laboratory result.

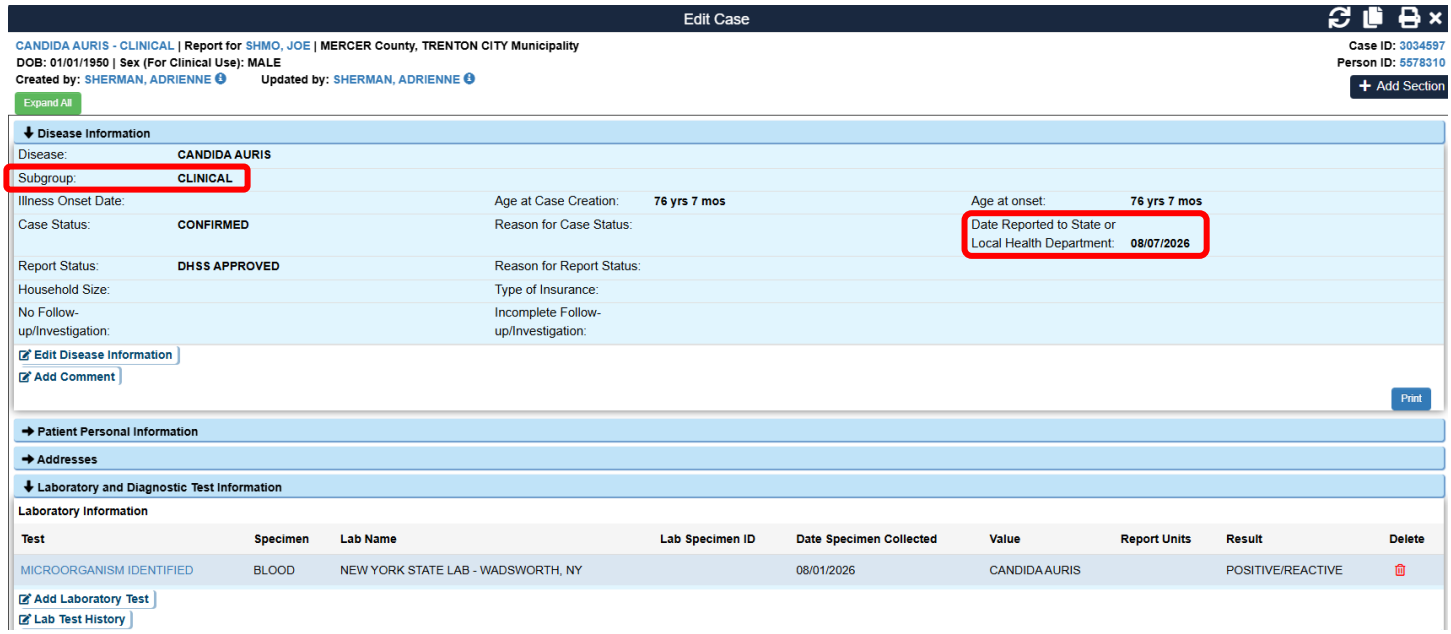


iii. To move the positive clinical laboratory test result into a new case, select “Add New” from the drop-down menu and click “Update”

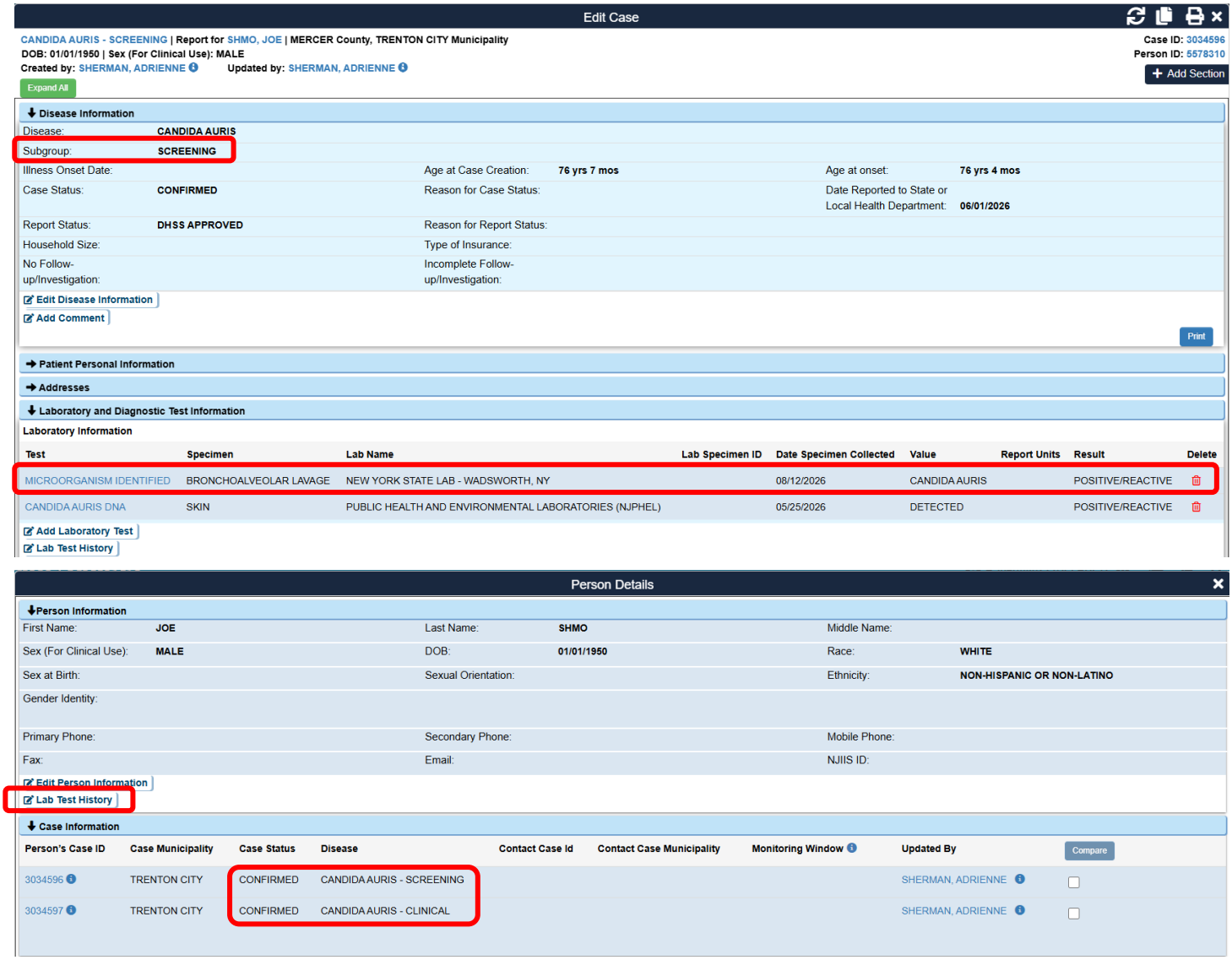




iv. Navigate to the newly created case record and update the case subtype and date reported to public health with information specific to the clinical case identification.

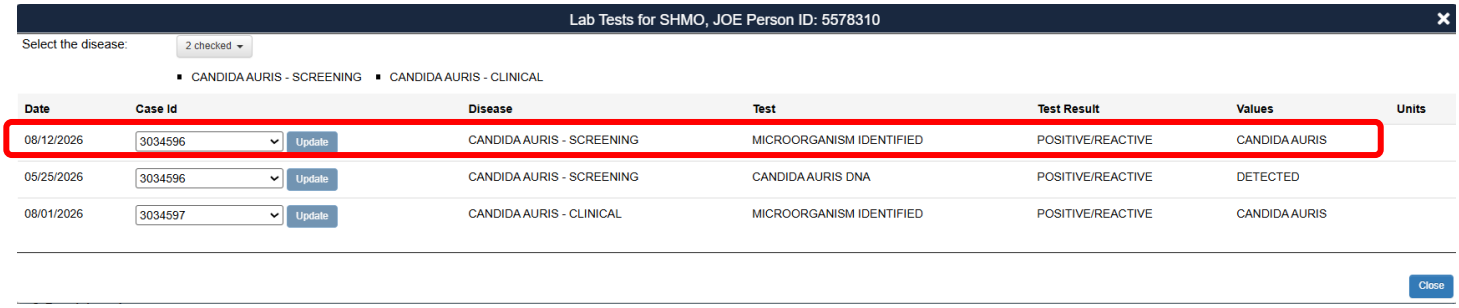


d. **SCENARIO 2:** If the case patient was **previously identified as both a screening case and a clinical case** and **a new positive specimen result is added into the wrong case record** (i.e., a new positive screening lab result appends to an existing clinical case record or a new positive clinical lab result appends to an existing screening case record), move the new positive lab result into the other existing case record. See the example provided below:

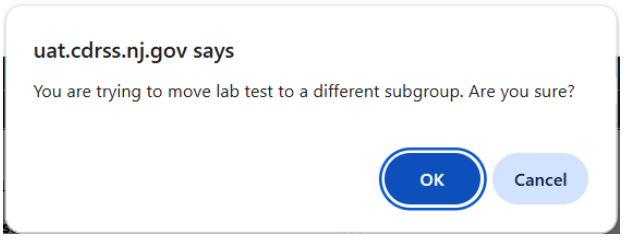


i. Individual laboratory results can be moved to another existing case record by searching the person ID, opening the person details, and selecting “Lab Test History”. A new window will display all lab tests associated with that person record.

ii. Identify the specific laboratory test result that needs to be moved to another existing case record and select the appropriate CDRSS Case ID to associate with the new positive lab result from the drop-down menu and click “Update”.



iii. The following confirmation message will appear; select “OK”



iv. CDRSS will display a confirmation message with the CDRSS case ID the laboratory result has been moved to:

4. **Determine the case status and update CDRSS accordingly.**
    a. Possible: Not an acceptable case status for *C. auris* cases. **Do not select.**
    b. Probable: Reserved for NJDOH use only. **Do not select.**
    c. Confirmed: If the case meets the confirmatory laboratory criteria.
    d. Not a Case: If the case doesn't meet the confirmed laboratory criteria. Provide detailed reasoning in CDRSS.
    e. Out of State: If the patient had their first positive specimen collected outside of New Jersey. **Do NOT select for patients that reside outside of New Jersey that had their first positive specimen collected at a New Jersey facility; such case patients should be classified as "Confirmed".**
5. **Review available information within the Laboratory and Diagnostic Test Information and Medical Facility and Provider Information sections of CDRSS (e.g., ordering facility, ordering provider and recent admissions to healthcare facilities) to determine where the positive specimen was collected.**
    a. Contact the ordering facility or testing laboratory to confirm the specific facility and location of where the positive specimen was collected.
6. **Contact the identifying healthcare facility's IP to determine the case patient's current location and any healthcare facilities** where the case patient received care in the 30 days prior to positive specimen collection. More than one healthcare facility associated with the case patient may need to be contacted in order to identify all healthcare facilities where the patient received care in the 30 days prior to positive specimen collection.
    a. If the identifying healthcare facility is out of your jurisdiction, let the facility know that someone from their local health department will be contacting them to collect additional information on the case patient and provide infection prevention and control recommendations.
    b. If the patient is no longer at the identifying facility, identify any healthcare facilities where the patient was subsequently transferred.
    c. If the patient was admitted from or discharged to an out-of-state facility, immediately contact NJDOH (DOH.CDS.HAIAR.EPI@doh.nj.gov) to communicate the case patient information and out-of-state facilities in need of notification and/or follow-up.

d. **If the patient is a resident of NJ but was identified to have *C. auris* at an out-of-state facility**, no further investigation is needed unless the case patient is known to have received healthcare at a facility in NJ in the 30 days prior to positive specimen collection or subsequently received healthcare at a facility in NJ.

    i. Facilities in NJ where the patient received care after their positive *C. auris* specimen was collected should be contacted by the LHD with jurisdiction over the facility to ensure they are aware of the patient's *C. auris* status and are following the setting-appropriate infection prevention and control measures for *C. auris*.

    ii. Setting-specific infection prevention and control recommendations for *C. auris* can be found on the Communicable Disease Service *C. auris* Disease Webpage

7. **Collect the remaining required data elements and enter the information into the appropriate sections within CDRSS**. It is recommended to contact the identifying facility's IP to obtain this information and other relevant details.

    a. Enter the patient's death date (if applicable) into the "Clinical Status" section within CDRSS. Do not enter an illness onset date into CDRSS. Due to the lack of signs and symptoms among screening cases and the lack of specificity of signs and symptoms associated with clinical infections, illness onset date is not informative for *C. auris* case investigations.

    b. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields. The fields required to be completed by the LHD with jurisdiction over the patient's primary address are annotated with red stars in the guide.

8. **Add or update investigation addresses associated with the case patient within CDRSS**.

    a. Include the names and addresses of healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

    b. Include the names and addresses of healthcare facilities where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented.

9. **Notify the other local health departments with jurisdiction over each healthcare facility** where the case patient received care in the 30 days prior to positive specimen collection and each healthcare facility where the case patient received care between positive specimen collection and receipt/notification of positive results.

    a. At a minimum, the LHD leading the case investigation shall email or call each LHD with jurisdiction over an impacted healthcare facility and provide them with the CDRSS case ID and the name of the healthcare facility/facilities in their jurisdiction that require completion of a healthcare facility exposure investigation and provision of infection prevention and control recommendations.

10. **Request that any positive clinical isolates are submitted to Wadsworth Center by the testing laboratory, when indicated.**

    a. Navigate to the Laboratory and Diagnostic Test Information section in CDRSS and determine if the same clinical source is documented to have been tested by "NEW YORK STATE LAB – WADSWORTH, NY".

b. If there is no record of that same clinical site/source being tested at "NEW YORK STATE LAB – WADSWORTH, NY", instruct the testing laboratory to submit the clinical isolate for further testing.

c. Instructions for laboratories submitting *C. auris* isolates for further testing can be located on NJDOH's Public Health and Environmental Laboratory Webpage.

11. **Keep the *C. auris* case report status as "LHD OPEN" within CDRSS** until the case patient investigation has been completed, all required data elements have been entered into the CDRSS case record (e.g., investigation addresses, risk factors, clinical status, DSQ), and all healthcare facility exposure investigations associated with the case have been completed.

    a. Change the case report status to "LHD CLOSED" when the required CDRSS data fields, case patient investigation and all the healthcare facility exposure investigations associated with the case have been completed. Completion of all healthcare facility exposure investigations should be indicated in the "Facility Exposure Investigation Status and Updates" section by the LHD conducting each facility exposure investigation.

Table 3: Required Components of a *C. auris* Case Patient Investigation

Investigation Type	Component	Notes & Additional Instructions
Case Patient Investigation	1. Search the patient information to determine if there are any prior *C. auris* case records associated with the patient's person ID. Confirm the case is entered in CDRSS.	Enter case if not already in CDRSS.
	2. Review specimen source information to determine and assign case subtype in CDRSS. Confirm the case meets confirmatory laboratory criteria; review prior positive laboratory results (if applicable) to determine if a new case record needs to be created. a. Enter the positive specimen source/site into the Test Result Data text box.	Review the specimen (SPM) segment of HL7 data from the Lab Section.
	3. Confirm the case meets confirmatory laboratory criteria; review prior positive laboratory results (if applicable) to determine if a new case record needs to be created. a. If the patient was previously identified as a screening case and is now newly identified as a clinical case, move the new positive lab result into a new case record and categorize the case as "clinical".	
	4. Determine the case status and update within CDRSS.	
	5. Review Laboratory and Diagnostic Test Information and Medical Facility and Provider Information sections of CDRSS to determine where the positive specimen was collected; contact the ordering facility or the testing laboratory to confirm.	Likely requires calling the ordering facility, ordering provider, and/or testing lab to confirm location of specimen collection.
	6. Contact the identifying facility to determine the case patient's current location and any healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.	More than one healthcare facility associated with the case patient may need to be contacted in order to identify all

	a. **If the identifying healthcare facility is out of your jurisdiction**, let the facility know that someone from their local health department will be contacting them to collect additional information on the case patient and provide infection prevention and control recommendations. b. **If the patient is no longer at the identifying facility**, identify any healthcare facilities where the patient was subsequently transferred. c. **If the patient was admitted from or discharged to an out-of-state facility**, immediately contact NJDOH (DOH.CDS.HAIAR.EPI@doh.nj.gov) to communicate the case patient information and additional facilities in need of notification and/or follow-up. d. **If the patient is a resident of NJ but was identified to have *C. auris* at an out-of-state facility**, no further investigation is needed unless the patient is known to have received healthcare at a facility in NJ in the 30 days prior to positive specimen collection or subsequently received healthcare at a facility in NJ. e. Facilities in NJ where the patient received care after their positive *C. auris* specimen was collected should be contacted by the LHD with jurisdiction over the facility to ensure they are aware of the patient's *C. auris* status and are following the setting-appropriate infection prevention and control measures for *C. auris*.	healthcare facilities where the patient received care in the 30 days prior to positive specimen collection.
	7. Collect the remaining required data elements and enter the information into the appropriate sections within CDRSS. a. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions. The fields required to be completed by the LHD with jurisdiction over the patient's primary address are annotated with red stars.	Contact the identifying facility's Infection Preventionist (IP) to obtain this information.
	8. Add or update investigation addresses associated with the case patient within CDRSS. a. Include the addresses of healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. b. Include the addresses of healthcare facilities where the case patient received care between the date of positive specimen collection and date of positive result receipt/notification (i.e., between positive specimen collection and implementation of appropriate Transmission-Based Precautions). This includes the identifying healthcare facility and any healthcare facilities where a patient was transferred before positive results were received and appropriate	Out-of-state healthcare facility admissions should be reported to NJDOH.

	Transmission-Based Precautions were implemented.	
	9. Notify the local health departments with jurisdiction over each healthcare facility where the case patient received care in the 30 days prior to positive specimen collection and each healthcare facility where the case patient received care between positive specimen collection and receipt/notification of positive results. a. Provide each impacted LHD with the CDRSS case ID and the name(s) of the healthcare facilities in their jurisdictions that require follow up.	Out-of-state healthcare facility admissions should be reported to NJDOH.
	10. Request that any positive clinical isolates are submitted to Wadsworth Center by the testing laboratory, when indicated. a. Navigate to the Laboratory and Diagnostic Test Information section in CDRSS and determine if the same clinical source is documented to have previously undergone testing conducted by "NEW YORK STATE LAB – WADSWORTH, NY". b. If there is no record of that same clinical site/source being tested at "NEW YORK STATE LAB – WADSWORTH, NY", instruct the testing laboratory to submit the clinical isolate for further testing.	Consult NJDOH if/when needed to confirm submission of a clinical isolate is indicated.
	11. Keep the *C. auris* case report status as "LHD OPEN" within CDRSS until the case patient investigation and all healthcare facility exposure investigations associated with the case have been completed, AND all required data elements have been entered into the CDRSS case record. a. Change the case report status to "LHD CLOSED" when the Facility Exposure Investigation Status and Updates section indicates all required information has been received and all facility exposure investigations associated with the case have been completed.	

Healthcare Facility Exposure(s) Investigation(s) Overview

Healthcare facility exposure investigations will be led by the LHD(s) with jurisdiction over each impacted healthcare facility. If the case patient is an out-of-state resident and is identified as a new case while at a healthcare facility in New Jersey, the healthcare facility exposure investigation will be led by the LHD with jurisdiction over the specific healthcare facility where potential exposures are being investigated. **A separate healthcare facility exposure investigation should be conducted for <u>each</u> healthcare facility** where the case patient received care in the 30 days prior to positive

specimen collection, the identifying healthcare facility and any healthcare facility where the case patient received care from the earliest positive specimen collection date until appropriate precautions were implemented. In most situations, a single case of *C. auris* requires conducting multiple healthcare facility exposure investigations. **All components of the healthcare facility exposure investigation are to be completed within 5 business days (Priority 3).** Information collected and/or confirmed during the healthcare facility exposure investigation must be digitally documented in the *C. auris* Epidemiological Assessment, which must be subsequently provided to NJDOH via secure email within 1 business day of completing the healthcare facility exposure investigation and entered into CDRSS within 5 business days.

Conducting a *C. auris* Healthcare Facility Exposure(s) Investigation(s) for a Single Case

It is recommended to contact the healthcare facility's Infection Preventionist (IP) to obtain necessary information, and other relevant details. The information required to be collected in steps #4-8 can be collected by having each healthcare facility digitally complete and return the *C. auris* Epidemiologic Assessment. Refer to the Healthcare Facility Exposure Investigation Checklist or the *C. auris* Epidemiologic Assessment. NJDOH recommends the following investigation steps at the LHD level **for each impacted healthcare facility within the LHD's jurisdiction**:

1. **Contact the healthcare facility and determine the specific dates the case patient was present within the facility.**
    a. Determine the **date the patient first presented to each facility**. Sometimes the date they first arrived at the Emergency Department and the date of admission are different.
    b. Determine the **date the patient left each facility**.
2. **Notify the healthcare facility** about the case patient's positive *C. auris* laboratory results.
3. **Provide the healthcare facility with setting-appropriate infection prevention and control recommendations for *C. auris***.
    a. It is recommended that infection prevention and control recommendations be provided both verbally and in writing through a follow-up email. Setting-specific infection prevention and control recommendations for *C. auris* can be found in the Appendix.
    b. NJDOH's infection prevention and control recommendations and educational resources for *C. auris* can be found in the Appendix and on the Communicable Disease Service *C. auris* Disease Webpage. The necessary resources to provide to the facility in a follow up email include:
        i. Transmission-Based Precautions Recommendations
        ii. Guidance for Care Activities
        iii. Patient Cohorting Considerations
        iv. Cleaning and Disinfection Guidance
        v. NJDOH Novel MDRO Transfer Sheet
4. **Determine whether the case patient was on the setting-appropriate Transmission-Based Precautions** (TBP), as indicated below, for any or all of their admission at each

healthcare facility. Document the type of TBP implemented for the case patient and the specific dates TBP was in-place, as well as dates that TBP were not in-place.

   a. Appropriate precautions for *C. auris* in acute care settings (i.e., short-term acute care hospital, long-term acute care hospital, comprehensive rehabilitation hospital) are Contact Precautions.

   b. Appropriate precautions for *C. auris* in long-term care settings (i.e., skilled nursing facility, ventilator-capable skilled nursing facility, subacute rehabilitation) are Enhanced Barrier Precautions or Contact Precautions, depending on the situation. Contact Precautions should be used for residents with acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained.

5. **Determine the type(s) of unit(s) the patient was admitted to and the corresponding dates for each unit admission.**

   a. Document the unit types, room numbers and corresponding dates of admission to each room and unit.

6. **Determine if the case patient had any roommates.**

   a. If the case patient had roommates, determine the current location of prior roommates. Prior and current roommates that are still within the facility should be prioritized for colonization screening if they do not have a history of *C. auris.*

   b. Within CDRSS, document the prior and current roommates as contacts of the case under the Contact Tracing section in CDRSS. Document roommates' names and dates of birth at a minimum. If available, document the dates they shared a room and their current location within the comments of the Contact Tracing section.

7. **Determine if the patient was admitted from another healthcare facility, including date of transfer, name and location of the transferring facility**. If the patient was not a direct transfer, inquire about any other known healthcare facility admissions in the 30 days prior to positive specimen collection.

   a. Confirm all other healthcare facility addresses are listed as investigation addresses linked to the case within CDRSS.

   b. If new facilities of admission are identified, add them as investigation addresses linked to the case within CDRSS and notify the LHD with jurisdiction over the healthcare facility.

8. **Collect the disease specific questionnaire (DSQ), risk factor and clinical status information** from each facility and **enter the information into the appropriate sections within CDRSS**.

   a. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.

   b. The "Pre-Existing Conditions" field within the **Clinical Status section** is **intended to combine and document all information on a patient's pre-existing conditions provided by all healthcare facilities** where the case patient received care in the 30 days prior to positive specimen collection.

      i. This field documents important information on comorbidities and underlying health conditions that may be associated with increased risk of *C. auris* acquisition. Consistent documentation of this information allows public health

professionals to track and assess trends and changes in risk factors among patient populations impacted by *C. auris*.

ii. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection.

iii. Some healthcare facilities may have more detailed information on a patient's history of pre-existing conditions, while other healthcare facilities may have incomplete or conflicting information on pre-existing conditions. For this reason, **once a pre-existing condition is indicated to be present, that pre-existing condition should not be changed based on information gathered from additional healthcare facilities**. Only pre-existing conditions not already selected from the drop-down menu should be changed (i.e., added) based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

c. The **Risk Factors section** is **intended to combine and document all information on a patient's risk factors provided by all healthcare facilities** where the case patient received care in the 30 days prior to positive specimen collection.

i. This section documents important information on factors that may be associated with increased risk of *C. auris* acquisition. Consistent documentation of this information allows public health professionals to track and assess trends and changes in risk factors among patient populations impacted by *C. auris*.

ii. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection.

iii. Some healthcare facilities may have more detailed information on a patient's history of indwelling medical devices and other risk factors, while other healthcare facilities may have incomplete or conflicting information on risk factors. For this reason, **once a risk factor is indicated to be present (i.e., answered with "Yes"), that answer should not be changed based on information gathered from additional healthcare facilities**. Only risk factors answered with "No" or "Not Asked" should be changed based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

d. The **Disease Specific Questionnaire section** ("ADDITIONAL REQUIREMENTS: CANDIDA AURIS") is **intended to combine and document a case patient's healthcare facility admission(s) and visit information provided by all healthcare facilities** where the case patient received care in the 30 days prior to positive specimen collection.

i. This section will be completed and updated by the local health department with jurisdiction over the case patient's primary address (questions marked with **red stars**) and each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection (all remaining questions).

ii. **Please note:** All fields in the DSQ are required to be completed. Due to the length of the DSQ, it is highly recommended that CDRSS users frequently save

progress while entering DSQ data to prevent the loss of data if CDRSS times out.

e. Please utilize the comments section within CDRSS to document any additional information, such as admissions to additional healthcare facilities in the 30 days prior to positive specimen collection or subsequent admissions to healthcare facilities where the patient's *C. auris* status was not known or where appropriate precautions were not implemented.

9. **Determine if there were other known *C. auris* case patients within the facility during/around the time the new case patient was present and assess potential epidemiologic links.**
    a. Potential epidemiologic links to assess between case patients include admission to a common unit, admission to a common room, shared staff, or shared equipment/devices.
    b. Enter the collected information into the DSQ in CDRSS.
10. **Determine if the case patient utilized any shared or reusable medical equipment and devices.**
    a. Common examples of medical equipment and devices used on or shared amongst patients include vitals machines, stethoscopes, glucometers, lifts, imaging machines, ultrasound machines, and computers on wheels.
11. Determine the risk of equipment contamination and subsequent transmission by **identifying the specific disinfectant products utilized for patient care equipment and devices**.
    a. Document the disinfectant products utilized for patient care equipment and devices and their EPA registration numbers. **EPA registration numbers for each disinfectant product are required to determine whether each product is effective against *C. auris*.**
    b. Document the disinfectant product(s) and their EPA registration number(s) in the comments section of the *C. auris* Epidemiological Assessment.
12. Determine the risk of environmental contamination and subsequent transmission by **identifying the specific disinfectant products utilized for environmental cleaning**.
    a. Document the disinfectant products utilized for environmental cleaning (i.e., room and patient care environment cleaning) and their EPA registration numbers. **EPA registration numbers for each disinfectant product are required to determine whether each product is effective against *C. auris***.
    b. Document the disinfectant product(s) and their EPA registration number(s) in the comments section of the *C. auris* Epidemiological Assessment.
13. **Determine whether the disinfectant products utilized by the facility for environmental cleaning AND equipment/device cleaning are effective against *C. auris*** by cross-referencing products' EPA registration numbers with EPA List P and EPA List K.
    a. Search for products' EPA registration numbers on EPA List P and EPA List K.
14. **Contact NJDOH, by email or phone, within 1 business day of information receipt, to provide documentation of all information collected during each healthcare facility investigation to determine if colonization screening is indicated.** NJDOH will determine if

colonization screening is warranted and assist in coordinating any necessary colonization screening at impacted healthcare facilities.

a. If NJDOH recommends colonization screening, proceed to step 15 or 16, depending on the situation. Otherwise, proceed to step 17.

15. **If/when NJDOH recommends colonization screening** at the healthcare facility **and testing is being conducted by the public health laboratory**:

    a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH, the facility's shipping address and contact information (i.e., name, phone number, email) for the primary point(s) of contact at the healthcare facility; provide this information to NJDOH as soon as possible.

    b. Provide the healthcare facility with NJDOH's colonization screening recommendations, including potential dates when colonization screening can be supported by the public health laboratory as determined by NJDOH.

    c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility.

    d. Provide the healthcare facility with NJDOH's *C. auris* Colonization Screening Instructions document and the line list template. Review colonization screening process and instructions with the healthcare facility prior to the date of scheduled specimen collection.

    e. Ensure the healthcare facility follows instructions for conducting *C. auris* colonization screening. On the date of the scheduled colonization screening:

        i. The line list template **cannot be modified in any way** and must be digitally completed and submitted to NJDOH once specimens have been collected. Only patients that have specimens successfully collected should be included in the line list.

        ii. NJDOH will utilize the completed line list to place electronic test orders and generate a specimen manifest to provide to the healthcare facility with a FedEx shipping label.

        iii. The healthcare facility must print and include the specimen manifest with the collected specimens being shipped to the public health laboratory for testing.

        iv. The healthcare facility must utilize the provided FedEx shipping label to ensure specimens are shipped to the correct testing laboratory and enable FedEx tracking of the shipment.

    f. NJDOH will provide copies of colonization screening test results back to the facility upon finalization of test results by the public health laboratory.

    g. Refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.

16. **If/when NJDOH recommends colonization screening** at the healthcare facility **and testing is being conducted by the facility's laboratory**:

    a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH; provide this information to NJDOH as soon as possible.

    b. Provide the healthcare facility with NJDOH's colonization screening recommendations and determine when the facility will conduct colonization screening.

c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility and the laboratory that will be conducting testing.

d. On the date of the scheduled colonization screening:

    i. Obtain a line listing of patients/residents included in the colonization screening from the healthcare facility that includes patient last name, patient first name, patient date of birth, patient sex, date of specimen collection and specimen source; provide to NJDOH upon receipt.

    ii. Request copies of all colonization screening test results be provided by the healthcare facility as soon as results are finalized; provide to NJDOH upon receipt.

e. Refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.

17. **Complete the Facility Exposure Investigation Status and Updates section within CDRSS;** enter the required information for each healthcare facility exposure investigation conducted.

    a. The Facility Exposure Investigation Status and Updates section is intended to track and monitor the status of each healthcare facility investigation stemming from the identification of the case.

    b. This section includes a series of 12 questions that repeat a total of five times to enable documentation of up to five different healthcare facility exposure investigations for a given case patient.

    c. Completion of this section by all involved LHDs indicates whether the LHD leading the case investigation can close out the case or if the case must remain open until all facility investigations have been completed and documented appropriately.

    d. Each LHD is required to complete the following fields for **each** healthcare facility in their jurisdiction that requires a Healthcare Facility Exposure Investigation:

        i. Name of the impacted healthcare facility

            1. If the facility is part of a larger healthcare system/network, please specify the facility location (e.g., RWJ New Brunswick, Complete Care at Westfield)

        ii. Name of the local health department responsible for this facility's exposure investigation

        iii. Has a *C. auris* epidemiologic assessment been completed and obtained from this facility?

        iv. Is there any information still pending/missing in order to complete this facility's exposure investigation?

            1. Indicate the required information that is still pending/missing from this facility

        v. Status of the healthcare facility exposure investigation

            1. All information obtained; investigation complete – this answer choice is intended to be used if all information has been obtained, documented and there are no pending public health actions (e.g., colonization screening)

2. All information obtained; investigation ongoing – this answer choice is intended to be used if all information has been obtained and documented, but there is pending public health action (e.g., colonization screening)
3. Required information pending; investigation incomplete/ongoing – this answer choice is intended to be used if any required information has not yet been obtained or documented
4. Other – this answer choice is intended to be used only as needed

vi. Was colonization screening recommended for this healthcare facility?

vii. Was/were there any new positive(s) detected during colonization screening at this healthcare facility?

1. This field should indicate if there were any new positives, the number of new positives, if there was a high number of screening refusals or if colonization screening was not carried out as recommended

viii. Is the healthcare facility conducting serial point prevalence surveys as a result of this case finding?

ix. Was a remote or on-site infection control assessment recommended for this healthcare facility?

x. Provide the date(s) of the scheduled and completed infection control assessment(s) for this healthcare facility and any other relevant details.

xi. Date last update was made

1. This field indicates the date that the LHD last entered an update on this facility exposure investigation and should be updated each time the LHD adds or changes information to this section

e. Refer to the CDRSS Data Field Completion Guide for *C. auris* (see Appendix) for detailed instructions on data entry and completion of the required fields.

Table 4: Required Components of a Healthcare Facility Exposure Investigation for a Single Case of *C. auris*

Investigation Type	Component	Notes & Additional Instructions
Healthcare Facility Exposure Investigation	1. Contact the healthcare facility and confirm the exact dates the case patient was present within the facility.	
	2. Notify the facility about the patient's positive *C. auris* test result.	
	3. Provide the healthcare facility with setting-appropriate infection prevention and control recommendations for *C. auris*.	Recommendations should be provided verbally and in writing.
	4. Determine whether the case patient was on appropriate Transmission-Based Precautions (TBP) for any or all of their admission. a. Document the type of TBP implemented for the case patient and the specific dates TBP was in-place, as well as dates that TBP were not in-place.	The appropriate precautions for *C. auris* are Enhanced Barrier Precautions or Contact Precautions in long-term care settings, and Contact Precautions in acute care settings.

	5. Determine the type(s) of unit(s) the patient was admitted to and the corresponding dates for each unit admission (e.g., ICU, vent unit, memory care unit). a. Document the unit types, room numbers and corresponding dates of admission to each room and unit.	This information will need to be obtained from the facility's Infection Preventionist (IP).
	6. Determine if the case patient had any roommates. a. Within CDRSS, document the prior and current roommates as contacts of the case under the Contact Tracing section. Document the roommates' names and dates of birth at a minimum. If available, document the dates they shared a room and their current location within the comments of the Contact Tracing section. b. Prior and current roommates that are still within the facility should be prioritized for colonization screening if they do not have a history of *C. auris*.	This information will need to be obtained from the facility's IP.
	7. Determine when and where the patient was admitted from and if there are any other known healthcare facility admissions or overnight stays in the 30 days prior to positive specimen collection. a. Confirm all other healthcare facility addresses are listed as investigation addresses linked to the case within CDRSS. If new facilities of admission are identified, add them as investigation addresses linked to the case within CDRSS and notify the LHD with jurisdiction over the healthcare facility..	This information will need to be obtained from the facility's IP.
	8. Collect the remaining disease specific questionnaire (DSQ), risk factor and clinical status information from the facility and enter the information into the appropriate sections within CDRSS.	This information will need to be obtained from the facility's IP. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.
	9. Determine if there were any other known *C. auris* case patients within the facility during/around the same time as the new case and assess potential epidemiologic links. Enter collected information into the DSQ in CDRSS.	This information will need to be obtained from the facility's IP. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.
	10. Determine if the case patient utilized any shared or reusable medical equipment and devices (e.g., vitals machines, glucometers, stethoscopes, lifts, imaging machines).	This information will need to be obtained from the facility's IP.
	11. Identify the specific disinfectant products and corresponding EPA registration numbers utilized for reusable equipment and devices (e.g., nursing carts, vitals machines, PT equipment).	This information will need to be obtained from the facility's IP.

	a. Document the disinfectant products utilized for patient care equipment and devices and their EPA registration numbers.	
	12. Identify the specific disinfectant products and corresponding EPA registration numbers utilized by the facility's environmental services or housekeeping staff for environmental cleaning. a. Document the disinfectant products utilized for environmental cleaning (i.e., room and patient care environment cleaning) and their EPA registration numbers.	This information will need to be obtained from the facility's IP or EVS/HK leadership.
	13. Determine whether the disinfectant products utilized for environmental disinfection and equipment/device disinfection are on EPA List P or EPA List K. a. Search for products' EPA registration numbers on EPA List P and EPA List K.	
	14. Contact NJDOH and provide documentation of all information collected during each healthcare facility exposure investigation to determine if colonization screening is indicated. NJDOH will assist in coordinating any necessary colonization screening at impacted healthcare facilities. a. If NJDOH recommends colonization screening, proceed to step 15 or 16, depending on the situation. Otherwise, proceed to step 17.	
	15. If/when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the public health laboratory: a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH, the facility's shipping address and contact information (i.e., name, phone number, email) for the primary point(s) of contact at the healthcare facility; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations, including potential dates when colonization screening can be supported by the public health laboratory as determined by NJDOH. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility. d. Provide the healthcare facility with NJDOH's colonization screening instructions document and the line list template. Review colonization screening process and instructions with the healthcare facility prior to the date of scheduled specimen collection. e. Ensure the healthcare facility follows instructions for conducting *C. auris* colonization screening. f. Upon receipt of test results, refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	

	16. If/ when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the facility's laboratory: a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations and determine when the facility will conduct colonization screening. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility and the laboratory that will be conducting testing. d. Obtain a line listing of patients/residents included in the colonization screening from the healthcare facility that includes patient last name, patient first name, patient date of birth, patient sex, specimen collection date and specimen source; provide to NJDOH upon receipt. e. Request copies of all colonization screening test results be provided by the healthcare facility as soon as results are finalized; provide to NJDOH upon receipt. f. Refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	
	17. Complete the Facility Exposure Investigation Status and Updates section within CDRSS; enter the required information for each healthcare facility exposure investigation conducted.	Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.

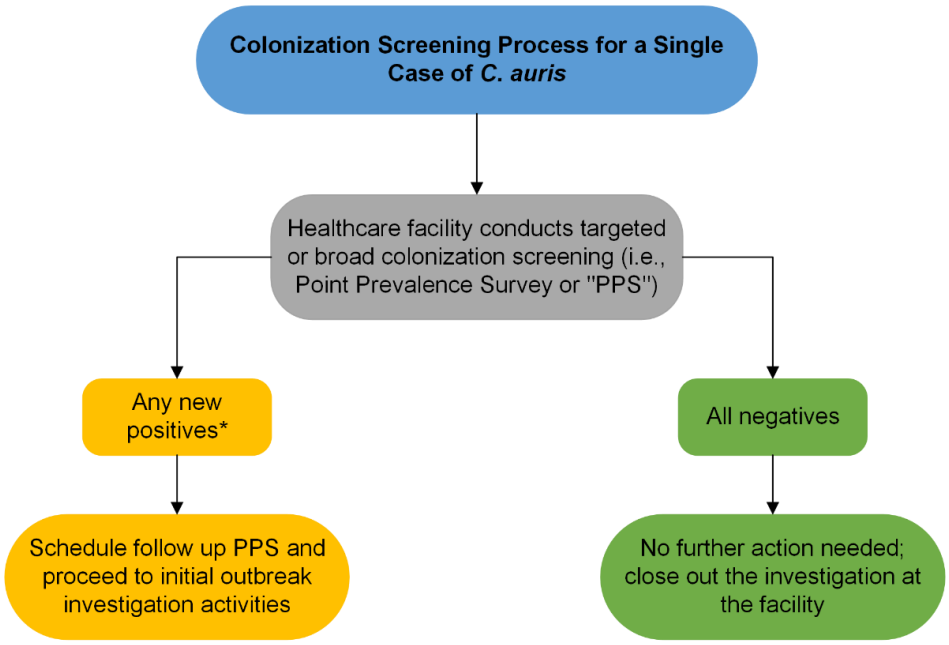
Colonization Screenings and Point Prevalence Surveys

Colonization screening means testing people who don't show symptoms to see if they are carrying a germ. Colonization screenings may be targeted towards the highest risk individuals, such as roommates of a case patient or a hallway where the case patient was admitted. A point prevalence survey (PPS) is broad (e.g., unit-wide) colonization screening of patients conducted to capture a point prevalence estimate at a given moment in time. The terms "colonization screening" and "PPS" are used interchangeably.

If a PPS is recommended, NJDOH will coordinate the screening with the facility and the LHD with jurisdiction over the healthcare facility conducting the screening. In most situations, positive screening results corresponding to testing conducted at public health laboratories will automatically create new cases in CDRSS upon receipt of positive results via Electronic Laboratory Reporting (ELR). Out-of-state residents that test positive for *C. auris* during colonization screening conducted in NJ may require manual case creation and entry of positive lab results. Positive screening results

corresponding to testing conducted at hospital or reference laboratories may require manual entry of cases into CDRSS if the testing laboratory is not reporting positives via ELR. When new cases are identified during a PPS, each case will be investigated by the LHD with jurisdiction over the case patient's primary address following the same protocol for a single case investigation. The corresponding healthcare facility exposure investigations will be conducted by the LHD with jurisdiction over each impacted healthcare facility as described in the protocol above. New positives identified in subsequent PPSs are generally indicative of ongoing transmission on a given unit, particularly if the positive individual screened negative during a prior PPS. However, other healthcare facility exposures need to be investigated and documented for each new case.

C. auris Colonization Screening Algorithm for a Single Case Investigation

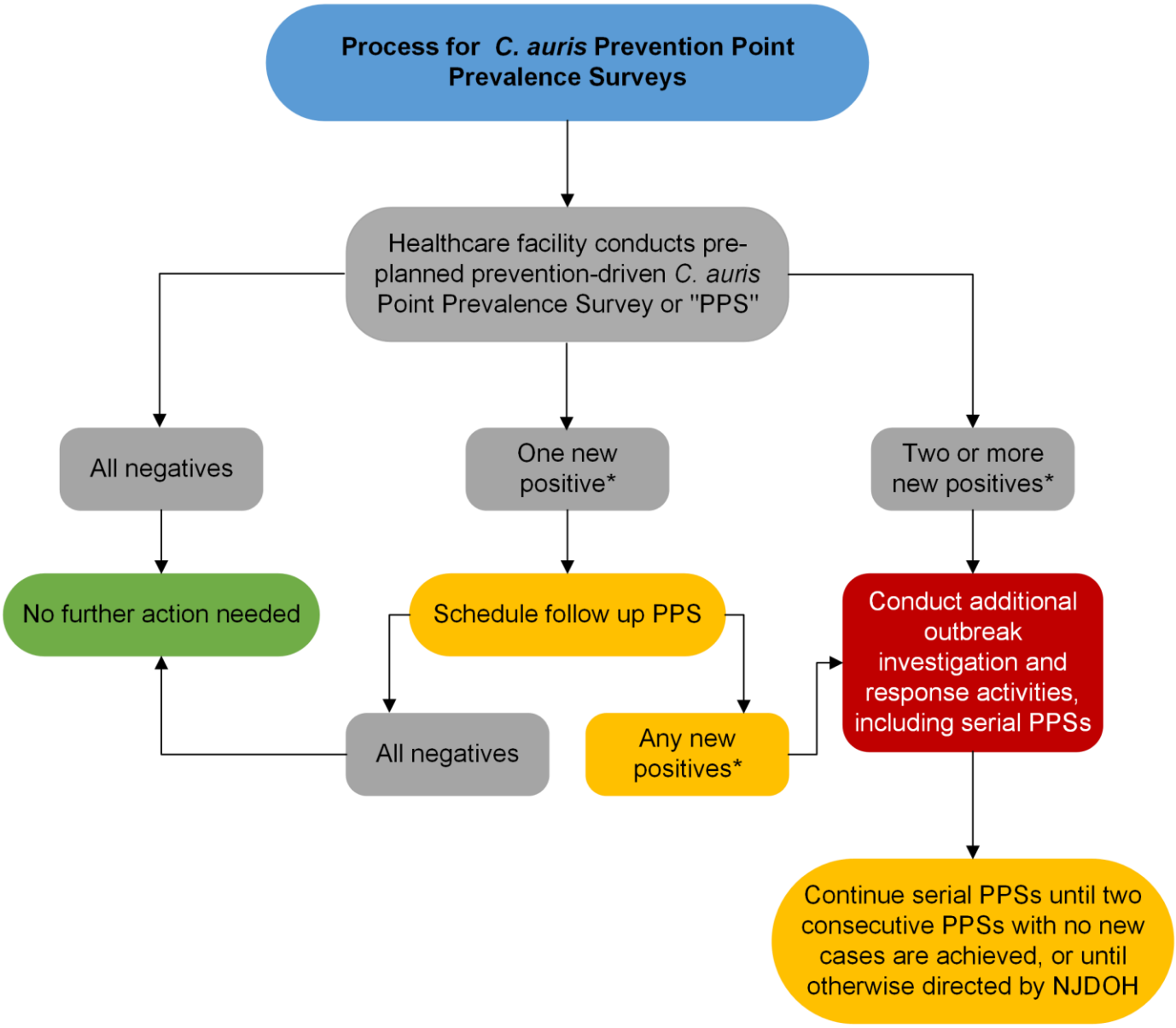


**All positive individuals identified during colonization screenings should have recent healthcare facility encounters, prior screening results and other epidemiologic factors reviewed by public health to determine likelihood of C. auris acquisition at another facility.*

C. auris Prevention Point Prevalence Surveys

Prevention-driven PPSs are colonization screenings proactively performed unit- or facility-wide based on the facility's or unit's level of risk for *C. auris* importation and transmission. Prevention PPSs are pre-planned, and therefore distinct from the response-driven PPSs, which are performed following the identification of a patient/resident with *C. auris*. Prevention PPSs are a tool used to identify asymptomatic colonized patients as early as possible, thereby allowing healthcare facilities to implement specific infection prevention and control measures to stop spread of the organism, preventing transmission events and large-scale outbreaks within high-risk settings. The goal of a prevention PPS is early identification of colonized individuals to prevent transmission events. This involves screening all patients/residents admitted to a unit or facility on a given day that are not known to have *C. auris*. Prevention PPSs are performed at a predetermined frequency, such as every three to six months.

High-risk settings, such as long-term acute care hospitals (LTACHs) and ventilator-capable skilled nursing facilities (vSNFs), that are not experiencing an active *C. auris* outbreak are highly encouraged to participate in proactive prevention-based *C. auris* PPSs (e.g., every 3-6 months) in accordance with CDC's guidance for the prevention of multidrug-resistant organisms. NJDOH will notify the LHD with jurisdiction over the healthcare facility that will be conducting a *C. auris* prevention PPS and provide the LHD with copies of results for testing conducted at public health laboratories.



**All positive individuals identified during colonization screenings should have recent healthcare facility encounters, prior screening results and other epidemiologic factors reviewed by public health to determine likelihood of C. auris acquisition at another facility.*

III. OUTBREAK INVESTIGATION PROCEDURES

The following recommendations are intended to help epidemiologists and other public health officials make decisions as they investigate common outbreak scenarios and should not be considered exhaustive.

General investigative steps are described below. Public Health officials may have already performed several steps during their initial index case investigation. Many of these steps will occur simultaneously or will vary during an investigation.

Every outbreak investigation is unique and requires careful planning and risk assessment to determine the most appropriate response, with consideration given to personnel, resources, or other competing priorities. Since response-based *Candida* (*Candidozyma*) *auris* (*C. auris*) colonization screening, a necessary component of outbreak investigations, is only available through the Antimicrobial Resistance Laboratory Network's Regional Laboratory for the Northeast Region, NJDOH must be actively involved in all *C. auris* outbreak responses: DOH.CDS.HAIAR.EPI@doh.nj.gov.

Roles and Responsibilities

Outbreak Response and Investigation

C. auris outbreaks are commonly associated with long-term care facilities, long-term acute care hospitals and short-term acute care hospitals. All LHDs should report any suspected or confirmed *C. auris* outbreaks via email/phone immediately upon detection to NJDOH (contact your regional epidemiologist and email NJDOH at: DOH.CDS.HAIAR.EPI@doh.nj.gov).

Jurisdictional Leads

N.J.A.C. 8:57-1.10 states that when a health officer receives a communicable disease or outbreak report, they shall conduct an investigation, with direction given by the NJ Department of Health, to determine if an outbreak of a disease exists, ascertain the source of the illness, and implement control measures to limit the spread of the disease. Case patients often reside in different jurisdictions than where their exposures occurred. If a healthcare facility is under investigation for *C. auris*, then the local health department with jurisdiction over the facility's municipality is responsible for conducting the outbreak investigation alongside NJDOH.

Below are some examples of activities that the Local Health Department is expected to do:

- Obtain digitally completed *C. auris* epidemiologic assessments; digitize epidemiologic assessments when necessary
- Obtain relevant medical records when appropriate
- Participate in conference calls and site visits with the facility and NJDOH
- Provide written communications and recommendations to the facility while including NJDOH on communications to the facility
- Assist in following up with the facility for progress updates, including but not limited to site visit recommendation implementation progress
- Maintain records pertinent to the investigation

The NJDOH recognizes that *C. auris* outbreak investigations require technical expertise and therefore can provide subject matter expertise and support to the LHD while not assuming the lead role. This may transition to a joint investigation with LHD/NJDOH if the situation becomes more extensive (e.g., outbreak involves multiple jurisdictions or colonization screening is indicated). NJDOH can provide the following support:

- Participate and help lead discussions in investigation follow-up conference calls and site visits, as needed
- Provide infection prevention and control recommendations for the facility
- Provide educational materials and other informative resources to LHD for the facility (i.e., disease fact sheets, point-prevalence survey instructions, example of screening consent language, micro-learns, inter-facility communication transfer sheets)
- Assist with review and analysis of collected data
- Review the Infection Prevention and Control policies to ensure adherence with CDC recommendations and best practices

Defining Outbreaks

C. auris outbreaks are most frequently identified through colonization screening, or point prevalence surveys (PPSs), initiated in response to the identification and investigation of a single case of *C. auris*. When identifying a suspected outbreak, or receiving a report of a suspected outbreak, the first step is to determine if further investigation is needed. The setting and a particular facility's history with *C. auris* can impact this decision. See the following examples of situations which could "trigger" an investigation:

- Evidence of *C. auris* transmission in a previously naïve facility;
- Cluster of cases in a distinct patient or resident population or unit;
- Increase of cases above baseline occurring in a non-naïve facility (e.g., long-term acute care hospitals);
- Increase in clinical cases (e.g., bloodstream) detected within a facility;
- Identification of concerning antifungal resistance (e.g., pan-resistant *C. auris*).

A suspected outbreak of *C. auris* is defined as two or more presumptive healthcare-associated cases of *C. auris* with an epidemiologic link identified within a four-week period. An **epidemiological link** includes, but is not limited to, the following examples:

- Admission to the same unit, or to the same healthcare facility if the facility is small (e.g., <90 beds)
- Commonly shared staff (e.g., nursing staff, wound care staff)
- Shared medical equipment or devices (e.g., vitals machines, glucometers, imaging machines)

Special Considerations

- Several high-risk facilities (i.e., long-term acute care hospitals and ventilator-capable skilled nursing facilities) in NJ have long-standing histories of sustained *C. auris* transmission over the course of years. Outbreak response activities in such facilities may be abbreviated or custom to the facility. LHDs should consult with NJDOH to determine which healthcare facilities in their jurisdiction have experienced sustained transmission of *C. auris* and do not require full outbreak investigations to be completed when new cases are identified.

Serial Point Prevalence Surveys & Outbreak Protocols

A point prevalence survey (PPS) is broad (e.g., unit-wide) colonization screening of patients conducted to capture a point prevalence estimate at a given moment in time. Serial PPSs are repeated broad (e.g., unit-wide) colonization screenings of all individuals not known to have the target pathogen (i.e., *C. auris*) at specific intervals (e.g., every 2-4 weeks). Serial PPSs are an outbreak containment strategy that aims to identify newly colonized individuals to interrupt transmission and assess effectiveness of control measures already in-place. The frequency of serial PPSs is dependent upon public health laboratory testing capacity, the level of acuity on the impacted unit(s), the average length of stay on the impacted unit(s), and the facility's history of *C. auris* transmission. At a minimum, serial PPSs should be conducted at least one week apart.

Outbreak Investigation Protocol for a Single Facility

Once public health officials have consulted with NJDOH and determined that they need to conduct an outbreak investigation, there is a series of activities that should take place. The following outbreak investigation activities are not exhaustive but are intended to help guide Local Health Departments during an outbreak investigation. These outbreak investigation activities are listed in no particular order, and many of these activities may occur simultaneously or in a different order than they are listed.

Outbreak Investigation Protocol: *Initial Outbreak Investigation Activities*

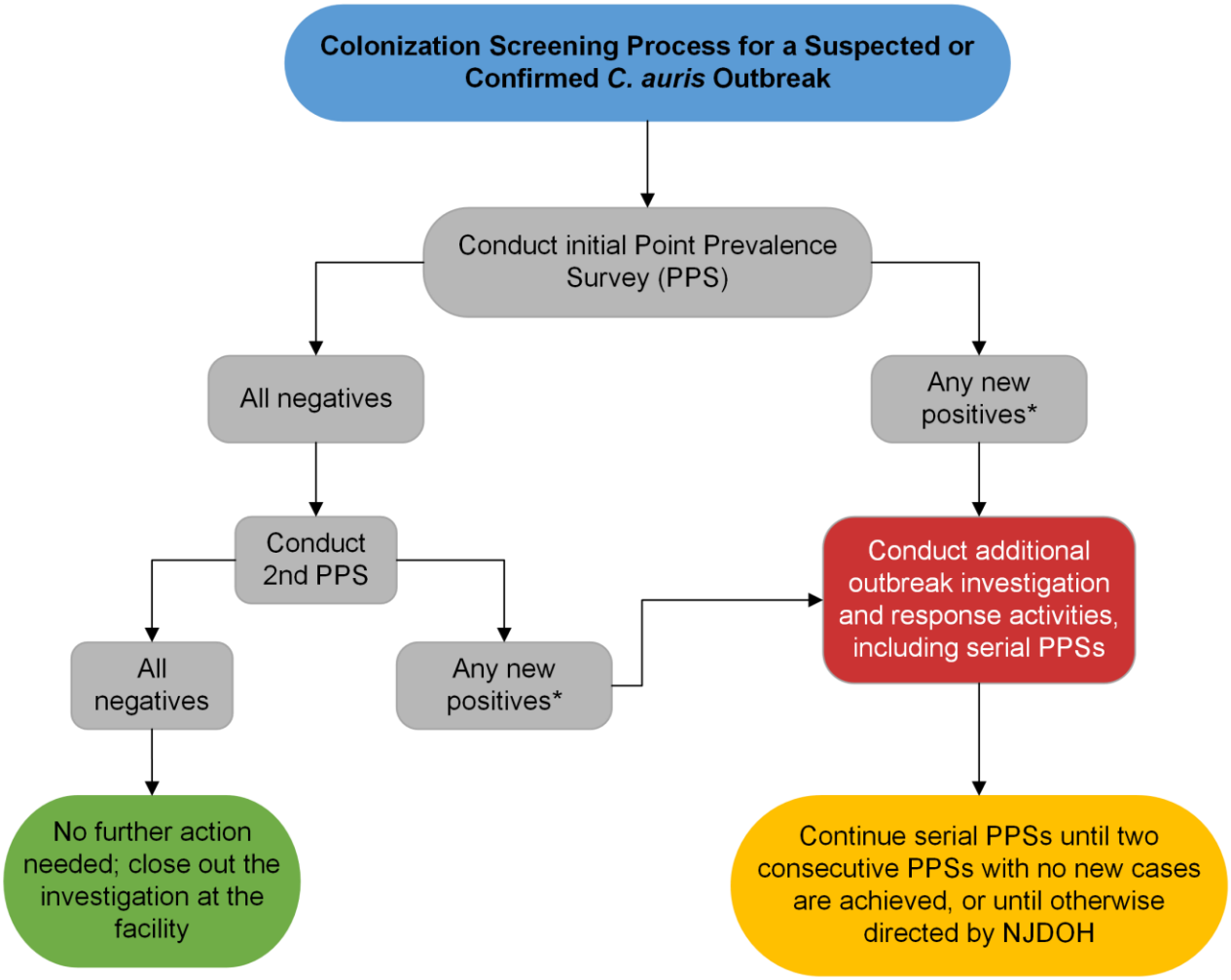
- **Epidemiologic Assessments:** The **LHD** will obtain digitally completed *C. auris* epidemiologic assessments for all cases associated with the healthcare facility. The LHD will securely provide copies of digitally completed *C. auris* epidemiologic assessments to **NJDOH** for review.
- **Confirmation of a Suspected Outbreak: NJDOH** will review *C. auris* epidemiologic assessments and determine if a *C. auris* outbreak is suspected.
- **E-number:** Upon confirmation of a suspected *C. auris* outbreak, **NJDOH** will generate a unique outbreak identification number, known as an e-number, using the Outbreak Module within the Communicable Disease Reporting and Surveillance System (CDRSS).
- **Coordinate Colonization Screenings: NJDOH** will coordinate and schedule a minimum of two point prevalence surveys (PPSs) at least one week apart at the affected healthcare facility based on statewide screening schedules and public health laboratory capacity. The **LHD** will provide colonization screening instructions to the facility and educate the facility on the PPS process in advance of the scheduled date for specimen collection. Results of the first two PPSs will determine whether additional outbreak investigation and response activities are warranted.
- **Establish Team:** Once the e-number is assigned, the **LHD with jurisdiction over the affected healthcare facility** will establish a *C. auris* Investigation Team, which may include the Health Officer, Disease Investigator, Public Health Nurse, and/or Registered Environmental Health Specialist. The Health Officer should designate a primary LHD Team Lead. **NJDOH** staff will be part of the *C. auris* Investigation Team to coordinate/approve all necessary colonization screenings and provide technical support and guidance.
- **Facility Notification:** The **LHD** will formally notify key healthcare facility leadership (e.g., facility owner, administrator, infection preventionist, director of nursing) that an outbreak investigation is being initiated. The notification is crucial for informing them about the public health investigation and outlining the necessary next steps. A template email for this communication can be found via the link provided below.

LHD Checklist

☐ Obtain completed *C. auris* epidemiologic assessments from the affected facility for all cases associated with the facility investigation	☐ Assign LHD staff member(s) to be part of the *C. auris* Investigation Team ☐ Send written notification to key healthcare facility leadership and points of contact

☐ Provide digitally completed *C. auris* epidemiologic assessments to NJDOH ☐ Link the outbreak identification number (e-number) to associated CDRSS cases	☐ Provide the facility with colonization screening instructions document ☐ Educate healthcare facility staff on the PPS process prior to the specimen collection date
Resources	
• *C. auris* Epidemiologic Assessment • Instructions for Digital Completion and Submission of the *C. auris* Epidemiologic Assessment • Template Letter to Notify a Healthcare Facility of a *C. auris* Outbreak Investigation • Facility Instructions for Conducting a *C. auris* PPS • *C. auris* Patient Screening Factsheet	

Protocol for Suspected or Confirmed Outbreaks in Inpatient Healthcare Settings



**All positive individuals identified during colonization screenings should have recent healthcare facility encounters, prior screening results and other epidemiologic factors reviewed by public health to determine likelihood of C. auris acquisition at another facility.*

Discontinuing Point Prevalence Surveys

At a minimum and as public health laboratory capacity allows, in order to discontinue serial PPSs, there should be two consecutive (i.e., back-to-back) PPSs conducted with:

- at least one week between PPSs, and
- no new cases identified during PPSs and clinical surveillance

If a facility achieves two consecutive PPSs without new cases, but new screening or clinical cases are identified at another healthcare facility and linked back to the facility and unit where serial PPSs are being conducted, this may be indicative of ongoing transmission. In such situations, NJDOH may recommend continuing PPSs. Discontinuation of serial PPSs may occur in tandem with, prior to or following the conclusion of the outbreak.

Outbreak Investigation Protocol: *Additional Outbreak Investigation & Response Activities*

- **Infection Control Assessment:** The **LHD** will ensure completion of the *C. auris* Infection Control Assessment tool. Depending on the situation, this standardized tool may be completed independently and submitted to the *C. auris* Investigation Team by the healthcare facility, completed during a conference call between the healthcare facility and the *C. auris* Investigation Team, or completed during the course of an outbreak site visit.
- **Outbreak Site Visit:** If **NJDOH** determines an outbreak site visit is warranted, the *C. auris* Investigation Team will conduct an on-site assessment of infection prevention and control practices at the outbreak facility. The **LHD** will coordinate with the *C. auris* Investigation Team (**LHD and NJDOH**) and the facility's staff to schedule an outbreak site visit, typically within 20 business days of issuing the e-number.
- **Infection Prevention and Control Recommendations:** Based on the findings of the infection control assessment and/or outbreak site visit, **NJDOH** will develop a written report outlining identified gaps and corresponding infection prevention and control recommendations. The **LHD** will provide the written report to the healthcare facility.
- **Continued Follow Up on IPC Gaps:** The **LHD** will support **NJDOH** in following up with the impacted healthcare facility to assess which IPC recommendations have been implemented and which IPC gaps remain unaddressed. Facility follow-up may be conducted remotely (e.g., by email, phone, video call) or on-site if/when feasible. Updates on infection prevention and control gaps and the implementation status of recommendations shall be documented in the site visit report template provided by **NJDOH**.
- **Ongoing Assessment of Transmission via Colonization Screenings: NJDOH**, in collaboration with the **LHD**, will schedule serial point prevalence surveys (PPSs) with the affected healthcare facility based on statewide screening schedules and public health laboratory capacity. The **LHD** will obtain and provide **NJDOH** with digitally completed *C. auris* epidemiologic assessments corresponding to additional new cases identified during subsequent PPSs.

LHD Checklist	
☐ Conduct the Infection Control Assessment	☐ Communicate timing of key care activities with *C. auris* Investigation Team to develop the outbreak site visit agenda

☐ Provide the completed *C. auris* Infection Control Assessment tool to NJDOH ☐ Receive written interim IPC recommendations from NJDOH (typically within 5 business days of completing the Infection Control Assessment) ☐ Provide the facility with interim IPC recommendations within 2 business days of receipt from NJDOH ☐ Link the outbreak identification number (e-number) to associated CDRSS cases newly identified through serial PPSs ☐ Schedule the outbreak site visit with the healthcare facility and the *C. auris* Investigation Team ☐ Prepare a summary of the outbreak and all associated cases for the outbreak site visit ☐ Coordinate timing of key care activity observations (e.g., wound care, respiratory therapy, blood glucose testing) with the healthcare facility	☐ Conduct the outbreak site visit ☐ Obtain any outstanding information or documents during the outbreak site visit ☐ Receive written outbreak site visit recommendations from NJDOH (typically within 20 business days of completing the outbreak site visit) ☐ Provide the facility with outbreak site visit recommendations within 2 business days of receipt from NJDOH ☐ Conduct recurring follow-up (e.g., every 2 weeks) with the healthcare facility to obtain updates on the implementation status of IPC recommendations ☐ Provide documentation of IPC recommendations implemented and remaining gaps to NJDOH ☐ Consult with NJDOH to determine when to conclude the outbreak investigation
Resources	
• NJDOH *C. auris* Outbreak Investigation Infection Control Assessment Tool • NJDOH audit tools (available on the Antimicrobial Resistance webpage) • Site Visit Agenda and Sign-in Sheet *(available upon request)*	

Conclusion of an Outbreak Investigation

Local public health officials will consult with NJDOH to determine when an outbreak is considered concluded on a case-by-case basis. Concluding *C. auris* outbreaks may be difficult due to the lack of a known incubation period for the organism. Considerations for determining an outbreak is concluded include:

1. No new screening cases of *C. auris* identified during a period of careful monitoring for new cases via colonization screening (i.e., two back-to-back PPSs with no new cases identified), and
2. No new clinical cases of *C. auris* identified during a period of careful monitoring for new cases

If an outbreak site visit was conducted, an updated progress report documenting interventions implemented and actions taken to resolve identified infection prevention and control gaps outlined in the site visit report must be received before an outbreak is considered concluded.

Public health authorities can extend the timeframe for colonization screening and enhanced clinical surveillance following an outbreak at any point if there is concern for ongoing transmission of *C. auris*.

IV. LABORATORY TESTING

Every case and outbreak investigation is unique and requires careful planning and risk assessment to determine the most appropriate response, with consideration given to personnel, resources, or other competing priorities. While access to *Candida (Candidozyma) auris (C. auris)* testing through clinical microbiology laboratories and reference laboratories is increasing, public health laboratory testing resources for *C. auris* remain limited and require coordination with and approval by NJDOH: DOH.CDS.HAIAR.EPI@doh.nj.gov.

Identification of *C. auris*

Identification of *C. auris* may occur when a clinical specimen is collected for the purpose of diagnosing or treating disease in the normal course of care. This includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of *C. auris* may simply represent colonization and not true infection. Swabs collected from a wound or draining ear as part of clinical care are considered clinical specimens. Clinical specimens most frequently have *C. auris* identified through culture-based methods, however molecular testing methods may also be utilized.

Identification of *C. auris* most often occurs when testing is being conducted for surveillance purposes. This involves collecting one or more swabs from individuals that do not have signs or symptoms of infection to detect *C. auris* colonization and implement setting-appropriate infection prevention and control measures. Typical screening specimen sites are skin (e.g., axilla, groin), nares, palms and fingertips, or other external body sites. Colonization screening, or surveillance testing, for *C. auris* is most frequently conducted using PCR-based testing methods, however culture-based testing methods may also be used.

Table 5: Overview of *C. auris* Specimen Sources, Case Types and Testing Methods

Test	Specimen Type(s)	Case Type	Notes
Culture	• Urine • Blood • Bone • Wound tissue • Cerebrospinal fluid • Abscess • Bronchial wash (e.g., BAL) • Lower respiratory secretions (e.g., sputum) • Lung tissue • Tracheal aspirate • Pleural fluid • Extrapulmonary site • Other body fluid	Clinical	• Slow (up to 14 days to grow) • Affected by topical antifungals and chlorhexidine gluconate (CHG) bathing • Typically requires chromogenic media • Less sensitive than PCR-based testing • Sensitivity highly dependent on technical skill
Culture	• Axilla swab • Groin swab • Nares swab • Axilla/Groin composite swab • Nares/Axilla/Groin tri-composite swab • Other skin swab	Screening	• Slow (up to 14 days to grow) • Affected by topical antifungals and chlorhexidine gluconate (CHG) bathing • Typically requires chromogenic media • Less sensitive than PCR-based testing • Sensitivity highly dependent on technical skill
PCR or Other NAAT	• Axilla swab • Groin swab • Nares swab • Axilla/Groin composite swab • Nares/Axilla/Groin tri-composite swab	Screening	• Rapid • Affected by topical antifungals and chlorhexidine gluconate (CHG) bathing • Currently only available for screening specimens • Highly sensitive • Only able to detect *C. auris*

Testing Methodologies

PCR Testing

Real-time polymerase chain reaction (PCR), a type of nucleic acid amplification test (NAAT), is the preferred method for laboratory detection of *C. auris* colonization. While there are currently no FDA-approved high throughput tests for colonization swabs, various PCR-based methods for detecting *C. auris* have been described in the scientific literature. Several commercial and clinical microbiology labs (e.g., Mayo Clinic, Quest Diagnostics) have validated their own laboratory-developed tests that utilize PCR-based methods to detect the presence of *C. auris*. For more information on the CDC *C. auris* PCR protocol, please visit the CDC's website at: https://www.cdc.gov/candida-auris/hcp/laboratories/real-time-pcr-identification.html

For the detection of *C. auris* colonization using PCR methods, NJDOH currently recommends collecting screening specimens from the nares, axilla and groin of patients (i.e., one swab is used for both nares, both axilla, and both sides of the groin). When tested using PCR-based methods, this tri-composite swab has an estimated test sensitivity of approximately 79.7% compared to a test sensitivity of only 61.9% when just the axilla and groin sites are swabbed (Proctor, D.M., Dangana, T., Sexton, D.J. *et al.* Integrated genomic, epidemiologic investigation of *Candida auris* skin colonization in a skilled nursing facility. *Nat Med* **27**, 1401–1409 (2021). https://doi.org/10.1038/s41591-021-01383-w).

Special Considerations

PCR methods may yield inconclusive test results for several reasons relating to specimen collection, specimen quality, handling or storage of the specimen, or positivity thresholds established for the testing platform. When PCR results are inconclusive, testing should be repeated if/when possible, which may require a new specimen to be collected. Inconclusive results should be considered negative unless the patient has previously tested positive for *C. auris* or tests positive for *C. auris* through retesting.

Fungal Culture

For the detection of *C. auris* during routine fungal culture, NJDOH and CDC recommend that all yeast obtained from sterile sites (e.g., bloodstream, cerebrospinal fluid) be identified to the species level. Identification of yeast and/or *Candida* in non-sterile body sites should be also strongly considered. At a minimum, facilities should consider germ tube testing when yeast is isolated from non-sterile sites to differentiate *Candida albicans* from other *Candida* species as a first step to determine the need for speciation. If germ tube testing is negative, further speciation is indicated. Unlike bacterial species, fungi like *C. auris* take longer to grow, and as such, it is critical that laboratories allow sufficient time before finalizing fungal cultures to reduce the likelihood of false negative results. For example, Wadsworth Center Mycology Laboratory utilizes a minimum incubation period of 14 days in the laboratory when utilizing fungal cultures to identify *C. auris*.

The preferred diagnostic devices to test for *C. auris* utilize matrix-assisted laser desorption/ionization time-of-flight (MALDI-TOF) because it can differentiate *C. auris* from other *Candida* species. However, not all the reference databases included in MALDI-TOF devices allow for accurate detection of *C. auris*.

- For more information regarding when to suspect *C. auris* based on identification methods, please visit the CDC's detailed algorithms available at: https://www.cdc.gov/candida-auris/media/pdfs/Testing-algorithm_by-Method_508_1.pdf

- For more information regarding diagnostic tests, please visit the CDC's website at: https://www.cdc.gov/candida-auris/hcp/laboratories/identification-of-c-auris.html

Testing Resources Available Through Public Health Laboratories

Clinical Isolate Testing

When *C. auris* is isolated by a clinical laboratory or reference laboratory, NJDOH coordinates confirmatory testing of isolates through CDC's Antimicrobial Resistance Laboratory Network (ARLN). The regional ARLN laboratory for New Jersey is Wadsworth Center, located within New York State Department of Health in Albany, New York. Testing using these public health resources are coordinated with NJDOH. *C. auris* isolates submitted for further testing undergo fungal species identification; clinical isolates submitted also undergo antifungal susceptibility testing. Instructions for the process of submitting isolates for *C. auris* testing can be located on NJDOH's Public Health and Environmental Laboratory Webpage.

Colonization Testing

Currently, all testing for *C. auris* colonization (i.e., colonization screening) for case investigations and outbreak response is coordinated through NJDOH and done at Wadsworth Center. NJDOH coordinates between Wadsworth and all facilities conducting *C. auris* colonization screenings to ensure the daily/weekly limit is not exceeded. Colonization testing performed at Wadsworth Center includes *C. auris* PCR-based testing, followed by culture-based testing for specimens indeterminate by PCR. Wadsworth Center is validated to test screening specimens collected from the following sources/body sites:

- Nares/Axilla/Groin tri-composite swab (preferred)
- Axilla/Groin composite swab
- Nares swab
- Axilla swab
- Groin swab

Healthcare facilities (e.g., acute care hospitals) that have access to PCR-based *C. auris* colonization screening through their own laboratories may opt to conduct recommended screenings using their laboratories. During times when public health capacity for *C. auris* colonization screening is limited, facilities with their own access to PCR-based *C. auris* colonization screening may be asked to conduct recommended testing internally. In such instances, NJDOH requires the facility to provide a line list of the patients screened (i.e., patient names, dates of birth, sex, date of specimen collection, specimen source) and copies of the corresponding test results for entry into NJDOH's internal tracking system for *C. auris* PPSs.

V. APPENDIX

The following section provides communication resources, investigation checklists, and educational materials to help guide Local Health Departments and healthcare facilities during *Candida auris* case investigations and outbreak responses. The most current version of these resources are available at https://www.nj.gov/health/cd/topics/cauris.shtml.

Case Patient Investigation Checklist Tool for a Single Case of Candida (Candidozyma) auris (C. auris)

Case Patient Investigation Component	Completion Status	Collected Information and/or Notes
1. Search the patient information within CDRSS to check for any prior *C. auris* case record(s) associated with the person. Enter the case into CDRSS if the case has not yet been created.	☐ Pending ☐ Completed	CDRSS Case ID: _____ CDRSS Person ID: _____ Prior CDRSS *C. auris* Case ID(s): _____
2. Review specimen source information to determine and assign case subtype in CDRSS. a. Enter the positive specimen source(s)/body site(s) in the Test Result Data text field.	☐ Pending ☐ Completed	Specimen source: _____ Case subtype: ☐ Screening case ☐ Clinical case
3. Confirm that the case meets confirmatory laboratory criteria. a. Review any prior positive laboratory results for the patient and determine if a new case needs to be created. b. If the patient was previously identified as a screening case and is now newly identified as a clinical case, move the new positive lab result into a new case record and categorize the case as “clinical”.	☐ Pending ☐ Completed	Confirmatory laboratory criteria met: ☐ Yes ☐ No Any prior positive laboratory results? ☐ Yes ☐ No New case needs to be created in CDRSS? ☐ Yes ☐ No ☐ Unknown
4. Determine the case status and update within CDRSS.	☐ Pending ☐ Completed	☐ Confirmed ☐ Not a Case
5. Review the Laboratory and Diagnostic Test Information and Medical Facility and Provider Information sections of CDRSS to determine where the positive specimen was collected; contact the ordering facility or testing laboratory to confirm.	☐ Pending ☐ Completed	Facility of Specimen Collection: _____ _____ Facility Address: _____ _____
6. Contact the identifying facility to determine the case patient’s current location and identify all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. More than one healthcare facility associated with the case patient may need to be contacted in order to identify all healthcare facilities where the patient received care in the 30 days prior to positive specimen collection.	☐ Pending ☐ Completed	Current Location of Case Patient: _____ _____ Other Involved Facilities: _____ _____ _____ _____ _____ _____ _____

Case Patient Investigation Component	Completion Status	Collected Information and/or Notes
a. **If the identifying healthcare facility is out of your jurisdiction**, let the facility know that someone from their local health department will be contacting them to collect additional information on the case patient and provide infection prevention and control recommendations. b. **If the patient is no longer at the identifying facility**, identify any healthcare facilities where the patient was subsequently transferred. c. **If the patient was admitted from or discharged to an out-of-state facility**, contact NJDOH at DOH.CDS.HAIAR.EPI@doh.nj.gov to provide case patient and out-of-state facility information. d. **If the patient is a resident of NJ but was identified to have *C. auris* at an out-of-state facility**, no further investigation is needed unless the patient received healthcare at a facility in NJ in the 30 days prior to first positive specimen collection or subsequently received healthcare at a facility in NJ.	☐ N/A ☐ Pending ☐ Completed ☐ N/A ☐ Pending ☐ Completed ☐ N/A ☐ Pending ☐ Completed ☐ N/A ☐ Pending ☐ Completed	_____ _____
7. Collect the remaining required data elements and enter the information into the appropriate sections within CDRSS. a. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.	☐ Pending ☐ Completed	Has the patient died? ☐ Yes ☐ No ☐ Unknown Date of death: _____ Has the patient been seen at any outpatient healthcare facilities in the 30 days prior to positive specimen collection? ☐ Yes ☐ No ☐ Unknown Other Involved Facilities and Visit Dates: _____ _____ _____ _____ _____ _____
8. Add or update investigation addresses associated with the case patient within CDRSS.	☐ Pending ☐ Completed	Healthcare Facility #1: _____ _____ Address: _____ _____

Case Patient Investigation Component	Completion Status	Collected Information and/or Notes
a. Include the names and addresses of all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. b. Include the names and addresses of healthcare facilities where the case patient received care between the date of positive specimen collection and date of positive result receipt/notification (i.e., between positive specimen collection and implementation of appropriate Transmission-Based Precautions). This includes the identifying healthcare facility and any healthcare facilities where a patient was transferred before positive results were received and appropriate Transmission-Based Precautions were implemented.		Healthcare Facility #2: _____ _____ Address: _____ _____ Healthcare Facility #3: _____ _____ Address: _____ _____ Healthcare Facility #4: _____ _____ Address: _____ _____ Healthcare Facility #5: _____ _____ Address: _____ _____
9. Notify the local health departments with jurisdiction over each healthcare facility where the case patient received care in the 30 days prior to positive specimen collection and each healthcare facility where the case patient received care between positive specimen collection and receipt/notification of positive results. a. Provide each impacted LHD with the CDRSS case ID and the name(s) of the healthcare facilities in their jurisdictions that require follow up.	☐ Pending ☐ Completed	Healthcare Facility #1: _____ _____ Corresponding LHD: _____ _____ Healthcare Facility #2: _____ _____ Corresponding LHD: _____ _____ Healthcare Facility #3: _____ _____ Corresponding LHD: _____ _____ Healthcare Facility #4: _____ _____ Corresponding LHD: _____ _____ Healthcare Facility #5: _____ _____ Corresponding LHD: _____ _____
10. Request that any positive clinical isolates are submitted by the testing laboratory, when indicated. a. Navigate to the Laboratory and Diagnostic Test Information section in CDRSS and determine if the same clinical source is	☐ Pending ☐ Completed	Is submission of a clinical isolate corresponding to this patient indicated? ☐ Yes ☐ No ☐ Unknown

Case Patient Investigation Component	Completion Status	Collected Information and/or Notes
documented to have previously undergone testing conducted by "NEW YORK STATE LAB – WADSWORTH, NY". b. If there is no record of that same clinical site/source being tested at "NEW YORK STATE LAB – WADSWORTH, NY", instruct the testing laboratory to submit the clinical isolate for further testing.		
11. Keep the *C. auris* case report status as "LHD OPEN" within CDRSS until the case investigation has been completed, all required data elements have been entered into the CDRSS case record, and all healthcare facility exposure investigations associated with the case have been completed. a. Change the case report status to "LHD CLOSED" when the Facility Exposure Investigation Status and Updates section indicates all required information has been received and all facility exposure investigations associated with the case have been completed.	☐ Pending ☐ Completed	

Healthcare Facility Exposure Investigation Checklist Tool for a Single Case of *Candida (Candidozyma) auris (C. auris)*

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
1. Contact the healthcare facility and confirm the exact dates the case patient was present within the facility.	☐ Pending ☐ Completed	Healthcare Facility Name: _____ _____ Date of Presentation: _____ Date of Admission (if applicable): _____ Date of Discharge/Transfer: _____
2. Notify the facility about the patient's positive *C. auris* test result.	☐ Pending ☐ Completed	Date Facility Notified of Positive Result: _____
3. Provide the healthcare facility with setting-appropriate infection prevention and control recommendations for *C. auris*.	☐ Pending ☐ Completed	☐ Recommendations provided verbally ☐ Recommendations provided in writing
4. Determine whether the case patient was on appropriate Transmission-Based Precautions (TBP) for any or all of their admission. a. Document the type of TBP implemented for the case patient and the specific dates TBP was in-place, as well as dates that TBP were not in-place	☐ Pending ☐ Completed	TBP implemented: ☐ Contact Precautions ☐ Enhanced Barrier Precautions ☐ Droplet Precautions ☐ Airborne Precautions Date TBP Implemented: _____ Date TBP Discontinued: _____ Date(s) TBP Not In-Place: _____ _____
5. Determine the type(s) of unit(s) the patient was admitted to and the corresponding dates for each unit admission (e.g., ICU, vent unit, memory care unit). a. Document the unit types, room numbers and corresponding dates of admission to each room and unit.	☐ Pending ☐ Completed	Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
		Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____ Unit: _____ Room #: _____ Admit Date:_____ Discharge Date:_____
6. Determine if the case patient had any roommates. a. Within CDRSS, document the prior and current roommates as contacts of the case under the Contact Tracing section. Document the roommates' names and dates of birth at a minimum. If available, document the dates they shared a room and their current location within the comments of the Contact Tracing section. b. Prior and current roommates that are still within the facility should be prioritized for colonization screening	☐ Pending ☐ Completed	Roommate #1: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ Roommate #2: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ Roommate #3:

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
if they do not have a history of *C. auris*.		Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ <u>Roommate #4</u>: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ <u>Roommate #5</u>: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____ <u>Roommate #6</u>: Name: _____ _____ DOB: _____ Dates of Overlap:_____ Current Location:_____ _____
7. Determine when and where the patient was admitted from and if there are any other known healthcare facility admissions or overnight stays in the 30 days prior to positive specimen collection. a. Confirm all other healthcare facility addresses are listed as investigation addresses linked to the case within CDRSS. b. If new facilities of admission are identified, add them as investigation addresses linked to the case within CDRSS and notify the LHD with jurisdiction over the healthcare facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ N/A	Facility/Location Prior to Admission: _____ _____ Other Known Healthcare Facility Admissions & Dates: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
8. Collect the remaining disease specific questionnaire (DSQ), risk factor and clinical status information from the facility and enter the information into the appropriate sections within CDRSS. a. Refer to the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.	☐ Pending ☐ Completed	In the 30 days leading up to positive specimen collection, did the case patient receive any of the following healthcare services? ☐ Chemotherapy ☐ Imaging ☐ Ultrasound ☐ Inpatient dialysis ☐ Outpatient dialysis ☐ Wound care ☐ Physical therapy or rehabilitation ☐ Respiratory therapy ☐ None ☐ Other:_____ In the 30 days leading up to positive specimen collection, did the case patient have any of the following indwelling medical devices? ☐ Mechanical ventilation ☐ Tracheostomy ☐ Urinary catheter ☐ Abdominal feeding tube ☐ Central venous catheter ☐ Other intravenous line (e.g., midline) ☐ Hemodialysis catheter ☐ Intraabdominal drain/catheter ☐ Nephrostomy ☐ Surgical drain ☐ None ☐ Other:_____ Is the patient diabetic? ☐ Yes ☐ No ☐ Unknown Does the case patient have a history of colonization or infection with another MDRO? ☐ Yes ☐ No ☐ Unknown In the 30 days leading up to positive specimen collection, did the case patient have any of the following: ☐ Chronic wounds ☐ Immunocompromising condition ☐ Non-ambulatory status In the 6 months leading up to positive specimen collection, did the case patient have any of the following: ☐ An organ or tissue transplant

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
		☐ An overnight stay at a healthcare facility in another state ☐ An overnight stay at a healthcare facility in another country Pre-existing conditions: ☐ Chronic lung disease ☐ Diabetes mellitus ☐ Cardiovascular disease ☐ Chronic renal disease ☐ Chronic liver disease ☐ Immunocompromised condition ☐ Neurologic/Neurodevelopmental/ Intellectual disability ☐ Other chronic diseases ☐ Cancer ☐ Obesity ☐ Congenital heart disease ☐ None Has the patient died? ☐ Yes ☐ No ☐ Unknown Date of death: _____
9. Determine if there were any other known *C. auris* case patients within the facility during/around the same time as the new case and assess potential epidemiologic links. a. Enter the collected information into the DSQ in CDRSS.	☐ Pending ☐ Completed ☐ Pending ☐ Completed	Were there any other known *C. auris* case patients admitted during the same time as the new *C. auris* case patient? ☐ Yes ☐ No ☐ Unknown If yes, does the new case have any of the following epi-links to any known cases? ☐ Common unit ☐ Shared staff ☐ Shared equipment/devices ☐ Other:_____ ☐ None
10. Determine if the case patient utilized any shared or reusable medical equipment and devices (e.g., vitals machines, glucometers, stethoscopes, lifts, imaging machines).	☐ Pending ☐ Completed	☐ No shared/reusable equipment or devices ☐ Any shared/reusable equipment or devices
11. Identify the specific disinfectant products and corresponding EPA registration numbers utilized for reusable equipment and devices (e.g., nursing carts, vitals machines, PT equipment). a. Document the disinfectant products utilized for patient care equipment	☐ Pending ☐ Completed	Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
and devices and their EPA registration numbers.		Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____
12. Identify the specific disinfectant products and corresponding EPA registration numbers utilized by the facility's environmental services (EVS) or housekeeping (HK) staff for environmental cleaning. a. Document the disinfectant products utilized for environmental cleaning (i.e., room and patient care environment cleaning) and their EPA registration numbers.	☐ Pending ☐ Completed	Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____ Product Name: _____ Product Manufacturer: _____ EPA Registration Number: _____
13. Determine whether the disinfectant products utilized for environmental disinfection and equipment/device disinfection are on EPA List P or EPA List K. a. Search for products' EPA registration numbers on EPA List P and EPA List K.	☐ Pending ☐ Completed	EVS/HK Disinfectants: ☐ On List P ☐ On List K ☐ Not on List P or List K Equipment/Device Disinfectants: ☐ On List P ☐ On List K ☐ Not on List P or List K
14. Contact NJDOH and provide documentation of all information collected during each healthcare facility exposure investigation to determine if	☐ Pending ☐ Completed	Date Information Provided to NJDOH: _____

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
colonization screening is indicated. NJDOH will assist in coordinating any necessary colonization screening at impacted healthcare facilities. a. If NJDOH recommends colonization screening, proceed to step 15 or 16, depending on the situation. Otherwise, proceed to step 17.		
15. If/when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the public health laboratory: a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH, the facility's shipping address and contact information (i.e., name, phone number, email) for the primary point(s) of contact at the healthcare facility; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations, including potential dates when colonization screening can be supported by the public health laboratory as determined by NJDOH. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility. d. Provide the healthcare facility with NJDOH's colonization screening instructions document and the line list template. Review colonization screening process and instructions with the healthcare facility prior to the date of scheduled specimen collection. e. Ensure the healthcare facility follows instructions for conducting *C. auris* colonization screening. f. Upon receipt of test results, refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed	Unit Floorplans Obtained: _____ _____ _____ _____ Unit 1: _____ Unit 1 Bed Count: _____ Unit 2: _____ Unit 2 Bed Count: _____ Unit 3: _____ Unit 3 Bed Count: _____ Unit 4: _____ Unit 4 Bed Count: _____ Unit(s)/Room(s) Being Screened: _____ _____ Scheduled Date for Testing: _____ Testing Laboratory: _____ # of Patients Screened: _____ # of New Positive Results:_____ Next Steps: ☐ Conclude facility investigation ☐ Proceed to initial outbreak investigation activities

Healthcare Facility Exposure Investigation Component	Completion Status	Collected Information and/or Notes
16. If/when NJDOH recommends colonization screening at the healthcare facility and testing is being conducted by the facility's laboratory: a. Obtain the unit bed count(s), a copy of the facility or unit floorplan(s) if requested by NJDOH; provide this information to NJDOH as soon as possible. b. Provide the healthcare facility with NJDOH's colonization screening recommendations and determine when the facility will conduct colonization screening. c. Confirm with NJDOH the date that colonization screening specimens will be collected at the healthcare facility and the laboratory that will be conducting testing. d. Obtain a line listing of patients/residents included in the colonization screening from the healthcare facility that includes patient last name, patient first name, patient date of birth, patient sex, specimen collection date and specimen source; provide to NJDOH upon receipt. e. Request copies of all colonization screening test results be provided by the healthcare facility as soon as results are finalized; provide to NJDOH upon receipt. f. Refer to the NJDOH *C. auris* Colonization Screening Algorithm for a Single Case Investigation to determine appropriate next steps for the facility.	☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed ☐ Pending ☐ Completed	Unit Floorplans Obtained: _____ _____ _____ _____ Unit 1: _____ Unit 1 Bed Count: _____ Unit 2: _____ Unit 2 Bed Count: _____ Unit 3: _____ Unit 3 Bed Count: _____ Unit 4: _____ Unit 4 Bed Count: _____ Unit(s)/Room(s) Being Screened: _____ _____ _____ Scheduled Date for Testing: _____ Testing Laboratory: _____ # of Patients Screened: _____ # of New Positive Results:_____ Next Steps: ☐ Conclude facility investigation ☐ Proceed to initial outbreak investigation activities
17. Complete the Facility Exposure Investigation Status and Updates section within CDRSS; enter the required information for each healthcare facility exposure investigation conducted. a. Refer to the disease chapter or the CDRSS Data Field Completion Guide for *C. auris* for detailed instructions on data entry and completion of the required fields.	☐ Pending ☐ Completed	

Candida (*Candidozyma*) *auris* (*C. auris*) Outbreak Investigation Protocol for a Single Facility

I. Outbreak Investigation Protocol: *Initial Outbreak Investigation Activities*

- **Epidemiologic Assessments:** The **LHD** will obtain digitally completed *C. auris* epidemiologic assessments for all cases associated with the healthcare facility. The LHD will securely provide copies of digitally completed *C. auris* epidemiologic assessments to **NJDOH** for review.
- **Confirmation of a Suspected Outbreak: NJDOH** will review *C. auris* epidemiologic assessments and determine if a *C. auris* outbreak is suspected.
- **E-number:** Upon confirmation of a suspected *C. auris* outbreak, **NJDOH** will generate a unique outbreak identification number, known as an e-number, using the Outbreak Module within the Communicable Disease Reporting and Surveillance System (CDRSS).
- **Coordinate Colonization Screenings: NJDOH** will coordinate and schedule a minimum of two point prevalence surveys (PPSs) at least one week apart at the affected healthcare facility based on statewide screening schedules and public health laboratory capacity. The **LHD** will provide colonization screening instructions to the facility and educate the facility on the PPS process in advance of the scheduled date for specimen collection. Results of the first two PPSs will determine whether additional outbreak investigation and response activities are warranted.
- **Establish Team:** Once the e-number is assigned, the **LHD with jurisdiction over the affected healthcare facility** will establish a *C. auris* Investigation Team, which may include the Health Officer, Disease Investigator, Public Health Nurse, and/or Registered Environmental Health Specialist. The Health Officer should designate a primary LHD Team Lead. **NJDOH** staff will be part of the *C. auris* Investigation Team to coordinate/approve all necessary colonization screenings and provide technical support and guidance.
- **Facility Notification:** The **LHD** will formally notify key healthcare facility leadership (e.g., facility owner, administrator, infection preventionist, director of nursing) that an outbreak investigation is being initiated. The notification is crucial for informing them about the public health investigation and outlining the necessary next steps. A template email for this communication can be found via the link provided below.

LHD Checklist

☐ Obtain completed *C. auris* epidemiologic assessments from the affected facility for all cases associated with the facility investigation ☐ Provide digitally completed *C. auris* epidemiologic assessments to NJDOH ☐ Link the outbreak identification number (e-number) to associated CDRSS cases	☐ Assign LHD staff member(s) to be part of the *C. auris* Investigation Team ☐ Send written notification to key healthcare facility leadership and points of contact ☐ Provide the facility with colonization screening instructions document ☐ Educate healthcare facility staff on the PPS process prior to the specimen collection date

Resources

- *C. auris* Epidemiologic Assessment
- Instructions for Digital Completion and Submission of the *C. auris* Epidemiologic Assessment
- Template Letter to Notify a Healthcare Facility of a *C. auris* Outbreak Investigation
- Facility Instructions for Conducting a *C. auris* PPS
- *C. auris* Patient Screening Factsheet

II. Outbreak Investigation Protocol: *Additional Outbreak Investigation & Response Activities*

- **Infection Control Assessment:** The **LHD** will ensure completion of the *C. auris* Infection Control Assessment tool. Depending on the situation, this standardized tool may be completed independently and submitted to the *C. auris* Investigation Team by the healthcare facility, completed during a conference call between the healthcare facility and the *C. auris* Investigation Team, or completed during the course of an outbreak site visit.
- **Outbreak Site Visit:** If **NJDOH** determines an outbreak site visit is warranted, the *C. auris* Investigation Team will conduct an on-site assessment of infection prevention and control practices at the outbreak facility. The **LHD** will coordinate with the *C. auris* Investigation Team (**LHD and NJDOH**) and the facility's staff to schedule an outbreak site visit, typically within 20 business days of issuing the e-number.
- **Infection Prevention and Control Recommendations:** Based on the findings of the infection control assessment and/or outbreak site visit, **NJDOH** will develop a written report outlining identified gaps and corresponding infection prevention and control recommendations. The **LHD** will provide the written report to the healthcare facility.
- **Continued Follow Up on IPC Gaps:** The **LHD** will support **NJDOH** in following up with the impacted healthcare facility to assess which IPC recommendations have been implemented and which IPC gaps remain unaddressed. Facility follow-up may be conducted remotely (e.g., by email, phone, video call) or on-site if/when feasible. Updates on infection prevention and control gaps and the implementation status of recommendations shall be documented in the site visit report template provided by **NJDOH**.
- **Ongoing Assessment of Transmission via Colonization Screenings: NJDOH**, in collaboration with the **LHD**, will schedule serial point prevalence surveys (PPSs) with the affected healthcare facility based on statewide screening schedules and public health laboratory capacity. The **LHD** will obtain and provide **NJDOH** with digitally completed *C. auris* epidemiologic assessments corresponding to additional new cases identified during subsequent PPSs.

LHD Checklist

☐ Conduct the Infection Control Assessment ☐ Provide the completed *C. auris* Infection Control Assessment tool to NJDOH	☐ Communicate timing of key care activities with *C. auris* Investigation Team to develop the outbreak site visit agenda ☐ Conduct the outbreak site visit

☐ Receive written interim IPC recommendations from NJDOH (typically within 5 business days of completing the Infection Control Assessment) ☐ Provide the facility with interim IPC recommendations within 2 business days of receipt from NJDOH ☐ Link the outbreak identification number (e-number) to associated CDRSS cases newly identified through serial PPSs ☐ Schedule the outbreak site visit with the healthcare facility and the *C. auris* Investigation Team ☐ Prepare a summary of the outbreak and all associated cases for the outbreak site visit ☐ Coordinate timing of key care activity observations (e.g., wound care, respiratory therapy, blood glucose testing) with the healthcare facility	☐ Obtain any outstanding information or documents during the outbreak site visit ☐ Receive written outbreak site visit recommendations from NJDOH (typically within 20 business days of completing the outbreak site visit) ☐ Provide the facility with outbreak site visit recommendations within 2 business days of receipt from NJDOH ☐ Conduct recurring follow-up (e.g., every 2 weeks) with the healthcare facility to obtain updates on the implementation status of IPC recommendations ☐ Provide documentation of IPC recommendations implemented and remaining gaps to NJDOH ☐ Consult with NJDOH to determine when to conclude the outbreak investigation
Resources	
• NJDOH *C. auris* Outbreak Investigation Infection Control Assessment Tool • NJDOH audit tools (available on the Antimicrobial Resistance webpage) • Site Visit Agenda and Sign-in Sheet *(available upon request)*	

Candida (Candidozyma) auris Infection Prevention & Control Recommendations for Acute Care Settings

The following infection prevention and control recommendations should be provided to acute care settings (e.g., short term acute care hospitals, long-term acute care hospitals, specialty hospitals, comprehensive rehabilitation hospitals) upon identification of a confirmed *Candida (Candidozyma) auris* (*C. auris*) case. Recommendations are the same regardless of case subtype (i.e., clinical case vs. screening case).

Case Patient Still Admitted to the Facility

1. Transmission-Based Precautions
    a. Immediately place the patient on Contact Precautions.
    b. Contact Precautions should be maintained for the entire duration of the case patient's admission and all future admissions to acute care settings.
2. Room placement
    a. Place the patient in a private room.
    b. If there are other patients with *C. auris* admitted to the facility, patients with *C. auris* can be placed in a shared room.
3. Cleaning and disinfectant product(s) use
    a. Ensure daily and terminal environmental cleaning and disinfection is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Perform thorough daily and terminal cleaning and disinfection of the patient's room(s) and other areas where they receive care (e.g., physical therapy, radiology).
        ii. Track the patient's prior room assignments and ensure thorough cleaning and disinfection with an effective product occurs in those rooms and in common areas of the unit.
    b. Ensure routine cleaning and disinfection of patient care equipment, devices, supply carts and workstations on wheels is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Reinforce cleaning and disinfection of mobile equipment and devices that are shared between patients (e.g., glucometers, temperature probes, blood pressure cuffs, ultrasound machines, nursing carts, wound scissors, physical therapy equipment) after each and every use.
    c. Review and re-educate staff on the appropriate contact time and dilution instructions (if applicable).
4. Equipment provision and storage of supplies
    a. Provide the patient with as much dedicated and/or disposable equipment as possible.
    b. Store dedicated wound care supplies in the patient's room if/when possible. Dispose of any unused wound care supplies dedicated to this patient after the conclusion of their stay at your facility.
5. Minimizing foot traffic
    a. To the extent possible, have staff entering multiple rooms ('rounding') enter the room of the *C. auris*+ patient last.
6. Hand hygiene
    a. Increase emphasis on hand hygiene. Alcohol-based hand sanitizer (ABHS) is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled.

b. Increase hand hygiene audits on units where patients with *C. auris* are placed. Consider re-educating healthcare personnel on hand hygiene through an in-service or retraining, especially if audits demonstrate low adherence to recommended hand hygiene practices.

7. Communication
    a. When transferring a patient with *C. auris* to another service/department/unit within the same facility, notify the receiving service/department/unit of the patient's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    b. When transferring a patient with *C. auris* to another healthcare facility, notify the receiving facility of the patient's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    c. Flag the patient's medical record to alert healthcare personnel of the patient's *C. auris* status/history and to implement recommended infection control measures in case of readmission.

Case Patient No Longer Admitted to the Facility

1. Flag the patient's medical record to alert healthcare personnel of the patient's *C. auris* status/history and to instruct providers to implement Contact Precautions immediately upon readmission.
2. Track the patient's prior room assignments and ensure thorough cleaning and disinfection occurs in those rooms and in other areas where the case patient received care (e.g., radiology, operating room, endoscopy) utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
3. Perform thorough cleaning and disinfection of shared equipment and devices on units where the case patient was previously admitted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.

Candida (Candidozyma) auris Infection Prevention & Control Recommendations for Nursing Homes

The following infection prevention and control recommendations should be provided to nursing homes upon identification of a confirmed *Candida (Candidozyma) auris* (*C. auris*) case. Recommendations are the same regardless of case subtype (i.e., clinical case vs. screening case).

Case Patient Still Admitted to the Facility

1. Transmission-Based Precautions
    a. Immediately place the patient on Enhanced Barrier Precautions or Contact Precautions (if indicated).
    b. Contact Precautions should be utilized for residents with *C. auris* if there are excretions or secretions that cannot be contained, or there is another diagnosis/condition (e.g., scabies) that requires the use of Contact Precautions.
    c. Enhanced Barrier Precautions should be utilized for residents with *C. auris* colonization or infection that do not otherwise require Contact Precautions.
2. Room placement
    a. If there are other residents with *C. auris* admitted to the facility, residents with *C. auris* can be placed in a shared room.
    b. Private rooms are NOT required for residents on Enhanced Barrier Precautions due to current or prior history of *C. auris*.
    c. Within long-term care facilities, private rooms should be prioritized for residents with acute infection with a communicable disease (e.g., influenza, COVID-19, hepatitis A) and residents that require Contact Precautions.
    d. If private rooms are not readily available and the case patient cannot be placed in a shared room with another resident that has current or prior history of *C. auris*, place the resident in a shared room with otherwise healthy residents that have few or no risk factors for MDRO acquisition (e.g., tracheostomy tubes, mechanical ventilators, central lines, central venous catheters, open wounds).
    e. Where possible, avoid placing residents with *C. auris* in the same room as residents without *C. auris* that have indwelling or invasive devices (e.g., tracheostomy tubes, mechanical ventilators, central lines, central venous catheters), open wounds, or immunocompromising conditions.
3. Cleaning and disinfectant product(s) use
    a. Ensure daily and terminal environmental cleaning and disinfection is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Perform thorough daily and terminal cleaning and disinfection of the resident's room(s) and other areas where they receive care (e.g., physical therapy, radiology).
        ii. Track the resident's prior room assignments and ensure thorough cleaning and disinfection with an effective product occurs in those rooms and in common areas of the unit.
    b. Ensure routine cleaning and disinfection of patient care equipment, devices, supply carts and workstations on wheels is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Reinforce cleaning and disinfection of mobile equipment and devices that are shared between patients (e.g., glucometers, temperature probes, blood pressure cuffs, ultrasound machines, nursing carts, wound scissors, physical therapy

equipment) after each and every use.
    c. Review and re-educate staff on the appropriate contact time and dilution instructions (if applicable).
4. Equipment provision and storage of supplies
    a. Provide the resident with as much dedicated and/or disposable equipment as possible.
    b. Store dedicated wound care supplies in the resident's room if/when possible. Dispose of any unused wound care supplies dedicated to this resident after the conclusion of their stay at your facility.
5. Minimizing foot traffic
    a. To the extent possible, have staff entering multiple rooms ('rounding') enter the room of the *C. auris*+ resident last.
6. Hand hygiene
    a. Increase emphasis on hand hygiene. Alcohol-based hand sanitizer (ABHS) is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled.
    b. Increase hand hygiene audits on units where residents with *C. auris* are placed. Consider re-educating healthcare personnel on hand hygiene through an in-service or retraining, especially if audits demonstrate low adherence to recommended hand hygiene practices.
7. Communication
    a. When transferring a resident with *C. auris* to another service/department/unit within the same facility, notify the receiving service/department/unit of the resident's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    b. When transferring a resident with *C. auris* to another healthcare facility, notify the receiving facility of the resident's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    c. Flag the resident's medical record to alert healthcare personnel of the resident's *C. auris* status/history and to implement recommended infection control measures in case of readmission.

Case Patient No Longer Admitted to the Facility

1. Flag the resident's medical record to alert healthcare personnel of the resident's *C. auris* status/history and to instruct providers to implement Enhanced Barrier Precautions or Contact Precautions (if indicated) immediately upon readmission.
2. Track the resident's prior room assignments and ensure thorough cleaning and disinfection occurs in those rooms and in other areas where the resident received care (e.g., physical therapy) utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
3. Perform thorough cleaning and disinfection of shared equipment and devices on units where the resident was previously admitted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.

Candida (Candidozyma) auris Infection Prevention & Control Recommendations for Other Post-Acute Care Settings

The following infection prevention and control recommendations and considerations should be provided to other post-acute long-term care settings (e.g., assisted living facilities) upon identification of a confirmed *Candida (Candidozyma) auris* (*C. auris*) case. These recommendations are **not** intended for nursing homes; refer to NJDOH's *Candida (Candidozyma) auris* Infection Prevention & Control Recommendations for Nursing Homes document. Recommendations are the same regardless of case subtype (i.e., clinical case vs. screening case). Please note that while the Centers for Disease Control and Prevention (CDC) currently only recommends the use of Enhanced Barrier Precautions in nursing homes, NJDOH recommends that other post-acute long-term care facilities, such as assisted living facilities, consider adapting the use of Enhanced Barrier Precautions for residents with a known history of *C. auris* and/or completing an Infection Control Risk Assessment to determine what (if any) additional infection control measures are appropriate for case patients within this particular setting.

Case Patient Still Admitted to the Facility

1. Transmission-Based Precautions
    a. Utilize gowns and gloves when providing care to this resident or entering their living space to provide high-contact resident care activities (e.g., changing linens, assisting with toileting).
    b. Consider implementing and maintaining Enhanced Barrier Precautions for residents with *C. auris* colonization or infection that do not otherwise require Contact Precautions.
2. Cleaning and disinfectant product(s) use
    a. Ensure daily and terminal environmental cleaning and disinfection is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Perform thorough daily and terminal cleaning and disinfection of the resident's room(s) and other areas where they receive care (e.g., physical therapy).
        ii. Track the resident's prior room assignments and ensure thorough cleaning and disinfection with an effective product occurs in those rooms and in common areas of the unit.
    b. Ensure routine cleaning and disinfection of patient care equipment, devices, supply carts and workstations on wheels is conducted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Reinforce cleaning and disinfection of mobile equipment and devices that are shared between patients (e.g., glucometers, temperature probes, blood pressure cuffs, ultrasound machines, nursing carts, wound scissors, physical therapy equipment) after each and every use.
    c. Review and re-educate staff on the appropriate contact time and dilution instructions (if applicable).
3. Equipment provision and storage of supplies
    a. Provide the resident with as much dedicated and/or disposable equipment as possible.
    b. Store dedicated wound care supplies in the resident's room if/when possible. Dispose of any unused wound care supplies dedicated to this resident after the conclusion of their stay at your facility.
4. Minimizing foot traffic
    a. To the extent possible, have staff entering multiple rooms ('rounding') enter the room of the *C. auris*+ resident last.

5. Hand hygiene
    a. Increase emphasis on hand hygiene. Alcohol-based hand sanitizer (ABHS) is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled.
    b. Increase hand hygiene audits on units where residents with *C. auris* are placed. Consider re-educating healthcare personnel on hand hygiene through an in-service or retraining, especially if audits demonstrate low adherence to recommended hand hygiene practices.
6. Communication
    a. When transferring a resident with *C. auris* to another service/department/unit/building within the same facility, notify the receiving service/department/unit/building of the resident's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    b. When transferring a resident with *C. auris* to another healthcare facility, notify the receiving facility of the resident's *C. auris* status, the necessary Transmission-Based Precautions, and the appropriate disinfectant product(s) to utilize.
    c. Flag the resident's medical record to alert healthcare personnel of the patient's *C. auris* status/history and to implement recommended infection control measures in case of readmission.

Case Patient No Longer Admitted to the Facility

1. Flag the resident's medical record to alert healthcare personnel of the resident's *C. auris* status/history and to instruct providers to implement Enhanced Barrier Precautions immediately upon readmission or to utilize gowns and gloves during provision of care.
2. Track the resident's prior room assignments and ensure thorough cleaning and disinfection occurs in those rooms and in other areas where the resident received care (e.g., physical therapy) utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
3. Perform thorough cleaning and disinfection of shared equipment and devices on units where the resident was previously admitted utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.

Candida (Candidozyma) auris Infection Prevention & Control Recommendations for Outpatient Settings

The following infection prevention and control recommendations should be provided to outpatient settings (e.g., primary care provider offices, urology clinics, podiatry clinics, urgent care centers) upon identification of a confirmed *Candida (Candidozyma) auris* (*C. auris*) case. These recommendations are **not** intended for outpatient dialysis settings; refer to NJDOH's Recommendations for Providing Safe Dialysis Care for Patients with *Candida auris*. Recommendations are the same regardless of case subtype (i.e., clinical case vs. screening case).

Case Patient Previously or Currently Being Seen at the Facility

1. Communication and Education
    a. If/when the patient returns to the facility for care, inform and educate healthcare personnel about the presence of a patient with *C. auris* and the necessary infection control measures (outlined below).
    b. Flag the patient's medical record to alert healthcare personnel of the patient's *C. auris* status/history and to prompt staff to implement recommended infection control measures during all future renderings of care.
    c. If the patient needs to be admitted or referred to another facility, inform the receiving facility of the patient's *C. auris* status.
2. Personal Protective Equipment (PPE)
    a. Utilize gowns and gloves when providing care to the patient and when contact with the patient is anticipated.
    b. Remove gowns and gloves, carefully dispose of soiled PPE and perform hand hygiene when leaving the patient's room.
    c. Re-educate and reinforce proper PPE donning and doffing techniques among healthcare personnel.
3. Cleaning and Disinfection
    a. Thoroughly clean and disinfect the areas in the facility the patient came into contact with (e.g., chairs, exam tables) utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
    b. Thoroughly clean and disinfect reusable patient care equipment and devices (e.g., blood pressure cuffs, bladder scanners, imaging machines) used in the care of the case patient utilizing a product effective against *C. auris* from EPA List P. If a List P disinfectant is not available, utilize a product from EPA List K.
        i. Reinforce cleaning and disinfection of reusable equipment and devices that are shared between patients (e.g., glucometers, temperature probes, wound scissors) after each and every use.
    c. Review and re-educate staff on the appropriate contact time and, if applicable, dilution instructions.
4. Hand Hygiene
    a. Increase emphasis on hand hygiene. Alcohol-based hand sanitizer (ABHS) is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled.
    b. Reinforce hand hygiene in between each and every glove change.

Email Template: Notification to a Healthcare Facility Regarding Initiation of a *Candida (Candidozyma) auris* Outbreak Investigation

Subject: Public Health Outbreak Investigation – *Candida auris* at [Facility Name]

Dear [Name of Facility Administrator and Infection Preventionist],

The [LHD] has been notified of a cluster of [Number] cases of *Candida (Candidozyma) auris (C. auris)* among [patients/residents] that received care at [Facility Name] in the [Unit Name/Specific Area] between [Date Range]. Based on preliminary information, these cases meet the criteria for a potential healthcare-associated outbreak. Our health department is working closely with NJDOH to initiate an outbreak investigation. We will be in contact in the next several days to obtain any necessary case patient information, coordinate colonization screenings on the impacted unit, and assess infection prevention and control practices.

In the meantime, please review the attached documents, which detail the process for conducting *C. auris* colonization screenings and the appropriate infection prevention and control precautions to implement and maintain for individuals with *C. auris*.

We appreciate your cooperation and look forward to working with you and your staff to ensure the safety and well-being of your [patients/residents]. If you have any questions, please contact [Name and Contact Details for LHD]. Thank you for your time and attention to this matter.

Sincerely,

[LHD POC name and contact details]

Candida (Candidozyma) auris Reporting Frequently Asked Questions (FAQs)

What is *Candida (Candidozyma) auris*?

- *Candida (Candidozyma) auris* (*C. auris*) is a fungal pathogen that has natural drug resistance and can be resistant to all three available classes of antifungals. *C. auris*:
  - can colonize medically vulnerable individuals without causing signs or symptoms of illness;
  - can cause serious, hard-to-treat infections, with mortality rates of up to 70%[2];
  - can persist in the healthcare environment for weeks, where it can easily spread through direct and indirect contact with patients infected or colonized with *C. auris* or contaminated environmental surfaces and equipment; and
  - can cause large outbreaks in healthcare facilities.[3]

Who will report *C. auris?*

- Healthcare professionals must report *C. auris* screening (i.e., colonization) cases and clinical cases within one business day of identification.
  - Healthcare professionals should report cases through the Communicable Disease Reporting and Surveillance System (CDRSS) and can use the *C. auris* epidemiologic assessment form[4] to report additional facility and epidemiological information for a case.
- Laboratories must report *C. auris* screening and clinical cases within one business day of identification via the CDRSS[1] Electronic Laboratory Reporting System.

What is reportable?

- Per the updated case definition,[5] healthcare providers and laboratories shall report the following results:
  - Detection of *C. auris* (no other *Candida* species) in a specimen using either culture or a validated culture-independent test (e.g., nucleic acid amplification test [NAAT])
- Positive results corresponding to an out-of-state resident that had a positive specimen collected in New Jersey shall be reported to NJDOH.

What are the isolate submission requirements?

- Laboratories must submit clinical *C. auris* isolates from sterile site specimens (e.g., blood) and other non-sterile sites (e.g., urine, sputum) to one of the following public health laboratories within 3 business days:
  - the Northeast Regional Antimicrobial Resistance Laboratory[6] at Wadsworth Center in New York (preferred), or
  - New Jersey Public Health and Environmental Laboratory (NJPHEL)
- Positive skin swabs collected for the purposes of colonization screening should NOT be submitted to a public health lab.
- Submitting laboratories should establish processes to identify duplicate isolates collected from the same patient and source within 12 months to prevent submission of duplicate isolates.
  - To help prevent submission of duplicate isolates, labs may contact NJDOH at DOH.CDS.HAIAR.EPI@doh.nj.gov to confirm if an isolate should be submitted.
- Laboratories can batch isolate submissions as long as specimens are submitted within 3 business days of identification.

What test methods are best for identifying *C. auris*?

- *C. auris* can be misidentified by some yeast identification methods. The Centers for Disease Control and Prevention (CDC) provide guidance for when to suspect *C. auris.*[7]
- For surveillance (screening) purposes, NAAT methods such as polymerase chain reaction (PCR) produce more timely and actionable results than culture-based test methods.
- NJDOH encourages all clinical laboratories to develop *C. auris* clinical and screening testing in-house, or access testing at a reference laboratory.

Where can I find additional resources?

- See the NJDOH website on *C. auris* for Public Health and Healthcare Professionals (https://www.nj.gov/health/cd/topics/cauris.shtml).

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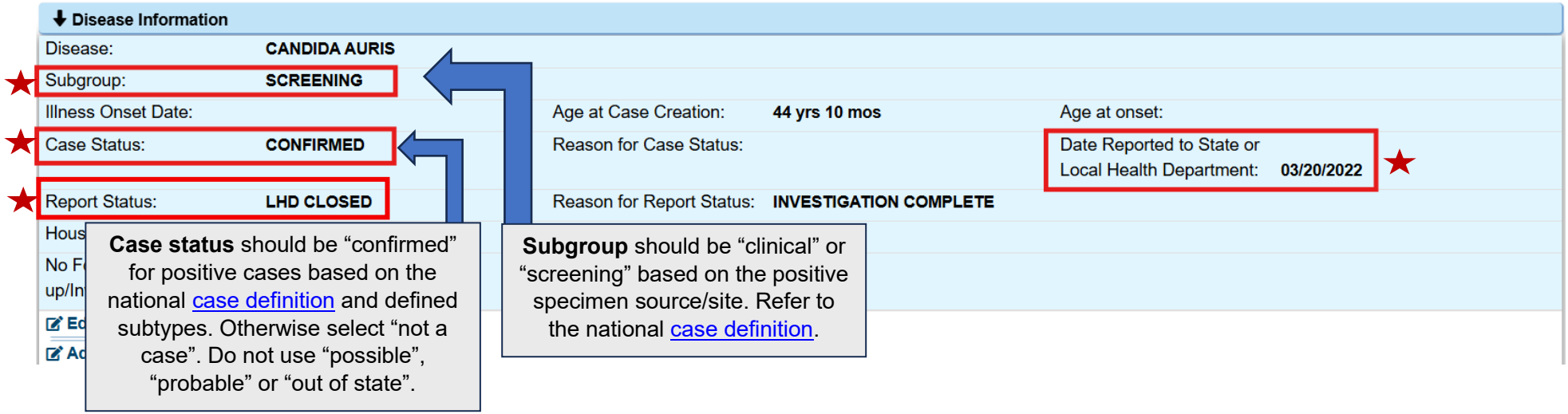
[1] NJDOH Communicable Disease Reporting Requirements (https://www.nj.gov/health/cd/reporting/)
[2] Cortegiani A, Misseri G, Fasciana T, Giammanco A, Giarratano A, Chowdhary A. Epidemiology, clinical characteristics, resistance, and treatment of infections by *Candida auris*. J Intensive Care. 2018;6:69. doi:10.1186/s40560-018-0342-4
[3] Karmarkar EN, O'Donnell K, Prestel C, et al. Rapid assessment and containment of *Candida auris* transmission in postacute care settings–Orange County, California, 2019. *Ann Intern Med*. 2021;174(11):1554-1562. doi:10.7326/M21-2013
[4] NJDOH *Candida auris* Epidemiological Assessment (https://www.nj.gov/health/cd/documents/topics/hai/Cauris_epidemiological_assessment_March2025.pdf)
[5] Council of State and Territorial Epidemiologists *C. auris* Position Statement (PDF) (cdn.ymaws.com/www.cste.org/resource/resmgr/ps/ps2022/22-ID-05_C_auris.pdf)
[6] CDC Antimicrobial Resistance Laboratory (AR Lab) Network (www.cdc.gov/drugresistance/ar-lab-networks/domestic.html)
[7] CDC Identification of *C. auris* (www.cdc.gov/fungal/candida-auris/recommendations.html#suspect)

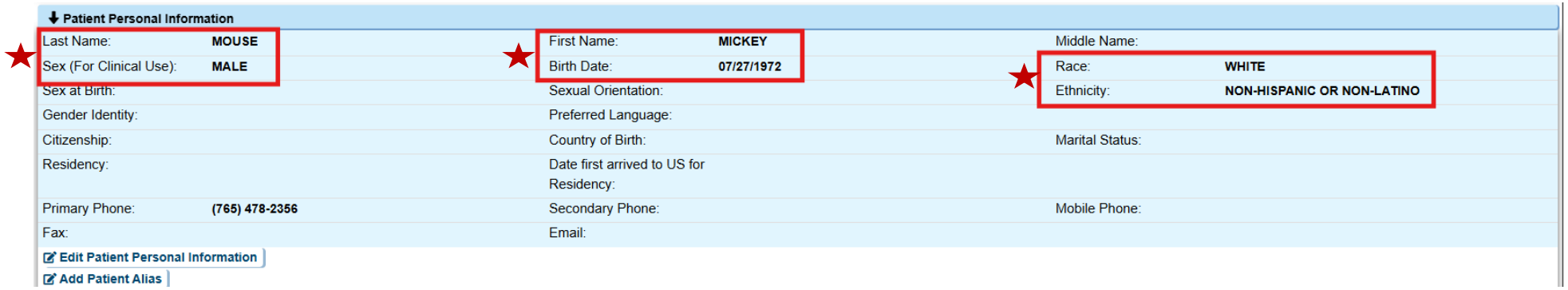
CDRSS Data Field Completion Guide for *Candida* (*Candidozyma*) *auris*

Local health departments (LHDs) should verify that all obtained data is entered into CDRSS prior to changing the report status to 'LHD closed'. Below is an example of a completed case investigation entered into CDRSS. The fields highlighted by **red boxes** are mandatory. The fields highlighted by **red stars** are to be completed by the LHD with jurisdiction over the patient's primary address, or the LHD with jurisdiction over the identifying healthcare facility if the patient is not a resident of NJ.

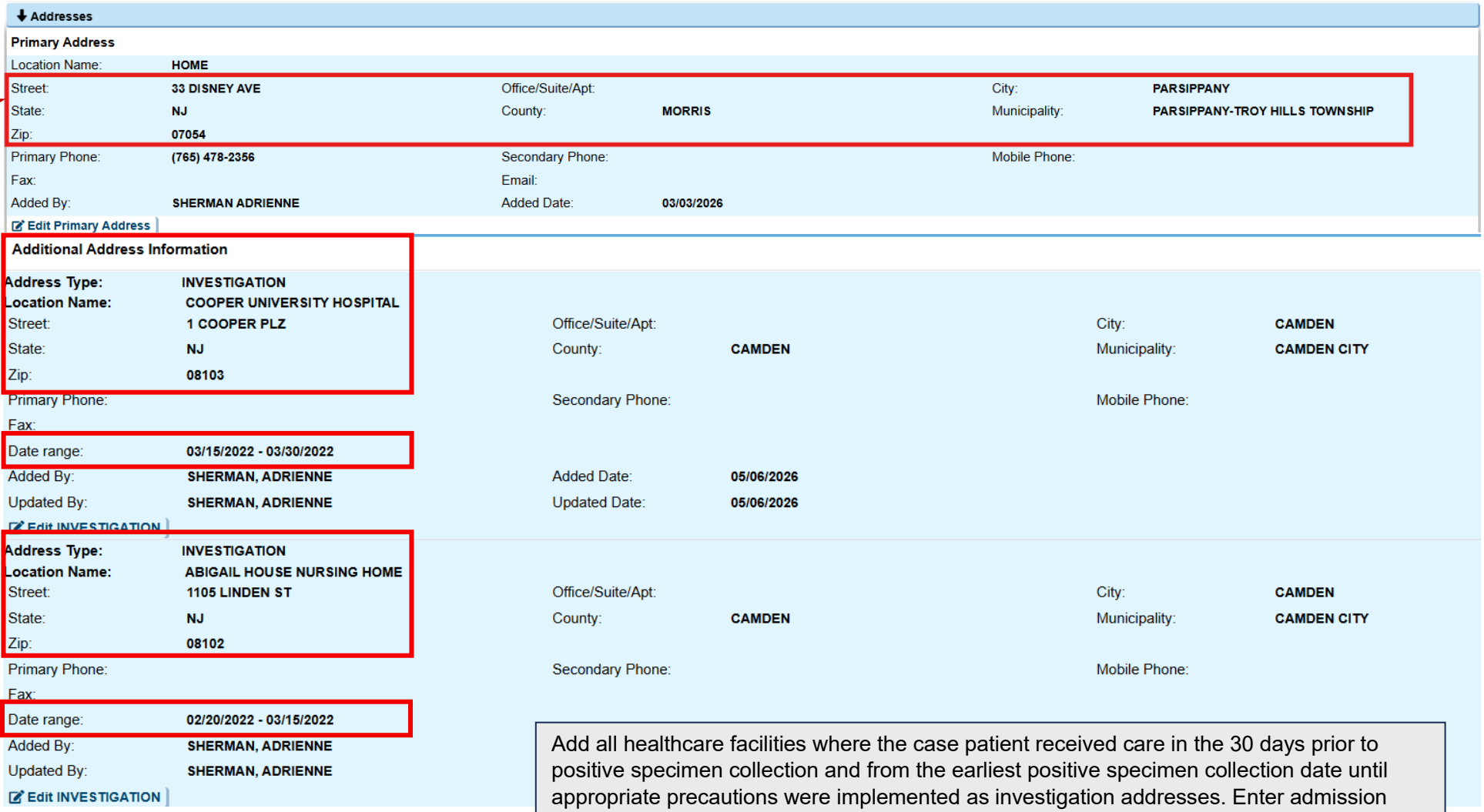
Disease Information



Patient Personal Information



Addresses



Add all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection and from the earliest positive specimen collection date until appropriate precautions were implemented as investigation addresses. Enter admission dates for each facility in the date range fields.

Address Type:	INVESTIGATION				
Location Name:	JEFFERSON CHERRY HILL				
Street:	2201 CHAPEL AVE W	Office/Suite/Apt:		City:	CHERRY HILL
State:	NJ	County:	CAMDEN	Municipality:	CHERRY HILL TOWNSHIP
Zip:	08002				
Primary Phone:		Secondary Phone:		Mobile Phone:	
Fax:					
Date range:	02/19/2022 - 02/20/2022				
Added By:	SHERMAN, ADRIENNE	Added Date:	05/06/2026		
Updated By:	SHERMAN, ADRIENNE	Updated Date:	05/07/2026		

Edit INVESTIGATION

Address Type:	INVESTIGATION				
Location Name:	CEDAR GROVE RESPIRATORY AND NURSING				
Street:	1420 S BLACK HORSE PIKE	Office/Suite/Apt:		City:	WILLIAMSTOWN
State:	NJ	County:	GLOUCESTER	Municipality:	MONROE TOWNSHIP
Zip:	08094				
Primary Phone:		Secondary Phone:		Mobile Phone:	
Fax:					
Date range:	01/01/2022 - 02/19/2022				
Added By:	SHERMAN, ADRIENNE	Added Date:	05/07/2026		
Updated By:	SHERMAN, ADRIENNE	Updated Date:	05/07/2026		

Edit INVESTIGATION

Laboratory and Diagnostic Test Information

Laboratory and Diagnostic Test Information

Laboratory Information

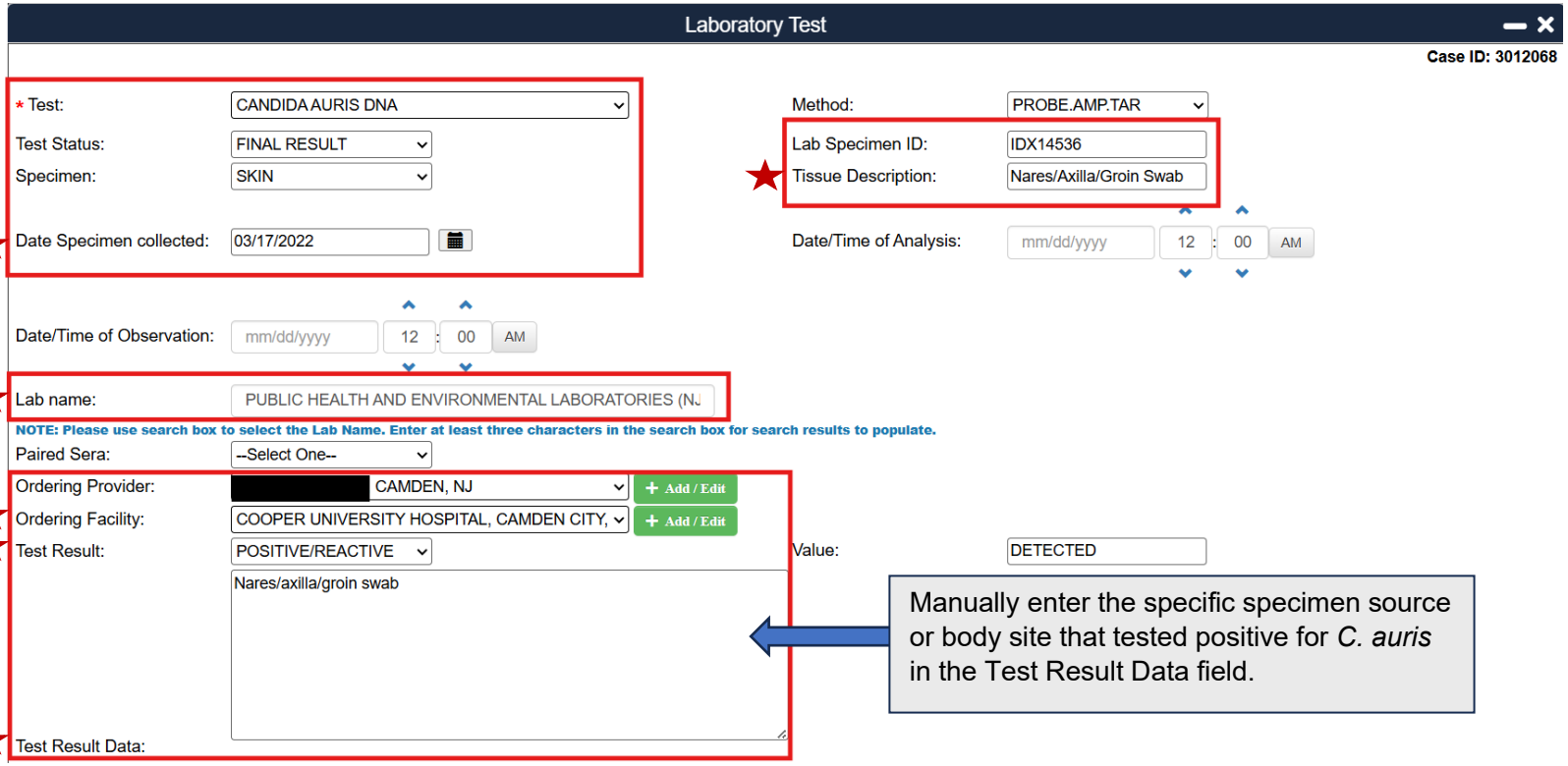
Test	Specimen	Lab Name	Lab Specimen ID	Date Specimen Collected	Value	Report Units	Result	Delete
CANDIDA AURIS DNA	SKIN	PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES (NJPHEL)	IDX14536	03/17/2022	DETECTED			

Add Laboratory Test

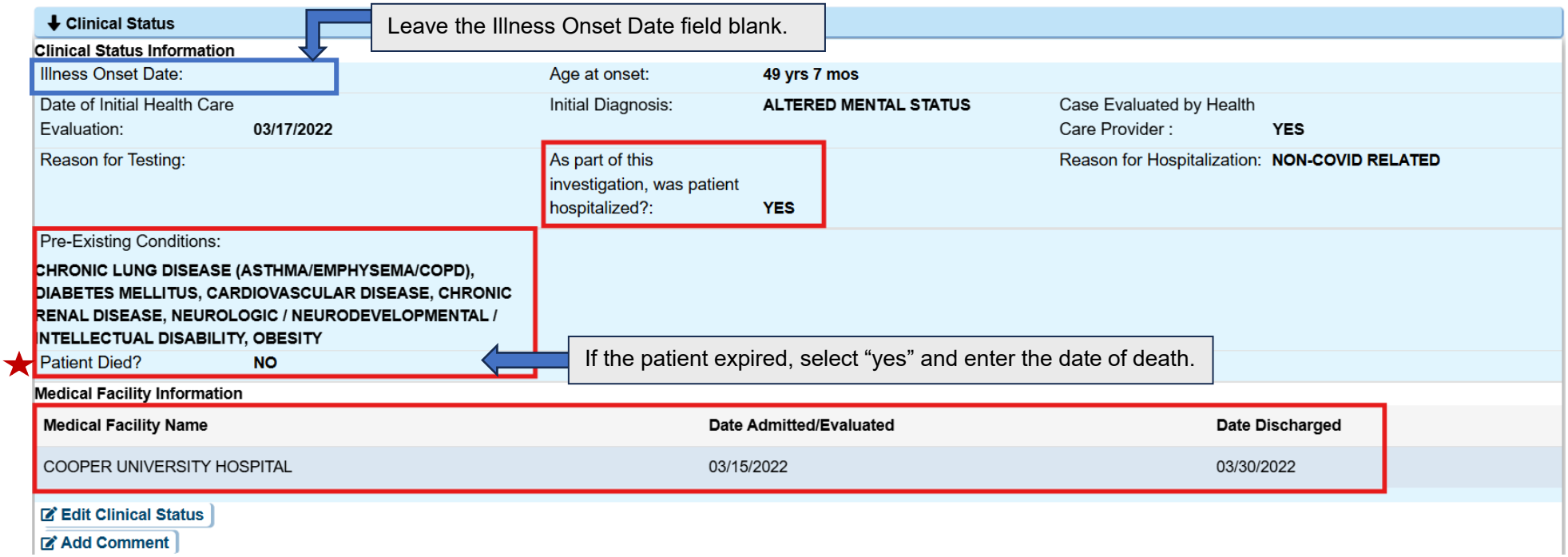
Lab Test History

If positive laboratory results are not already in CDRSS, add a laboratory test for each positive specimen corresponding to the case patient.

Click on the test name shown in blue to open the laboratory test information section.

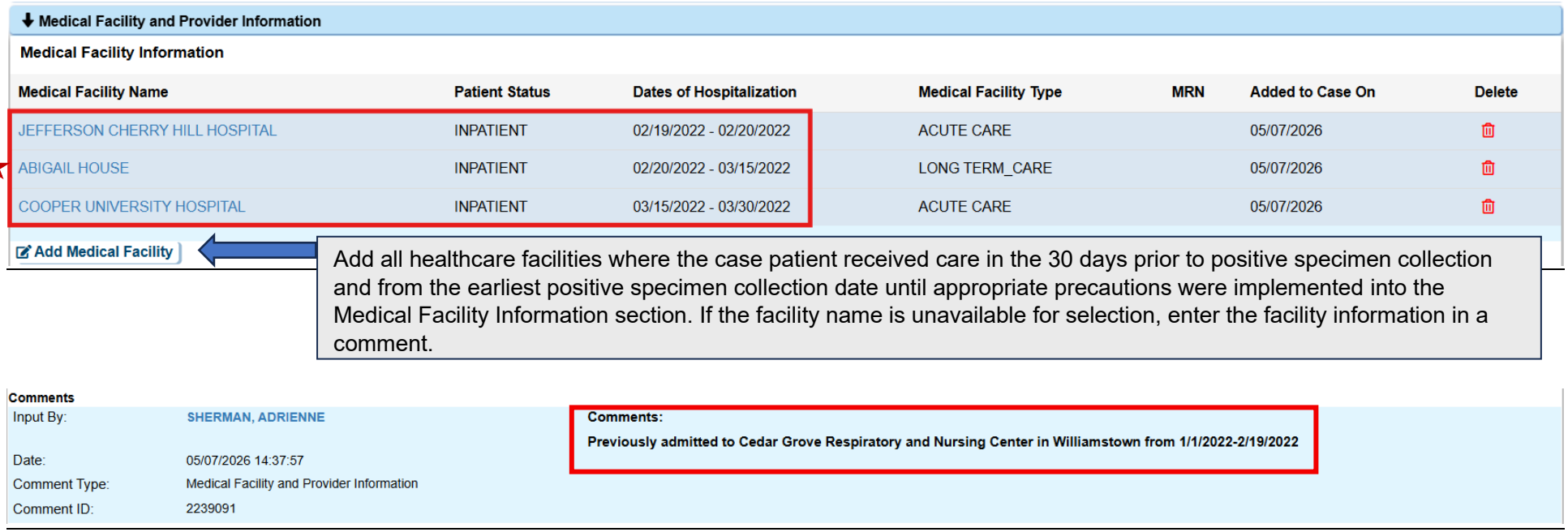

Laboratory Test
Case ID: 3012068
* Test:
CANDIDA AURIS DNA
Test Status:
FINAL RESULT
Specimen:
SKIN
Date Specimen collected:
03/17/2022
Method:
PROBE.AMP.TAR
Lab Specimen ID:
IDX14536
Tissue Description:
Nares/Axilla/Groin Swab
Date/Time of Analysis:
mm/dd/yyyy
12
00
AM
Date/Time of Observation:
mm/dd/yyyy
12
00
AM
Lab name:
PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES (NJ
NOTE: Please use search box to select the Lab Name. Enter at least three characters in the search box for search results to populate.
Paired Sera:
--Select One--
Ordering Provider:
[redacted]
CAMDEN, NJ
+ Add / Edit
Ordering Facility:
COOPER UNIVERSITY HOSPITAL, CAMDEN CITY,
+ Add / Edit
Test Result:
POSITIVE/REACTIVE
Value:
DETECTED
Nares/axilla/groin swab
Test Result Data:
Manually enter the specific specimen source or body site that tested positive for C. auris in the Test Result Data field.

Clinical Status



The “Pre-Existing Conditions” field within the Clinical Status section is intended to combine and document all information on a patient’s pre-existing conditions provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection. Some healthcare facilities may have more detailed information on a patient’s history of pre-existing conditions, while other healthcare facilities may have incomplete or conflicting information on pre-existing conditions. For this reason, once a pre-existing condition is indicated to be present, that pre-existing condition should not be changed based on information gathered from additional healthcare facilities. Only pre-existing conditions not already selected from the drop-down menu should be changed (i.e., added) based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

Medical Facility



Risk Factors

The risk factor section is intended to combine and document all information on a patient's risk factors provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection. Some healthcare facilities may have more detailed information on a patient's history of indwelling medical devices and other risk factors, while other healthcare facilities may have incomplete or conflicting information on risk factors. For this reason, once a risk factor is indicated to be present (i.e., answered with "Yes"), that answer should not be changed based on information gathered from additional healthcare facilities. **Only risk factors answered with "No" or "Not Asked" should be changed** based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

Risk Factor	Response	Attribute
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A TRACHEOSTOMY?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A SURGICAL DRAIN?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A CENTRAL VENOUS CATHETER?	YES	Central line
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE MECHANICAL VENTILATION?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, WAS THE PATIENT NON-AMBULATORY?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE CHRONIC WOUNDS?	YES	
DOES THE PATIENT HAVE A HISTORY OF COLONIZATION OR INFECTION WITH A CARBAPENEMASE-PRODUCING ORGANISM(S) OR OTHER MDRO(S)?	YES	Acinetobacter baumannii
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN INDWELLING URINARY CATHETER?	YES	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT STAY OVERNIGHT IN A HEALTHCARE FACILITY LOCATED IN A DIFFERENT STATE?	YES	Prior stay at Thomas Jefferson Center City
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A HEMODIALYSIS CATHETER?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A NEPHROSTOMY?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN ABDOMINAL FEEDING TUBE?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN IMMUNOCOMPROMISING CONDITION?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN INTRAABDOMINAL DRAIN/CATHETER?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE ANOTHER INDWELLING MEDICAL DEVICE?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE ANOTHER INTRAVENOUS LINE (E.G., MIDLINE)?	NO	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT RECEIVE AN ORGAN OR TISSUE TRANSPLANT?	NO	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT STAY OVERNIGHT IN A HEALTHCARE FACILITY LOCATED IN A DIFFERENT COUNTRY?	NO	
IS THE PATIENT DIABETIC?	NO	

Add/Edit Risk Factors

Add Comment

All risk factor fields are required to be completed.

Additional Requirements: *Candida auris* – Disease Specific Questionnaire (DSQ)

The Disease Specific Questionnaire section is intended to combine and document a case patient's healthcare facility admission and visit information provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by the local health department with jurisdiction over the case patient's primary address (questions marked with **red stars**) and each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection (all remaining questions).

Please note: All fields in the DSQ are required to be completed. Due to the length of the DSQ, it is highly recommended that CDRSS users frequently save progress while entering DSQ data to prevent the loss of data if CDRSS times out during data entry.

This section asks about the facility/facilities that identified and reported the *C. auris* case.

↓ ADDITIONAL REQUIREMENTS: CANDIDA AURIS	
NJDOH ASSIGNED CANDIDA AURIS CASE ID (FOR NJDOH USE ONLY)	
★ NAME OF REPORTING FACILITY	**Cooper University Hospital**
★ SELECT THE LOCATION TYPE OF THE REPORTING FACILITY	**Acute Care Hospital**
★ NAME OF FACILITY WHERE IDENTIFYING SPECIMEN WAS COLLECTED (IF DIFFERENT FROM REPORTING FACILITY)	**N/A**
★ SELECT THE LOCATION TYPE WHERE THE SPECIMEN WAS COLLECTED (IF DIFFERENT FROM REPORTING FACILITY)	**Not Applicable**

This section asks about the reason for *C. auris* testing and the patient's prior history of *C. auris*.

★ INDICATE THE REASON FOR SPECIMEN COLLECTION	**Point Prevalence Screening (PPS)**
WAS THE PATIENT PREVIOUSLY IDENTIFIED AS A COLONIZATION/SCREENING CASE FOR THIS ORGANISM?	**No**
WAS THE PATIENT PREVIOUSLY IDENTIFIED AS A CLINICAL CASE FOR THIS ORGANISM?	**No**

This section asks about the patient's dates of admission at the identifying/reporting facility, their location prior to admission and their discharge disposition.

WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Skilled Nursing Facility (Non-Vent)**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Abigail House, Camden**
IS THE PATIENT STILL CURRENTLY ADMITTED TO THIS FACILITY?	**No**
DATE OF DISCHARGE OR EXPIRATION	**03/30/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Long-Term Acute Care**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Select Specialty Hospital Willingboro**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at the identifying/reporting facility.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION?	**Droplet Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**03/15/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/20/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**03/18/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/30/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at the identifying/reporting facility and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**Yes**
ARE ANY OF THE FOLLOWING EPIDEMIOLOGIC LINKS PRESENT FOR ANY KNOWN C. AURIS CASE PATIENT(S) AND THE NEW C. AURIS CASE PATIENT?	**Admission to a common unit**
IF "OTHER" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY OTHER EPIDEMIOLOGIC LINK(S)	**N/A**
IF "ADMISSION TO A COMMON UNIT" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY THE UNIT(S) OF COMMON ADMISSION	**Neuro ICU**

This section asks about the healthcare services the patient received at the identifying/reporting facility in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT THE IDENTIFYING FACILITY?	**Imaging,Wound Care,Other**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**Interventional Radiology**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #1), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS ADMITTED IMMEDIATELY PRIOR TO THE IDENTIFYING HEALTHCARE FACILITY (I.E., "PRIOR FACILITY #1")?	**Abigail House**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #1"?	**Skilled Nursing Facility (Non-Vent)**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #1"?	**02/20/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Acute Care Hospital**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Jefferson Cherry Hill**
IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #1"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #1"?	**03/15/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Acute Care Hospital**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Cooper University Hospital, Camden**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #1.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #1"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #1"?	**Enhanced Barrier Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**02/20/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/15/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #1 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #1" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**No**

This section asks about the healthcare services the patient received at Prior Facility #1 in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #1"?	**Rehabilitation or Physical Therapy**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**N/A**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #2), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS PREVIOUSLY ADMITTED (I.E., "PRIOR FACILITY #2")?	**Jefferson Cherry Hill**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #2"?	**Acute Care Hospital**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #2"?	**02/19/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Ventilator Skilled Nursing Facility**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Cedar Grove Respiratory, Williamstown**
IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #2"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #2"?	**02/20/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Skilled Nursing Facility (Non-Vent)**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Abigail House, Camden**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #2.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #2"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #2"?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**02/19/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**02/20/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #2 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #2" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**No**

This section asks about the healthcare services the patient received at Prior Facility #2 in the 30 days prior to positive specimen

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #2"?	**Wound Care,Respiratory Therapy,Ultrasound**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**N/A**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #3), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS PREVIOUSLY ADMITTED (I.E., "PRIOR FACILITY #3")?	**Cedar Grove Respiratory, Williamstown**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #3"?	**Ventilator Skilled Nursing Facility**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #3"?	**01/01/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Acute Care Hospital**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Thomas Jefferson Center City**

IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #3"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #3"?	**02/19/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Acute Care Hospital**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Jefferson Cherry Hill**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #3.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**01/01/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**01/09/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Enhanced Barrier Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**01/09/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**02/19/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #3 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #3" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**Yes**
ARE ANY OF THE FOLLOWING EPIDEMIOLOGIC LINKS PRESENT FOR ANY KNOWN C. AURIS CASE PATIENT(S) AND THE NEW C. AURIS CASE PATIENT?	**Admission to a common unit,Shared staff,Other**

IF "OTHER" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY OTHER EPIDEMIOLOGIC LINK(S)	**Shared room**
IF "ADMISSION TO A COMMON UNIT" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY THE UNIT(S) OF COMMON ADMISSION	**Vent unit**

This section asks about the healthcare services the patient received at Prior Facility #3 in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #3"?	**Respiratory Therapy,Wound Care,Other**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**Podiatry**

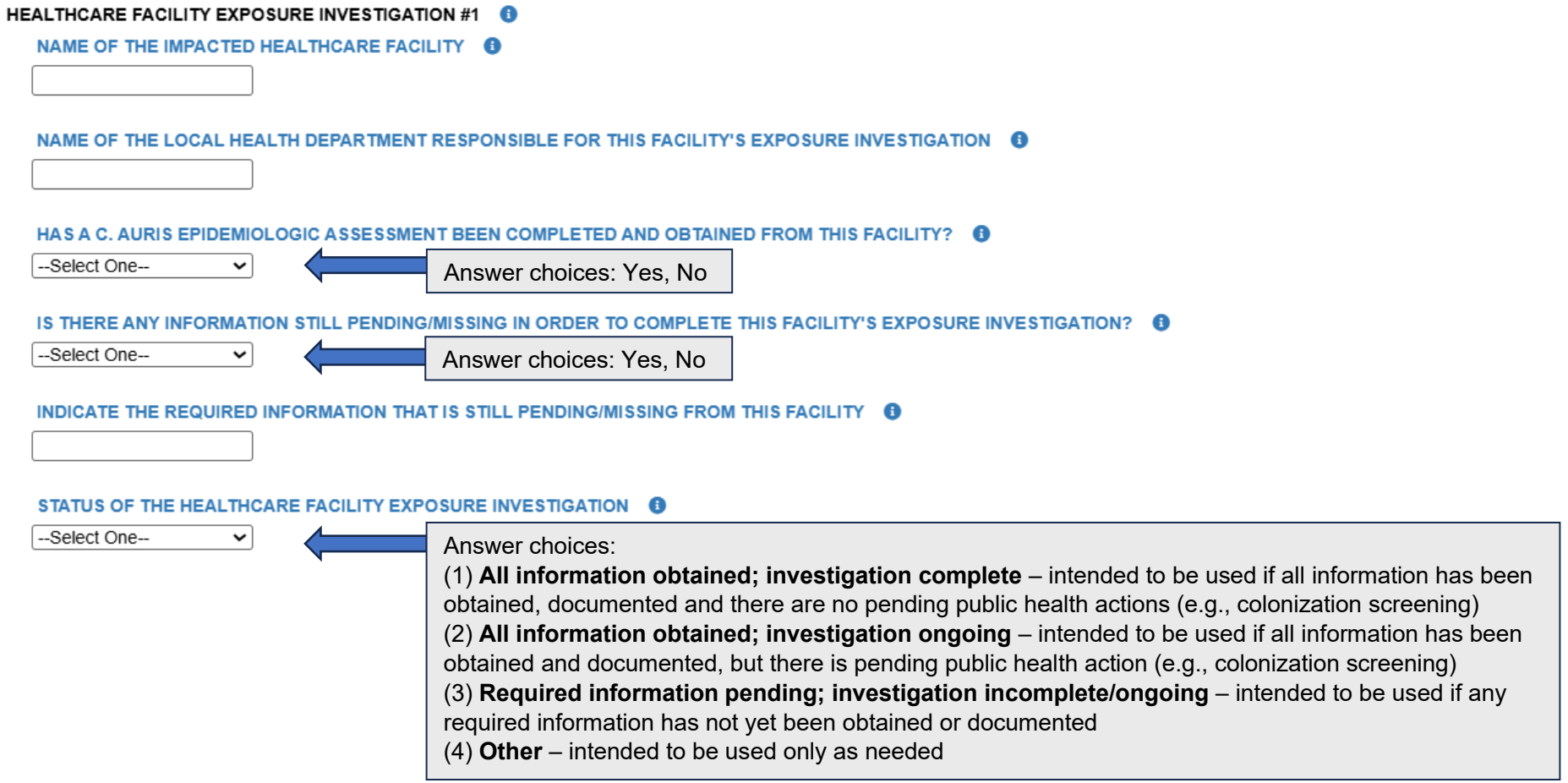
This section asks about visits to outpatient facilities and outpatient healthcare services the patient received in the 30 days prior to positive specimen collection.

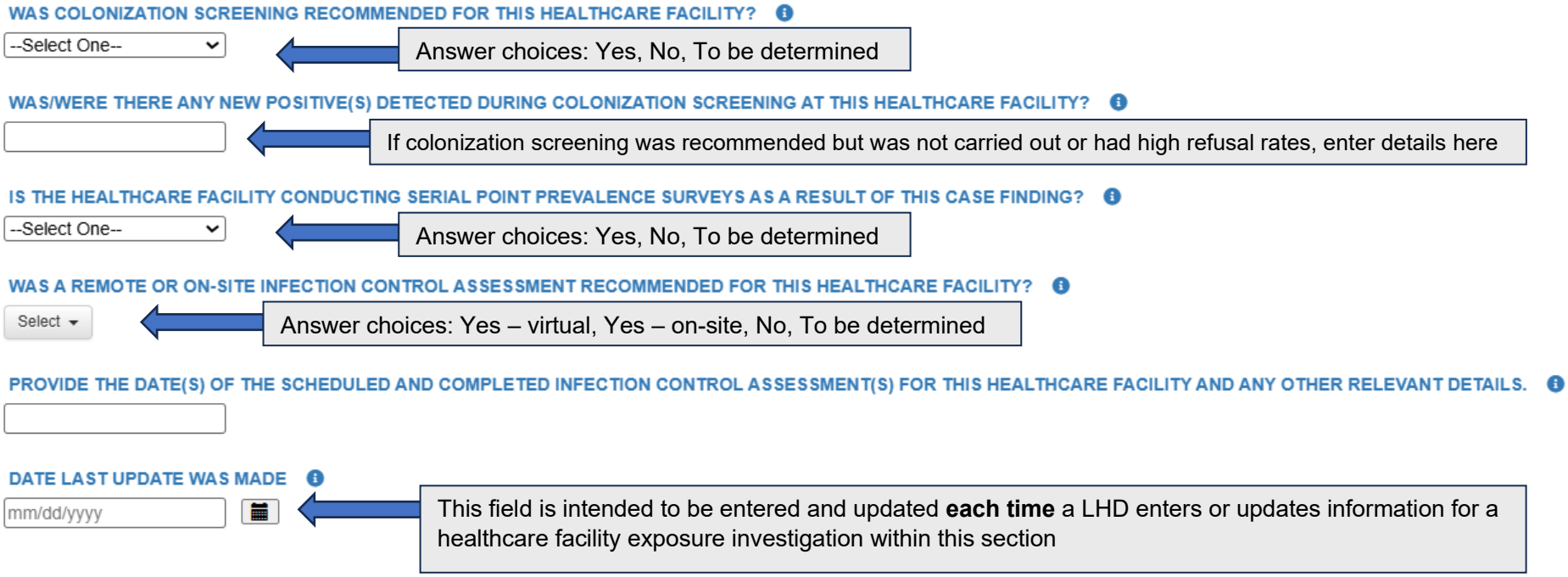
★ DID THIS PATIENT RECEIVE CARE AT ANY OUTPATIENT HEALTHCARE FACILITIES IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ SPECIFY THE NAME(S) AND LOCATION(S) OF THE OUTPATIENT FACILITY/FACILITIES WHERE THE PATIENT RECEIVED CARE IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION	**Summit Health Urology Voorhees**

Please utilize the comments section within CDRSS to document any additional information, such as admissions to additional healthcare facilities in the 30 days prior to positive specimen collection or subsequent admissions to healthcare facilities where the patient's *C. auris* status was not known or appropriate precautions were not implemented.

Facility Exposure Investigation Status and Updates

The Facility Exposure Investigation Status and Updates section is intended to track and monitor the status of each healthcare facility investigation stemming from the identification of the case. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that requires a healthcare facility exposure investigation (i.e., healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection and from the earliest positive specimen collection date until appropriate precautions were implemented). This section includes a series of 12 questions that repeat a total of five times to enable documentation of up to five different healthcare facility exposure investigations for a given case patient. Completion of this section by all involved LHDs helps to indicate whether the LHD leading the case investigation can close out the case or if the case must remain open until all facility investigations have been completed and documented appropriately.




WAS COLONIZATION SCREENING RECOMMENDED FOR THIS HEALTHCARE FACILITY?
--Select One--
Answer choices: Yes, No, To be determined
WAS/WERE THERE ANY NEW POSITIVE(S) DETECTED DURING COLONIZATION SCREENING AT THIS HEALTHCARE FACILITY?
If colonization screening was recommended but was not carried out or had high refusal rates, enter details here
IS THE HEALTHCARE FACILITY CONDUCTING SERIAL POINT PREVALENCE SURVEYS AS A RESULT OF THIS CASE FINDING?
--Select One--
Answer choices: Yes, No, To be determined
WAS A REMOTE OR ON-SITE INFECTION CONTROL ASSESSMENT RECOMMENDED FOR THIS HEALTHCARE FACILITY?
Select
Answer choices: Yes – virtual, Yes – on-site, No, To be determined
PROVIDE THE DATE(S) OF THE SCHEDULED AND COMPLETED INFECTION CONTROL ASSESSMENT(S) FOR THIS HEALTHCARE FACILITY AND ANY OTHER RELEVANT DETAILS.
DATE LAST UPDATE WAS MADE
mm/dd/yyyy
This field is intended to be entered and updated each time a LHD enters or updates information for a healthcare facility exposure investigation within this section